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STATE OF MAINE
122nd LEGISLATURE
SECOND REGULAR SESSION

Final Report of the HEALTH CARE SYSTEM & HEALTH SECURITY BOARD

January 2006

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Rep. Marilyn E. Canavan, Chair
Sen. Richard W. Rosen
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Table of Contents

Page

Executive Summary i

I. Introduction 1

II. History of the Health Care System and Health Security Board 3

III. Health Security Board's Scope and Focus: Progress Toward Universal Coverage 7

IV. Health Security Board's Findings and Recommendation 8

V. Conclusion 10

Appendices

A. Resolve 2005, chapter 119
B. Preliminary Report, January 15, 2003
C. Mathematica Feasibility Study, December 2002
D. Final Report, November 2004

Executive Summary

This is the final report of the Health Care System and Health Security Board, hereafter referred to as the Health Security Board. The Health Security Board was originally established in Public Law 2001, chapter 439, Part ZZZ and first convened in 2001. The purpose of the Health Security Board was to develop recommendations to provide universal access to health care coverage for all Maine citizens after assessing the feasibility and cost of implementing a single-payer health care system in Maine. The Health Security Board contracted with Mathematica Policy Research, Inc. to conduct the feasibility study, which was completed in December 2002. In January 2003, the Health Security Board submitted a preliminary report asking for more time to fully consider the feasibility study before making recommendations for the adoption of a single-payer health care plan. The Legislature extended the Health Security Board's authority and delayed submission of a final report until November 2004.

However, also during the 2003 legislative session, the Legislature enacted the Dirigo Health reform law (Public Law 2003, chapter 492). Because Dirigo Health was developed to achieve universal coverage over time, the Health Security Board now faced a changing landscape for Maine's health care system. The Health Security Board's primary focus became the consideration of its future role and the role of a single-payer health care plan as Dirigo Health began to implements its comprehensive health care reforms. Given this health care reform initiative and changes in the political landscape, the Health Security Board submitted its final report in November 2004 without making a recommendation on a single-payer health care system. Instead, the Health Security Board recommended the Legislature reestablish the Health Security Board to continue the evaluation and planning for a single-payer health system if Dirigo Health failed to meet its expectations for universal coverage. In response to the Health Security Board's recommendation, the 122nd Legislature reestablished the Health Security Board, but limited the scope of the Health Security Board's authority. The resolve directs the Health Security Board "to finalize its recommendations regarding the feasibility of a single-payer health plan to provide health care coverage to all citizens of this State."

While the enabling legislation states that the Health Security Board's "sole purpose" is to finalize its recommendations regarding the feasibility of a single-payer health plan, the Health Security Board felt it was important to focus as well on whether or not the State's efforts to achieve universal coverage have been successful. An evaluation of both the operation of the Dirigo Health Program and the expansion of MaineCare became key in determining whether the Health Security Board would recommend that Maine pursue and implement a single-payer health care plan as the mechanism to achieve universal coverage. The Health Security Board believes that Maine's policymakers have made a conscious decision to expand access to health care coverage for Maine's uninsured on two fronts---the voluntary DirigoChoice health insurance program and the expansion of the State's MaineCare program. While ongoing funding for each of these programs presents certain challenges, the current administration appears committed to this approach.

The Health Security Board makes the following findings and recommendation.

Universal coverage remains the Health Security Board's highest priority—every man, woman and child living in Maine must have health care coverage.

In its preliminary report, the Health Security Board identified universal coverage as its primary goal and priority. Although the Legislature has directed the Health Security Board to evaluate the single-payer model as the proposed mechanism for providing universal coverage, the Health Security Board can support reforms or policies that will result in health care coverage for all Maine residents, especially those that are currently uninsured. The Health Security Board is not necessarily wedded to a single-payer model, but the Board remains committed to making universal coverage a reality.

While Health Security Board, with the exception of one member, continues to believe that a single-payer health plan seems feasible, the Health Security Board finds that implementation of a single-payer health plan at this time is unlikely.

While, in the Health Security Board's opinion, the Mathematica feasibility study provided an excellent foundation to evaluate the likely impact of a single-payer health care system on health care spending and financing in Maine, the Health Security Board identified certain unanswered questions and unexplored issues related to planning for a single-payer health care plan. The feasibility study provided an initial assessment of how a single-payer system will affect Maine's economy. However, the microsimulation model had limitations that would benefit from additional analysis and refinement. In addition, the model and the feasibility study did not address many practical and policy issues affecting the operation of a single-payer system. Foremost among these issues, it is unclear how a State could implement such a system on its own and still maintain the same level of federal funding for Medicare, MaineCare, military employees and federal employees without approval of a waiver from the federal government. The Health Security Board continues to believe it is critically important to evaluate these issues before a single-payer health care plan can be implemented.

Further, the Health Security Board recognizes that the political and economic reality that a single-payer health care system is not likely to be implemented in Maine in the near future. The current burden on Maine's taxpayers is significant and there are many competing interests for additional funding from the State budget. Although many proposals for change to Maine's health insurance market have been proposed, the Legislature has not pursued significant reform of the way health care is delivered in this State. The Dirigo Health reforms and the MaineCare expansions show promise and are making progress, albeit slowly, toward health care coverage for Maine's uninsured, but will require additional funding to provide coverage for all of the uninsured.

The Health Security Board, with the exception of one member, supports the State's efforts to achieve universal coverage through the operation of the Dirigo Health Program and the expansion of the MaineCare program, but believes the current

timeline toward universal coverage must be accelerated so that all of the uninsured in Maine have coverage by 2009.

The Health Security Board, with the exception of one member, supports the State's efforts to achieve universal coverage through DirigoChoice and expansion of MaineCare. The next year of operation for Dirigo is critical as the savings offset payment is expected to contribute funding for the program to support premium subsidies and expanded enrollment. Originally, the administration projected incremental enrollment in DirigoChoice enrollees with a goal of reaching universal coverage for all uninsured Mainers in 2009. To date, however, enrollment figures have been lower than expected, especially among small businesses. Additional efforts are needed to increase enrollment in DirigoChoice among small businesses, sole proprietors and individuals. Estimates for the uninsured in Maine remain at more than 130,000. The Health Security Board believes that a renewed commitment to universal coverage is needed. The expansion of the MaineCare program has worked in combination with the Dirigo Health Program to increase access to health care. The federal matching funds under this program make it an attractive option for the State if the State can provide its share of the financing. While progress is being made, the State's policymakers should recommit to reaching universal coverage within 5 years---the original goal when the Dirigo Health reforms were passed in 2003---and commit to making the necessary policy decisions to meet this goal by 2009.

The Health Security Board recommends that the State's policymakers and the Legislature consider additional mechanisms to expand access to health care coverage for Maine residents including, but not limited to, expanding eligibility and participation in the DirigoChoice program and exploring regional partnerships to purchase health care coverage.

The Health Security Board believes that more can be done to expand access to affordable health care. The Health Security Board recommends that the State's policymakers explore additional mechanisms to expand access. Some of the policy options that should be strongly considered include expanding participation in the DirigoChoice Program through expanded eligibility or by requiring publicly funded health care plans like the State Employee Health Plan and the health plan for the University of Maine System to join Dirigo, and exploring regional partnerships to purchase health care coverage with other New England states similar to regional efforts relating to prescription drug coverage. Before implementing any of these options, the State should carefully evaluate their feasibility and impact on current collective bargaining arrangements and publicly funded health plans. The State should not be content with the current timeline for reaching universal coverage. Policymakers should consider improvements to DirigoChoice, changes to the health insurance laws and other approaches to expand access to health care.

In conclusion, the Health Security Board strongly believes that it has made a positive contribution to the dialogue among policymakers and others surrounding reform of Maine's health care system. In part, the development of Dirigo Health was based on

information and research from the Health Security Board's preliminary report and feasibility study. Although the current approach to universal health care coverage is not based on a single-payer health plan model, the Health Security Board is hopeful that the ultimate goal---coverage for all Mainers---will be achieved by 2009. If universal coverage is not achieved in 2009, the Health Security Board believes that the implementation of a single-payer health plan must be reconsidered.

I. Introduction

This is the final report of the Health Care System and Health Security Board, hereafter referred to as the Health Security Board. The Health Security Board was established in Public Law 2001, chapter 439, Part ZZZ. The Health Security Board was first convened on October 12, 2001 and met more than 20 times throughout 2002. While the purpose of the Health Security Board was to develop recommendations to provide universal access to health care coverage for all Maine citizens, the Health Security Board was specifically required to assess the feasibility and cost of implementing a single-payer health care system in Maine. Such a system would provide universal health care coverage to every Maine resident through a standard benefit plan administered and paid for by a single payer, the State of Maine. With the assistance of a significant grant from the Maine Health Access Foundation and funding from the Maine State Nurses Association, the Maine Nurse Practitioners Association, the Maine chapter of Certified Nurse Midwives Assocation and the American Association of Registered Nurses in California, New York, Pennsylvania and Massachusetts, the Health Security Board contracted with Mathematica Policy Research, Inc. to conduct the feasibility study. This study was completed in December 2002. The Health Security Board issued its preliminary report on January 15, 2003. In its preliminary report, the Health Security Board recommended to the Legislature that the Health Security Board be given additional time to fully consider the Mathematica feasibility study and develop final recommendations for a single-payer health plan.

During the 2003 legislative session, a law was enacted to extend the Health Security Board's authority and delay submission of a final report. Also during that session, the Legislature enacted the Dirigo Health reform law (Public Law 2003, chapter 492). Because Dirigo Health was developed to achieve universal coverage over time, the Health Security Health Security Board now faced a changing landscape for Maine's health care system. The Health Security Board's primary focus became the consideration of its future role and the role of a single-payer health care plan as Dirigo Health began to implement its comprehensive health care reforms. Given this health care reform initiative and changes in the political landscape, the Health Security Board submitted its final report in November 2004 without making a recommendation on a single-payer health care system. Instead, the Health Security Board recommended the Legislature reestablish the Health Security Board to continue the evaluation and planning for a single-payer health system if Dirigo Health failed to meet its expectations for universal coverage. In response to the Health Security Board's recommendation, the 122nd Legislature reestablished the Health Security Board, but limited the scope of the Health Security Board's authority. Resolve 2005, chapter 119 is included as Appendix A. The resolve directs the Health Security Board "to finalize its recommendations regarding the feasibility of a single-payer health plan to provide health care coverage to all citizens of this State."

The Health Security Board, chaired by Senator John Martin and Representative Marilyn Canavan, is a bipartisan task force with 20 members including representatives of both branches and both parties within the Legislature, the Department of Health and Human Services, the State Employee Health Commission and the State Tax Assessor and representatives of provider organizations, employers, insurers and advocacy groups. Due to resignations, there are currently 4 vacant positions. The members of the Health Security Board and their appointing authorities are as follows:

Members appointed by the President of the Senate:

- **Sen. John L. Martin, Chair**
- **Sen. Richard Rosen,** Senate member
- **Robert Downs,** Representing Statewide Organizations of Health Insurers
- **Tammy Greaton**, Representing Statewide Organization Advocating Universal Health Care
- **Hilary Schneider**, Representing Health Care Economists
- **Marjorie Medd**, Representing Statewide Organizations Defending Rights of Children
- **Vacant position**, Representing Small Hospitals in the State
- **Vacant position**, Representing Statewide Organizations of Physicians

Members appointed by the Speaker of the House:

- **Rep. Marilyn C. Canavan**, Chair
- **Rep. John T. Brautigam,** House Member
- **James Amaral**, Representing the Business Community
- **Vacant position**, Representing Large Hospitals in the State
- **John Moran**, Representing Statewide Senior Citizen's Organizations
- **Frank O'Hara**, Representing Self-employed Persons
- **Patricia Philbrook**, Representing Statewide Organization of Nurses
- **Vacant position**, Representing Statewide Labor Organizations, Maine AFLCIO
- **Paul Volenik,** Representing the public

Appointments required by statute:

- **Frank A. Johnson**, Director, State Office of Employee Health and Benefits
- **Jerome Gerard**, Acting State Tax Assessor
- **Christine Zukas-Lessard**, Deputy Director, Bureau of Medical Services, Designee of the Commissioner of Health and Human Services

The Health Security Board wants to acknowledge the significant contributions of those members who have previously served on the Health Security Board: the Honorable Mary Small, the Honorable Florence Young, Howard Buckley, Beth Kilbreth, Victoria Kuhn, Anthony Neves, Violet Raymond, Leo Siegel and Richard Wexler.

The Health Security Board met three times on October 11, 2005, November 14, 2005 and December 2, 2005. At its meeting on October 11th, the Health Security Board reviewed its history and prior reports, findings and recommendations. The meeting also included a briefing on the status of the Dirigo Health reforms from the Governor's Office of Health Policy and Finance. On November 14th, the Health Security Board heard a presentation comparing the Canadian health care system and the United States system by Dr. Gordon Guyatt, a physician and professor at McMaster University in Ontario, Canada. At that time, the Health Security Board also decided to focus on an analysis of Maine's current efforts to achieve universal coverage before developing any recommendations regarding a single-payer health plan. When the Health Security Board met on December 2nd, they received information on the State's Dirigo Health and MaineCare programs. And the Health Security Board discussed the findings and recommendations to be included in this report.

Resolve 2005, chapter 119 requires that the Health Security Board submit a final report, including any suggested legislation, on or before December 7, 2005 to the Legislature. The resolve also gives authority to the Joint Standing Committee on Insurance and Financial Services to report out a bill based on the Health Security Board's report and recommendations to the Second Regular Session of the 122nd Legislature.

II. History of the Health Care System and Health Security Board

A. Initial Creation

The Health Care System and Health Security Board was created by the Maine Legislature in 2001 to assess the feasibility and cost of implementing a single-payer health care system in Maine. The Legislature opted to study this issue when LD 1277, An Act to Establish a Single-payor Health Care System, which was enacted in the House of Representatives, was not removed from the Special Appropriations Table and died upon adjournment of the First Regular Session of the 120th Legislature. Legislative language to establish the Health Security Board was added to the Part II budget, Public Law 2001, chapter 439, Part ZZZ.

As outlined in the enabling legislation, the purpose of the Health Security Board was "to develop recommendations to provide health care coverage to all citizens of this State through a plan or plans that emphasize 24-hour coverage, quality, cost containment, choice of provider and access to comprehensive, preventive and long-term care." In addition, the Health Security Board was asked to:

- Examine prior studies in Maine and other States;
- Determine the savings that might be realized from a single-payor health care system by hospitals, schools and correctional facilities and other lines of insurance that pay for health care services, including automobile insurance, general liability insurance and workers' compensation insurance;
- Develop a proposal to implement a single-payer plan and make recommendations related to standards for eligibility, covered benefits and health care services, health care delivery throughout the State, provider participation and reimbursement, and the role of federal health care programs and ERISA plans;
- Examine funding for the single-payor plan from a combination of sources, including payments from government sources, including federal, state and other governmental health care and aid programs; payments from workers' compensation, pension and health insurance employee benefit plans; payments from state, county and municipal governmental units for coverage; payments from tobacco settlement funds; and payments from any taxes or fees;
- Conduct a feasibility study of the economic impacts on individuals and businesses of a single-payor plan that guarantees a minimum 5% savings over existing health care costs and the impact of such a plan on the State's economy;
- Stress prevention of disease and maintenance of health in developing proposals to implement the single-payer plan and attempt to retain and strengthen existing health facilities whenever possible in developing those proposals; and
- Examine any other issues or gather information necessary to fulfill its purpose and duties.

B. Preliminary Report

The Health Security Board, chaired by Sen. John Martin and Rep. Paul Volenik, was convened in October 2001 and met more than 20 times throughout 2002. From its inception, the Health Security Board focused it efforts on its mandate to conduct a

feasibility study of the economic impact on individuals and businesses of a single-payer plan that guarantees a minimum 5% savings over existing health care costs and that addresses the potential positive or negative impact of the plan on the State's economy. The Health Security Board raised more than $234,000 to support the costs of the study---primary funding came from a $200,000 grant from the Maine Health Access Foundation and more than $34,000 was raised from contributions from the Maine State Nurses Association, the Maine Nurse Practitioners Association, the Maine chapter of Certified Nurse Midwives Association and the American Association of Registered Nurses chapters in California, New York, Pennsylvania and Massachusetts. The Health Security Board contracted with Mathematica Policy Research, Inc., a national health care consulting firm, to conduct the study and develop a microsimulation model to project the financial and economic impact of a single-payer health care plan designed by the Health Security Board. Mathematica completed the feasibility study in December 2002. The complete feasibility study prepared by Mathematica, including documentation of the microsimulation model, its assumptions and sensitivity analyses, and its results projecting the costs of a single-payer health plan, is included here as Appendix C.

On January 15, 2003, the Health Security Board submitted its preliminary report to the Legislature with the following findings and recommendations:

The Health Security Board supports universal coverage for all Maine citizens---every man, woman and child living in this State deserves comprehensive health care coverage.

The Health Security Board finds that maintaining the "status quo" for Maine's health care system cannot be sustained.

While additional information and further analysis is needed, the Health Security Board finds that a single-payer health care system providing universal coverage appears to be financially feasible.

The Health Security Board recommends that the Legislature authorize the Health Security Board to continue its work until January 1, 2004 to refine and extend the financial feasibility study and to develop a transition and implementation plan for achieving universal coverage through a single-payer health care system in Maine.

The Health Security Board's preliminary report is included as Appendix B.

C. Final Report

In its preliminary report, the Health Security Board recommended to the Legislature that the Health Security Board be given additional time to fully consider the Mathematica feasibility study and develop final recommendations for a single-payer health plan. Following the Health Security Board's recommendation, the Legislature authorized the Health Security Board to continue its work and submit a final report by November 1, 2004. Also during that session, the Legislature enacted the Dirigo Health reform law

(Public Law 2003, chapter 492). The law focused on three areas to reform Maine's health care system: (1) a mechanism to increase access to health care for all Maine residents;(2) measures to ensure quality of care; and (3) measures to contain rising health care costs. The cornerstone of the law was the creation of the Dirigo Health Agency, a public agency charged with overseeing a voluntary health insurance program for small businesses, self-employed persons and individuals. Because Dirigo Health was developed to achieve universal coverage over time, the Health Security Board now faced a changing landscape for Maine's health care system. The Health Security Board's primary focus became the consideration of its future role and the role of a single-payer health care plan as Dirigo Health began to implement its comprehensive health care reforms.

As part of the Act, the DirigoChoice health insurance program was created to provide access to health coverage for individuals and small businesses. DirigoChoice's goal was to provide universal coverage incrementally with all of Maine's uninsured (approximately 136,000) covered by 2009. Given this health care reform initiative and changes in the political landscape, the Health Security Board submitted its final report in November 2004 without making a final recommendation on a single-payer health care system. Instead, the Health Security Board made the following recommendation:

The Health Security Board recommends that the Legislature reestablish the Health Security Board's authority to continue the evaluation and planning for a single-payer system if Dirigo Health fails to meets its expectations for universal coverage.

The Health Security Board submitted legislation to the 122nd Legislature that proposed to authorize the Health Security Board to meet, as needed, through the next biennium. The Health Security Board's final report is included as Appendix D.

D. Resolve 2005, Chapter 119

With the passage of this resolve, the Legislature reestablished the Health Security Board, but limited the scope of the Health Security Board's authority. Although the original legislation would have authorized the Health Security Board to act through the end of 2006, the resolve was amended in committee to direct the Health Security Board to "finalize its recommendations regarding the feasibility of a single-payer health care plan to provide health care coverage to all citizens of this State." The resolve further restricted the Health Security Board's activities and prohibited the Health Security Board from seeking outside funding. Also, the Health Security Board may not submit its own legislation, but may make recommendations, including proposed legislation, to the Joint Standing Committee on Insurance and Financial Services.

III. Health Security Board's Scope and Focus: Progress Toward Universal Coverage

While the enabling legislation states that the Health Security Board's "sole purpose" is to finalize its recommendations regarding the feasibility of a single-payer health plan, the Health Security Board felt it was important to focus as well on whether or not the State's efforts to achieve universal coverage have been successful. An evaluation of both the operation of the Dirigo Health Program and the expansion of MaineCare became key in determining whether the Health Security Board would recommend that Maine pursue and implement a single-payer health care plan as the mechanism to achieve universal coverage.

With the enactment of the Dirigo Health Act in 2003, Maine's policymakers have made a conscious decision to expand access to health care coverage for Maine's uninsured on two fronts---the voluntary DirigoChoice health insurance program and the expansion of the State's MaineCare program. While ongoing funding for each of these programs presents certain challenges, the current administration appears committed to this approach.

A. Dirigo Health Program

Under the law, Dirigo Health must contract with one or more health insurance carriers to offer health insurance to eligible small businesses with 50 or fewer employees and individuals. Dirigo Health has contracted with Anthem Blue Cross and Blue Shield of Maine to provide the DirigoChoice health plan. DirigoChoice is a comprehensive health insurance product that uses Anthem's current network of preferred providers. DirigoChoice began offering coverage on January 1, 2005 to small employers with 50 or fewer employees and to self-employed individuals. Limited enrollment of other eligible individuals and their dependents began on April 1, 2005. Through the 3rd quarter of operation, the DirigoChoice program had a total of 7115 enrollees, 22% individuals, 32% sole proprietors and 46% small businesses. As a result of the MaineCare expansion, 3766 parents have been enrolled directly in MaineCare.[1] In January, more than 3000 prospective members on a waiting list are expected to begin enrolling in the program. There is no cap on individual enrollment in DirigoChoice's second year of operation.

Employers who participate in DirigoChoice are required to contribute at least 60% toward the cost of coverage for employees who work at least 20 hours per week. Participating employers must enroll at least 75% of their eligible employees. Discounts toward the cost of coverage and reduced deductibles and out-of-pocket maximum costs will be made available to eligible employees and individuals whose household earnings are below 300% of the federal poverty level.

Recently, the Superintendent of Insurance ruled that $43.7 million in savings had been achieved as a result of the operation of Dirigo Health and the expansion of the MaineCare

[1] Dirigo Health Agency 3rd Quarter Report to the Legislature, October 25, 2005.

program. Although this decision has been appealed to the Superior Court, the Dirigo Health Board of Directors has voted to use the full amount of the savings as the target amount for the savings offset payment assessment. The savings offset payment is an assessment on paid claims of insurance carriers, third-party administrators and employee benefit excess insurers. By law, the total amount of the assessment cannot exceed the aggregate measurable cost savings achieved as a result of the operation of Dirigo Health and the MaineCare expansion. For 2006, the maximum amount is $43.7 million. In addition, the savings offset payment may not exceed 4% of paid claims. This funding will support the costs of the program and the Maine Quality Forum and the State's share of the MaineCare expansion. In 2006, the Dirigo Health Agency projects that enrollment in Dirigo Choice will total more than 10,000 members and more than 10,000 parents will be enrolled through the MaineCare expansion.[2]

B. MaineCare Program

MaineCare is the State's Medicaid program. Medicaid is a joint state-federal health insurance program. Under the program, each state has certain flexibility within federal law regarding eligibility, covered services, limitations on services and reimbursement levels for providers. Federal funding to support the program is based on a formula that compares a State's growth in per capita income relative to growth in national per capita income. Currently, the federal match for Maine's program is approximately 65%. For each dollar spent by the State, the federal government contributes almost 2 dollars. Since 1998, MaineCare enrollment has been increased by more than 55% as the Legislature has expended eligibility. Current enrollment for all populations exceeds 300,000.[3] The Dirigo Health Act increased eligibility for parents with children with incomes at 200% or below the federal poverty level. Other expansions of the program have extended coverage to children up to 200% of the federal poverty level, and to so-called non-categorical adults (single with no dependent children) up to 100% of the federal poverty level. The Dirigo Health Act also authorized other MaineCare expansions of eligibility which have not yet been implemented.

IV. Health Security Board's Findings and Recommendation

The Health Security Board makes the following findings and recommendation.

Universal coverage remains the Health Security Board's highest priority—every man, woman and child living in Maine must have health care coverage.

In its preliminary report, the Health Security Board identified universal coverage as its primary goal and priority. Although the Legislature has directed the Health Security Board to evaluate the single-payer model as the proposed mechanism for providing

[2] Presentation to Dirigo Health Agency Board of Directors, Karynlee Harrington, Executive Director, November 22, 2005 Meeting.

[3] Written presentation to Health Security Board, Maine Department of Health and Human Services, Michael Hall, December 2, 2005.

universal coverage, the Health Security Board can support reforms or policies that will result in health care coverage for all Maine residents, especially those that are currently uninsured. The Health Security Board is not necessarily wedded to a single-payer model, but remains committed to making universal coverage a reality.

While Health Security Board, with the exception of one member, continues to believe that a single-payer health plan seems feasible, the Health Security Board finds that implementation of a single-payer health plan at this time is unlikely.

While, in the Health Security Board's opinion, the Mathematica feasibility study provided an excellent foundation to evaluate the likely impact of a single-payer health care system on health care spending and financing in Maine, the Health Security Board identified certain unanswered questions and unexplored issues related to planning for a single-payer health care plan. The feasibility study provided an initial assessment of how a single-payer system will affect Maine's economy. However, the microsimulation model had limitations that would benefit from additional analysis and refinement. In addition, the model and the feasibility study did not address many practical and policy issues affecting the operation of a single-payer system. Foremost among these issues, it is unclear how a State could implement such a system on its own and still maintain the same level of federal funding for Medicare, MaineCare, military employees and federal employees without approval of a waiver from the federal government. The Health Security Board continues to believe it is critically important to evaluate these issues before a single-payer health care plan can be implemented.

Further, the Health Security Board recognizes that the political and economic reality that a single-payer health care system is not likely to be implemented in Maine in the near future. The current burden on Maine's taxpayers is significant and there are many competing interests for additional funding from the State budget. Although many proposals for change to Maine's health insurance market have been proposed, the Legislature has not pursued significant reform of the way health care is delivered in this State. The Dirigo Health reforms and the MaineCare expansions show promise and are making progress, albeit slowly, toward health care coverage for Maine's uninsured, but will require additional funding to provide coverage for all of the uninsured.

The Health Security Board, with the exception of one member, supports the State's efforts to achieve universal coverage through the operation of the Dirigo Health Program and the expansion of the MaineCare program, but believes the current timeline toward universal coverage must be accelerated so that all of the uninsured in Maine have coverage by 2009.

The Health Security Board, with the exception of one member, supports the State's efforts to achieve universal coverage through DirigoChoice and expansion of MaineCare. The next year of operation for Dirigo is critical as the savings offset payment is expected to contribute funding for the program to support premium subsidies and expanded enrollment. Originally, the administration projected incremental enrollment in DirigoChoice enrollees with a goal of reaching universal coverage for all uninsured

Mainers in 2009. To date, however, enrollment figures have been lower than expected, especially among small businesses. Additional efforts are needed to increase enrollment in DirigoChoice among small businesses, sole proprietors and individuals. Estimates for the uninsured in Maine remain at more than 130,000. The Health Security Board believes that a renewed commitment to universal coverage is needed. The expansion of the MaineCare program has worked in combination with the Dirigo Health Program to increase access to health care. The federal matching funds under this program make it an attractive option for the State if the State can provide its share of the financing. While progress is being made, the State's policymakers should recommit to reaching universal coverage within 5 years---the original goal when the Dirigo Health reforms were passed in 2003---and commit to making the necessary policy decisions to meet this goal by 2009.

The Health Security Board recommends that the State's policymakers and the Legislature consider additional mechanisms to expand access to health care coverage for Maine residents including, but not limited to, expanding eligibility and participation in the DirigoChoice program and exploring regional partnerships to purchase health care coverage.

The Health Security Board believes that more can be done to expand access to affordable health care. The Board recommends that the State's policymakers explore additional mechanisms to expand access. Some of the policy options that should be strongly considered include expanding participation in the DirigoChoice Program through expanded eligibility or by requiring publicly funded health care plans like the State Employee Health Plan and the health plan for the University of Maine System to join Dirigo, and exploring regional partnerships to purchase health care coverage with other New England states similar to regional efforts relating to prescription drug coverage. Before implementing any of these options, the State should carefully evaluate their feasibility and impact on current collective bargaining arrangements and publicly funded health plans. The State should not be content with the current timeline for reaching universal coverage. Policymakers should consider improvements to DirigoChoice, changes to the health insurance laws and other approaches to expand access to health care.

V. Conclusion

The Health Security Board strongly believes that it has made a positive contribution to the dialogue among policymakers and others surrounding reform of Maine's health care system. In part, the development of Dirigo Health was based on information and research from the Health Security Board's preliminary report and feasibility study. Although the current approach to universal health care coverage is not based on a single-payer health plan model, the Health Security Board is hopeful that the ultimate goal---coverage for all Mainers---will be achieved by 2009. If universal coverage is not achieved in 2009, the Health Security Board believes that the implementation of a single-payer health plan must be reconsidered.

APPENDIX A:

Resolve 2005, chapter 119

CHAPTER 119

H.P. 35 - L.D. 32

Resolve, To Reestablish the Health Care System and Health Security Board

Sec. 1. Board reestablished; duties. Resolved: That the Health Care System and Health Security Board, established by Public Law 2001, chapter 439, Part ZZZ, and amended by Public Law 2003, chapter 492, and referred to in this resolve as "the board," is reestablished and those members serving on the board on November 1, 2004 continue to serve as members, except that new legislative members must be appointed in accordance with Public Law 2001, chapter 439, Part ZZZ, section 1. The board is reestablished for the sole purpose of finalizing its recommendations regarding the feasibility of a single-payor health plan to provide health care coverage to all citizens of this State and may not conduct any other activities; and be it further

Sec. 2. Report; extension prohibited. Resolved: That, no later than December 7, 2005, the board shall submit a report, including any suggested legislation, for presentation to the Joint Standing Committee on Insurance and Financial Services and the Legislative Council. Following receipt and review of the report, the Joint Standing Committee on Insurance and Financial Services may report out a bill related to the report to the Second Regular Session of the 122nd Legislature. The board is not authorized to introduce legislation. The board may not apply to the Legislative Council for an extension and may not take any further action after December 7, 2005, unless further action is authorized by law; and be it further

Sec. 3. Funding; limitation. Resolved: That any unexpended funds allocated to the board as of November 1, 2004 must be carried forward for use by the board and may not lapse. Except for these unexpended funds, no additional funds may be appropriated or allocated from any source to support the board. The board may not seek any outside funding. The board may not incur expenses that exceed available funds; and be it further

Sec. 4. Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

LEGISLATURE

Miscellaneous Studies 0444

Initiative: Allocates funds to support the meeting costs of the Health Care System and Health Security Board.

OTHER SPECIAL REVENUE FUNDS	**2005-06**	**2006-07**
Personal Services	$1,100	$0
All Other	$4,305	$0
OTHER SPECIAL REVENUE FUNDS TOTAL	$5,405	$0

APPENDIX B:

Preliminary Report Issued January 15, 2003

STATE OF MAINE
120th LEGISLATURE
SECOND REGULAR SESSION

Preliminary Report
of the

HEALTH CARE SYSTEM AND HEALTH SECURITY BOARD

January 15, 2003

Senator John L. Martin, Chair
Representative Paul Volenik, Chair
Senator Mary E. Small
Representative Florence T. Young

James Amaral
Howard Buckley
Robert Downs
Tammy Greaton
Frank A. Johnson
Beth Kilbreth
Marjorie Medd
John Moran
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Table of Contents

Page

Executive Summary i

I. Introduction 1

II. Health Security Board's Scope and Focus 4

III. Overview of Single-payer Health Care Plan Model 4

IV. Microsimulation Model Developed by Mathematica 7

V. Preliminary Findings and Recommendations 10

Appendices

A. Public Law 2001, chapter 439, Part ZZZ
B. Feasibility Study of a Single-payer Health Care Plan Model for the State of Maine, Mathematica Policy Research, Inc.
C. Draft Legislation to Implement Board's Recommendations

Acknowledgements

The Health Care System and Health Security Board gratefully acknowledges the generous financial award of $200,000 from the Maine Health Access Foundation, Inc. to support the feasibility study conducted by Mathematica Policy Research, Inc. In addition, the Board raised over $34,000 from several organizations and individuals, including the Maine State Nurses Association and nurses associations in California, NewYork, Pennsylvania and Massachusetts; the Maine Chapter of the Association of Certified Nurse Midwives; and the Maine Nurse Practitioners Association. The Board thanks all who have contributed to its efforts.

The Health Security Board also acknowledges the cooperation of the Department of Human Services, Bureau of Medical Services and the Maine Health Management Coalition with providing Maine data for use in the feasibility study. We appreciate their willingness to share this information. The Maine Health Information Center provided technical assistance to the Board and Mathematica Policy Research in analyzing the claims data from the State's MaineCare program and from the Maine Health Management Coalition. Anthem Blue Cross and Blue Shield of Maine also contributed claims data for use in the feasibility study.

Executive Summary

The Health Care System and Health Security Board, hereafter referred to as the Health Security Board or Board, was established in Public Law 2001, chapter 439, Part ZZZ. While the purpose of the Board was to develop recommendations to provide universal access to health care coverage for all Maine citizens, the Health Security Board was specifically required to assess the feasibility and cost of implementing a single-payer health care system in Maine. Such a system would provide universal health care coverage to every Maine resident through a standard benefit plan administered and paid for by a single payer, the State of Maine.

The Health Security Board, chaired by Senator John Martin and Representative Paul Volenik, is a bipartisan task force with 19 members including representatives of both chambers and both major parties within the Legislature, the Department of Human Services, the State Employee Health Commission and the State Tax Assessor and representatives of provider organizations, employers, insurers and advocacy groups. Charlene Rydell, a member of the Maine Health Access Foundation Board of Trustees, provided valuable input and assistance as a liaison from the Foundation to the Board. The Health Security Board was first convened on October 12, 2001 and met more than 20 times throughout 2002.

From its inception, the Health Security Board focused it efforts on its mandate to conduct a feasibility study of the economic impact on individuals and businesses of a single-payer plan that guarantees a minimum 5% savings over existing health care costs and that addresses the potential positive or negative impact of the plan on the State's economy. To meet its mandate, the Board contracted with Mathematica Policy Research, Inc., a national health care consulting firm, to conduct the feasibility study.

The Board asked Mathematica to develop a microsimulation model to project the financial and economic impact of a single-payer health care plan in Maine. Briefly, the microsimulation model developed by Mathematica is comprised of four modules: (1) a population module used to project the demographic and health insurance coverage characteristics; (2) a cost module used to project health care spending by type of service and the source of spending that includes both medical and administrative costs; (3) a financing module used to project current levels of revenue from current and available sources for funding health care expenditures; and (4) an economic impact module used to project the impact of a single-payer health plan on the State's economy and employment. The complete feasibility study prepared by Mathematica, including documentation of the microsimulation model, its assumptions and sensitivity analyses, and its results projecting the costs of a single-payer health plan, is included as an appendix to the full report.

As defined by the Health Security Board, the single-payer health plan would provide health care coverage to all Maine residents through one standard benefit design. Coverage of Maine residents eligible for federally supported programs like Medicare, MaineCare, CHAMPUS and the federal employee plan would be subsumed under the single-payer plan. Federal approval and waivers would be needed to assure continued participation and funding. For use in the feasibility study, the Board developed 3 primary benefit designs:

(1) a benefit plan modeled on MaineCare (Maine's Medicaid program); (2) a benefit plan that requires cost sharing in the form of copayments only for certain services with a cap on out-of-pocket spending; and (3) a benefit plan that requires cost-sharing in the form of copayments and coinsurance for certain services with a cap on out-of-pocket spending. For each of the alternative benefit designs, the Board asked Mathematica to model 3 different cost projections based on income level--- incomes at or below 200%, 300% and 400% of the federal poverty level--- to determine whether cost sharing would be required.

To finance the costs of the single-payer plan, the model developed by the Board assumes that federal and State government funding for health care coverage and the direct provision of health care services would be maintained at its current level. In addition, the model assumes full enrollment of an eligible population for public programs to maximize the federal and State financial contribution. The remaining costs of the single-payer plan would be paid from the State's General Fund either by raising new revenue through targeted taxes or redirecting current tax revenue. An individual or employer's contribution in the form of premiums would be eliminated, although employers and employees might pay into the system through a payroll tax and individuals may be asked to participate through cost sharing with a cap on out-of-pocket spending.

While the Board believes additional time is needed to consider the Mathematica feasibility study and develop final recommendations to the Legislature, the Health Security Board makes these preliminary findings and recommendations:

The Health Security Board supports universal coverage for all Maine citizens--- every man, woman and child living in this State deserves comprehensive health care coverage.

The Health Security Board finds that maintaining the "status quo" for Maine's health care system cannot be sustained.

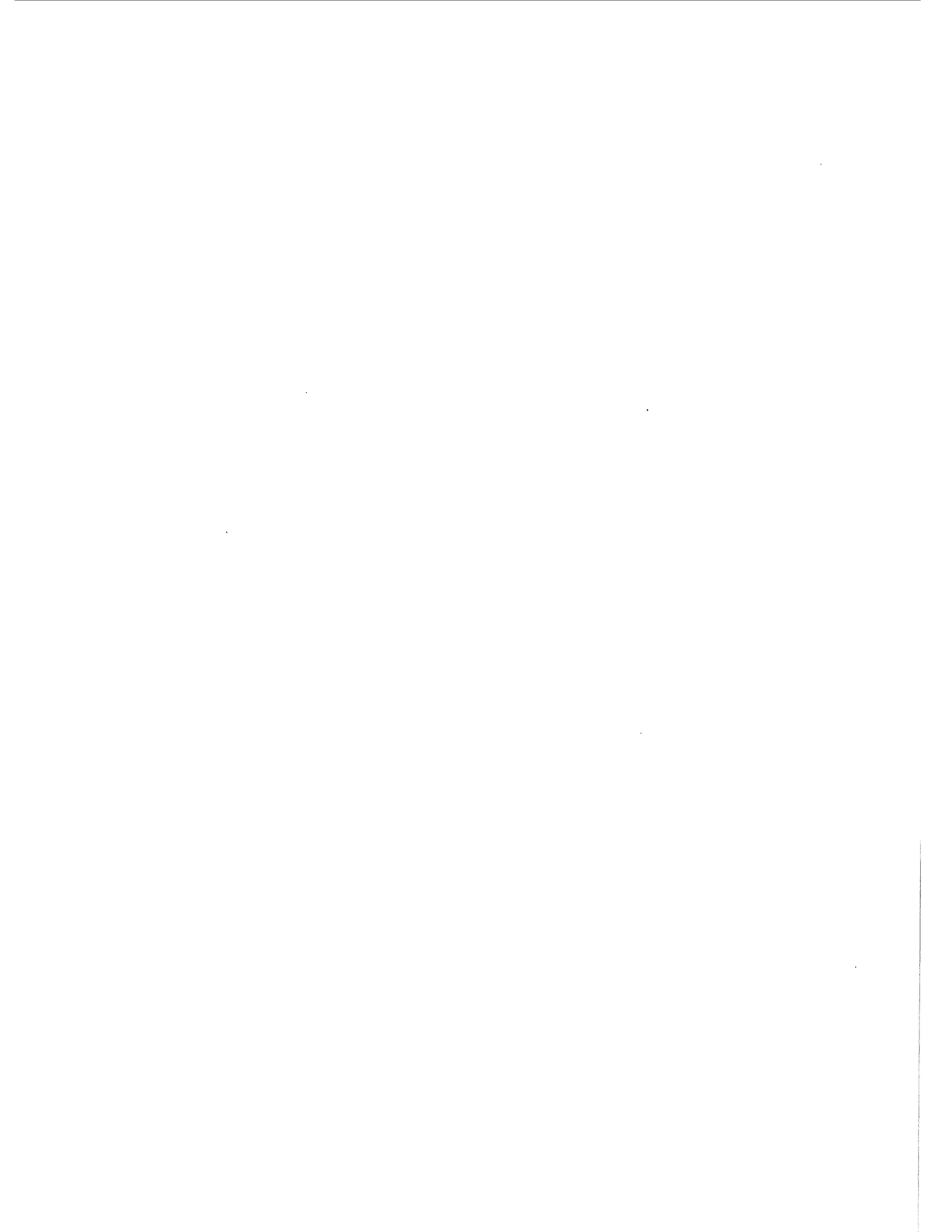
While additional information and further analysis is needed, the Health Security Board finds that a single-payer health care system providing universal coverage appears to be financially feasible.

The Health Security Board recommends that the Legislature authorize the Board to continue its work until January 1, 2004 to refine and extend the financial feasibility study and to develop a transition and implementation plan for achieving universal coverage through a single-payer health care system in Maine.

The rationale for these decisions is explained in the full report.

The Health Security Board hopes that this report and the microsimulation model will provide a foundation for informed and constructive dialogue among policymakers and others interested in reforming Maine's current health care system. The results of the feasibility study suggest that a single-payer health care system appears to be a feasible

approach to achieving universal coverage but more information and analysis is needed. With additional time and resources, the Health Security Board believes it can help develop a blueprint for universal coverage. We look forward to the goal of universal coverage.



I. Introduction

The Health Care System and Health Security Board, hereafter referred to as the Health Security Board or Board, was first established in Public Law 2001, chapter 439, Part ZZZ. While the purpose of the Board was to develop recommendations to provide universal access to health care coverage for all Maine citizens, the Health Security Board was specifically required to assess the feasibility and cost of implementing a single-payer health care system in Maine. Such a system would provide universal health care coverage to every Maine resident through a standard benefit plan administered and paid for by a single payer, the State of Maine. With the assistance of a significant grant from the Maine Health Access Foundation, the Health Security Board contracted with Mathematica Policy Research, Inc. to conduct the feasibility study. This study was completed in December 2002. The Health Security Board issued its preliminary report on January 15, 2003.

In its preliminary report, the Health Security Board recommended to the Legislature that the Board be given additional time to fully consider the Mathematica feasibility study and develop final recommendations for a single-payer health plan. During the 2003 legislative session, a law was enacted to extend the Board's authority and delay submission of a final report. A copy of Public Law 2003, chapter 492 is included as Appendix A. Also during that session, the Legislature enacted the Dirigo Health reform law (Public Law 2003, chapter 492). The law focused on three areas to reform Maine's health care system: (1) a mechanism to increase access to health care for all Maine residents;(2) measures to ensure quality of care; and (3) measures to contain health care costs. The cornerstone of the law was the creation of Dirigo Health, a public agency charged with overseeing a voluntary health insurance program for small businesses, self-employed persons and individuals. Because Dirigo Health was developed to achieve universal coverage over time, the Health Security Board now faced a changing landscape for Maine's health care system. The Board's primary focus became the consideration of its future role and the role of a single-payer health care plan as Dirigo Health began to implements its comprehensive health care reforms.

The Health Security Board, now chaired by Senator John Martin and Representative Marilyn Canavan, is a bipartisan task force with 20 members including representatives of both branches and both parties within the Legislature, the Department of Health and Human Services, the State Employee Health Commission and the State Tax Assessor and representatives of provider organizations, employers, insurers and advocacy groups. Due to resignations, there are currently 3 vacant positions. The members of the Board and their appointing authorities are as follows:

Members appointed by the President of the Senate:

- **Sen. John L. Martin, Chair**
- **Vacant position, Senate member**
- **Robert Downs,** Representing Statewide Organizations of Health Insurers
- **Tammy Greaton**, Representing Statewide Organization Advocating Universal Health Care
- **Vacant position**, Representing Health Care Economists
- **Marjorie Medd**, Representing Statewide Organizations Defending Rights of Children
- **Leo Siegel, MD**, Representing Small Hospitals in the State
- **Richard Wexler, MD,** Representing Statewide Organizations of Physicians

Members appointed by the Speaker of the House:

- **Rep. Marilyn C, Canavan**, Chair
- **Rep. Florence T. Young**
- **James Amaral**, Representing the Business Community
- **Vacant position**, Representing Large Hospitals in the State
- **John Moran**, Representing Statewide Senior Citizen's Organizations
- **Frank O'Hara**, Representing Self-employed Persons
- **Patricia Philbrook**, Representing Statewide Organization of Nurses
- **Violet Raymond**, Representing Statewide Labor Organizations, Maine AFLCIO
- **Paul Volenik,** Representing the public

Appointments required by statute:

- **Frank A. Johnson**, Director, State Office of Employee Health and Benefits
- **Jerome Gerard**, Acting State Tax Assessor
- **Christine Zukas-Lessard**, Deputy Director, Bureau of Medical Services, Designee of the Commissioner of Health and Human Services

Since the submission of its preliminary report, the Health Security Board met twice on April 2, 2004 and September 22, 2004. The Health Security Board was first convened on October 12, 2001 and met more than 20 times throughout 2002.

A. Authority of Health Care System and Health Security Board Extended

The Health Security Board was originally created in the Part II budget, Public Law 2001, chapter 439, Part ZZZ. In its preliminary report, the Health Security Board recommended legislation to extend its authority and delay submission of its final report until after the completion of the 121st Legislature. This legislation was enacted as Public Law 2003, chapter 492. The law added a 20th member representing the public and required the board to submit a final report on or before November 1, 2004.

B. Preliminary Findings and Recommendations

While the Board believed additional time was needed to fully consider the Mathematica feasibility study and develop final recommendations to the Legislature, the Health Security Board made these preliminary findings and recommendations in January 2003.

The Health Security Board supports universal coverage for all Maine citizens---every man, woman and child living in this State deserves comprehensive health care coverage.

The Health Security Board finds that maintaining the "status quo" for Maine's health care system cannot be sustained.

While additional information and further analysis is needed, the Health Security Board finds that a single-payer health care system providing universal coverage appears financially feasible.

The Health Security Board recommends that the Legislature authorize the Board to continue its work to refine and extend the financial feasibility study and to develop a transition and implementation plan for achieving universal

coverage through a single-payer health care system in Maine until January 1, 2004.

At that time, the Health Security Board felt it could not adequately meet its charge from the Legislature. The request for an extension was made to give the Board time to thoughtfully consider and evaluate the work done by Mathematica. In addition, Governor Baldacci had just been elected and announced plans to develop and introduce health care reform legislation for consideration by the 121st Legislature. The Health Security Board wanted more time to continue its work and evaluate its role in the public policy debate for changes to Maine's health care system.

C. Health Security Board's Refined Duties

Once the Health Security Board reconvened in April 2004, the landscape of Maine's health care system had changed. In June 2003, the Legislature enacted the Dirigo Health Reform law, Public Law 2003, chapter 427. Because of Dirigo Health, the Board was now faced with the following duties: (1) to evaluate the future role for the Health Security Board and the development of a single-payer health care plan for Maine; and (2) to continue its work to refine and extend the financial feasibility study and to develop a transition and implementation plan for achieving universal coverage through a single-payer health care system in Maine. However, the primary consideration for the Board in all of its recent deliberations has been the evaluation of its future role in Maine's health policy.

D. Report and Legislation

The amended legislation required that the Board submit a final report, including any necessary legislation, on or before November 1, 2004. Draft legislation to implement the recommendations of the Health Security Board is included in Appendix C.

II. Health Security Board's Scope and Focus

While the Health Security Board planned to use its additional time to further evaluate the feasibility of a single-payer health care plan, thc Board's shifted its scope and focus to the question of its future role given the existence of Dirigo Health. This issue became key in determining whether the Board should continue its effort to develop recommendations for a single-payer health care plan for Maine.

However, the Health Security Board also had a secondary focus centered on completing the work begun in its preliminary report. While, in the board's opinion, the Mathematica feasibility study provided an excellent foundation to evaluate the likely impact of a single-payer health care system on health care spending and financing in Maine, the Board identified certain unanswered questions and unexplored issues related to planning for a single-payer health care plan. An outline of these questions and issues from the

preliminary report is included as Appendix B. The feasibility study provided an initial assessment of how a single-payer system will affect Maine's economy. However, the microsimulation model had limitations that would benefit from additional analysis and refinement. In addition, the model and the feasibility study did not address many practical and policy issues affecting the operation of a single-payer system. The Health Security Board continues to believe it is critically important to evaluate these issues before making final recommendations to the Legislature on the feasibility of a single-payer health care plan.

III. Dirigo Health Reform Law

At each of its meetings in 2004, the Health Security Board received briefings on the status and implementation of the Dirigo Health Reform Act from the Governor's Office of Health Policy and Finance. The following highlights the major accomplishments for Dirigo Health in its first year.

DirigoChoice Health Plan. Under the law, Dirigo Health must contract with one or health insurance carriers to offer health insurance to eligible small businesses with 50 or fewer employees and individuals. After a competitive bidding process, Dirigo Health has contracted with Anthem Blue Cross and Blue Shield of Maine to provide the DirigoChoice health plan. DirigoChoice is a comprehensive health insurance product that uses Anthem's current network of preferred providers. DirigoChoice will begin offering coverage on January 1, 2005 to small employers with 50 or fewer employees and to self-employed individuals. Limited enrollment of other individuals and their dependents will begin on April 1, 2005. Expected enrollment in the first year is 31,000 enrollees with a goal of reaching universal coverage for all uninsured Mainers in 2009.

Employers who participate in DirigoChoice are required to contribute at least 60% toward the cost of coverage for employees who work at least 20 hours per week. Participating employers must enroll at least 75% of their eligible employees. Subsidies toward the cost of coverage and reduced deductibles and out-of-pocket maximum costs will be made available to eligible employees and individuals whose earnings are below 300% of the federal poverty level.

State Health Plan. Under the Dirigo Health reform law, the Governor is required to issue a biennial state health plan designed to provide a comprehensive, coordinated approach to the development of health care facilities and health resources in the State based on statewide cost, quality and access goals. An interim one-year plan was issued in June 2004 based on input from an advisory council. The first biennial State Health Plan will be issued in July 2005.

Capital Investment Fund and Strengthened Certificate of Need Process. The Governor's Office of Health Policy and Finance is required to establish an annual limit, called the Capital Investment Fund, on the dollar amount of third-year operating costs for capital expenditures and investments in new technology allowed under the Certificate of Need program. The Capital Investment Fund has been initially established through

emergency rulemaking and the cap set at $6. 6 million. The Legislative will review the major substantive rule next session. In addition, the State Health Plan sets priorities and criteria to be used in evaluating CON applications.

Maine Quality Forum. The Maine Quality Forum has been established as part of the Dirigo Health Agency to pursue initiatives to improve the quality of health care delivered in Maine. The Forum will collect and disseminate research, adopt quality and performance measures, coordinate quality data, issue quality reports in conjunction with the Maine Health Data Organization, conduct consumer education and technology assessment reviews, encourage the adoption of electronic technology, make recommendations for the State Health Plan and issue an annual report. The Forum works with an advisory group of health care providers, insurers, consumers and business representatives.

IV. Board's Recommendation

The Health Security Board recommends that the Legislature reestablish the Board's authority to continue the evaluation and planning for a single-payer system if Dirigo Health fails to meets its expectations for universal coverage.

Given the progress with DirigoChoice and the other Dirigo reform efforts, the Board is hopeful that universal access can be achieved over time with this approach. However, with enrollment in DirigoChoice just beginning and coverage not expected until January 1, 2005, it is premature to measure the success of the Dirigo Health reforms. While the Board supports these overall reforms, the members also agree that it is worthwhile for the Board to seek continued authority to meet in the event that these reforms, especially DirigoChoice, are not successful. The preliminary results from the Mathematica study demonstrated that a single-payer health care plan appeared feasible, although additional analysis is necessary. If universal coverage is not achieved through the Dirigo Health reforms, the Health Security Board believes that planning for universal coverage through a single-payer health care plan should continue. Therefore, the Board recommends that legislation be drafted for consideration by the 122nd Legislature that will authorize the Board to meet, as needed, through the next biennium.

Conclusion

The Health Security Board strongly believes that it has made a positive contribution to the dialogue among policymakers and others surrounding reform of Maine's health care system. In part, the development of Dirigo Health was based on information and research from the Health Security Board's preliminary report and feasibility study. Although Dirigo Health has taken a different approach to achieving universal coverage, the Health Security Board is hopeful that the ultimate goal---coverage for all Mainers---can be reached over time. However, if Dirigo Health fails to meet expectations, then the development of a single-payer health care plan must be reconsidered. And, if it is reestablished, the Health Security Board believes it is the appropriate group to make that effort successful.

APPENDIX C:

Mathematica Feasibility Study
December 2002

MPR Reference No.: 8889-300

MATHEMATICA
Policy Research, Inc.

Feasibility of a Single-Payer Health Plan Model for the State of Maine

Final Report

December 24, 2002

Deborah Chollet
Glen Mays
January Angeles
Mathematica Policy Research, Inc.

Roland McDevitt
Ryan Lore
Watson Wyatt and Company

Submitted to:

Health Care System and Health Security Board
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ACKNOWLEDGEMENTS

Mathematica Policy Research, Inc. is grateful for the cooperation and assistance of numerous individuals and organizations during the conduct of this study for the Health Care System and Health Security Board. The Maine Health Management Coalition generously agreed to allow use of information from its health care claims data base for this study. Similarly, the Maine Bureau of Medical Services permitted use of information from its Medicaid health care claims data base. Jim Harnar, Brian Pearson, Karl Finnison, and other staff at the Maine Health Information Center provided expert consultation on the use of health care claims data from both of these sources, and performed key data extraction and processing activities for the study. Anthem Blue Cross and Blue Shield of Maine also provided valuable information used in this study, and we appreciate the work of Sharon Roberts, Michael Coughlin, and other staff at Anthem to make this information available. Other organizations contributing data and information for use in this study include the Maine Hospital Association, Maine Health Data Organization, Maine Bureau of Insurance, Maine Revenue Service, and the Maine Bureau of Human Resources.

Members of the Health Care System and Health Security Board provided sound direction, advice, and candid feedback throughout the conduct of this study. We are especially grateful to Colleen McCarthy Reid, staff to the Board, for facilitating the conduct of this study.

Mary Grider and Mark Brinkley at Mathematica Policy Research played key roles in designing and developing the Maine Microsimulation Model, and provided expert programming and data processing capabilities for this study. Melanie Lynch managed the study's word processing and document production needs.

The Maine Health Management Coalition, the Maine Health Information Center, and other organizations and individuals contributing data and information for this study do not necessarily endorse the study's findings and conclusions, including those presented in this report. Any remaining errors and omissions are solely the responsibility of Mathematica Policy Research, Inc.

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CONTENTS

Chapter **Page**

EXECUTIVE SUMMARY xv

I INTRODUCTION 1

II OVERVIEW OF THE SINGLE-PAYER PLAN 3

III DESCRIPTION OF THE MAINE MICROSIMULATION MODEL 7

A. POPULATION MODULE 7

1. Input Data 7
2. Adjustments to Enhance Maine's CPS Population Sample 10
3. Module Outputs 12

B. COST MODULE 14

1. Base-Case Estimates 14
2. Single-Payer Estimates 17

C. FINANCING MODULE 20

1. Input Data 23
2. Module Outputs 26

D. ECONOMIC IMPACT MODULE 26

1. Input Data and Major Assumptions 26
2. Sources of Employment Change 27
3. Module Outputs 29

Chapter **Page**

IV MODEL RESULTS 31

A. POPULATION PROJECTIONS 31

B. HEALTH CARE SPENDING ESTIMATES 32

1. Health Care Spending Under Current Policy (Base-Case) 32
2. The Cost of a Single-Payer Plan 36

C. HEALTH CARE FINANCING ESTIMATES 40

1. Maintenance of Effort and Obligated Funding 40
2. Financing the Net Cost of a Single-Payer System 43

D. ECONOMIC IMPACT ESTIMATES 44

E. ACHIEVING FIVE PERCENT SAVINGS IN HEALTH CARE SPENDING 49

V SENSITIVITY ANALYSES 53

A. ASSUMPTIONS USED IN TESTING PLAN COST SENSITIVITY 53

B. SENSITIVITY OF SINGLE-PAYER COST ESTIMATES 56

1. Variation in Administrative Cost Savings And Constraints on Cost In A Low Managed Care Environment 56
2. Variation in Administrative Cost Savings and Constraints on Cost in a Low Managed Care Environment 59

C. FINANCING STRATEGIES 60

1. Implications of Cost Sensitivity for the Net Cost of a Single-Payer Plan 60
2. Variation in Net Cost as a Percentage of Payroll 61

D. SUMMARY AND DISCUSSION 63

Chapter **Page**

VI REMAINING ISSUES AND MODEL LIMITATIONS 65

A. TRANSITION ISSUES 65

1. Federal Maintenance of Effort 65
2. Phasing in Coverage Groups 67
3. Addressing Growth in Demand for Care 68
4. Changing Provider Payment Levels and Methods 68
5. Incorporating Other Health Care Payers 69
6. Accommodating Residents Employed Out-of-State 70
7. Addressing the Potential for In-migration 70

B. IMPORTANT CAVEATS AND LIMITATIONS OF THE CURRENT MODEL 71

1. Regional Estimates 71
2. Single-Payer Estimates by Coverage Subgroups 72
3. Interaction between Financing and Economic Impact Estimates 72

C. RECOMMENDATIONS FOR ADDITIONAL RESEARCH 73

REFERENCES 75

LIST OF ACRONYMS 79

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T A B L E S

Table **Page**

II.1 REQUIRED COST SHARING BY FAMILY INCOME IN ALTERNATIVE SINGLE-PAYER PLANS 4

II.2 BENEFIT DESIGNS, COST SHARING, AND LIMITS ON OUT-OF-POCKET EXPENSE IN ALTERNATIVE SINGLE-PAYER PLANS 5

III.1 PARAMETER ASSUMPTIONS USED IN THE POPULATION MODULE OF THE MAINE MICROSIMULATION MODEL 13

III.2 DEMOGRAPHIC, ECONOMIC, AND REGIONAL STRATIFICATIONS OF THE MAINE POPULATION 14

III.3 PARAMETER ASSUMPTIONS USED IN THE COST MODULE OF THE MAINE MICROSIMULATION MODEL 21

III.4 PARAMETER ASSUMPTIONS USED IN THE FINANCING MODULE OF THE MAINE MICROSIMULATION MODEL 27

III.5 PARAMETER ASSUMPTIONS USED IN THE ECONOMIC MODULE OF THE MAINE MICROSIMULATION MODEL 28

IV.1 PROJECTED POPULATION SIZE BY BASELINE SOURCE OF COVERAGE (IN THOUSANDS) 33

IV.2 NUMBER AND PERCENT OF MEDICARE COVERED POPULATION BY SOURCE OF COVERAGE, PROJECTED 2004 AND 2008 (BASELINE) 34

TABLES (*continued*)

IV.3 BASE CASE HEALTH CARE SPENDING IN MAINE BY SOURCE.......... 35

IV.4 PROJECTED HEALTH CARE SPENDING BY TYPE OF SERVICE UNDER BASE CASE AND SINGLE-PAYER ASSUMPTIONS 37

IV.5 PROJECTED HEALTH CARE SPENDING BY SOURCE UNDER BASE CASE AND SINGLE-PAYER ASSUMPTIONS 39

IV.6 SUMMARY OF FINANCING SOURCES OF BASELINE AND SINGLE-PAYER HEALTH PLANS, 2004 AND 2008....................................... 41

IV.7 ESTIMATED TAX RATES REQUIRED TO FINANCIAL ALTERNATIVE SINGLE-PAYER PLANS IN 2004 AND 2008: ILLUSTRATIVE ALTERNATIVE FINANCING SCENARIOS... 45

IV.8 CHANGE IN PROJECTED TOTAL EMPLOYMENT BY SOURCE OF CHANGE, ALL INDUSTRY GROUPS, 2004 AND 2008 (EMPLOYMENT IN THOUSANDS)... 47

IV.9 PROJECT CHANGE IN EMPLOYMENT ASSOCIATED WITH A SINGLE-PAYER SYSTEM BY SELECTED INDUSTRY GROUPS (IN THOUSANDS).. 48

IV.10 PROJECTED CHANGE IN EMPLOYMENT ASSOCIATED WITH A SINGLE-PAYER SYSTEM BY SELECTED OCCUPATIONAL GROUPS (IN THOUSANDS).. 50

V.1 DEFINITION OF HIGH AND LOW MANAGED CARE: ENROLLMENT IN HMO/PCCM ARRANGEMENTS.................................... 55

V.2 DEFINITION OF ADMINISTRATIVE COST REDUCTION: HEALTH PLANS AND PROVIDERS 55

V.3 SENSITIVITY OF TOTAL SPENDING TO ALTERNATIVE ADMINISTRATIVE COST AND COST GROWTH ASSUMPTIONS (LOW MANAGED CARE)... 57

V.4 SENSITIVITY OF TOTAL SPENDING TO ALTERNATIVE ADMINISTRATIVE COST AND COST GROWTH ASSUMPTIONS (HIGH MANAGED CARE).. 58

V.5 PROJECTED NET COST OF A SINGLE PAYER SYSTEM WITH ALTERNATIVE ADMINISTRATIVE COST SAVINGS IN A LOW MANAGED CARE ENVIRONMENT, 2004 (IN MILLIONS) 61

TABLES *(continued)*

V.6 PROJECTED NET COST OF A SINGLE PAYER SYSTEM WITH ALTERNATIVE ADMINISTRATIVE COST SAVINGS IN A LOW MANAGED CARE ENVIRONMENT, 2008 (IN MILLIONS) 62

V.7 PROJECTED NET COST OF SELECTED SINGLE PAYER PLAN DESIGNS AS A PERCENTAGE OF PAYROLL IN 2004: ALTERNATIVE ADMINISTRATIVE COST ASSUMPTIONS IN A LOW MANAGED CARE ENVIRONMENT 63

V.8 PROJECTED NET COST OF SELECTED SINGLE PAYER PLAN DESIGNS AS A PERCENTAGE OF PAYROLL IN 2008: ALTERNATIVE ADMINISTRATIVE COST ASSUMPTIONS IN A LOW MANAGED CARE ENVIRONMENT 64

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F I G U R E S

Figure		Page
I.1	WATSON WYATT'S PREVIEW MEDICAL BENEFITS MODEL	2
III.1	INFORMATION FLOW DIAGRAM FOR THE MAINE MICROSIMULATION MODEL	8
IV.1	PROJECTED HEALTH CARE SPENDING UNDER BASE CASE AND SINGLE-PAYER HEALTH PLANS: 2004 AND 2008	38

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EXECUTIVE SUMMARY

The Health Care System and Health Security Board was established by the Maine legislature to study the feasibility of a single-payer health insurance plan that would provide coverage to all Maine citizens and guarantee a minimum savings of 5 percent relative to existing health care costs. To assist the Board in this effort, Mathematica Policy Research, Inc. (MPR), has developed an interactive policy microsimulation model to project the cost, financing, and economic impact of alternative specifications of a single-payer health insurance plan in Maine.

The Maine Microsimulation Model includes four interrelated components: (1) a population module that estimates the size and composition of Maine's population by age group, health insurance coverage categories, and other demographic characteristics in 2004 and 2008; (2) a cost module that estimates health care spending levels under current policy (base case) and under various single-payer health plan designs; (3) a financing module that simulates alternative ways of raising the revenue needed to fund health care expenditures under a single-payer health plan; and (4) an economic impact module that projects how a single-payer plan may affect health care providers, insurers, and Maine's economic and employment bases at large. The model relies primarily on data and parameters derived from existing Maine-specific information sources, supplemented with information from the published literature and from the informed judgments of the Board and other experts and relevant officials in Maine.

Estimates from the model indicate that, under current policy, health care spending in Maine will continue on a path of steady increase—rising by 37 percent between 2001-04 and by 31 percent between 2004-08. The model projects that a single-payer health system would produce a net increase in total health care spending under most benefit designs that we estimated, but this increase in spending would decline over time as the system realized savings through global budgeting, reductions in administrative costs, and enhanced access to primary and preventive care. Of the single-payer benefit designs that we estimated, some that include consumer cost-sharing would produce net savings in health care spending (relative to projected levels without reform) by 2008.

To finance the costs of a single-payer system, Maine would need to retain the value of private employer contributions to health insurance that now occur; ensure federal and state maintenance of effort for public employees, program beneficiaries, and direct purchase of

health care services; and, for most of the single-payer benefit designs we estimated, tap additional revenue sources.

By reducing administrative spending and increasing overall demand for health care, a single payer system would generate some change in employment in Maine. Single payer plan designs that generate a relatively small increase in the demand for health care services would produce a small net loss in health-sector employment. However, a single payer plan would improve health sector productivity by redistributing jobs from administrative to clinical positions.

Sensitivity analyses demonstrate that projections of single-payer spending and net cost vary within narrow ranges under alternative assumptions about the system's ability to reduce administrative costs and constrain underlying health care cost trends. Thus, error in assumptions appears to produce a tolerable range of uncertainty about the future cost and financing requirements of a single payer system in Maine.

In summary, a single payer system appears to be economically feasible for Maine. Much lower cost sharing and more limited use of managed care than now prevail among insured consumers in Maine would increase the cost of a single payer system and make financing more difficult. However, providing every resident with approximately the same benefit as large-firm employees receive would minimize demand growth among the insured population and achieve net savings from a single payer system, even in the near term.

The challenges of transitioning to a single payer system in Maine should not be overlooked. Maine might benefit from some additional information in key areas to plan such a transition. These would include a better understanding of insurers' and providers' administrative costs to improve estimates of potential cost savings; access to care in Maine and the relationship to economic productivity; and the need for workforce training associated with greater demand for health care services and displacement of administrative workers.

CHAPTER I

INTRODUCTION

The Maine legislature established the Health Care System and Health Security Board (the Board) to study the feasibility of a single-payer health insurance plan that would provide coverage to all Maine citizens and guarantee a minimum savings of 5 percent relative to existing health care costs. To assist the Board in this effort, Mathematica Policy Research, Inc. (MPR), has developed an interactive policy microsimulation model to project the cost, financing, and economic impact of alternative specifications of a single-payer health insurance plan in Maine.

The Maine Microsimulation Model includes four interrelated modules: (1) a population module that projects the distribution of Maine's population among demographic and health insurance coverage categories in 2004 and 2008; (2) a cost module that projects health care spending by source and service category, including both spending for medical services and administrative costs; (3) a financing module that projects levels of revenue obtainable from current sources and other sources available to the state for funding health care expenditures; and (4) an economic impact module that projects how a single-payer plan may affect health care providers, insurers, and Maine's economic and employment bases at large.

The Maine Microsimulation Model relies primarily on data and parameters derived from existing sources, including health care claims databases maintained by the Maine Health Information Center for the Maine Health Management Coalition and the Maine Bureau of Medical Services, as well as information from published health services research literature and studies available from Maine state agencies and health care organizations. In developing the cost module, MPR worked with Watson Wyatt and Company, an international employee benefits consulting firm. Actuarial projections of the cost of alternative health benefit designs are based on Watson Wyatt's PreView™ Medical Benefits Model (see Figure I.1). MPR also consulted with the Board and with other experts and relevant officials in Maine to develop the benefit design assumptions, parameters, and data that drive the model's results. The model produces base-case (no reform) and simulation (reform) results for 2004 and for a five-year projection period extending to 2008.

Figure I.1. Watson Wyatt's PreView Medical Benefits Model

PreView is a comprehensive health benefit microsimulation model that has been developed over the past 14 years to facilitate the estimation of health care expenditures in employer-sponsored health plans. It has also been used to estimate the plan expense and out-of-pocket costs associated with various health care reform proposals for both the pre-65 and post-65 populations. PreView allows the health benefit consultants to "repay" medical claims under alternative plan designs, population assumptions, utilization levels, and charge levels. It is a well established valuation model that has been widely used with many public and private clients.

This report describes the model's current architecture and assumptions and, based on model outcomes, presents estimates of the cost and economic impact of single-payer reform. Chapter II provides an overview of the single-payer health insurance system under study by the Health Security Board, including major eligibility assumptions and the alternative benefit designs examined in the report. In Chapter III, we describe the design and methodology of the Maine Microsimulation Model, including data and parameter sources, major assumptions, and methods used to estimate costs and economic impact. Chapter IV presents the health care cost, financing and economic impact projections generated by the model, including base-case and single-payer estimates for each alternative benefit design. To understand how the model's estimates of cost and economic impact are affected by alternative assumptions about health care cost trends, single-payer cost savings, and economic growth in Maine, Chapter V outlines findings from sensitivity analyses conducted on several major model parameters. Finally, in Chapter VI, we consider transitional strategies for implementing a single-payer health plan, taking into account the estimated costs and financing needs associated with each alternative benefit design.

CHAPTER II

OVERVIEW OF THE SINGLE-PAYER PLAN

A single-payer health insurance system would provide health coverage to all Maine residents under a single standardized health plan. The new system would be administered and funded by the state and would replace all current public and private health insurance, including Medicare, Medicaid, CHAMPUS, the Federal Employees Health Benefits Plan (FEHBP), the State Employee Health Plan, and all employer- and individually sponsored health insurance. Financing for the single-payer system would come from new tax revenues and from current state and federal funding of health programs that would be subsumed into the system. The system would eliminate health insurance premiums paid by employers, employees, and other individuals.

The single-payer benefits design is modeled on the benefits provided by MaineCare, the state's Medicaid program. The plan would cover inpatient and outpatient hospital care, primary and specialty care physician services, laboratory tests, prescription drugs, mental health services, home health services, and routine vision and dental care. Long-term care services would be provided to persons eligible for these services under current MaineCare policy. The plan would limit out-of-pocket health care costs.

We use the Maine Microsimulation Model to study the costs and economic impacts of three alternative benefit designs for a single-payer plan (see Table II.1). Each benefit design covers the same comprehensive set of health care services and varies only in the amount and type of cost sharing required of plan members. The first benefit design is modeled on the benefits currently provided by MaineCare with little or no cost sharing for broad coverage of health care services. The second and third benefit designs involve either copayments or coinsurance for families and individuals whose incomes exceed a specified percentage of the federal poverty level (FPL). We test three alternative poverty thresholds within each of these latter two alternative benefit designs to create a total of seven different scenarios for the benefit design of a single-payer health plan. Table II.2 documents the covered services and detailed cost sharing provisions of these single-payer plan designs.

Table II.1. Required Cost Sharing by Family Income in Alternative Single-Payer Plans

Single-Payer Plan	Family Income Relative to Poverty	Level of Benefits
1	All levels	MaineCare Benefit
2A	< 200 % FPL	MaineCare benefit
	≥ 200 % FPL	Broad coverage with copayments
2B	< 300 % FPL	MaineCare benefit
	≥ 300 % FPL	Broad coverage with copayments
2C	< 400 % FPL	MaineCare benefit
	≥ 400 % FPL	Broad coverage with copayments
3A	< 200 % FPL	MaineCare benefit
	≥ 200 % FPL	Broad coverage with coinsurance
3B	< 300 % FPL	MaineCare benefit
	≥ 300 % FPL	Broad coverage with coinsurance
3C	< 400 % FPL	MaineCare benefit
	≥ 400 % FPL	Broad coverage with coinsurance

Table II.2. Benefit Designs, Cost Sharing, and Limits on Out-of-pocket Expense in Alternative Single-Payer Plans

Plan-Level Features	Plan 1 MaineCare Benefit	Plan 2 Copayment Plan	Plan 3 Coinsurance Plan
Income Level Subject to Cost Sharing	None	200%; 300%; or 400% FPL	200%; 300%; or 400% FPL
Out-of-Pocket Maximums Individual Family	None	 $500 $1,000	 $1,000 $2,000
Deductibles	None	None	None
Life-Time Maximum	None	None	None
Hospital Inpatient	$0–$3 per day; $30 maximum per month	$50 per day; $300 maximum per admission	$50 per day; $300 maximum per admission
Hospital Outpatient/Diagnostic, X-Ray, Laboratory	$0–$3 per day; $30 maximum per month	$25 copayment	20% coinsurance
Primary Care Provider Visits	Covered in full	$10 copayment	$10 copayment
Specialty Care Provider Visits	Covered in full	$20 copayment	$20 copayment
Emergency Room	Covered in full	$50 copayment; waived if admitted	$50 copayment; waived if admitted
Mental Health/Substance Abuse Benefits	Covered in full	Parity	Parity
Prescription Drugs Copayment--Generic Copayment--Brand/Preferred Copayment--Brand/Nonpreferred	 $0–$2 $0–$3 $0–$3	 $5 $13 $28	 $10 $20 $35
Skilled Nursing	Covered in full	$25 per day; $150 maximum per admission	$25 per day; $150 maximum per admission
Home Health Care	Covered in full	$10 copayment	$10 copayment
Durable Medical Equipment	Covered in full	Covered in full	20% coinsurance
Eyeglasses	$100 cap every 2 years	$100 cap every 2 years	25% coinsurance; $100 cap every 2 years
Included Benefits (not subject to cost sharing)	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehabilitation, routine dental care, routine vision care	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehabilitation, routine dental care, routine vision care	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehabilitation, routine dental care, routine vision care
Excluded Benefits	Cosmetic, infertility/sex change, routine foot care, custodial care, vision correction surgery (LASIK)	Cosmetic, infertility/sex change, routine foot care, custodial care, vision correction surgery (LASIK)	Cosmetic, infertility/sex change, routine foot care, custodial care, vision correction surgery (LASIK)

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CHAPTER III

DESCRIPTION OF THE MAINE MICROSIMULATION MODEL

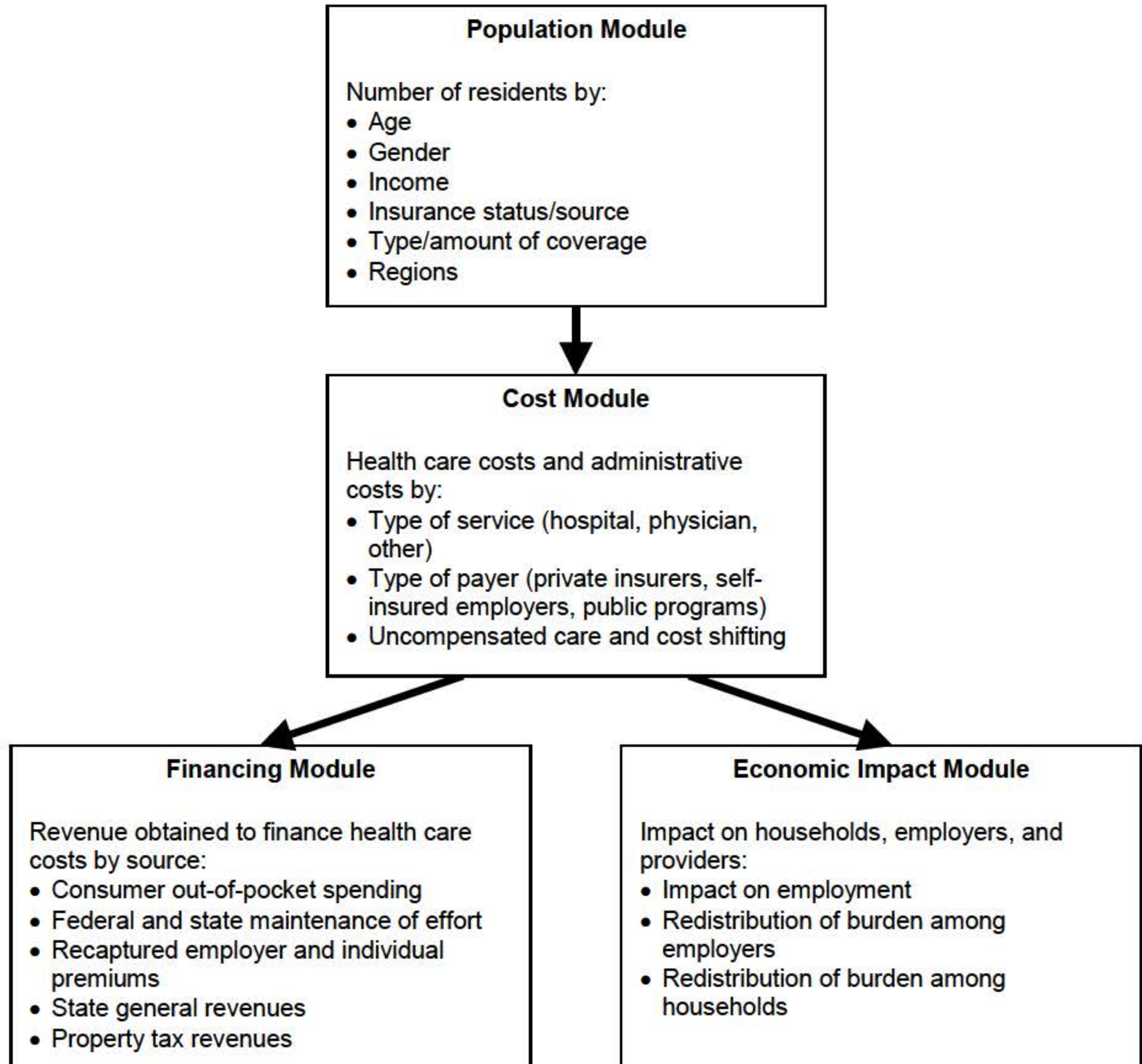
The Maine Microsimulation Model includes four interrelated modules: (1) a population module that projects the demographic and health insurance coverage characteristics of Maine's population to 2004 and 2008; (2) a cost module that projects health care spending by source and service category, including both spending for medical and administrative costs; (3) a financing module that projects levels of revenue obtainable from current sources and other sources available to the state for funding health care expenditures; and (4) an economic impact module that projects how a single-payer plan may affect health care providers, insurers, and Maine's economic and employment bases at large. The general design of the model is presented graphically in Figure III.1. In essence, the model links detailed population and per capita cost information, and then allows the user both to explore alternative methods of financing the plan and also provides estimates of job loss, premium relief for large and small employers, and changes in out-of-pocket cost for families by level of income. The following sections describe each of the model's component parts and the sources of data and major assumptions underpinning each module.

A. POPULATION MODULE

1. Input Data

The primary input data come from the March 2002 Current Population Survey (CPS) of the non-institutionalized population. The CPS is a household survey that captures information about the household, each family in the household, and each person in the family; person-level records can be matched to other persons in the family as well as to family- and household-level characteristics. Compared to all other available household surveys, the CPS samples the largest number of households in Maine and, therefore, offers

Figure III.1. Information Flow Diagram for the Maine Microsimulation Model



the most precise estimates of household and family composition, economic characteristics, and insurance coverage.[1]

Each March, the Census fields a supplement to the CPS that includes detailed questions about income, employment, and health insurance. Respondents answer questions about insurance coverage during the previous calendar year (2001) and may respond that they received coverage from an employer, a privately purchased plan, Medicare, Medicaid or the State Children's Health Insurance Program (SCHIP), Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), or any other health insurance plan. The supplement to the CPS identifies as uninsured only those individuals who state that they were without coverage from any of these sources during the entire previous year.[2]

To assemble the input data, we started with the full U.S. population sample and concatenated family and household records with each person-level record. We identified each person as Medicare-covered or not, identified other potential sources of insurance coverage, and then assigned each person to a unique source of coverage (alone or in combination with Medicare) in the following sequence:

- Employer coverage from own employer
- Employer coverage only as a dependent
- Individual coverage from own plan
- Individual coverage only as a dependent
- CHAMPUS
- Medicaid

Persons who reported only Medicare coverage but no other coverage were identified as having only Medicare coverage. Those who reported neither Medicare nor any other source

[1] In 2003, we will replace the CPS distributions in the population module with data from November/December 2002 Household Survey conducted in support of Maine's State Health Planning Grant.

[2] Because the CPS does not allow the user to differentiate between part-year and full-year coverage, it produces an undercount of individuals who are uninsured at some time during the year. Historically, The CPS count of uninsured is much like available panel survey counts of ever-uninsured individuals, suggesting that the CPS recall period may be less than 15 months. That is, the CPS appears to produce an estimate of the uninsured that is higher than an estimate of always-uninsured, but somewhat less than an estimate of ever-uninsured.

of coverage were identified as uninsured. This process of identification produced 14 unique insurance coverage categories.

For each person, we identified an insurance reference person (IRP). Persons who had coverage from their own employer or their own individual insurance plan were identified as their own IRP, as were persons with coverage from Medicaid, SCHIP, CHAMPUS, or Medicare only. Persons who had employer or other private coverage only as a dependent were matched to their source of coverage via their record line identification in the CPS.

2. Adjustments to Enhance Maine's CPS Population Sample

While the March CPS 2002 sample in Maine produces valid estimates for selected population characteristics, its size is insufficient for a microsimulation model that requires 14 unique coverage categories as well as firm size (if employed or the dependent of an employed person) and family income information. To resolve this problem and gain precision, we employed a method that reweights the entire CPS sample, allowing Maine to "borrow" statistical strength from the much larger U.S. population (Schirm et al. 2000). We fitted a Poisson regression model to the national CPS sample to obtain the estimated prevalence in Maine of household types defined by the characteristics of families and individuals in Maine households. The Poisson model was specified to control for the prevalence in Maine of the following person- and family-level characteristics:

- Insurance coverage (14 categories, as described above)
- Age (in five intervals: 0–5; 6–18; 19–39; 40–64; and 65 or older)
- Race (White non–Hispanic, Hispanic, American Native/Asian, and other)
- Income as a percent of federal poverty (in four categories: 0–200 percent; 201–300 percent; 301–400 percent; and 401 percent and above)
- Household and family size

This process produced a "synthetic" sample of the Maine population. Unweighted, the sample size is equal to the size of the full U.S. sample. Weighted, the synthetic sample matches Maine totals and significant subtotals. The much larger sample produces the more precise estimates of the Maine population (within demographic, economic, and insurance coverage cells) that we require for the microsimulation.

We performed a number of integrity checks of the population (comparing significant subtotals as well as subtotals on variables that we did not control) to confirm that the synthetic sample is, within acceptable levels of error, an accurate representation of Maine's non-institutionalized population. The much larger sample supports the more precise estimates of the Maine population (within demographic, economic, and insurance coverage cells) that we require for the microsimulation.

We mapped the person-level output data from this process into the 14 coverage categories as described above. We further classified those with employer coverage from their own employer or as a dependent as having coverage from a large firm (100 or more employees) or a small firm (respectively, 25–99 employees or fewer than 25 employees) according to the firm size of their IRP's principal employer during the previous year (2001). We assigned persons with an employer-covered IRP who did not report employment during the previous year (for example, retirees or persons continuing coverage under the Consolidated Omnibus Budget Reconciliation Act, or COBRA) to firm sizes in the same proportion that persons were distributed by firm size when their IRP did report having an employer.

To classify IRPs as federal or state employees, we obtained counts of total federal employment in Maine from the U.S. Office of Personnel Management's Web site and counts of state employment from the state of Maine and calculated the percentage of employment in firms of 100 or more attributable to federal or state employment. We then randomly assigned persons with an IRP in the largest firm size to federal or state employment within demographic cells to produce the correct count of federal and state workers; we classified all other workers as private-sector or local-government employees.

We adjusted the estimates of the number of Maine residents with Medicaid (MaineCare) coverage to address the fact that Medicaid coverage is underreported in the CPS. The reweighted 2002 CPS sample for Maine indicates that MaineCare covered 133.3 thousand residents in 2001, compared to the Maine Bureau of Medical Services count of 190.8 thousand full-time equivalent persons with full MaineCare coverage in 2001. We assume that this discrepancy results in our having misclassified approximately 57.5 thousand MaineCare recipients as uninsured or as covered by Medicare only. To address this discrepancy, we raised the model's count of FTE Medicaid recipients to 190.8 thousand in 2001, reduced the model's count of the uninsured by 45.5 thousand, and reduced the model's count of individuals with Medicare coverage only by 12.0 thousand. As a result, the model's estimates of the uninsured population in Maine are lower than estimates from other published studies relying on CPS data alone.

We further allocated persons to underinsured status and to MaineCare eligibility as follows: We used data provided by Anthem Blue Cross and Blue Shield of Maine on enrollment in high-deductible (at least $2,500) health insurance products to develop an approximation of the proportion of members who are underinsured in each commercial market segment (large group, small group, and nongroup). We then used the proportions to allocate people within the CPS sample to underinsurance status based on their coverage type and IRP employer firm size. Similarly, we used estimates provided by the Maine Bureau of Medical Services on the number of people eligible but not enrolled in MaineCare to allocate individuals within the CPS sample to this eligibility category based on their classification as uninsured individuals below 200 percent of the federal poverty level.

Finally, we "aged" the 2002 non-institutionalized population to 2004 and 2008 by using age- and gender-specific growth rates for Maine as projected by the U.S. Census. By again reweighting the synthetic Maine sample to produce population totals equal to Census

projections, we produced new estimates of Maine's population by coverage status and poverty level. In effect, the population module's output assumes that all changes in coverage and family income between 2002 and 2004-2008 are solely attributable to changes in the age distribution and size of the population.

Table III.1 summarizes the major assumptions used in setting default values for each parameter in the population module.

3. Module Outputs

The population module projects the number of Maine residents in each of 38 unique coverage categories:

- Coverage from a small employer (1-24 or 25-99 employees), a large private employer (100+ employees), federal government, or state government; either directly or as a dependent (10 categories)
- Coverage from an individual plan, directly or as a dependent (2 categories)
- Employer-sponsored or individual private coverage (direct or as a dependent), but underinsured (6 categories)
- Any of the first 12 categories in combination with Medicare (12 categories)
- CHAMPUS
- MaineCare
- MaineCare-eligible, but not enrolled
- CHAMPUS, MaineCare, or MaineCare-eligible in combination with Medicare (3 categories)
- Medicare only
- Other uninsured

The module further classifies persons in each coverage category by whether the IRP is a worker or not (e.g., a retiree), family income (in 5 categories), age (in 4 categories), gender, and region of the state (6 categories, including county of residence unknown). Table III.2 documents these additional classifications. In all, the module exports unique population counts in 18,240 cells. This level of population detail supports relatively precise actuarial estimates of aggregate plan cost for each single-payer benefit design and also more accurate estimates of the plans' financing requirements. Because the CPS does not support substate estimates in Maine, we have in effect assigned the Maine sample randomly to regions within the state.

Table III.1. Parameter Assumptions Used in the Population Module of the Maine Microsimulation Model

Parameter	Mean Value	Source
Annual population growth rate, by region 2001-04	0.4%	Colgan (2002)
Annual population growth rate, by region 2004-08	0.6%	Colgan (2002)
Percent of individuals with large employer coverage who receive coverage through:		
Federal employer	2.1%	Colgan (2002)
State Employee Health Plan	4.0%	Bureau of Human Resources
Proportion of state population residing in each region:		
Medicare beneficiaries	--	CMS (2002)
Medicaid (MaineCare) beneficiaries	--	Bureau of Medical Services
Federal employees	--	Colgan (2002)
Other	--	U.S. Census (2000)
Percent of commercially insured population that is enrolled in high-deductible health plans		
Nongroup/individual market	22.0%	Based on information provided by Anthem Blue Cross and Blue Shield of Maine
Small group market (2-99 members)	11.0%	Based on information provided by Anthem Blue Cross and Blue Shield of Maine
Large group Market (100+ members)	2.0%	Based on information provided by Anthem Blue Cross and Blue Shield of Maine
Percent of uninsured who are eligible for MaineCare	12.0%	Based on information provided by the Bureau of Medical Services

Source: Mathematica Policy Research, Inc.

Table III.2. Demographic, Economic, and Regional Stratifications of the Maine Population

Characteristic	Stratification
Individual Age	0–18
	19–39
	40–64
	65 or older
Family Income	Below 150% FPL
	150–200% FPL
	201–300% FPL
	301–400% FPL
	400% FPL or more
Geographic Area	Bangor (Penobscot County)
	Lewiston-Auburn (Androscoggin County)
	Portland Metropolitan Area (Cumberland County)
	Nonmetro North (Franklin, Somerset, Piscataquis, Aroostook, and Washington counties)
	Nonmetro South (Oxford, Hancock, Kennebec, Knox, Lincoln, Sagadahoc, Waldo, and York counties)
	Place of residence unknown

Source: Mathematica Policy Research, Inc.

B. COST MODULE

The cost module estimates per capita health care spending within each population cell under base-case assumptions that reflect Maine's current health policy environment and under the assumptions of a single-payer health plan. Below we describe the data and methods used to develop spending estimates under each set of assumptions.

1. Base-Case Estimates

a. Input Data

The model uses baseline health care cost data from several sources. To begin, we used claims data from the Maine Health Management Coalition to estimate baseline health care expenditures for individuals who obtain coverage from large employers. The Maine Health Information Center (MHIC) constructed measures of plan payments per member per month

as well as out-of-pocket payments by type of service (hospital, physician, pharmacy, and other services), age group, gender, dependent status, county, and year (1999 through 2001). We then aggregated the measures to develop separate measures for each of five regions as documented in Table III.2. Given that some of the claims incurred in 2001 were missing provider identification numbers and therefore could not be identified accurately by type of service, we chose to use data from year 2000 claims and extrapolate the data to 2001 by using the overall trend rate observed between 2000 and 2001.

We used enrollment and claims data from Maine's Medicaid and SCHIP programs (MaineCare and CubCare) maintained by the Maine Health Information Center to estimate baseline health care expenditures for individuals covered by these programs. We constructed estimates of program payments per member per month by type of service, age group, gender, and coverage type (full Medicaid coverage, limited Medicaid coverage, or state-only coverage), dual eligibility status for Medicare (yes or no), region, and year. We tracked Medicaid payments for nursing facilities, nonmedical institutions, Bureau of Mental Retardation waivers, and other long-term care services separately from payments for hospital, physician, pharmacy, and other services. Because approximately 4 percent of the Medicaid claims incurred in 2001 were missing from MHIC's data files, we used estimates from year 2000 claims data and trended them forward to 2001.

We used Maine-specific aggregate claims data from the Centers for Medicare and Medicaid Services (CMS) to construct baseline estimates of Medicare payments per member per month and out-of-pocket expenses by type of service for 2001. We used information from the Medicare Current Beneficiary Survey (MCBS) to estimate private health insurance payments for Medicare beneficiaries with employer-provided or individually purchased supplemental coverage. We also used the MCBS to estimate Medicare payments for individuals who are dually eligible for Medicaid and Medicare.

b. Adjustments

To estimate costs for population groups not represented in the baseline data and to project costs for future years, the cost module applies a variety of adjustments to the baseline cost data. The adjustments are computed by multiplying the baseline cost data by a series of parameters developed from earlier studies and, where clear evidence is lacking, from informed judgments. These parameters include:

- ***Baseline per capita health care spending for individuals covered by small employers, privately purchased nongroup policies, the Federal Employee Health Benefits Program (FEHBP), CHAMPUS, or the Maine State Employee Health Plan.*** To estimate spending for each of these coverage groups, the model uses a set of "relativity" parameters that expresses per capita spending as a percentage of the baseline spending estimates for individuals covered by large employers in the Maine Health Management Coalition claims database. For this analysis, we assume that there are no differences in per capita health care charges among these coverage groups after accounting for age, gender, dependent status, and region. However, we assume that the proportion

of covered charges paid out-of-pocket varies directly with the payer administrative cost rate, as described below. Specifically, we assume that the higher administrative costs incurred in small group and nongroup health insurance policies are financed through higher out-of-pocket expenses for consumers. This assumption, combined with the administrative cost estimates detailed below, results in the assumption that out-of-pocket expenses account for 18 percent of total spending for individuals covered by large employers, 27 percent of spending for individuals covered by small employers, and 40 percent of spending for individuals covered by individual (nongroup) policies.

- ***Baseline health care spending for the uninsured.*** To develop spending estimates for the uninsured, we used the methodology employed in the Year 2000 Blue Ribbon Commission on Health Care's report on health care costs in Maine. First, we assumed that spending for the uninsured approximates 70% of the spending for fully insured individuals (Long and Marquis 1994). Second, we assumed that the uninsured pay approximately 40 of their incurred health care charges out of pocket, with the remaining 60 of charges covered by charity care and bad debt (Year 2000 Blue Ribbon Commission 2000; Young 1995). We applied these two parameters to the per capita spending estimates from the Maine Health Management Coalition claims data in order to calculate per capita estimates of spending for the uninsured, net of uncompensated care costs.

- ***Projected growth rates in per capita health care spending by type of service and by payer.*** We use one set of parameters to project growth between 2001 and 2004 and another set of parameters to project growth between 2004 and 2008. We assume that medical care spending for the privately insured and uninsured increases at an average annual rate of 13 percent between 2001 and 2004, based on a blend of national estimates from the Kaiser/HRET annual survey of employer health benefits (HRET 2002) and Maine-specific estimates from the Maine Health Management Coalition claims database for 1999-2001. For Medicare beneficiaries, we use an annual trend rate of 3.2 percent for medical care spending based on data from the Centers for Medicare and Medicaid Services (CMS 2002). For MaineCare beneficiaries, we assume an annual trend rate of 7 percent based on a blend of actual MaineCare spending estimates for 1999-2001 and on national estimates from the Kaiser/HRET survey (HRET 2002). We assume that prescription drug spending for all Mainers increases at an average annual rate of 14 percent during 2001-04, based on national estimates produced by the pharmacy benefits administrator MedCo (MedCo 2002). For the 2004-2008 period, we use spending projections produced by the Centers for Medicare and Medicaid Services (CMS) Office of the Chief Actuary (2002), which indicate an average annual growth rate in medical care spending of 5 percent and an increase in prescription drug spending of 7 percent. Consistent with CMS practice, we do not use separate trend estimates for Medicare and non-Medicare populations in the 2004-2008 period given the uncertainties in long-term projections of cost trends.

- ***Payer administrative costs as a percentage of total costs.*** We use separate parameters to approximate the administrative costs of private health insurance plans for large employers, small employers, and individuals and the administrative costs of Medicare and Medicaid. Estimates of private health insurance administrative costs were based on estimates from an analysis of underwriting practices of major insurers performed for the Congressional Research Service (1988). These estimates assume that administrative costs account for 12 percent of total health insurance costs for large groups of 100 or more employees, 22 percent of costs for groups of 2 to 99 employees, and 30 percent of costs for individual (nongroup) policies. These estimates are somewhat higher than the 13 percent administrative cost rate estimated by the Maine Bureau of Insurance based on financial statements from fully insured HMOs in Maine in 2001 (Bureau of Insurance 2002); however, we use the CRS estimates because they are based on actual insurer administrative practices and therefore are less sensitive to underlying medical cost trends and insurance underwriting cycles. Estimates of Medicare and Medicaid administrative costs were based on information reported by CMS (2002), including a 2.1 percent administrative cost rate for Medicare and a 6.4 percent administrative cost rate for Medicaid (combined federal and state rate).

c. Output

The cost module produces estimates of health plan payments and out-of-pocket costs in 2004 and 2008 for persons in each of the population cells that it imports from the population module. For each population cell it computes costs in each of four service categories: hospital care, medical provider services, prescription drugs, and other medical services and equipment. It retains estimates of the cost of MaineCare services for institutional care and other long-term care, which cannot be linked to the population module's tally of the non-institutionalized population.

2. Single-Payer Estimates

To estimate the costs of different health benefit designs that may be offered through a single-payer health plan, we use the Preview™ benefits simulation model developed by Watson Wyatt and Company. As inputs to the model, we use the Maine-specific baseline per capita spending estimates for individuals covered by employer-provided insurance, individually purchased insurance, Medicare, and Medicaid. PreView™ then estimates the per capita plan payments and out-of-pocket spending associated with a specified benefit design. We used PreView™ to develop per capita cost estimates for the three different benefit designs: Maine's current Medicaid benefit design and two alternative designs that involve higher cost sharing. To simulate the costs and cost savings associated with a single-payer health plan, the cost module applies several adjustments to the estimates obtained from the PreView™ model. The adjustments are computed by multiplying the PreView™ cost estimates by a series of parameters developed from earlier studies and informed judgments. We later vary the most critical of these (in terms of their impact on estimated

cost) to gauge how sensitive the model's cost, financing and economic results are to the accuracy of the parameter.

The model's key parameters include:

- ***Single-payer administrative costs.*** This parameter specifies the costs of administering a single-payer system. Such a system would centralize the processing of claims and decrease or eliminate costs related to activities such as billing and the adjudication of claims. It would increase economies of scale by covering all Maine citizens under a single program and eliminating the complexities associated with the participation of multiple insurers with multiple benefit designs. We expect the single-payer administrative costs to be less than those incurred by private health insurers under current policy. For this analysis we set the single-payer administrative cost rate at 5.0 percent—a rate that is somewhat below the 6.4 percent rate incurred by Maine's Medicaid program under the assumption that the single-payer plan will have fewer administrative processes to perform concerning eligibility determination and outreach. This rate is considerably higher than the estimate used in some other single-payer simulations—such as the 1.4 percent estimate used in the Lewin Group's study of a single-payer system in Massachusetts (Sheils et al. 1998). However, we feel it is more realistic to assume a rate that is relatively close to the current Medicaid rate during the initial years of a single-payer system, especially given the assumption that Maine would maintain its MaineCare primary care case management program as a cost containment and care coordination feature of the system. We test alternative assumptions about single-payer administrative cost savings as part of the sensitivity analyses.

- ***Changes in provider administrative costs.*** Provider administrative costs include all labor and overhead expenses associated with tasks that are not directly related to patient care, such as billing and accounting. Under a single-payer plan, these costs would decrease due to the standardization of all claims submission, payment, and utilization review processes. Hospital administrative costs are based on regional estimates obtained from an analysis of Medicare cost report data submitted by New England hospitals (Woolhander and Himmelstein 1997), while medical providers' administrative costs are based on national estimates from the American Medical Association's Socioeconomic Monitoring System physician survey (AMA 2002). We assume that a single-payer system reduces both by 15 percent due to movement to uniform processes for claims submission and benefits determination and to reductions in billing for uncompensated care. That is, net administrative cost are 28.4 percent for hospitals and 27.2 percent for medical providers. By comparison, simulations of single-payer health insurance systems in other states have assumed administrative cost savings of 14 percent for hospitals and 26 percent for medical providers (Sheils et al. 1998). We test alternative assumptions about cost changes due to provider administrative cost savings as part of the sensitivity analyses.

- ***Changes in managed care.*** These parameters indicate expected changes in health care spending as a result of eliminating commercial HMOs. We expect a rise in spending due to the increase in health care utilization among privately insured persons who currently have HMO coverage and who may not have managed care in the single payer system. In this analysis we assume that total spending increases by 10 percent for individuals enrolled in commercial HMOs at baseline. We base these parameters on both published and proprietary estimates of the effectiveness of HMOs in containing health care costs (Cutler, McClellan and Newhouse 2000; Mobley 1998; Zwanziger, Melnick and Bamezai 2000; Glied 2000). We assume that approximately 55 percent of Maine's population with commercial health insurance is currently enrolled in an HMO, based on data provided by Anthem Blue Cross and Blue Shield of Maine. Note that the model retains MaineCare's primary care case management (PCCM) program for 43 percent of persons who qualify for the MaineCare benefit design; this is the current rate of PCCM enrollment among MaineCare enrollees. We test alternative assumptions about cost changes due to managed care as part of the sensitivity analyses.

- ***Changes in uncompensated care.*** We presume that providers charge private insurance carriers higher prices to compensate for unpaid services delivered to uninsured patients. By covering all Maine residents, the single-payer plan would eliminate uncompensated care (charity care and bad debt) and end cost shifting. We assume that average per unit payments to providers would decline as providers are reimbursed for previously uncompensated care under a single-payer system. We use parameters to indicate the expected change in the pricing of hospital and medical provider services due to the elimination of uncompensated care. We base the hospital parameters on MedPAC estimates of hospital uncompensated care costs in New England, using data from the American Hospital Association's 2000 Survey of Hospitals (MedPAC 2001). Using the American Medical Association's 2000 Socioeconomic Monitoring System survey, we base the physician parameters on estimates of physicians' charity care provision in New England.

- ***Changes in demand for health services.*** The single-payer health plan designs modeled in this study would reduce out-of-pocket expenses for uninsured and underinsured individuals and thereby increase their utilization of health services to levels reported by insured persons with similar demographic characteristics. Similarly, we expect that utilization will increase among insured persons covered by the single-payer plan as compared with less generous coverage. For individuals who are uninsured in the base case, we assume that health care spending increases to 100 percent of the per capita spending estimate for insured individuals of the same age group. For individuals who are insured in the base case, we specify parameters to indicate the expected increase in health care utilization associated with a given reduction in out-of-pocket health care costs under the single-payer health plan. The parameters are based on demand elasticities estimated in the RAND health insurance experiment (Newhouse

1993) and in more recent studies conducted by CBO. These parameters assume that a 10% decrease in consumer out-of-pocket spending produces a 1.7% increase in overall health care utilization.

- ***Changes in avoidable health care utilization.*** By providing uninsured and underinsured individuals with enhanced financial access to routine primary care and preventive services, a single-payer health plan may reduce the need for care in more intensive settings such as hospitals and emergency rooms. We use parameters to approximate the net reduction in avoidable health care costs, basing them on estimates of ambulatory care-sensitive hospitalizations and emergency room utilization among uninsured and underinsured populations (Ayanian et al. 2000; Friedman and Basu 2001; Eisert and Babow 2002; Steiner et al. 2002).

- ***Changes in provider reimbursement.*** The establishment of a single-payer program allows the state to control annual health spending levels by setting hospital operating budgets and provider reimbursement levels. Hospitals and providers can use the budgets to create incentives for reducing unnecessary care utilization and delivering health care services efficiently. We use a set of parameters to project changes in underlying health care cost trends between 2004 and 2008 as a result of a single-payer health plan that uses a global budgeting system for all Maine health care spending. The parameters are based on the assumption that hospital costs are paid in accordance with a case rate methodology similar to Medicare's Diagnosis Related Grouping (DRG) system, in which rates are subject to an annual global budget cap for hospital services. Similarly, we assume that physicians are paid on a resource-indexed fee scale such as Medicare's Resource-Based Relative Value Scale (RBRVS) system, whereby fees are subject to a global budget cap for physician care. In this analysis we assume that a single-payer system produces a 5 percent reduction in the underlying health care cost trend rate between 2004 and 2008; we test alternative assumptions about the magnitude of trend reduction as part of the sensitivity analyses.

Table III.3 summarizes the major assumptions used in setting default values for each parameter in the cost module. These parameter values represent conservative but realistic assumptions, and are used to generate the base-case and single-payer cost projections described in Chapter IV.

C. FINANCING MODULE

The financing module estimates revenues from alternative tax bases that could be used to fund a single-payer health plan. The module considers additional revenue that might be generated from existing sources, including assessments on personal and corporate income, personal and real property, and sales.

Table III.3. Parameter Assumptions Used in the Cost Module of the Maine Microsimulation Model

Parameters	Mean Value	Source
Annual growth rate in per capita health care spending in base case, 2001-04		
Medical care spending for privately insured and uninsured	13.0%	HRET (2001, 2002)
Medical care spending for Medicare beneficiaries	3.2%	CMS (2002)
Medical care spending for Medicaid beneficiaries	7.0%	Blend of actual MaineCare trends for 1999-2001 and HRET (2001,2002)
Prescription drug spending	14.0%	Medco (2002)
Annual growth rate in per capita health care spending in base case, 2004-08		
Medical care	5.0%	CMS (2002)
Prescription drugs	7.0%	CMS (2002)
Payer administrative costs as a percentage of total costs:		
Private insurer costs for large groups (≥ 100 members)	12.0%	CRS (1988)
Private insurer costs for small groups (< 100 members)	22.0%	CRS (1988)
Private insurer costs for individual (nongroup) policyholders	30.0%	CRS (1988)
Medicare	2.1%	CMS (2002)
Medicaid	6.4%	CMS (2002)
CHAMPUS	8.0%	CRS (1988)
Single-payer administrative cost rate	5.0%	Benchmarked with Medicare and Medicaid cost rate
Hospital administrative cost rate in the base case	33.4%	Woolhander and Himmelstein (1997); Sheils et al. (1998); Sheils and Haught (2000)
Percent reduction in administrative costs under single-payer plan	15.0%	Judgment based on Woolhander and Himmelstein (1997); Sheils et al. (1998)

Source: Mathematica Policy Research, Inc.

Table III.3 (continued)

Parameters	Mean Value	Source
Physician administrative costs in the base case	32.0%	AMA (2000); Sheils et al. (1998)
Percent reduction in administrative costs under single-payer plan	15%	Judgment based on AMA (2000); Sheils et al. (1998)
Proportion of commercially insured population enrolled in HMOs in base case	55%	Judgment based on Anthem Blue Cross and Blue Shield of Maine; Interstudy (2002); Bureau of Insurance (2002)
Change in per-capita health care costs due to a 10 percent increase in commercial HMO enrollment	-1.0%	Judgment based on Cutler, McClellan and Newhouse (2000); Mobley (1998); Zwanziger, Melnick and Bamezai (2000); Glied (2000)
Percent of MaineCare population enrolled in PCCM in base case	43.0%	CMS (2002)
Percent of population below 200% FPL enrolled in PCCM in single-payer system	43.0%	Based on MaineCare experience as reported by CMS
Change in per-capita health care costs due to a 10% increase in PCCM enrollment.	-1.0%	Judgment based on Cutler, McClellan and Newhouse (2000); Glied (2000); Hurley et al. (1991); Meyer et al. (1996); Rask et al. (1999)
Base case uncompensated care costs as a percent of total private payer costs		
Hospitals	10.0%	American Hospital Association 2000 Survey of Hospitals, New England estimate (MedPac 2001)
Physicians	6.0%	American Medical Association 2000 Socioeconomic Monitoring System Survey, New England estimate (AMA 2002)
Percent reduction in uncompensated care costs under single-payer plan		
Hospitals	90.0%	Judgment based on care for individuals who are not Maine citizens
Physicians	90.0%	
Health care utilization by uninsured as a percent of utilization by insured populations	70.0%	Long and Marquis (1994)
Percent of health care spending on the uninsured paid out-of-pocket	40.0%	Blue Ribbon Commission (2000); Young (1995)

Table III.3 (continued)

Parameters	Mean Value	Source
Percent change in hospital care spending for formerly under-insured and uninsured residents due to elimination of avoidable hospitalizations and emergency visits	-4.0%	Informed judgment based on Ayanian et al. (2000); Culler et al. (1998); Parchman and Culler (1999); Friedman and Basu (2001)
Percent change in ambulatory care spending for formerly under-insured and uninsured residents due to elimination of avoidable hospitalization and emergency visits	-2.0%	Informed judgment based on Friedmand and Basu (2001); Eisert and Gabow (2002); Steiner et al. (2002)
Percent increase in total health care spending due to 10% decrease in consumer out-of-pocket spending on health care	1.7%	RAND Health Insurance Experiment (Newhouse 1993) and unpublished estimates from Congressional Budget Office

Source: Mathematica Policy Research, Inc.

Because most of Maine's current private health insurance is employer-sponsored and therefore now financed as an offset to wages and salaries, the financing module also allows Maine to consider the equitable reallocation of some or all of the costs of a single-payer system back to wages and salaries via a tax on payroll (wages and salaries) and farm income.

1. Input Data

The financing module considers five major sources of financing for a single-payer system: (1) various general revenue tax bases; (2) real and personal property; (3) earnings; (4) public sector maintenance of effort; and (5) consumer out-of-pocket spending for health care. Each is described below.

a. General Revenue Sources

The financing module incorporates information about Maine's current general revenues from the following 10 sources:

- Individual income tax
- Corporate income tax
- Sales and use taxes
- Motor fuel taxes
- Business taxes
- Succession taxes

- Real estate transfer tax
- Special industry taxes
- Cigarette and tobacco taxes
- Taxes on spirits, beer, and wine

We base revenues from these sources on the 2002 projected revenues obtained from the Maine Revenue Services. We project revenues from each source to 2004 and 2008 at the historical average annual growth in revenues from each source between 1997 and 2002. The module allows the user to adjust the assumption about projected growth and to increase revenues from each source (by one or more percentage points or a fraction of a percentage point) to produce additional revenues. It exempts amounts paid as a tax on payroll (discussed below) from additional taxation as personal income.

b. Real and Personal Property

The module incorporates information about Maine's property values and the effective rate of taxation on property, obtained from the Web site of the Maine Revenue Service (http:// www.state.me.us/revenue/propertytax/homepage.html). The module contains assessed municipal property valuations (aggregated real and personal property) by county, projected to 2004 and 2008 by using the historical rate of growth reported between 2000 and 2001. Property in unorganized territories is valued at the state valuation and projected forward as an aggregate. Current effective tax rates by county and for unorganized territories are calculated as total revenues per total assessed valuation in 2001. To calculate net revenues from additional property taxation by county, the module allows the user to adjust effective tax rates and to revise assumptions about projected growth in property valuation.

c. Earnings from Employment

The module incorporates payroll and farm income projections as of July 2002, obtained from the Maine Consensus Economic Forecasting Commission. Earnings per worker are calculated from the Commission's projections of total employment and total payroll and farm income to 2002 and 2004, and both employment and earnings per worker are projected to 2008 by the average annual rate of growth implicit in the Commission's short-term projections from 2002 to 2004. The module allows the user to adjust assumptions about projected earnings per worker (separately for payroll and farm income) and to estimate the revenues that might be obtained by imposing a tax on either or both.

We assume that the value of contributions that employers could have made to health insurance will be passed forward to workers as an increase in wages and salaries. The model automatically calculates private employer payments for health insurance as a percentage of payroll (public employer payments are retained separately as maintenance of effort, described below), and retains this value as the default rate of taxation on payroll to finance the single-

payer system. The default rate of taxation on farm income is set to zero, as we presume that all health insurance among farm workers is individually purchased.

d. Public Sector Maintenance of Effort

The financing module assumes federal maintenance of effort for Medicare, MaineCare, CHAMPUS, and federal employees as well as current federal spending for direct health care services. It assumes that federal funding for Medicare, FEHBP, and CHAMPUS would continue as in the base case (without single-payer reform), in effect as if these programs made capitated payments for all Maine beneficiaries. Because this assumption has precedent elsewhere, we believe that it is the most likely scenario for federal maintenance of effort in Maine.[3]

Federal funding for MaineCare also would continue, and it would include additional matching funds associated with new enrollees who had been eligible but not enrolled. We estimate federal funding at current reimbursement rates only for current MaineCare enrollees. For persons who are newly enrolled in MaineCare, we assume providers are paid the same average rate as for all single-payer plan enrollees. In 2004, these standard rates are benchmarked to private insurer payment levels and then trended to 2008 using the same cost trends implicit in all of the model's cost estimates.

We assume that the federal matching rate remains at two thirds of MaineCare spending for medical services, and calculate state MaineCare financing as a residual (total minus federal matching). The financing module presumes state maintenance of effort only for base-case MaineCare enrollees; it seeks new funding for the state's cost of enrolling additional MaineCare beneficiaries through the single-payer system.

e. Consumer Out-of-Pocket Expenditures for Health Care

Finally, the financing module incorporates the cost module's calculation of consumer out-of-pocket spending for health care. Given that variation in benefit design and in income thresholds for consumer cost sharing drives differences in plan cost as well as out-of-pocket spending, the financing module re-estimates financing for each benefit design and cost-sharing variant.

[3] The United Mineworkers plan offers a precedent for this way of handling federal maintenance of effort. Specifically, Medicare uses capitated payments to fund Medicare beneficiaries enrolled in the United Mineworkers plan. While alternative forms of federal maintenance of effort might be feasible (such as coordination of benefits), modeling such alternatives would require precise information about how Maine might set payment rates or risk-adjust providers for specific segments of the Maine population enrolled in the single-payer plan.

Table III.4 documents the assumptions used in developing financing estimates from the Maine Microsimulation Module.

2. Module Outputs

The financing module produces base-case and single-payer estimates of the sources and levels of revenues available to finance health care spending in 2004 and 2008. It compares the revenues to estimates of health plan costs net of financing for each of the seven single-payer designs. At present, the model assumes no macroeconomic impact associated with increases or decreases in overall tax burden or the redistribution of tax burden associated with a single-payer health plan.

D. ECONOMIC IMPACT MODULE

The economic impact module projects employment change in Maine by sector related to changes in health care financing. At this time, the economic impact module is fully integrated with the population and cost modules but is not integrated with the financing module. The independence of the financing and economic modules has implications for the findings of each. Some of these implications are discussed at the end of this section.

1. Input Data and Major Assumptions

We obtained projections of employment by industry (at the two-digit SIC level) from the Maine Consensus Economic Forecasting Commission. The data reflect Maine's consolidated economic forecast as of July 2002 and include employment projections through 2005. We estimated 2008 employment by extrapolating 2005 employment levels by the projected average annual rate of growth in each industry group between 2002 and 2005.

To develop estimates of employment in specific health-related sectors within major industry groups, we applied projected 2005 national ratios of sector employment per industry-wide employment to Maine's projected employment by industry (Pfleeger and Wallace 1994). Using the same ratio for both 2004 and 2008, we estimated baseline employment in nine sectors within four industries: construction; manufacturing; finance, insurance, and real estate; and services. The specific sectors for which we estimated employment are:

- Construction of health care facilities
- Manufacturing of medical instruments and supplies
- Manufacturing of pharmaceuticals
- Health insurance carriers and brokers, agents, and related insurance services
- Private hospitals

Table III.4 Parameter Assumptions Used in the Financing Module of the Maine Microsimulation Model

Parameters	Mean Value	Source
Percent of insurance premium paid by employee	16.5%	MEPS, Maine Subsample (AHRQ 2000)
Percent of adjusted gross income from wages and salaries among Maine-median income taxpayers	81.3%	Internal Revenue Service (2001)
Percent of adjusted gross income in taxpaying households at Maine median income	96.4%	Internal Revenue Service (2001)
Effective personal income tax rate per total adjusted gross income	8.0%	Bureau of Revenue Services.

Source: Mathematica Policy Research, Inc.

- State hospitals
- Offices of health practitioners
- Nursing and personal care facilities
- Other health services

We implicitly assumed that employment in each of these sectors grew at the same rate as employment in the industry. Moreover, we assumed that health insurance represents 20 percent of total employment in insurance companies as well as 20 percent of employment in insurance brokerages and agents.

Table III.5 documents the assumptions used in developing estimates of the economic impact of a single-payer system in Maine.

2. Sources of Employment Change

We estimated employment change attributable to three features of a single-payer system in Maine: (1) reduction in administrative costs; (2) increase in spending for medical care; and (3) management of increases in health care costs. Each of these sources is described briefly below.

Table III.5. Parameter Assumptions Used in the Economic Impact Module of the Maine Microsimulation Model

Parameters	Mean Value	Source
Percent of employment in Finance, Insurance and Real Estate associated with insurance carriers	19.9%	Pfleeger and Wallace (1994)
Percent of employment in Finance, Insurance and Real Estate associated with insurance agents and brokers	11.4%	Pfleeger and Wallace (1994)
Percent of insurance employment associated with health insurance	20.0%	Judgment based on distribution of total insurance premium revenues
Percent of private service employment associated with health care services	26.4%	Pfleeger and Wallace (1994)
Percent of government employment associated with health care services	5.9%	Pfleeger and Wallace (1994)
Percent of construction and manufacturing employment associated with health care services	1.1 to 2.4%	Pfleeger and Wallace (1994)
Percent increase in employment associated with 10% increase in health care spending	6.0%	Hammermesh (1986)

Source: Mathematica Policy Research, Inc.

a. Reduction in Administrative Costs

We assume administrative cost savings related to the sale and administration of insurance and to providers' billing activity. Specifically, we assume that the administrative cost percentage associated with insurance decreases from a weighted average of 10.3 percent to 5 percent—a rate somewhat below MaineCare's administrative cost ratio.[4] To reflect the administrative cost assumptions used in developing the model's cost estimates, we further assume that physicians and hospitals realize a 15 percent reduction in administrative costs as a consequence of administrative efficiency. Moreover, we assume that the revenue elasticity of employment in all sectors is 0.6. This rate is approximately the midpoint of the range reported in the literature (Hammermesh 1986), allowing for limited ability in the short-run to retrain administrative workers for other jobs at their current places of employment. We assume no change in the administrative costs of nursing or personal care facilities associated with a single-payer system.

[4] This rate of administrative cost is similar to that reported for Canada's national system, 6 percent in 2001 (Canadian Institute for Health Information 2001).

b. New Spending for Health Care Services

A single-payer system generates increased consumption of health care services by covering individuals who were previously uninsured and making insurance coverage more comprehensive for those who were underinsured relative to the single-payer benefit design. To the extent that the single-payer benefit design is more comprehensive (reducing consumer cost sharing for covered services and extending coverage to services that before might not have been covered at all), it encourages greater consumption of health care services. The impact of new spending for health care services affects all sectors either directly (the production of health care services) or indirectly (the production of complementary goods and services, such as construction of new facilities, manufacture of medical goods and equipment, and the administration of health care). Again, we assume that the employment response to an increase in health care spending is inelastic (0.6) in all employment sectors directly affected by greater demand for health care services.

c. Management of Growth of Health Care Costs

Finally, we consider the impact of constraining the growth in health care spending in Maine on employment throughout the state – that is, the multiplier effect of moderating the growth of health care costs. We adopt estimates produced by researchers at the U.S. Department of Labor who projected the long-range employment effects of slow versus rapid growth in health care spending (Pfleeger and Wallace 1994) and compute the employment change for Maine associated with slow health care cost growth between 2004 and 2008. We use the same adjustment factor in both years and for each of the seven alternative single-payer plan designs.

3. Module Outputs

The economic impact module projects total employment in the base-case and in the single-payer system, for each plan design in 2004 and 2008. It calculates separate estimates of employment change in selected health care-related industries based on net health care spending and administrative costs in the single-payer plan, as imported from the cost module.

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CHAPTER IV

MODEL RESULTS

Estimates from the Maine Microsimulation Model project how health care spending, financing, and economic activity are likely to change over time under current policy (the base case) and under several different single-payer health plan designs. The results indicate that, under current policy, health care spending in Maine will continue on a path of steady increase—rising by 37 percent between 2001-04 and by 31 percent between 2004-08. A variety of factors contribute to this cost trend, including continued growth in the volume and intensity of health care utilization, increases in the unit costs of health care due to new technology such as pharmaceuticals, and an aging Maine population. Implementation of a single-payer health system would increase health care spending at least in the short-term by expanding health insurance coverage to all formerly uninsured and under-insured populations and by enhancing the insurance benefits of many insured populations, including Medicare beneficiaries. At the same time, a single-payer system would also help to constrain growth in health care spending through reductions in administrative costs, elimination of uncompensated care cost-shifting, and constraints on underlying health care cost trends created by global budgeting and other payment policies.

The model projects that a single-payer health system would result in a net increase in total health care spending relative to the base case under most benefit designs, but this increase in spending declines over time. Some benefit designs that include consumer cost-sharing would produce a net savings in health care spending by 2008. In this chapter we present spending estimates for an array of different single-payer benefit designs, and examine the financing and economic impact estimates associated with each design. We begin by summarizing estimates of how population and insurance coverage characteristics change during the period of study, and then examine the cost, financing, and economic impact estimates under base case and single-payer assumptions.

A. POPULATION PROJECTIONS

Table IV.1 summarizes the analysis of the population module output. In 2004, 62.8 percent of Maine's population is projected to have employer coverage. This proportion is projected to drop to 62.3 percent by 2008, reflecting the relatively faster growth of the

population over age 65. Maine's low-income population is projected to rise by 1 percentage point. However, MaineCare enrollment (based on current eligibility rules and the current percentage of the population that is eligible but not enrolled) is projected to remain at approximately 15 percent of the population. The uninsured population—with neither Medicare nor any other source of coverage—is projected to remain at 7.4 percent of the total population. For both 2004 and 2008, we estimate that 3.2 percent of the total population, while insured, is underinsured.

As Maine's population ages, Medicare will become a larger source of health coverage in the state. The Medicare-covered population is projected to rise to nearly 19 percent of the noninstitutionalized population in 2004 and to nearly 20 percent in 2008. Among the MaineCare population, the percentage with Medicare coverage also is projected to rise to 23.3 percent in 2004 and to 24.2 percent in 2008 (see Table IV.1). Similarly, a larger proportion of the employer-insured population is projected to constitute retirees with Medicare coverage, rising from 8.4 percent in 2004 to 9.3 percent in 2008.

Table IV.2 provides the same information for Medicare beneficiaries in Maine. In both 2004 and 2008, approximately 28 percent of the Medicare population is projected to have supplemental employer coverage with 25 percent expected to carry Medigap coverage. Approximately 25 percent of Medicare beneficiaries are projected to rely solely on Medicare.

B. HEALTH CARE SPENDING ESTIMATES

Estimates from the Maine Microsimulation Model provide aggregate and per capita health care spending projections under base-case and single-payer assumptions for 2004 and 2008. The base-case projections assume that Maine's current health insurance and health care system remains in place through 2008. The single-payer projections assume that one of three alternative single-payer plan designs is fully implemented in 2004. For two of the three single-payer designs, we test several alternative cost-sharing requirements as described in Chapter III. All spending estimates are in nominal dollars not adjusted for inflation.

1. Health Care Spending Under Current Policy (Base-Case)

Under Maine's current system of health care financing, spending for health services in the state will reach an estimated $8.4 billion in 2004, an increase of 37 percent over spending in 2001 (the most recent year for which complete cost data in Maine are available). State and federal spending on MaineCare is projected to reach $2.2 billion in 2004 compared with projected Medicare spending of $1.9 billion and private health insurance spending of $2.8 billion (see Table IV.3). Out-of-pocket spending for health services for both the insured and uninsured is projected to total $1.2 billion in 2004 (exclusive of premium contributions and uncompensated care), equal to 14.1 percent of all health care spending in Maine. By 2008, Maine's total health care spending is expected to grow another 31.4 percent, reaching nearly $11 billion.

Table IV.1. Projected Population Size by Baseline Source of Coverage (in Thousands)

	2004				2008			
		Percent of Total Population				Percent of Total Population		
	Total Count	Medicare	No Medicare	Total	Total Count	Medicare	No Medicare	Total
Total	1,290.3	18.9%	81.1%	100.0%	1,324.8	20.3%	79.7%	100.0%
Employer Provided Insurance	810.8	5.3%	57.5%	62.8%	825.7	5.8%	56.5%	62.3%
Firms < 25	161.4	2.2%	10.3%	12.5%	166.1	2.4%	10.1%	12.5%
Firms 25-99	99.1	0.5%	7.2%	7.7%	100.6	0.5%	7.1%	7.6%
Firms >= 100	550.3	2.7%	40.0%	42.6%	559.0	2.9%	39.3%	42.2%
Federal	5.9	0.0%	0.4%	0.5%	6.0	0.0%	0.4%	0.5%
State	26.8	0.1%	1.9%	2.1%	27.3	0.1%	1.9%	2.1%
Other	517.6	2.5%	37.6%	40.1%	525.8	2.7%	37.0%	39.7%
Other Private Insurance	102.3	4.7%	3.2%	7.9%	109.8	5.1%	3.2%	8.3%
CHAMPUS	26.7	0.7%	1.4%	2.1%	28.0	0.8%	1.3%	2.1%
Medicaid/SCHIP	193.9	3.5%	11.6%	15.0%	197.7	3.6%	11.3%	14.9%
No Supplemental Coverage	156.7	4.7%	7.4%	12.1%	163.6	5.0%	7.3%	12.4%
Medicaid/SCHIP Eligible	13.2	0.2%	0.9%	1.0%	13.5	0.2%	0.8%	1.0%
Not Eligible	143.4	4.5%	6.6%	11.1%	150.1	4.9%	6.5%	11.3%
< 200% FPL		9.2%	23.3%	32.6%		10.1%	23.5%	33.6%
200-299% FPL		4.7%	13.0%	17.7%		5.3%	13.1%	18.4%
300-399% FPL		1.9%	15.6%	17.4%		2.0%	15.7%	17.7%
400+ % FPL		3.3%	30.1%	33.4%		3.7%	30.4%	34.1%
Percent Underinsured		0.0%	3.2%	3.2%		0.0%	3.2%	3.2%

Source: Mathematica Policy Research, Inc.

Table IV.2 Number and Percent of Medicare Covered Population by Source of Coverage, Projected 2004 and 2008 (Baseline)

	2004		2008	
	Medicare (in thousands)	Percent of Medicare Population	Medicare (in thousands)	Percent of Medicare Population
Employer Provided Insurance	69.0	28.3%	76.8	28.5%
Firms < 25	28.8	11.8%	32.1	11.9%
Firms 25-99	5.9	2.4%	6.5	2.4%
Firms >= 100	34.3	14.1%	38.2	14.2%
Federal	0.4	0.2%	0.4	0.2%
State	1.7	0.7%	1.9	0.7%
Other	32.3	13.2%	35.9	13.3%
Other Private Insurance	60.6	24.8%	67.6	25.1%
CHAMPUS	9.2	3.8%	10.3	3.8%
Medicaid/SCHIP	44.5	18.2%	47.9	17.8%
No Supplemental Coverage	60.6	24.8%	66.8	24.8%
Medicaid/SCHIP Eligible	2.2	0.9%	2.4	0.9%
Not Eligible	58.4	23.9%	64.4	23.9%
Total	244.1	100.0%	269.2	100.0%

Source: Mathematica Policy Research, Inc.

Table IV.3. Base Case Health Care Spending in Maine by Source

	Spending by Year (in millions)		
Source of Funds	2001	2004	2008
Aggregate Spending (in millions)			
Government Programs			
Medicaid/SCHIP program spending	$1,375.6	$2,237.3	$2,930.9
Medicaid out-of-pocket spending	$5.0	$9.4	$12.2
Medicare program spending	$1,259.4	$1,884.8	$2,590.3
Medicare out-of-pocket spending	$59.0	$84.5	$120.3
Private Health Insurance			
Large group (>100 members) health plan spending	$1,484.9	$1,653.2	$2,096.3
Large group out-of-pocket spending	$279.5	$370.7	$472.4
Small group (2-99 members) health plan spending	$690.0	$827.8	$1,061.4
Small group out-of-pocket spending	$177.0	$297.5	$382.9
Nongroup/individual health plan spending	$237.8	$334.5	$453.3
Nongroup/individual out-of-pocket spending	$154.4	$224.5	$304.9
CHAMPUS health plan spending	$96.0	$127.3	$167.0
CHAMPUS out-of-pocket spending	$5.0	$7.9	$10.5
Uninsured out-of-pocket spending[a]	$121.9	$171.1	$217.5
Total Third Party Spending	$5,114.1	$7,183.2	$9,449.2
Total Out-of-Pocket Spending	$985.1	$1,175.9	$1,534.0
Total Spending	$6,099.2	$8,359.1	$10,983.2
Per Capita Spending (in dollars)			
Third Party Spending	$4,016	$5,567	$7,133
Out-of-Pocket Spending	$774	$911	$1,1158
Total Spending	$4,790	$6,478	$8,291

Source: Mathematica Policy Research, Inc.

On a per capita basis, health care spending in Maine is projected to average $6,478 in 2004 and $8,291 by 2008. These estimates reflect a 3.2 percent annual growth rate in Medicare medical care spending and a 13 percent annual growth rate for non–Medicare spending through 2004, converging to a 5 percent annual growth rate thereafter. We assume prescription drug spending rises by 14 percent annually through 2004 and by 7 percent thereafter.

The base-case distribution of spending across broad categories of health care services remains relatively stable, with 38 percent of spending allocated to hospital services, 15 percent to physician and other medical provider services, 19 percent to prescription drugs, 10 percent to other medical care services, and 10 percent to administration (see Table IV.4). The model also tracks an additional 8 percent of health care spending that reflects other services (such as long-term care, board and care, and other nonmedical services) covered by MaineCare, but not by other sources of coverage.[1] Prescription drug spending is projected to grow faster than other service categories in the base-case, rising by 38 percent between 2004 and 2008. By comparison, spending on hospital care and medical provider services is projected to grow by 26 percent and inpatient care by 28 percent during the same period.

2. The Cost of a Single-Payer Plan

Both aggregate and per capita health care spending rise in the short term under most of the single-payer health plan designs examined in this study (Figure IV.1). Under all of the single-payer designs, new spending for formerly uninsured and underinsured individuals is substantially offset by reductions in insurer and provider administrative costs and by the elimination of uncompensated hospital and physician care. Our estimates indicate that during the first year of implementation (2004), a universal single-payer health plan results in spending changes that vary from a *reduction* of 2 percent (Plan 3 with all persons above 200 percent FPL subject to cost sharing) to an *increase* of 14 percent (Plan 1, the MaineCare benefit design) relative to base case spending. With spending growth constrained at a level 5 percent below the base case trends between 2004 and 2008, net spending under a single-payer system would vary between -8 percent and +7 percent of the base case spending.

Single-Payer Plan 1: MaineCare Benefit Design. The MaineCare benefit design provides the highest ratio of covered benefits to total expenditures (99 percent); out-of-pocket spending represents less than 1 percent of total health plan spending (Table IV.5). This design is much more generous than the base-case, in which estimated out-of-pocket spending accounts for 18 percent of total spending for health services.

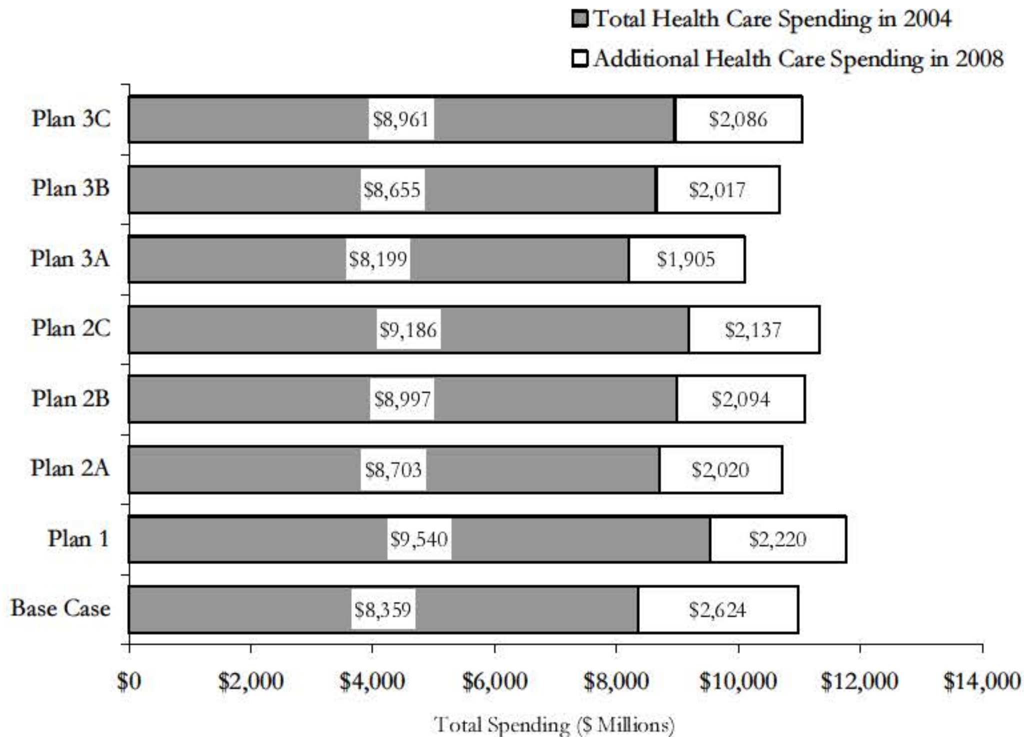
[1] Tracking these Medicaid-only services separately allows more accurate comparisons of spending and utilization among different sources of health insurance and program coverage in the model.

Table IV.4. Projected Health Care Spending by Type of Service Under Base Case and Single-Payer Assumptions

	Spending by Type of Service (in millions)							
Benefit Plan	Hospital	Physician	Pharmacy	Other Services	Other Medicaid	Admin	Total Spending	Percent of Base Case
Base Case								
2004	$3,153.6	$1,221.6	$1,613.0	$827.8	$678.9	$864.2	$8,359.1	100%
2008	$3,975.1	$1,558.9	$2,224.4	$1,165.7	$924.7	$1,134.3	$10,983.2	100%
Plan 1								
2004	$3,618.9	$1,678.5	$1,642.7	$1,498.9	$678.9	$421.9	$9,539.8	114%
2008	$4,352.3	$2,019.7	$2,146.4	$1,800.7	$924.7	$516.0	$11,759.7	107%
Plan 2A								
2004	$3,254.5	$1,545.7	$1,497.6	$1,344.4	$678.9	$382.1	$8,703.2	104%
2008	$3,908.9	$1,857.5	$1,953.3	$1,611.8	$924.7	$466.6	$10,722.8	98%
Plan 2B								
2004	$3,368.3	$1,588.9	$1,550.1	$1,415.1	$678.9	$396.1	$8,997.5	108%
2008	$4,049.8	$1,911.2	$2,024.1	$1,696.7	$924.7	$484.1	$11,090.6	101%
Plan 2C								
2004	$3,453.6	$1,619.5	$1,581.9	$1,447.5	$678.9	$405.1	$9,186.4	110%
2008	$4,152.5	$1,948.1	$2,066.0	$1,736.1	$924.7	$495.1	$11,322.6	103%
Plan 3A								
2004	$3,025.7	$1,464.5	$1,415.0	$1,256.6	$678.9	$358.1	$8,198.7	98%
2008	$3,633.2	$1,759.3	$1,844.6	$1,505.1	$924.7	$437.1	$10,104.0	92%
Plan 3B								
2004	$3,204.2	$1,531.5	$1,494.8	$1,365.6	$678.9	$379.8	$8,654.7	104%
2008	$3,853.2	$1,842.3	$1,951.9	$1,635.6	$924.7	$464.2	$10,671.9	97%
Plan 3C								
2004	$3,344.2	$1,581.4	$1,545.3	$1,416.9	$678.9	$394.4	$8,961.1	107%
2008	$4,021.4	$1,902.3	$2,018.3	$1,698.0	$924.7	$482.0	$11,046.6	101%

Source: Mathematica Policy Research, Inc.

Figure IV.1. Projected Health Care Spending Under Base Case And Single-Payer Health Plans: 2004 And 2008



Source: Mathematica Policy Research, Inc.

Reflecting the very low cost sharing, projected total spending under Plan 1 is $9.5 billion in 2004, approximately $1.2 billion (14 percent) higher than spending in the base-case. However, by 2008, the difference in spending between the two plans is projected to narrow to less than $0.8 billion (7 percent) as the single-payer plan realizes cost savings from global budgeting and preventable hospital and emergency room use.

Single-Payer Plan 2: Copayment Plan (2A-2C). Given that Plan 2 involves several conventional forms of cost sharing for some share of the population (defined by family income relative to the poverty level), projected health care spending under the plan is lower than for Plan 1. When cost sharing is required of all families with income above 200 percent of the federal poverty level, projected total spending is $8.7 billion in 2004, 4 percent higher than base-case spending but 8 percent lower than plan 1. By 2008, spending under Plan 2 is projected to be 2 percent less than the base case assuming the rate of cost growth is constrained at 5 percent below the base case trends. In 2004, an additional $294 million in health plan spending occurs when the cost-sharing threshold is relaxed to 300 percent FPL and another $189 million when the threshold is relaxed to 400 percent FPL.

Table IV.5. Projected Health Care Spending by Source Under Base Case and Single-Payer Assumptions

	2004 Spending (in millions)			2008 Spending (in millions)		
Benefit Plan	Health Plan	Out-of-Pocket	Total	Health Plan	Out-of-Pocket	Total
Base Case	$7,183.0	$1,176.0	$8,359.0	$9,449.0	$1,534.0	$10,983.0
Single-Payer Plan 1	$9,500.0	$39.0	$9,540.0	$11,710.0	$49.0	$11,760.0
Single-Payer Plan 2A	$8,470.0	$233.0	$8,703.0	$10,432.0	$291.0	$10,723.0
Single-Payer Plan 2B	$8,821.0	$175.0	$8,997.0	$10,874.0	$216.0	$11,091.0
Single-Payer Plan 2C	$9,057.0	$129.0	$9,186.0	$11,162.0	$160.0	$11,323.0
Single-Payer Plan 3A	$7,826.0	$373.0	$8,199.0	$9,640.0	$464.0	$10,104.0
Single-Payer Plan 3B	$8,379.0	$276.0	$8,655.0	$10,331.0	$341.0	$10,672.0
Single-Payer Plan 3C	$8,764.0	$197.0	$8,961.0	$10,803.0	$244.0	$11,047.0

Source: Mathematica Policy Research, Inc.

Single-Payer Plan 3: Coinsurance Plan (3A-3C). Because Plan 3 involves higher cost-sharing requirements than Plan 2, it generates the lowest health care spending projections of all the designs we examined. When cost sharing is imposed at or above 200 percent FPL, projected health care spending totals $8.2 billion in 2004, approximately 2 percent less than the base-case spending projection and 14 percent less than spending for plan 1. By 2008, spending under Plan 3 reaches $10.1 billion, representing an 8 percent reduction in spending from the base case. Relaxing Plan 3's cost-sharing threshold to 300 percent FPL and 400 percent FPL yields spending increases of $456 million and $306 million, respectively, in 2004.

C. HEALTH CARE FINANCING ESTIMATES

For all benefit designs that we considered, the total cost of a single-payer system could be offset substantially by the spending that is projected to occur in 2004 and 2008 in the base case (i.e. without single-payer reform). However, because none of the single-payer scenarios involves premium financing, all of the base case expenditures on insurance by employers, employees, and individuals are released. The model estimates the proportion of health care expenditures in a single-payer system that must be financed from alternative sources net of the public funding that is projected to remain in Maine's health care system.

1. Maintenance of Effort and Obligated Funding

Table IV.6 summarizes the financing that we assume would remain in a single-payer system. As described in Chapter III, funds include substantial federal spending for Medicare and MaineCare beneficiaries as well as federal spending for FEHBP and CHAMPUS. State spending for MaineCare beneficiaries also would continue, and total MaineCare spending would rise as eligible persons who are not enrolled are swept into the single-payer system and providers are paid at the higher single-payer plan rates for new beneficiaries.

Assuming no reform, public-sector spending in Maine is projected to finance 54 percent of all health care expenditures in Maine by 2004 and 55 percent by 2008. These expenditures include funding for Medicare and MaineCare, as well as federal, state, and local government spending for public employees and direct health care services.

In a single payer system, the proportion of cost that would be financed by maintenance of effort varies with the overall cost of the system, largely because the model assumes that Medicare, FEHBP, and CHAMPUS expenditures are capitated at base-case levels. Consequently, federal and state maintenance of effort generally funds a smaller share of the cost of plan designs that generate higher additional demand for services. Maintenance of effort is projected to fund 48 percent of the total cost of Plan 1 in 2004 but 56 percent of the cost of Plan 3A (the least generous plan design). In 2008, maintenance of effort is projected to fund 52 percent of Plan 1 costs, assuming that federal capitation rates are not adjusted to reflect constrained health care spending in Maine (the most literal definition of maintenance of effort). Federal, state, and local maintenance of effort is projected to fund nearly 60 percent of the total cost of Plan 3A in 2008.

Table IV.6. Summary of Financing Sources for Baseline and Single-Payer Health Plans, 2004 and 2008

	Baseline		Single-Payer Plan 1		Single-Payer Plan 2A		Single-Payer Plan 2B	
	2004	2008	2004	2008	2004	2008	2004	2008
Total health plan cost (in millions)	$8,359.1	$10,983.2	$9,539.8	$11,759.7	$8,703.2	$10,722.8	$8,997.5	$11,090.6
Insurance premiums[a]	34.8%	34.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Consumer out of pocket[b]	14.1%	14.0%	0.4%	0.4%	2.7%	2.7%	1.9%	2.0%
Maintenance of effort[c]	53.7%	54.6%	48.0%	51.5%	52.6%	56.4%	50.9%	54.6%
Federal								
Medicare	22.5%	23.6%	19.8%	22.0%	21.7%	24.2%	20.9%	23.4%
MaineCare	17.9%	17.8%	16.5%	17.6%	18.1%	19.3%	17.5%	18.7%
State								
MaineCare (baseline enrollment)	8.9%	8.9%	7.8%	8.3%	8.6%	9.1%	8.3%	8.8%
Obligated general revenues for state and local employees and state direct spending for health care services	2.6%	2.5%	2.3%	1.9%	2.5%	2.0%	2.4%	2.0%
Total financing in place	--	--	48.4%	51.9%	55.3%	59.2%	52.8%	56.5%
Net health plan cost (in millions)	--	--	$4,923.8	$5,658.0	$3,894.0	$4,379.6	$4,246.7	$4,821.8
Percent of total	--	--	51.6%	48.1%	44.7%	40.8%	47.2%	43.5%

Table IV.6 (*continued*)

	Single-Payer Plan 2C		Single-Payer Plan 3A		Single-Payer Plan 3B		Single-Payer Plan 3C	
	2004	2008	2004	2008	2004	2008	2004	2008
Total health plan cost (in millions)	$9,186.4	$11,322.6	$8,198.7	$10,104.0	$8,654.7	$10,671.9	$8,961.1	$11,046.6
Insurance premiums[a]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Consumer out of pocket[b]	1.4%	1.4%	4.5%	4.6%	3.2%	3.2%	2.2%	2.2%
Maintenance of effort[c]	49.8%	53.5%	55.8%	59.9%	52.9%	56.7%	51.1%	54.8%
Federal								
Medicare	20.5%	22.9%	23.0%	25.6%	21.8%	24.3%	21.0%	23.4%
MaineCare	17.2%	18.3%	19.2%	20.5%	18.2%	19.4%	17.6%	18.8%
State								
MaineCare (baseline enrollment)	8.1%	8.6%	9.1%	9.7%	8.6%	9.1%	8.3%	8.8%
Obligated general revenues for state and local employees and state direct spending for health care services	2.4%	1.9%	2.7%	2.2%	2.5%	2.1%	2.4%	2.0%
Total financing in place	51.2%	54.9%	60.4%	64.5%	56.1%	59.9%	53.3%	57.0%
Net health plan cost (in millions)	$4,480.8	$5,109.8	$3,249.6	$3,588.0	$3,802.6	$4,278.7	$4,187.8	$4,750.6
Percent of total	48.8%	45.1%	39.6%	35.5%	43.9%	40.1%	46.7%	43.0%

Source: Mathematica Policy Research, Inc.

[a]Estimates includes health insurance premium payments by non-Federal employers, employees, and individuals

[b]Base-case estimate includes spending by both insured and uninsured consumers net of uncompensated care. Uncompensated care expenditures are presumed to be financed by insurance payments and federal and state direct payments for health care.

[c]All estimates include federal payments for FEHBP, CHAMPUS, and direct federal and state spending for health care services, as well as, Medicare and MaineCare spending. Simulation estimates exclude direct state spending for health care services, which are retained as obligated general revenues."

To calculate the net financing burden of a single-payer system, the financing module retains other "obligated" funds from a number of sources, including public sector expenditures that now finance health insurance benefits for state and local government employees as well as projected state expenditures (in the base case) for direct health care services. The financing module also considers consumer out-of-pocket spending for health care, which falls from 14 percent of total spending in the base case (in 2004 and 2008) to less than 5 percent of total expenditures in Plan 3A and to about 0.5 percent in Plan 1.

Net of these sources of financing already in Maine's health care system–and assuming full premium relief for employers, employees, and other individuals–the projected net cost of a single-payer system in 2004 is projected to range from $3.2 billion (for Plan 3A) to $4.9 billion (for Plan 1). In 2008, the projected net cost ranges from $3.6 billion to $5.7 billion for these plan designs.

2. Financing the Net Cost of a Single-Payer System

In any major reform that offers premium relief, the principal financing challenge lies in the withdrawal of employer payments for health care. Economic theory holds that workers bear the cost of employer-paid insurance premiums in the form of reduced cash compensation—in effect, a tax on wages and salaries. The financing module recaptures the value of private employer contributions to health insurance as the default value of a tax on payroll. The projected value of such a tax (implicit in the base case spending estimates) is 6.6 percent in 2004 and 6.8 percent in 2008, although, among covered workers, we project employer contributions to health insurance to be roughly 10 percent of wages and salaries in both years.[2]

While the Maine Microsimulation Model offers users flexibility in considering financing options, this report cannot provide a comprehensive look at all possible financing options. Table IV.7 reports the results of two sets of simulations that compare alternative methods of financing with the net cost of a single-payer system. The first simulation assumes that all net costs are financed as a tax on wages and salaries (including self-employed earnings). The second assumes more diversified financing of net costs, retaining only the current effective burden of the employer cost of health insurance benefits on wages and salaries in both years.

In 2004, the rate of *additional* taxation on payroll required to fund the net cost of a single-payer system varies from 4.5 percent (for Plan 3A) to 10.2 percent (for Plan 1). Under the model's assumptions about the ability of a single-payer system to constrain cost growth over time, the rate of additional taxation that would be required in 2008 is somewhat less

[2] Including all employers (public as well as private sector), projected employer spending financed as tax on payroll in the base case is substantially higher—7.9 percent in 2004 and 8.1 percent in 2008. The financing module retains federal contributions to FEHBP as maintenance of effort and state and local contributions to public employee health insurance as obligated general revenues.

than in 2004: 4 and 8.7 percent, respectively. These out-year taxation rates produce *total* rates of payroll taxation that would vary between 11.1 percent (for Plan 3A) and 16.8 percent (for Plan 1) in 2004 and between 9.7 and 15.5 percent in 2008. It is important to note that in 2008, the lowest-cost single-payer plan that we estimated–Plan 3B–offers current employer-insured workers substantially more complete coverage than they now receive, at a somewhat lower average percent of payroll than we project that they would pay in the base case as a discount on wages and salaries (9.7 percent versus 10 percent).

Table IV.7 offers a second financing scenario that retains only the base-case level of private employer financing as a tax on payroll (6.6 and 6.8 percent in 2004 and 2008, respectively); additional financing takes the form of an increase in revenues from five sources that now contribute to Maine's general revenues: the individual income tax, the corporate income tax, sales and use taxes, and taxes on both tobacco and alcohol. Assuming no additional taxation on payroll, the projected burden of a single- payer system on Maine's general revenue sources is substantial for the most generous plan designs as well as for the designs that require minor cost sharing. For Plan 1, revenue from the individual income tax, the corporate income tax, and sales and use taxes would have to rise by 130 percent–more than doubling the current rates in these categories, assuming that the projected taxable base does not expand. For Plan 3A, the burden would be substantially less but still high: the net cost of the single-payer plan could be financed by raising revenues from individual and corporate income taxes and sales and use taxes by 57 percent and from tobacco and alcohol taxes by 76 percent.

Consideration of these two relatively extreme scenarios suggests two rules for financing the net cost of a single-payer system. First, the benefit design of the single-payer plan is critical in determining the plan's financing requirements. By constraining new demand, plan designs with somewhat more cost sharing correspond to a substantially lower need for additional financing. Second, broad financing of a single-payer system is essential. The change in tax burden estimated in the second financing scenario above seems likely to generate substantial economic dislocation. Broader financing–including not only "break-even" payroll tax financing but additional taxation on payroll as well as additional use of the state's current sources of revenue–would mitigate adverse economic effects.

D. ECONOMIC IMPACT ESTIMATES

We expect the impact of a single-payer system on total employment in Maine to derive from three main aspects of such a system: reduced administrative costs, increased demand for health care services, and constrained cost growth over time. Table IV.8 reports the projected changes in total employment related to each aspect. As with all other simulations reported in this chapter, the estimates reflect intermediate enrollment in managed care as well as moderate administrative cost savings and cost containment in a single-payer system. Further, as described in Chapter III, the estimates primarily reflect employment change in industries *directly* related to the health care and health insurance industry and do not include potential economy-wide impacts related to the financing of the single-payer system. In general, they should be regarded as "initial impact" projections of employment change.

Table IV.7. Estimated Tax Rates Required to Financial Alternative Single-Payer in 2004 and 2008: Illustrative Alternative Financing Scenarios

	Single-Payer Plan 1		Single-Payer Plan 2A		Single-Payer Plan 2B		Single-Payer Plan 2C	
	2004	2008	2004	2008	2004	2008	2004	2008
Payroll Tax Financing Only								
Current effective percent of payroll	6.6%	6.8%	6.6%	6.8%	6.6%	6.8%	6.6%	6.8%
Additional percent of payroll	10.2%	8.7%	6.7%	5.1%	7.9%	6.4%	8.7%	7.2%
Total percent of payroll	16.8%	15.5%	13.3%	11.9%	14.5%	13.2%	13.9%	14.0%
Diversified Financing								
Current effective percent of payroll	6.6%	6.8%	6.6%	6.8%	6.6%	6.8%	6.6%	6.8%
Increase in general revenues from:								
Individual income	130.1%	118.0%	83.1%	67.4%	99.1%	84.6%	110.0%	96.5%
Corporate income	130.1%	118.0%	83.1%	67.4%	99.1%	84.6%	110.0%	96.5%
Sales and use	130.1%	118.0%	83.1%	67.4%	99.1%	84.6%	110.0%	96.5%
Tobacco	150.0%	130.0%	127.8%	106.5%	136.5%	117.6%	138.5%	117.2%
Alcohol	150.0%	130.0%	127.8%	106.5%	136.5%	117.6%	138.5%	117.2%

Table IV.7. (Continued)

	Single-Payer Plan 3A		Single-Payer Plan 3B		Single-Payer Plan 3C	
	2004	2008	2004	2008	2004	2008
Payroll Tax Financing Only						
Current effective percent of payroll	6.6%	6.8%	6.6%	6.8%	6.6%	6.8%
Additional percent of payroll	4.5%	3.1%	6.4%	4.9%	7.7%	6.2%
Total percent of payroll	11.1%	9.9%	13.0%	11.7%	14.3%	13.0%
Diversified Financing						
Current effective percent of payroll	6.6%	6.8%	6.6%	6.8%	6.6%	6.8%
Increase in general revenues from:						
Individual income	56.5%	39.3%	80.0%	65.0%	97.5%	83.1%
Corporate income	56.5%	39.2%	80.0%	65.0%	97.5%	83.1%
Sales and use	56.5%	39.2%	80.0%	65.0%	97.5%	83.1%
Tobacco	76.1%	55.2%	111.3%	85.7%	125.0%	101.1%
Alcohol	76.1%	55.2%	111.3%	85.7%	125.0%	101.1%

Source: Mathematica Policy Research, Inc.

Due primarily to the substantial differences in new demand for health services associated with each benefit design, the estimates of employment change presented in Table IV.9 vary among the single-payer plan designs. However, in every case, gains or losses in net employment are relatively small–ranging from a small net loss of jobs (200, in Plan 2B) in 2004 to a potential gain of 3,000 jobs (Plan 1) in 2004. By 2008, as administrative costs continue below the projected base case and costs are reduced in the single-payer system, the model projects a net job loss in the health sector for every plan design. Relative to the base case, Plan 3A is projected to result in 8,200 fewer jobs in Maine by 2008; Plans 2A and 3B are projected to result in at least 5,000 fewer jobs by 2008.

Table IV.8. Change in Projected Total Employment by Source of Change, All Industry Groups, 2004 and 2008 (Employment in thousands)

	Single-Payer Plan 1		Single-Payer Plan 2A		Single-Payer Plan 2B		Single-Payer Plan 2C	
	2004	2008	2004	2008	2004	2008	2004	2008
Total change in employment	3.0	-0.2	-2.0	-5.2	-0.2	-3.4	0.9	-2.3
Reduced administrative cost	-5.7	-6.1	-6.2	-6.5	-6.0	-6.4	-5.9	-6.3
Increased health care use	9.2	6.4	4.7	1.9	6.3	3.5	7.3	4.5
Constrained cost growth	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5

	Single-Payer Plan 3A		Single-Payer Plan 3B		Single-Payer Plan 3C	
	2004	2008	2004	2008	2004	2008
Total change in employment	-5.0	-8.2	-2.3	-5.4	-0.4	-3.6
Reduced administrative cost	-6.5	-6.8	-6.2	-6.6	-6.0	-6.4
Increased health care use	2.0	-0.8	4.4	1.7	6.1	3.3
Constrained cost growth	-0.5	-0.5	-0.5	-0.5	-0.5	-0.5

Source: Mathematica Policy Research, Inc.

Most telling, however, is the distribution of projected job loss among industry groups and occupations. Table IV.9 offers a picture of the distribution by industry group for each single-payer plan design in 2004 and 2008. Direct job losses in the insurance industry are projected to be relatively small–in total, fewer than 1,000 jobs in either 2004 or 2008. This estimate reflects the low level of employment that Maine projects in these industries in 2004 and 2008 as well as the model's assumption that health insurance accounts for a relatively small share of employment among insurance carriers, agents, and brokers (20 percent). However, reflecting the drop in administrative costs in a single-payer system, the net loss of employment in hospitals and medical provider practices is significant in nearly all plan designs and in both years. Only in Plan 1 does the large initial increase in demand for health services in 2004 offset the loss of administrative positions in 2004, producing a small net gain in projected employment that year.

Table IV.9. Projected Change in Employment Associated with a Single-Payer System by Selected Industry Groups (in thousands)

	Single Payer Plan 1		Single Payer Plan 2A		Single Payer Plan 2B		Single Payer Plan 2C		Single Payer Plan 3A		Single Payer Plan 3B		Single Payer Plan 3C	
	2004	2008	2004	2008	2004	2008	2004	2008	2004	2008	2004	2008	2004	2008
Total employment[a]	3.0	-0.2	-2.0	-5.2	-0.2	-3.4	0.9	-2.3	-5.0	-8.2	-2.3	-5.4	-0.4	-3.6
Construction														
New hospitals and institutions	0.1	0.1	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Manufacturing														
Medical instruments and supplies	0.1	0.1	0.1	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Pharmaceuticals	0.1	0.1	0.1	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.1	0.0
Finance, insurance, real estate														
Insurance carriers	-0.2	-0.3	-0.4	-0.5	-0.3	-0.4	-0.3	-0.4	-0.4	-0.5	-0.4	-0.5	-0.3	-0.4
Insurance agents, brokers and services	-0.2	-0.2	-0.3	-0.3	-0.2	-0.3	-0.2	-0.3	-0.3	-0.4	-0.3	-0.3	-0.2	-0.3
Services														
Hospitals, private	0.1	-0.9	-1.5	-2.5	-0.9	-1.9	-0.5	-1.6	-2.4	-3.5	-1.6	-2.6	-1.0	-2.0
Offices of health practitioners	0.3	-0.5	-1.0	-1.8	-0.5	-1.3	-0.3	-1.1	-1.7	-2.5	-1.0	-1.8	-0.6	-1.4
Nursing and personal care facilities	1.0	0.6	0.4	0.0	0.6	0.2	0.8	0.3	0.0	-0.4	0.3	-0.1	0.6	0.2
Health services, n.e.c.	0.2	-0.1	-0.3	-0.6	-0.1	-0.5	0.0	-0.3	-0.6	-0.9	-0.3	-0.7	-0.2	-0.5
Government														
State and local hospitals	0.1	-0.2	-0.4	-0.7	-0.2	-0.5	-0.1	-0.4	-0.7	-1.0	-0.4	-0.7	-0.3	-0.6

Source: Mathematica Policy Research, Inc.

[a]Includes industries not shown.

These changes by industry are more clearly understood by considering changes in employment by occupational group as reported in Table IV.10. The model projects a loss of administrative jobs, including jobs in the insurance industry, hospitals, and medical provider offices, of 5,300 to 6,200 in either simulation year. However, the increased demand for health services associated with new coverage and reduced cost sharing is projected to drive increased employment among medical service providers, ranging from just 200 jobs (in Plan 3A) to 6,600 jobs (in Plan 1). By 2008, constrained cost growth moderates the increased demand for health care providers. Nevertheless, the model projects at least level employment among medical service providers (relative to the base case) in all plans except Plans 3A and 3B and continued, substantial net job growth in Plan 1.

In summary, the model projects a redistribution of jobs in Maine associated with a single-payer system that brings about reduced administrative costs and greater demand for health care services. A single-payer system would create a loss of administrative jobs that, in our projections, would continue in the long term. It also would create new medical provider jobs related to greater demand for health care services, as persons who had been uninsured gain coverage and the insured population gains greater coverage and reduced cost sharing.

The redistribution of jobs ultimately may ease the burden of financing a single-payer system, although the model at this point does not integrate the economic impact estimates with the financing estimates. In particular, a single-payer system would create new professional jobs in the health care sector–jobs that are more likely to remain local and that are potentially higher-paying than the jobs in insurance administration that they replace. Relative to the model's current financing estimates, the redistribution may reduce the per capita burden of financing the system either through a payroll tax or Maine's general revenue tax sources.

E. ACHIEVING FIVE PERCENT SAVINGS IN HEALTH CARE SPENDING

The Maine Legislature directed the Health Security Board to consider a single-payer health system that guarantees a minimum five percent savings over existing health care spending. Estimates from the Maine Microsimulation Model suggest that none of the seven single-payer health plans analyzed in this study would achieve this goal in 2004. The only health plan that achieves this goal by 2008—Plan 3C—would produce an 8 percent savings over the base case spending under current model assumptions. This plan achieves these savings by applying higher consumer cost-sharing requirements to larger segments of the Maine population than do other plan designs examined in this analysis.

Table IV.10. Projected Change in Employment Associated with a Single-Payer by Selected Occupational Groups (in thousands)

	Single-Payer Plan 1		Single-Payer Plan 2A		Single-Payer Plan 2B		Single-Payer Plan 2C	
	2004	2008	2004	2008	2004	2008	2004	2008
Total employment	3.0	-0.2	-2.0	-5.2	-0.2	-3.4	0.9	-2.3
Insurance administration[a]	-5.3	-5.8	-5.6	-6.1	-5.5	-6.0	-5.4	-5.9
Health care providers	6.6	4.1	2.6	0.0	4.0	1.5	4.9	2.4
Other	1.7	1.6	1.0	0.9	1.2	1.1	1.4	1.3

	Single-Payer Plan 3A		Single-Payer Plan 3B		Single-Payer Plan 3C	
	2004	2008	2004	2008	2004	2008
Total employment	-5.0	-8.2	-2.3	-5.4	-0.4	-3.6
Insurance administration[a]	-5.7	-6.2	-5.6	-6.1	-5.5	-6.0
Health care providers	0.2	-2.4	2.4	0.2	3.9	1.3
Other[b]	-0.5	-0.4	-0.9	-0.8	1.2	1.1

Source: Mathematica Policy Research, Inc.

[a]Includes administrative staff in hospitals and medical provider offices.
[b]Includes industries not shown.

One option for achieving a five percent savings by 2004 involves the use of still higher consumer cost-sharing requirements. Although it generates the lowest spending estimates of all the plan designs examined in this study, Plan 3C provides a more generous benefit package than is commonly available in most employer-provided health insurance plans. This benefit package covers 92.4 percent of all health plan expenditures for individuals above 200 percent of the federal poverty level, and 99.6 percent of expenditures for those below this income threshold (producing an average benefit rate of 95.6 percent). Introducing higher levels of cost-sharing for individuals above the income threshold would reduce health spending for these populations and lower the total cost of a single-payer system.

A preliminary analysis of alternative benefit designs suggest that a single-payer system could generate a minimum 5 percent savings in 2004 using a benefit package that covers 85 percent of all health plan expenditures for individuals above 200 percent FPL. Such a benefit package would be similar to conventional health plan designs currently offered in the employer-provided health insurance market, and include the following provisions:

- Annual deductibles of $250 for individuals and $500 for families
- Coinsurance of 80 percent on all services, subject to a $1250 out-of-pocket maximum for individuals and a $2500 maximum for families
- Three-tiered copayment for prescription drugs, requiring $10 for generic prescriptions, $20 for preferred brands, and $35 for nonpreferred brands.

Changing the benefit design is only one possible way of achieving cost savings within a single-payer health system. Other strategies could include more aggressive cost containment through managed care, global budgeting, or other payment and care management policies. We examine the projected effects of these strategies as part of the sensitivity analyses in Chapter V.

Finally, none of the estimates produced by the Maine Microsimulation Model account for the start-up and transition costs associated with implementing major health system reform. We discuss these transition issues and their possible costs in Chapter VI.

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CHAPTER V

SENSITIVITY ANALYSES

Estimates of the cost, financing requirements, and economic impact of a single-payer health system in Maine depend heavily on assumptions about the administrative costs and cost savings associated with the system. Because it is impossible to specify all the assumptions with certainty in a microsimulation model, it is important to test the sensitivity of model estimates to alternative but still realistic assumptions. To conduct the sensitivity tests, we varied—within plausible ranges—the values of major parameters used in the Maine Microsimulation Model and computed new estimates of single-payer cost and economic impact for each new set of parameter values.

This chapter presents our microsimulation results projecting the range of costs associated with alternative assumptions, and explores the implications of uncertainty for financing a single-payer system. We find that the intermediate-case estimates presented in Chapter IV are quite stable. That is, having selected the larger framework of the single payer system—the plan design and managed care environment in which it will operate—projected total spending and net cost are quite stable within plausible ranges of error in forecasting administrative cost savings and health care cost trends.

A. ASSUMPTIONS USED IN TESTING PLAN COST SENSITIVITY

The simulation estimates presented in Chapter IV derive from several assumptions regarding the implementation and operation of a single-payer health system in Maine. Among the most important assumptions are (1) the degree of managed care that is eliminated or retained within the single-payer system and the impact of such a change on health care spending; (2) the amount of administrative cost savings produced by the single-payer system at both the health plan and provider levels; and (3) the degree to which the single-payer system constrains underlying health care cost growth through global budgeting and other payment policies.

Considerable uncertainty exists around each of these assumptions, raising the possibility that incorrect assumptions could cause the microsimulation model to over- or underestimate the true cost and impact of a single-payer health system in Maine. For this reason, we examine how the projected cost and economic impact of a single-payer system changes

relative to the base case (status quo) estimate given alternative assumptions about the extent of managed care, potential administrative cost savings, and long-term cost trends. In all, we report on 17 sensitivity analyses and compare the results of each with the model's intermediate projections as presented in Chapter IV.

We first test the model's results related to the degree of managed care that will be retained in the single-payer system. We test a "low" managed care scenario and a "high" managed care scenario (see Table V.1). In the low managed care scenario, commercial HMO enrollment is eliminated. Health care spending increases by 10 percent for individuals who in the base case are enrolled in commercial HMOs (an estimated 55 percent of the privately insured population). However, we assume that the MaineCare primary care case management (PCCM) program continues to operate and that Maine residents exempt from cost sharing under the single-payer benefit design also are enrolled in a PCCM program in the same relative numbers as MaineCare beneficiaries in the base case (43 percent in 2002, as estimated by CMS).

In the high managed care scenario, the single-payer system retains all cost savings associated with commercial HMO enrollment. Moreover, 60 percent of persons exempt from cost sharing under the single-payer benefit design enroll in PCCM; this rate is approximately 50 percent greater than the base-case MaineCare enrollment rate. We assume that per capita health care spending is approximately 10 percent lower for those who enroll in PCCM compared with those who do not. By comparing these two scenarios, we can understand the range of costs in a single-payer system due to reducing or retaining the savings associated with managed care.

Within each of these managed care scenarios, we then test the sensitivity of single-payer costs to assumptions about the amount of administrative cost savings that a single-payer system might achieve. We test three alternative levels of potential cost savings (see Table V.2):

- ***Low administrative cost savings.*** In this scenario, the single-payer system reduces health plan administrative costs from an average of 10.3 percent of total costs (the weighted average of all private and public payers in the base case) to 7.5 percent—a level that is 50 percent greater than the "moderate" administrative cost rate described below and higher than MaineCare's current administrative cost rate of 6.4 percent. Hospital and physician spending on administration also declines modestly—by 7.5 percent, one-half the rate used in our "moderate" scenario.

- ***Moderate administrative cost savings.*** This scenario retains the intermediate assumptions about the decline in administrative costs that drives the model results described in Chapter IV. Specifically, the health plan administrative cost rate drops to 5 percent under the single-payer system—that is, to one-half the average rate in the base case. We assume that the administrative costs of hospitals and physicians decline by 15 percent.

Table V.1. Definition of High and Low Managed Care: Enrollment in HMO/PCCM Arrangements

	Managed Care Scenario	
Populations Covered	Low Managed Care	High Managed Care
Persons exempt from cost sharing	Current MaineCare PCCM enrollment (43 percent)	60 percent PCCM enrollment
Persons subject to cost-sharing	No managed care enrollment	Current commercial HMO enrollment

Source: Mathematica Policy Research, Inc.

- ***High administrative cost savings.*** In this scenario, health plan administrative costs decline to 2.5 percent of total costs (comparable to reported administrative costs in Medicare), hospital and physician administrative spending declines by 22.5 percent (to 25.6 percent and 24.8 percent, respectively)—1.5 times the administrative cost reductions assumed in the moderate scenario.

The administrative cost savings produced by a single-payer system will depend in part on the selected plan design. Under Plan 1, for example, providers expend relatively few resources on billing and collections because there are no deductibles and minimal copayments to administer. Similarly, the health plan requires relatively little administrative infrastructure for tracking consumer out-of-pocket spending. By contrast, Plan 3A requires administrative processes at both the provider and health plan levels for the purpose of managing the plan design's cost-sharing components. For this reason, it may be reasonable for the reader to focus on estimates associated with higher administrative savings assumptions for Plan 1 and on estimates associated with lower cost savings for other single payer plan designs. However, some of the administrative savings that we expect from a single payer system relate to standardization of data transmissions between health care providers and insurers—which under HIPAA will occur with or without a single payer system. Thus, the reader should view estimates associated with alternative levels of cost savings as savings net of the somewhat lower absolute level that may occur due to implementation of HIPAA standards.

Table V.2. Definition of Administrative Cost Reduction: Health Plans and Providers

Location of Administrative Cost	Low Reduction in Administrative Cost	Moderate Reduction in Administrative Cost	High Reduction in Administrative Cost
Change in health plan administrative cost	-25.0%	-50.0%	-75.0%
Change in provider administrative cost	-7.5%	-15.0%	-22.5%

Source: Mathematica Policy Research, Inc.

Finally, in addition to varying the model's managed care assumptions and administrative cost savings, we test the sensitivity of the model's cost results to the long-term cost trend of a single-payer system. This trend would vary with the ability of a single-payer system to constrain underlying health care cost growth through global budgeting or other payment policies. Again, we test three alternative cost trends:

- ***Low constraints on cost growth.*** In this scenario, the single-payer system reduces the underlying health care cost growth trend by 2.5 percent between 2004 and 2008 so that the effective cost trend is 4.3 percent per year for the four-year period (compared with the base-case trend of 5 percent).

- ***Moderate constraints on cost growth.*** In this scenario, the single-payer system reduces underlying the health care cost trend by 5 percent, producing an effective cost trend of 3.6 percent per year between 2004 and 2008.

- ***High constraints on cost growth.*** In this scenario, the underlying cost trend is reduced by 7.5 percent, producing an effective trend rate of 3 percent per year between 2004 and 2008.

By varying each of the three sets of assumptions described above, we define 17 alternatives to the intermediate-case results presented in Chapter IV. In Tables V.3 and V.4, those intermediate-case estimates fall into the mid-range cost scenario against which more conservative and more ambitious scenarios can be compared.

B. SENSITIVITY OF SINGLE-PAYER COST ESTIMATES

1. Variation in Administrative Cost Savings and Constraints on Cost in a Low Managed Care Environment

Table V.3 presents the cost estimates for all the scenarios that assume (as in Chapter IV) lower HMO savings under a single-payer health system than are projected to occur in the without reform. The estimates reflect moderate administrative cost savings and moderate constraints on underlying cost trends are the same as those presented in Chapter IV: 2004 spending for the single-payer plan designs ranges from $8.2 billion in Plan 3A to $9.5 billion in Plan 1—98 and 114 percent, respectively, of spending in the base case.

More conservative assumptions about administrative savings produce single-payer cost estimates ranging from $8.5 billion to $9.9 billion in 2004 (see Table V.3). These estimates exceed the base-case spending levels by 2 and 18 percent, respectively. Conversely, if the single-payer system achieved particularly high administrative savings (reaching approximately the level reported by Medicare), single-payer costs could range from 95 percent (Plan 3A) to 110 percent (Plan 1) of the base case in 2004.

Table V.3. Sensitivity of Total Spending to Alternative Administrative Cost and Cost Growth Assumptions (Low Managed Care)

	Low Administrative Savings		Moderate Administrative Savings		High Administrative Savings	
Year and Plan Type	Total Spending (in millions)	Percent of Base Case	Total Spending (in millions)	Percent of Base Case	Total Spending (in millions)	Percent of Base Case
2004 Projections						
Plan 1	$9,898.1	118%	$9,539.8	114%	$9,188.3	110%
Plan 2A	$9,024.6	108%	$8,703.2	104%	$8,387.8	100%
Plan 2B	$9,331.2	112%	$8,997.5	108%	$8,670.0	104%
Plan 2C	$9,528.6	114%	$9,186.4	110%	$8,850.7	106%
Plan 3A	$8,497.1	102%	$8,198.7	98%	$7,905.9	95%
Plan 3B	$8,972.3	107%	$8,654.7	104%	$8,343.1	100%
Plan 3C	$9,292.6	111%	$8,961.1	107%	$8,635.8	103%
2008 Projections with Low Constraint in Cost Growth						
Plan 1	$12,491.6	114%	$12,044.9	110%	$11,606.7	106%
Plan 2A	$11,380.8	104%	$10,980.6	100%	$10,587.9	96%
Plan 2B	$11,774.0	107%	$11,358.1	103%	$10,950.1	100%
Plan 2C	$12,022.6	109%	$11,596.2	106%	$11,177.8	102%
Plan 3A	$10,717.0	98%	$10,345.6	94%	$9,981.0	91%
Plan 3B	$11,324.2	103%	$10,928.4	100%	$10,539.9	96%
Plan 3C	$11,726.1	107%	$11,313.0	103%	$10,907.5	99%
2008 Projections with Moderate Constraint in Cost Growth						
Plan 1	$12,195.0	111%	$11,759.7	107%	$11,332.8	103%
Plan 2A	$11,112.7	101%	$10,722.8	98%	$10,340.1	94%
Plan 2B	$11,495.8	105%	$11,090.6	101%	$10,693.0	97%
Plan 2C	$11,738.1	107%	$11,322.6	103%	$10,914.9	99%
Plan 3A	$10,465.9	95%	$10,104.0	92%	$9,748.8	89%
Plan 3B	$11,057.6	101%	$10,671.9	97%	$10,293.3	94%
Plan 3C	$11,449.2	104%	$11,046.6	101%	$10,651.5	97%
2008 Projections with Aggressive Constraint in Cost Growth						
Plan 1	$11,898.4	108%	$11,474.6	104%	$11,058.9	101%
Plan 2A	$10,844.6	99%	$10,464.9	95%	$10,092.3	92%
Plan 2B	$11,217.6	102%	$10,823.1	99%	$10,435.9	95%
Plan 2C	$11,453.5	104%	$11,048.9	101%	$10,652.0	97%
Plan 3A	$10,214.8	93%	$9,862.4	90%	$9,516.6	87%
Plan 3B	$10,790.9	98%	$10,415.4	95%	$10,046.8	91%
Plan 3C	$11,172.2	102%	$10,780.2	98%	$10,395.6	95%

Source: Mathematica Policy Research, Inc.

Table V.4. Sensitivity of Total Spending to Alternative Administrative Cost and Cost Growth Assumptions (High Managed Care)

Year and Plan Type	Low Administrative Savings		Moderate Administrative Savings		High Administrative Savings	
	Total Spending (in millions)	Percent of Base Case	Total Spending (in millions)	Percent of Base Case	Total Spending (in millions)	Percent of Base Case
2004 Projections						
Plan 1	$9,650.1	115%	$9,302.0	111%	$8,960.6	107%
Plan 2A	$8,804.0	105%	$8,491.7	102%	$8,185.2	98%
Plan 2B	$9,105.1	109%	$8,780.7	105%	$8,462.4	101%
Plan 2C	$9,295.3	111%	$8,962.8	107%	$8,636.5	103%
Plan 3A	$8,297.5	99%	$8,007.3	96%	$7,722.5	92%
Plan 3B	$8,763.1	105%	$8,454.1	101%	$8,150.9	98%
Plan 3C	$9,070.8	109%	$8,748.4	105%	$8,432.1	101%
2008 Projections with Low Constraint in Cost Growth						
Plan 1	$12,186.8	111%	$11,752.6	107%	$11,326.6	103%
Plan 2A	$11,109.7	101%	$10,720.6	98%	$10,338.8	94%
Plan 2B	$11,496.2	105%	$11,091.7	101%	$10,694.8	97%
Plan 2C	$11,736.0	107%	$11,321.3	103%	$10,914.4	99%
Plan 3A	$10,471.6	95%	$10,110.2	92%	$9,755.4	89%
Plan 3B	$11,067.1	101%	$10,681.7	97%	$10,303.5	94%
Plan 3C	$11,453.6	104%	$11,051.6	101%	$10,657.0	97%
2008 Projections with Moderate Constraint in Cost Growth						
Plan 1	$11,898.0	108%	$11,475.0	104%	$11,059.9	101%
Plan 2A	$10,848.5	99%	$10,469.4	95%	$10,097.4	92%
Plan 2B	$11,225.1	102%	$10,831.0	99%	$10,444.2	95%
Plan 2C	$11,458.8	104%	$11,054.8	101%	$10,658.3	97%
Plan 3A	$10,226.8	93%	$9,874.7	90%	$9,529.0	87%
Plan 3B	$10,807.0	98%	$10,431.5	95%	$10,063.0	92%
Plan 3C	$11,183.6	102%	$10,791.9	98%	$10,407.5	95%
2008 Projections with Aggressive Constraint in Cost Growth						
Plan 1	$11,609.3	106%	$11,197.3	102%	$10,793.2	98%
Plan 2A	$10,587.4	96%	$10,218.2	93%	$9,856.0	90%
Plan 2B	$10,954.1	100%	$10,570.3	96%	$10,193.7	93%
Plan 2C	$11,181.6	102%	$10,788.2	98%	$10,402.1	95%
Plan 3A	$9,982.0	91%	$9,639.1	88%	$9,302.6	85%
Plan 3B	$10,546.9	96%	$10,181.4	93%	$9,822.6	89%
Plan 3C	$10,913.6	99%	$10,532.2	96%	$10,157.9	92%

Source: Mathematica Policy Research, Inc.

Different assumptions about the single-payer system's ability to constrain the underlying cost trend also have large effects on our estimates of total spending beyond the implementation year. Assuming moderate cost constraints and depending on the benefit design, single-payer spending is projected to range between $10.1 billion and $11.8 billion by 2008. These estimates are 92 to 107 percent of base-case spending in 2008. A more conservative assumption about the ability of a single-payer health system to constrain underlying health care cost trends produces 2008 spending projections that range between 94 percent (Plan 3A) and 110 percent (Plan 1) of cost in the base case. Conversely, with more aggressive constraints on cost growth, projected total costs would range between 90 percent (Plan 3A) and 104 percent (Plan 1) of the base case by 2008.

The low managed care environment contains the highest-cost scenario within the plausible ranges that we tested—low administrative cost savings and low constraints on underlying cost trends, together with low managed care. With the convergence of these conditions, the cost of a single-payer system in 2004 would range from at least 2 percent higher (Plan 3A) to as much as 18 percent higher than the base case (Plan 1). These percentage differences correspond to a higher total cost for a single-payer system that would range from $0.1 billion to $1.5 billion more than the projected cost of Maine's current system. By 2008, the cost margin between a single-payer system and the base case would still narrow, reflecting the retention of some cost control in a single-payer system. Assuming low administrative savings, Plan 1 would cost 14 percent more than the base case while Plan 3A would cost 2 percent less.

2. Variation in Administrative Cost Savings and Constraints on Cost in a High Managed Care Environment

Spending projections for all plan designs are predictably lower under the assumption that base-case HMO savings are fully retained under a single-payer system. Higher HMO enrollment, however, is likely to generate somewhat higher administrative costs, consistent with the broader use of cost containment strategies such as primary care case management and utilization review. Thus, in considering the high managed care scenarios in Table V.4, the reader should pay particular attention to the scenarios with relatively low administrative cost savings.

Assuming a high managed care environment, projected total spending in a single-payer system ranges between 99 percent (Plan 3A) and 115 percent (Plan 1) of base case costs in 2004. With moderate constraints on health care cost trends, the projected cost of these plan designs drops in 2008 to 93 and 108 percent, respectively, of the base case. A more conservative assumption about the potential for constraining underlying cost trends yields only slightly higher estimates of total spending in 2008: between 95 and 111 percent of the base case.

The least-cost scenario for the single-payer health care system occurs with the convergence of more extensive managed care, high administrative cost savings, and aggressive constraints on cost growth. With these conditions in place, projected spending in single-payer Plan 1 is 107 percent of the base case in 2004; in Plan 3A, projected spending is

92 percent 7 the base case. By 2008, all the single-payer plan designs generate lower costs than the base case, with Plan 1 producing 2 percent savings and Plan 3A producing 15 percent savings.

C. FINANCING STRATEGIES

The range of cost estimates presented above provides a general sense of how unexpected cost levels and growth may affect net costs of a single-payer system and therefore the adequacy of the system's financing. Considering the obvious uncertainties inherent in any health insurance system, Maine would be prudent to consider the amount of reserves that might be required to ensure a stable system over time. This is not a trivial problem and certainly warrants more analysis than we are able to offer here, specifically as related to the major concerns of any insurance plan in projecting cost: possible changes in patterns of illness or injury, technology, and provider organization. However, the sensitivity results suggest the general range of reserves that might be required in both the near and longer terms to finance the net costs of a single-payer system, that is, projected total spending net of consumer out-of-pocket cost, federal and state maintenance of effort, obligated general revenues, and a baseline payroll tax that would retain the value of private employer contributions to premiums.

We also consider the financing requirements suggested by the sensitivity results measured as a percentage of payroll. While it probably would be unwise for Maine to consider financing a single-payer system on a single base, consideration of the range of projected net costs as a percentage of payroll offers a clear sense of the range of burden that is associated with differences in administrative cost savings and constraints on effective health care cost trends.

1. Implications of Cost Sensitivity for the Net Cost of a Single-Payer Plan

Table V.5 reports the projected net cost of each single-payer plan design in 2004 within the low managed care environment. Regardless of plan design, differences in the administrative costs may be an important component of uncertainty in the implementation year of a single-payer system. A single-payer plan that achieved low administrative cost savings would incur a net cost that is 12 to 23 percent higher than a plan that achieved moderate administrative cost savings. However, the highest-percentage difference—associated with Plan 3A—corresponds to the lowest absolute difference in cost: about $3 million on a projected net cost base of $1.3 billion in 2004.

Although the level of administrative costs in a single-payer system becomes known in the years following implementation, the uncertainty associated with the underlying cost trends remains. Table V.6 displays the net cost of each plan design under alternative assumptions about cost growth between 2004 and 2008, given the level of administrative

Table V.5. Projected Net Cost of a Single Payer System with Alternative Administrative Cost Savings in a Low Managed Care Environment, 2004 (in millions)

	Low Administrative Savings	Moderate Administrative Savings	Ratio	Difference
Plan 1	$3,348.9	$2,990.6	112.0%	$358.3
Plan 2A	$2,282.1	$1,960.7	116.4%	$321.4
Plan 2B	$2,647.1	$2,313.4	114.4%	$333.7
Plan 2C	$2,889.8	$2,547.6	113.4%	$342.2
Plan 3A	$1,614.6	$1,316.2	122.7%	$298.4
Plan 3B	$2,186.9	$1,869.2	117.0%	$317.7
Plan 3C	$2,586.0	$2,254.5	114.7%	$331.5

Source: Mathematica Policy Research, Inc.

cost savings that may emerge. For most of the plan designs, regardless of the administrative cost savings of a single-payer system, a higher cost trend produces net plan costs 18 to 33 percent higher than an intermediate cost trend. Again, greater percentage margins systematically correspond to the lower-cost plan designs: for Plan 3A, the net cost margin associated with the different cost trends is 40 to 55 percent, depending on the administrative cost savings that the single-payer system would achieve.

2. Variation in Net Cost as a Percentage of Payroll

Table IV.7 expresses the net cost of Plans 1 and 3A in terms of the additional rate on payroll that would be required to finance them. The net cost of the two plan designs defines the range of net costs for all the plan designs that we considered. Recognizing that substantial burden on payroll is currently built into employer-sponsored financing of health care, we also report net costs in terms of the total implied burden on payroll.

In 2004, the difference between moderate and high administrative cost savings for Plan 1 (a relatively likely range for this plan design) translates to an additional rate on payroll of 10 percent versus 9 percent. Measured as total burden on payroll, high administrative cost savings would reduce the financing burden for Plan 1 from 17 percent of payroll to 16 percent. Because Plan 3A involves cost sharing for a larger share of the population, it probably would incur higher administrative costs. Therefore, it is instructive to look at the difference in burden associated with achieving moderate versus low administrative cost savings. Again, the difference in additional burden relative to payroll is about 1 percentage point: 4.5 percent versus 5.5 percent, if administrative cost savings were moderate versus low. This translates into a total burden relative to payroll of 12.1 percent versus 11.1 percent.

Table V.6. Projected Net Cost of a Single Payer System with Alternative Administrative Cost Savings and Cost Trends in a Low Managed Care Environment, 2008 (in millions)

	Low Administrative Savings				Moderate Administrative Savings			
	Low constraint on cost growth	High constraint on cost growth	Ratio	Difference	Low constraint on cost growth	High constraint on cost growth	Ratio	Difference
Plan 1	$3,868.4	$3,277.8	118.0%	$590.6	$3,421.7	$2,854.1	119.9%	$567.6
Plan 2A	$2,509.9	$1,989.0	126.2%	$520.9	$2,109.7	$1,609.3	131.1%	$500.4
Plan 2B	$2,979.4	$2,434.4	122.4%	$545.0	$2,563.5	$2,039.9	125.7%	$523.6
Plan 2C	$3,285.5	$2,724.9	120.6%	$560.6	$2,859.1	$2,320.3	123.2%	$538.8
Plan 3A	$1,668.6	$1,190.9	140.1%	$477.7	$1,297.2	$838.5	154.7%	$458.7
Plan 3B	$2,402.0	$1,886.6	127.3%	$515.4	$2,006.1	$1,511.1	132.8%	$495.0
Plan 3C	$2,903.6	$2,362.5	122.9%	$541.1	$2,490.4	$1,970.5	126.4%	$519.9

Source: Mathematica Policy Research, Inc.

In 2008, uncertainty about the system's ability to constrain health care costs is greater than uncertainty about administrative cost savings. However, the potential volatility of the financing burden is lower in 2008—that is, for a given plan design and a given administrative cost savings level, differences in the ability of the system to constrain cost translate into relatively narrow differences in net cost expressed as a percentage of payroll. Comparing the results of low versus moderate constraints on underlying costs in Plan 1 (see Table V.8), net costs expressed as the additional burden on payroll vary less than 1 percentage point—between 8.7 and 9.4 percent (a total burden of 15.5 to 16.2 percent). For Plan 3A, net costs vary between 3.6 and 4 percent of payroll (a total burden of 9.7 to 10.4 percent).

Finally, consideration of the "worst-case" scenario—with low managed care, low administrative cost savings and low constraints on cost growth—is instructive. The difference in burden relative to payroll between the moderate-constraint and low-constraint estimates (assuming low administrative cost savings) is 0.6 percentage points for both Plans 1 and 3A. That is, the additional burden of Plan 1 associated with a high cost trend would be 10.7 percent versus 9.9 percent (a total burden of 17.5 percent versus 16.7 percent). For Plan 3A, a high cost trend would raise the additional burden relative to payroll to 4.6 percent from 4 percent (a total burden of 11.4 percent versus 10.8 percent).

Table V.7. Projected Net Cost of Selected Single Payer Plan Designs a Percentage of Payroll in 2004: Alternative Administrative Cost Assumptions in a Low Managed Care Environment

	Low administrative cost savings		Moderate administrative cost savings		High administrative cost savings	
	Additional rate	Total rate	Additional rate	Total rate	Additional rate	Total rate
Plan 1	11.4%	18.0%	10.2%	16.8%	9.0%	15.6%
Plan 3A	5.5%	12.1%	4.5%	11.1%	3.5%	10.1%

Source: Mathematica Policy Research, Inc.

D. SUMMARY AND DISCUSSION

The sensitivity estimates presented in this chapter offer a valuable perspective on the implications of uncertainty about administrative costs and cost trends for a single-payer system in Maine. They yield important information about the significance of managed care and also about the "worst-case" costs that such a system may incur. Managed care is potentially a critical factor in making a single-payer system affordable relative to the status quo. For every plan design, elimination of private sector enrollment in managed care (retaining only PCCM for the same percentage of persons who receive the MaineCare benefit as now exists among MaineCare beneficiaries) raises projected total costs by about 3 percentage points relative to the base case.

The "worst-case" scenario estimated in this chapter—-that is, low managed care coupled with low administrative cost savings and low constraints on spending—is also instructive. Depending on the plan design, the scenario yields total plan costs that range between just 102 and 118 percent of the base case in 2004. By 2008, the various plan designs would cost from 98 to 114 percent of the base case. These estimates are less optimistic than those developed for other states using different analytic methods, but they are more encouraging than some might expect.

Table V.8. Projected Net Cost of Selected Single Payer Plan Designs as a Percentage of Payroll in 2008: Alternative Administrative Cost Assumptions in a Low Managed Care Environment

	Low Administrative Cost Savings		Moderate Administrative Cost Savings		High Administrative Cost Savings	
	Additional rate	Total rate	Additional rate	Total rate	Additional rate	Total rate
Low Constraint on Cost Growth						
Plan 1	10.7%	17.5%	9.4%	16.2%	8.2%	15.0%
Plan 3A	4.6%	11.4%	4.0%	10.4%	2.6%	9.4%
Moderate Constraint on Cost Growth						
Plan 1	9.9%	16.7%	8.7%	15.5%	7.5%	14.3%
Plan 3A	4.0%	10.8%	3.6%	9.7%	2.0%	8.8%
Aggressive Constraint on Cost Growth						
Plan 1	9.1%	15.9%	7.9%	14.7%	6.7%	13.5%
Plan 3A	3.3%	10.1%	2.3%	9.1%	1.4%	8.2%

Source: Mathematica Policy Research, Inc.

Finally, the alternative scenarios yield estimates of net plan cost (after subtracting consumer out-of-pocket spending, federal and state maintenance of effort, obligated general revenues, and the retained value of employer contributions to health insurance) that offer a sense of the financing burden that might evolve, given uncertainty about the potential for reducing administrative costs and containing health care costs.

Two concluding points are in order with respect to the projected financing burden. First, given the managed care environment and plan design of a single-payer system, the net cost of the single-payer plan is sensitive to administrative cost savings as well as to cost trends. The net cost projections presented in this chapter suggest that the percentage and level of reserves that Maine might consider for a single-payer system would vary with the plan's design and the state's confidence about constraining administrative costs and underlying cost growth.

Secondly, given the managed care environment and plan design, the implications of uncertainty about administrative costs and cost growth for financing the system are not what might be expected. Differences in net plan cost expressed as a percentage of payroll are narrow—and always within a percentage point for plausible ranges of error.

CHAPTER VI

REMAINING ISSUES AND MODEL LIMITATIONS

Estimates from the Maine Microsimulation Model provide valuable information about how a single-payer health insurance system is likely to affect health care spending, financing and economic activity in Maine. Nevertheless, like all policy simulation models, this model imposes simplifying assumptions on the health care and health insurance systems it represents in order to make the estimation tractable. Users must interpret estimates from the microsimulation model with caution, taking into account the assumptions used in the model and how they affect the results. In addition, the model is silent on many important operational and policy issues that must be addressed in order to make the transition to a single-payer system.

This chapter examines some pressing policy issues and questions concerning a single-payer health care system that the Maine Microsimulation Model does not address. We begin by exploring a number of practical and policy questions that Maine must consider in designing a single payer system. We believe that these questions have policy importance, but most are unlikely to affect the model's estimates fundamentally. They include options for achieving federal maintenance of effort, phasing in different coverage groups, addressing the growth in demand for care, and setting provider payment levels.

Next, we examine important caveats and limitations of the Maine Micosimulation Model that should be considered when interpreting model results. In this light, we recommend several enhancements to the model that may improve its precision and usefulness to Maine in considering impacts of a single payer system or other major health care financing reforms.

Finally, we identify areas where Maine might benefit from additional research specific to the state's current health care and health insurance markets. This additional research might help Maine refine the estimates of cost and economic impact associated with a single-payer system and also support a planning process for implementation.

A. TRANSITION ISSUES

1. Federal Maintenance of Effort

Federal programs are a major source of payments for health care in Maine, and retaining federal funds would be essential to the feasibility of a single payer system. Therefore, understanding in some detail how a single payer system might calculate and accept federal funds is essential.

The two largest programs with federal funding in Maine are MaineCare and Medicare. Retaining federal matching funds for MaineCare seems straightforward. The scenarios we have estimated assume no disruption of the MaineCare program and full enrollment of all persons who are eligible. They entail no change in either eligibility rules or the MaineCare benefit. For such a system, we would anticipate no change that would require specific state or federal attention related to integration of the MaineCare program.

Reflecting the aging of the population, Medicare will become an increasingly important source of health care financing in Maine, and retaining federal funding for Medicare beneficiaries in a single payer system will require attention. Including Medicare beneficiaries in the single payer system would provide them with full supplemental coverage and make the transition into Medicare coverage seamless and transparent.

There are a number of ways that the single payer system might draw Medicare funds to finance Mainers who are Medicare-eligible. The financing estimates presented in this report (and built into the microsimulation model) assume that Medicare payments are calculated as they would occur in the base case and paid as a capitation amount. While such an arrangement would require that Maine enter into a special arrangement with Medicare, there is some precedent for this approach—including Medicare's current arrangement with the United Mineworkers Plan and a past arrangement with TriCare. Nevertheless, negotiating such an arrangement might require considerable effort for Maine, as would negotiating an update factor that would retain Medicare funding per capita as the single payer system succeeded in curbing cost growth in the long term.

Alternatively, the single payer system might consider simply coordinating Medicare benefits with the single payer system—making Medicare first payer for Medicare-covered services. While this approach is relatively simple administratively, it would complicate the overall financing of the single payer system by subjecting it to changes in Medicare reimbursement levels. In addition, with coordination of benefits, hospitals and medical care providers would remain subject to Medicare's administrative rules and procedures for Medicare payment, quality assurance and cost reporting. In effect, it would retain a second payer in Maine's system to which providers would remain directly accountable.

Deciding between these alternatives will require both more specific analysis of current Medicare payments in Maine and undertaking at least preliminary conversations with CMS to understand more fully whether there may be additional options. We would advise also

building a separate small component of the microsimulation model to calculate Medicare payments under alternative, specific forms of maintenance of effort.

2. Phasing in Coverage Groups

Maine might consider building a single payer system up gradually, phasing in specific populations over time. Such populations might include Medicare beneficiaries, self-insured employer groups (i.e., ERISA plans), federal employees who are enrolled in FEHBP, CHAMPUS/VA enrollees, and persons served by the Indian Health Service. All of these populations are now insured and therefore may not be priority populations in considering major system reform.

However, moving all of Maine's population into a single payer system at the same time would offer some important advantages. First, it would simplify the administration of health care financing by standardizing coverage and consolidating the source of payment. This simplification is critical to achieving the level of administrative savings needed to finance coverage for Mainers who now uninsured, together with a high benefit standard for all. Second, it would ensure that cost shifting among payer groups is eliminated. The ability of payers to shift cost, intentionally or otherwise, would make the financing of a single payer system more difficult. Third, it would eliminate the potential for problems of biased selection, if individuals were able to choose among sources of coverage. Fourth, it would eliminate the potential for gaps in coverage for individuals and families in transition, and potentially problems of access for some insured populations. Finally, it would maximize risk spreading and minimize problems of equity in financing. In addition to these advantages, the small size of Maine's population makes managing the whole population in a single plan relatively simple administratively.

We would advise that the relative costs and benefits of phasing in some populations be given very careful consideration, potentially taking the following questions as a template for analysis:

- Does holding a specific population out of the single payer system seriously affect the system's ability to reduce overall administrative complexity and cost?
- Is it possible to "firewall" the single payer system from cost shifting and for how long?
- How might the parallel system cause adverse selection for the single payer system?
- What is the potential for gaps in coverage? What populations are most at risk, and how might gaps in coverage affect single payer plan cost?
- How might nonparticipation of a specific population affect the cost/benefit tradeoff for participants in the single payer system?

- Is it possible to negotiate and retain federal maintenance of effort, if that population otherwise would draw federal funding?

3. Addressing Growth in Demand for Care

Expanding health insurance coverage to the uninsured and underinsured through a single-payer health care system would improve financial access to care and, therefore, stimulate additional demand for health care. Accommodating this additional demand will be a key concern for health care providers, particularly in rural areas where access to health care professionals and facilities is already a problem. The single-payer spending estimates presented in Chapter IV are based on a projected average increase in demand for health care ranging from 15 to 23 percent, depending on the plan design. Geographic areas where health insurance coverage is lower than Maine's statewide average are likely to experience higher than average increases in demand.

Relieving health care providers of some administrative burden might help them to accommodate some of the increased demand for health care, improving their productivity. In a single-payer system with lower administrative burden, clinicians might spend a larger share of time on direct patient care and less on administrative tasks such as billing, prior authorization, and benefits determination. However, even with enhanced productivity, many providers will need to add clinical staff and facilities. A sound implementation strategy for a single-payer health system should include provisions for increasing health professions training and recruitment activities to meet the anticipated new demand for health care.

At present, the single-payer health care spending projections produced by the Maine Microsimulation Model do not include costs for clinical training and recruitment, or the additional economic activity associated with clinical training and recruitment. Similarly, unemployment and retraining costs associated with the disruption of employment among administrative staff (especially in hospitals and medical provider offices) are not estimated in the model. All of these changes will require time, training, and expense to move through a transition to the single-payer system.

4. Changing Provider Payment Levels and Methods

A single-payer health care system may require health care providers to accommodate a number of important changes in payment levels and methods that collectively would reprice health care services. Such changes would include:

- Lowering payments to reflect a reduction in providers' administrative costs

- Lowering payments to reflect the reduction or elimination of uncompensated care

- Constraining growth in total health care spending, using global budgeting and other payment incentives.

The Maine Microsimulation Model develops estimates of single-payer spending as if these payment changes occur instantaneously and universally across Maine's health care system. In reality, however, these payment changes will need to be instituted over time (and synchronized with changes in the underlying operating costs of health care providers) to avoid overburdening Maine's health care delivery system. Health care providers are likely to see their administrative costs decline gradually under a single-payer system, as they adjust their administrative processes and personnel to fit the requirements of the new financing system. Similarly, uncompensated care costs may decline gradually over time, if Maine phases enrollment in the single-payer system.

Accommodate gradual changes in the underlying cost structure of health care providers will require consideration of transitional payment policies that introduce payment adjustments over time. One strategy for phasing in payment adjustments is to hold providers harmless in the initial years of implementation, guaranteeing providers a minimum level of revenue per capita (per case or per relative value unit). This guaranteed payment level could be set at the current level of spending in the first year of single-payer implementation, and then adjusted in subsequent years to reflect administrative savings, reductions in uncompensated care, and the underlying health care cost trend.

5. Incorporating Other Health Care Payers

In general, it may be very difficult for Maine to create a true single-payer system. While Maine may succeed in making some major payers transparent to providers (including MaineCare, Medicare, FEHBP, and CHAMPUS), it may be impossible to enfold every resident and every health care expenditure into the single payer system. Some (including retirees moving into Maine with benefits from an out-of-state employer, or emergency care for non-residents) may inevitably remain outside the system, although, they will represent a very small share of total spending.

The estimates presented in this report do not consider some entities' payments for health care services that Maine may ultimately wish to consider incorporating into the single-payer health plan. These entities include Workers Compensation and automobile insurers, as well as general liability insurers that cover bodily injury. The total payments associated with these insurers are small; Maine Bureau of Insurance estimates suggest that they are less than 2 percent of total spending for health care services in Maine.

Fully incorporating these insurers' liabilities for health care would offer several advantages. It would maintain administrative simplicity in the single payer system, as providers would no longer bill multiple payers. It would reduce the cost of Workers Compensation and general liability insurance, relieving employers of significant burden. Finally, it would reduce the cost of automobile insurance, recognizing that the single-payer system would in any case absorb the health care costs associated with drivers who are uninsured or underinsured.

However, absorbing these costs into the single payer system might also introduce some problems, both in the short term and in the long term. In the short term, retaining the funds

that these insurance systems now contribute to Maine's health care system probably would be desirable. In any case, Maine should consider the incidence of burden for these insurance payments carefully, and identify the implications for equity and economic efficiency that may result from absorbing the burden of these payments into the single payer system. In the long term, Maine should consider the incentives for safety that might result by divorcing the cost of health care from activities (such as hazardous jobs or reckless driving) that may cause illness or injury.

6. Accommodating Residents Employed Out-of-State

A substantial minority of Maine's working population is employed in nearby states and may also have coverage from their out-of-state employer. Maine would need to consider whether and how such workers and their families might become eligible to participate in the single payer system. Assuming either payroll-tax or personal income tax financing (or both), this situation would require that the worker elect both to participate in Maine's single payer system and to have their out-of-state employer withhold appropriately from their paycheck.

Adjusting withholding for greater personal income tax payments, regardless of the employer's location, seems straightforward. However, use of a payroll tax would require that out-of-state employers modify their current systems of withholding and direct payments to Maine. Maine might consider developing guidelines (and even software) to assist out-of-state employers in payroll withholding in order to facilitate Maine residents' participation in the single payer system. Because Mainers are likely to use health care where they reside, greater participation of Maine residents in the single payer system, regardless of where they are employed, would reduce the system's administrative complexity.

There are a number of models specifically related to current local tax systems that Maine might consider. For example, some cities tax the earnings of residents regardless of their place of work (as well as persons who work there). Maine might investigate whether and how residents who are employed outside such a city withhold income to pay these taxes, in order to inform the development of income withholding guidelines for out-of-state employers.

Finally, the failure of residents to select the single payer system when they have employer-provided coverage out-of-state introduces some potential for adverse selection in the single payer plan, although it probably is not great. Maine might deal with this problem by using conventional insurance methods to deter adverse selection, such as waiting periods or periodic open enrollment. However, any such method is likely to result in gaps in coverage for some individuals and families, and therefore, some level of uncompensated care for Maine health care providers.

7. Addressing the Potential for In-migration

Implementation of a universal coverage, single-payer health system at a state level raises the possibility that individuals who reside outside the state would relocate to Maine obtain health care coverage. The incentives for relocation may be particularly strong for individuals

excluded from private health insurance coverage in other states due to pre-existing medical conditions or insurance rating practices. If Maine's single payer system attracted individuals who were particularly costly to insure and also contributed relatively little to Maine's tax base, they could add significantly to the cost of financing a single-payer health insurance system.

While Maine's experience with other public programs (for example, cash assistance under the Temporary Assistance for Needy Families program) suggests that the relocation incentives associated with program generosity are relatively modest, it may still wish to consider some strategy to reduce the incentives for in-migration created by a single-payer health system. For example, Maine might impose a look-back provision or waiting period for new residents to become eligible for coverage under the single-payer system. This might reduce relocation incentives by requiring new Maine residents to meet minimum residency requirements before obtaining eligibility for coverage under the single-payer system.

B. IMPORTANT CAVEATS AND LIMITATIONS OF THE CURRENT MODEL

The Maine Microsimulation Model includes a number of important limitations that should be borne in mind when using the model and interpreting its results and implications. Like all policy simulation applications, the model imposes simplifying assumptions on the health care and health insurance systems it represents in order to make the estimation of costs and economic impacts tractable. Some of these simplifying assumptions and limitations will be relaxed when additional data and model development time become available under Maine's HRSA State Planning Grant activities that will take place during 2003. However, the current version of the Maine Microsimulation Model must be used with the following limitations in mind.

1. Regional Estimates

The model is designed to produce both statewide and regional estimates of health care spending in Maine. Regional estimates are based in part on regional per capita health care cost estimates. These were constructed from claims data maintained by the Maine Health Care Management Coalition (for large employers) and the Bureau of Medical Services (for Medicaid). However, because the CPS does not provide regional estimates of population and insurance coverage characteristics, we allocated Maine's CPS sample into regions based on county-level Medicare and Medicaid distributions (for Medicare and Medicaid beneficiaries) and based on county age and gender distributions (for everyone else in the CPS sample). Because we were unable to identify regional differences in health insurance coverage rates beyond those due to Medicaid and Medicare coverage and population demographics, the model's regional spending estimates are relatively imprecise. This limitation of the current model can be addressed when data from the Maine household survey become available; this survey is being conducted under the HRSA State Planning Grant.

2. Single-Payer Estimates by Coverage Subgroups

The Maine Microsimulation Model uses per capita health care cost estimates generated from Watson Wyatt and Company's PreView™ Medical Benefits Model to project health care spending under alternative benefit designs for a single-payer health plan. For each benefit design, the PreView model produces age-group specific estimates of per capita covered charges and out-of-pocket expenses by type of service. These estimates represent statewide averages for all Maine residents; they do not reflect the underlying variation in health care utilization across population subgroups defined by their base case source of insurance coverage. The current version of the Maine Microsimulation Model adjusts these statewide single-payer spending estimates for changes in the demand for health care that are expected to result from changes in out-of-pocket spending in a single-payer health system. However, it does not adjust spending estimates for underlying variation in health care utilization due to differences in health status or health risk (other than age). For example, the model does not account for the fact that individuals covered by MaineCare in the base case are likely to have higher than average health care spending in the single-payer system due to differences in health status and health risks.

This limitation is likely to introduce some imprecision into estimates of how health care spending changes for specific population subgroups when they obtain coverage under the single-payer health system. Specifically, the model may under-estimate changes in health care spending for subgroups with higher-than-average health care needs and risks, and over-estimate spending changes for low-risk subgroups. Additional model development as part of the HRSA State Planning Grant work will address this limitation by constructing adjustment parameters for the single-payer spending estimates produced by the PreView model.

3. Interaction between Financing and Economic Impact Estimates

At present, the model does not integrate the financing and economic impact estimates. Thus, net increases in tax burden generate no change in work effort or employment, and projected employment levels do not adjust automatically when other aspects of the model are changed. Similarly, changes in employment do automatically case levels of payroll or taxable income to change. Incorporating these interactions into the Maine Microsimulation Model would help in understanding and predicting impacts more precisely, and could also help in guiding the system's management and policy direction after implementation.

Maine has in place an economic forecasting model as well as a state revenue model. The most reasonable approach to integrating the financing and economic impact modules would be to incorporate the specific logic and results of these models directly into the Maine Microsimulation Model, to ensure that the results of all three correspond. This enhancement would allow us to understand not only how changes in plan cost and financing might affect Maine's economy, but also the distributional impacts of a single payer system on Maine households.

C. RECOMMENDATIONS FOR ADDITIONAL RESEARCH

In completing this microsimulation study, we identified a number of areas where Maine might benefit from additional research specific to Maine's health care and health insurance markets. These areas include:

- ***The level and composition of insurers' administrative expense.*** Administrative cost savings are essential to the feasibility of a single payer system in Maine – and indeed, to any reform that would significantly broaden coverage or improve benefits for the covered population. The policy discussion would benefit from a clearer understanding of the composition of insurers' administrative expense in Maine, as well as the factors that drive greater or less administrative expense. This latter analysis might include a comparison of Maine insurers to insurers in other states.

- ***The level and composition of provider expenses.*** A single-payer system would change the cost structure of health care providers by reducing provider spending on administration and reducing cost-shifting for uncompensated care. Like savings on insurer administration, provider cost savings are essential to the feasibility of a single payer system in Maine. Acquiring more detailed information on the composition of hospital and physician practice expenses in Maine would support more precise estimates of the cost-savings likely to accrue through a single-payer system, and the economic impact of such a system on health care providers. A detailed cost study of a representative group of Maine hospitals and medical practices could provide this valuable information.

- ***The economic impact of health care access.*** Very little analysis of the impact of greater access to health care on worker's productivity and economic development is available. Moreover, it is extremely difficult to compare what research is available with the situation that Maine may encounter with improved access. The population survey data that Maine is collecting under its State Health Planning Grant, compared with other states' data, may offer an excellent opportunity to refine estimates of employment and productivity that may result from improved access to care.

- ***The economic impact of health care reform on employment and training in Maine.*** In the timeframe of this project, we were unable to adequately explore the implications and cost of the change in employment that may result from major reform of Maine's health care sector. Addressing this question would require a workforce study that might occur in the context of a larger look at workforce and economic development in Maine. Such a study would offer a clearer picture of the time, resources and training that major reform of health care financing in Maine would entail, and assist in developing a planning process to accommodate reform.

Additional information in these areas would support refinements to the Maine Microsimulation Model and improved estimates of the cost and economic impacts of a single-payer reform, as well as alternative major reforms that Maine may consider.

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List of Acronyms

AHA: American Hospital Association

AHRQ: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

AMA: American Medical Association

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services

CMS: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1986

CPS: Current Population Survey

CRS: Congressional Research Service

DRG: Diagnosis Related Groups, as defined in Medicare's hospital payment system

ERISA plans: Employer-sponsored benefit plans subject to the Employee Retirement Income Security Act of 1974

FEHBP: Federal Employee Health Benefits Program

FPL: Federal Poverty Level

HIPAA: Health Insurance Portability and Accountability Act of 1996

HMO: Health maintenance organization

HRET: Health Research and Educational Trust

HRSA: Health Resources and Services Administration, U.S. Department of Health and Human Services

IRP: Insurance reference person, as defined in the Current Population Survey

MCBS: Medicare Current Beneficiary Survey, conducted by CMS

MEPS: Medical Expenditure Panel Survey, conducted by AHRQ

MHIC: Maine Health Information Center

MHMC: Maine Health Management Coalition

PCCM: Primary care case management

RBRVS: Resource Based Relative Value Scale, as defined in Medicare's physician payment system

SCHIP: State Children's Health Insurance Program

TRICARE: Managed health care program of the U.S. Department of Defense

VA: U.S. Department of Veterans Affairs

APPENDIX D:

Final Report Issued November 1, 2004

STATE OF MAINE
122nd LEGISLATURE
FIRST REGULAR SESSION

Final Report of the

HEALTH CARE SYSTEM AND HEALTH SECURITY BOARD

November 1, 2004

Table of Contents

Page

Executive Summary i

I. Introduction 1

II. Health Security Board's Scope and Focus 4

III. Dirigo Health Reform Act 5

IV. Recommendation 6

Appendices

A. Public Law 2003, chapter 492
B. Additional Questions and Issues Identified in Preliminary Report
C. Draft Legislation to Implement Board's Recommendations
D. Summaries of Board Meetings on April 2, 2004 and September 22, 2004

Executive Summary

The Health Security Board, now chaired by Senator John Martin and Representative Marilyn Canavan, is a bipartisan task force with 20 members including representatives of both branches and both parties within the Legislature, the Department of Health and Human Services, the State Employee Health Commission and the State Tax Assessor and representatives of provider organizations, employers, insurers and advocacy groups. Due to resignations, there are currently 3 vacant positions.

The Health Care System and Health Security Board was established to develop recommendations to provide universal access to health care coverage and to assess the feasibility and cost of implementing a single-payer health care system in Maine. Such a system would provide universal health care coverage to every Maine resident through a standard benefit plan administered and paid for by a single payer, the State of Maine. With the assistance of a significant grant from the Maine Health Access Foundation, the Health Security Board contracted with Mathematica Policy Research, Inc. to conduct the feasibility study. This study was completed in December 2002. The Health Security Board issued its preliminary report on January 15, 2003.

In its preliminary report, the Health Security Board recommended to the Legislature that the Board be given additional time to fully consider the Mathematica feasibility study and develop final recommendations for a single-payer health plan. During the 2003 legislative session, a law was enacted to extend the Board's authority and delay submission of a final report. Also during that session, the Legislature enacted the Dirigo Health reform law. The law focused on three areas to reform Maine's health care system: (1) a mechanism to increase access to health care for all Maine residents;(2) measures to ensure quality of care; and (3) measures to contain health care costs. The cornerstone of the law was the creation of Dirigo Health, a public agency charged with overseeing a voluntary health insurance program for small businesses, self-employed persons and individuals. Because Dirigo Health was developed to achieve universal coverage over time, the Health Security Board now faced a changing landscape for Maine's health care system. The Board's primary focus became the consideration of its future role and the role of a single-payer health care plan as Dirigo Health began to implements its comprehensive health care reforms.

Given the progress with DirigoChoice and the other Dirigo reform efforts, the Board is hopeful that universal access can be achieved over time with this approach. However, with enrollment in DirigoChoice just beginning and coverage not expected until January 1, 2005, it is premature to measure the success of the Dirigo Health reforms. While the Board supports these overall reforms, the members also agree that it is worthwhile for the Board to seek continued authority to meet in the event that these reforms, especially DirigoChoice, are not successful. The preliminary results from the Mathematica study demonstrated that a single-payer health care plan appeared feasible, although additional analysis is necessary. If universal coverage is not achieved through the Dirigo Health reforms, the Health Security Board believes that planning for universal coverage through

a single-payer health care plan should continue. Therefore, the Board makes the following recommendation:

The Health Security Board recommends that the Legislature reestablish the Board's authority to continue the evaluation and planning for a single-payer system if Dirigo Health fails to meets its expectations for universal coverage.

The Health Security Board strongly believes that it has made a positive contribution to the dialogue among policymakers and others surrounding reform of Maine's health care system. In part, the development of Dirigo Health was based on information and research from the Health Security Board's preliminary report and feasibility study. Although Dirigo Health has taken a different approach to achieving universal coverage, the Health Security Board is hopeful that the ultimate goal---coverage for all Mainers---can be reached over time. However, if Dirigo Health fails to meet expectations, then the development of a single-payer health care plan must be reconsidered. And, if it is reestablished, the Health Security Board believes it is the appropriate group to make that effort successful.

I. Introduction

The Health Care System and Health Security Board, hereafter referred to as the Health Security Board or Board, was established in Public Law 2001, chapter 439, Part ZZZ. A copy of the Board's enabling legislation is included as Appendix A. While the purpose of the Board was to develop recommendations to provide universal access to health care coverage for all Maine citizens, the Health Security Board was specifically required to assess the feasibility and cost of implementing a single-payer health care system in Maine. Such a system would provide universal health care coverage to every Maine resident through a standard benefit plan administered and paid for by a single payer, the State of Maine.

The Health Security Board, chaired by Senator John Martin and Representative Paul Volenik, is a bipartisan task force with 19 members including representatives of both chambers and both major parties within the Legislature, the Department of Human Services, the State Employee Health Commission and the State Tax Assessor and representatives of provider organizations, employers, insurers and advocacy groups. The members of the Board and their appointing authorities are as follows:

Members appointed by the President of the Senate:

- **Sen. John L. Martin, Chair**
- **Sen. Mary E. Small**
- **Robert Downs/Victoria Kuhn,** Representing Statewide Organizations of Health Insurers
- **Tammy Greaton**, Representing Statewide Organization Advocating Universal Health Care
- **Beth Kilbreth, PhD,** Representing Health Care Economists*
- **Marjorie Medd**, Representing Statewide Organizations Defending Rights of Children
- **Leo Siegel, MD,** Representing Small Hospitals in the State
- **Richard Wexler, MD,** Representing Statewide Organizations of Physicians

Members appointed by the Speaker of the House:

- **Rep. Paul Volenik**, Chair
- **Rep. Florence T. Young**
- **James Amaral**, Representing the Business Community

- **Howard Buckley**, Representing Large Hospitals in the State
- **John Moran,** Representing Statewide Senior Citizen's Organizations
- **Frank O'Hara**, Representing Self-employed Persons
- **Patricia Philbrook**, Representing Statewide Organization of Nurses
- **Violet Raymond**, Representing Statewide Labor Organizations, Maine AFLCIO

Appointments required by statute:

- **Frank A. Johnson,** Director, State Office of Employee Health and Benefits
- **Anthony Neves,** State Tax Assessor
- **Christine Zukas-Lessard,** Deputy Director, Bureau of Medical Services, Designee of the Commissioner of Human Services

Charlene Rydell, a member of the Maine Health Access Foundation Board of Trustees, provided valuable input and assistance as a liaison from the Foundation to the Board.

The Health Security Board was first convened on October 12, 2001 and met more than 20 times throughout 2002. Summaries of the Board's meetings are available electronically at *www.state.me.us/legis/opla/hsboardmins.htm.*

* Dr. Kilbreth resigned from the Board effective December 31, 2002 because of time constraints related to her role as Project Director for the HRSA-funded Maine State Planning Grant.

A. Creation of Health Care System and Health Security Board

The Health Security Board was created in the Part II budget, Public Law 2001, chapter 439, Part ZZZ. During the First Regular Session of the 120th Legislature, the Joint Standing Committee on Banking and Insurance considered several bills proposing the establishment of a single-payer health care system in Maine. The committee also considered 2 bills that proposed the establishment of a study commission to consider the feasibility of a single-payer system and other options for universal coverage. In its consideration of these proposals, the committee reported out 2 legislative proposals with majority reports of "Ought to Pass as Amended": LD 1277, An Act to Establish a Single-payor Health Care System, sponsored by Rep. Paul Volenik, and LD 1490, Resolve, to Establish the Commission to Develop and Finance Health Care Coverage for All Maine People, sponsored by Rep. Christopher O'Neil. When these bills were referred to the House and Senate for further action, differences between the legislative bodies arose as to

their final disposition. LD 1277, An Act to Establish a Single-payor Health Care System, was enacted in the House of Representatives, but was not removed from the Special Appropriations Table in the Senate and died upon adjournment of the First Regular Session of the 120th Legislature. LD 1490, Resolve, to Establish the Commission to Develop and Finance Health Care Coverage for All Maine People, died in non-concurrence when the House and Senate could not agree on the appointment of a committee of conference. As a compromise, legislative language to conduct a study of the economic feasibility of a single-payer system and to establish the Health Security Board was added to the Part II budget legislation.

B. Health Security Board's Purpose and Duties

As outlined in the enabling legislation, the purpose of the Health Security Board was "to develop recommendations to provide health care coverage to all citizens of this State through a plan or plans that emphasize 24-hour coverage, quality, cost containment, choice of provider and access to comprehensive, preventive and long-term care."

In addition, the Board was asked to:

- Examine prior studies in Maine and other States;
- Determine the savings that might be realized from a single-payor health care system by hospitals, schools and correctional facilities and other lines of insurance that pay for health care services, including automobile insurance, general liability insurance and workers' compensation insurance;
- Develop a proposal to implement a single-payer plan and make recommendations related to standards for eligibility, covered benefits and health care services, health care delivery throughout the State, provider participation and reimbursement, and the role of federal health care programs and ERISA plans;
- Examine funding for the single-payor plan from a combination of sources, including payments from government sources, including federal, state and other governmental health care and aid programs; payments from workers' compensation, pension and health insurance employee benefit plans; payments from state, county and municipal governmental units for coverage; payments from tobacco settlement funds; and payments from any taxes or fees;
- Conduct a feasibility study of the economic impacts on individuals and businesses of a single-payor plan that guarantees a minimum 5% savings over existing health care costs and the impact of such a plan on the State's economy;
- Stress prevention of disease and maintenance of health in developing proposals to implement the single-payer plan and attempt to retain and strengthen existing health facilities whenever possible in developing those proposals; and

- Examine any other issues or gather information necessary to fulfill its purpose and duties.

C. Report and Legislation

Originally, the enabling legislation required that the Board submit a report, including any necessary legislation, on or before March 1, 2002. Upon request to the Legislative Council, the Board's reporting deadline was extended to March 3, 2003; a preliminary report was requested by January 15, 2003. Draft legislation to implement the recommendations of the Health Security Board is included in Appendix C.

II. Health Security Board's Scope and Focus

From its inception, the Health Security Board focused it efforts on its mandate to conduct a feasibility study of the economic impact on individuals and businesses of a single-payer plan that guarantees a minimum 5% savings over existing health care costs and that addresses the potential positive or negative impact of the plan on the State's economy. To meet its mandate, the Board contracted with Mathematica Policy Research, Inc., a national health care consulting firm with offices in Washington, D.C., Princeton, NJ and Cambridge, MA, to conduct the feasibility study. The Board chose Mathematica after a competitive bid process that garnered proposals from five prominent national health care consulting firms specializing in economic modeling.

The Board asked Mathematica to develop a microsimulation model to project the financial and economic impact of a single-payer health care plan in Maine. The Board began meeting with Mathematica in early August and held regular meetings and telephone consultations throughout September, October and November. The final report and results were delivered to the Board on December 18, 2002. The results of the feasibility study form the basis for the Board's findings and recommendations.

III. Overview of Single-payer Health Plan Model Used in Feasibility Study

As defined by the Health Security Board, the single-payer health plan would provide health care coverage to all Maine residents through one standard benefit design. The single-payer plan would be paid for by the State and administered by the State, or, in part, by a private entity under contract with the State. Public and private health insurance programs like Medicare, MaineCare, CHAMPUS, federal and state employee plans and individual and group health insurance plans would subsumed by the single-payer plan. Coverage of Maine residents eligible for federally supported programs would be consolidated assuming approval of waivers from the federal government.

To finance the costs of the single-payer plan, the model developed by the Board assumes that federal and State government funding for health care coverage and the direct provision of health care services would be maintained at its current level. In addition, the

model assumes full enrollment of an eligible population for public programs to maximize the federal and State financial contribution. The remaining costs of the single-payer plan would be paid from the State's General Fund either by raising new revenue through targeted taxes or redirecting current tax revenue. An individual or employer's contribution in the form of premiums would be eliminated, although employers and employees might pay into the system through a payroll tax and individuals may be asked to participate through cost sharing with a cap on out-of-pocket spending.

In consultation with Mathematica, the Board established guidelines for benefit design and cost containment within the single-payer system.

A. Single-payer Health Plan Benefit Designs

For use in the feasibility study, the Board developed 3 primary benefit designs: (1) a benefit plan modeled on MaineCare (Maine's Medicaid program); (2) a benefit plan that requires cost sharing in the form of copayments only for certain services with a cap on out-of-pocket spending; and (3) a benefit plan that requires cost-sharing in the form of copayments and coinsurance for certain services with a cap on out-of-pocket spending. For each of the alternative benefit designs, the Board asked Mathematica to model 3 different cost projections based on income level--- incomes at or below 200%, 300% and 400% of the federal poverty level--- to determine whether cost sharing in the form of copayments or coinsurance would be required. Depending on the benefit design, the Board asked Mathematica to assume that no cost-sharing would be required for those with incomes at or below 200%, 300% or 400% of the poverty level.

A matrix of the benefit designs is presented as Table 1.

Table 1. Matrix of Single-Payer Health Plan Benefit Designs.

Plan-level features	Plan # 1: MaineCare Benefit Package	Plan # 2: Alternative Benefit Design	Plan # 3: Alternative Benefit Design
Income-level Subject to Cost-sharing /No Cost-sharing below income level	None	Plan 2A: 200% FPL; Plan 2B: 300% FPL; or Plan 2C: 400% FPL	Plan 3A: 200% FPL; Plan 3B: 300% FPL; or Plan 3C: 400% FPL
Out-of-Pocket Maximums			
• Individual	None	$500 annually	$1000 annually
• Family	None	$1000 annually	$2000 annually
Deductibles	None	None	None
Lifetime maximum	None	None	None
Hospital inpatient	$0 - $3 per day; $30 max per month	$50 per day; $300 max per admission	$50 per day; $300 max per admission
Hospital outpatient/diagnostic, X-ray, Lab	$0 - $3 per day; $30 max per month	$25 copay	20% coinsurance
Primary Care Provider Visits	Covered in full	$10 copay	$10 copay
Specialty Provider Visits	Covered in full	$20 copay	$20 copay
Emergency Room	Covered in full	$50 copay; waived if admitted	$50 copay; waived if admitted
Mental Health/Substance Abuse Benefits	Covered in full	Parity	Parity
Prescription Drugs			
Copay-generic	$0-$2	$5	$10
Copay-brand/preferred	$0-$3	$10	$20
Copay-brand/nonpreferred	$0-$3	$15	$30
Out-of-pocket maximum (annual)	None	$200 individual; $500 family	$200 individual; $500 family
Skilled Nursing	Covered in full	$25 per day; $150 max per admission	$25 per day; $150 max per admission
Home Health Care	Covered in full	$10 copay	$10 copay
Durable Medical Equipment	Covered in full	None	20% coinsurance
Long-term Custodial Care	Covered based on current income eligibility requirements	Covered based on current income eligibility requirements	Covered based on current income eligibility requirements
Eyeglasses	$100 cap every 2 years	$100 cap every 2 years	25% coinsurance and $100 cap every 2 years
Included Benefits (not subject to cost-sharing)	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehab, routine dental care, routine vision care	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehab, routine dental care, routine vision care	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehab, routine dental care, routine vision care
Excluded Benefits	Cosmetic, infertility/sex change, routine foot care, custodial care (long-term custodial care included as described above), vision correction surgery (LASIK)	Cosmetic, infertility/sex change, routine foot care, custodial care (long-term custodial care included as described above), vision correction surgery (LASIK)	Cosmetic, infertility/sex change, routine foot care, custodial care (long-term custodial care included as described above), vision correction surgery (LASIK)

Sources: Alternative Benefit Design Matrix, Office of Policy and Legal Analysis, Mathematica Policy Research

B. Cost Containment Strategies

The Board envisions that overall spending under the single-payer health plan would be administered through a global budget. As a baseline, the Board assumes that provider reimbursement be determined using the DRG (Diagnosis-Related Groups) payment system familiar to hospitals and the RBRVS (Resource-Based Relative Value Scale) payment system familiar to physicians, nurses and other health care practitioners. Ultimately, the reimbursement for providers will be negotiated like all other costs under the single-payer system.

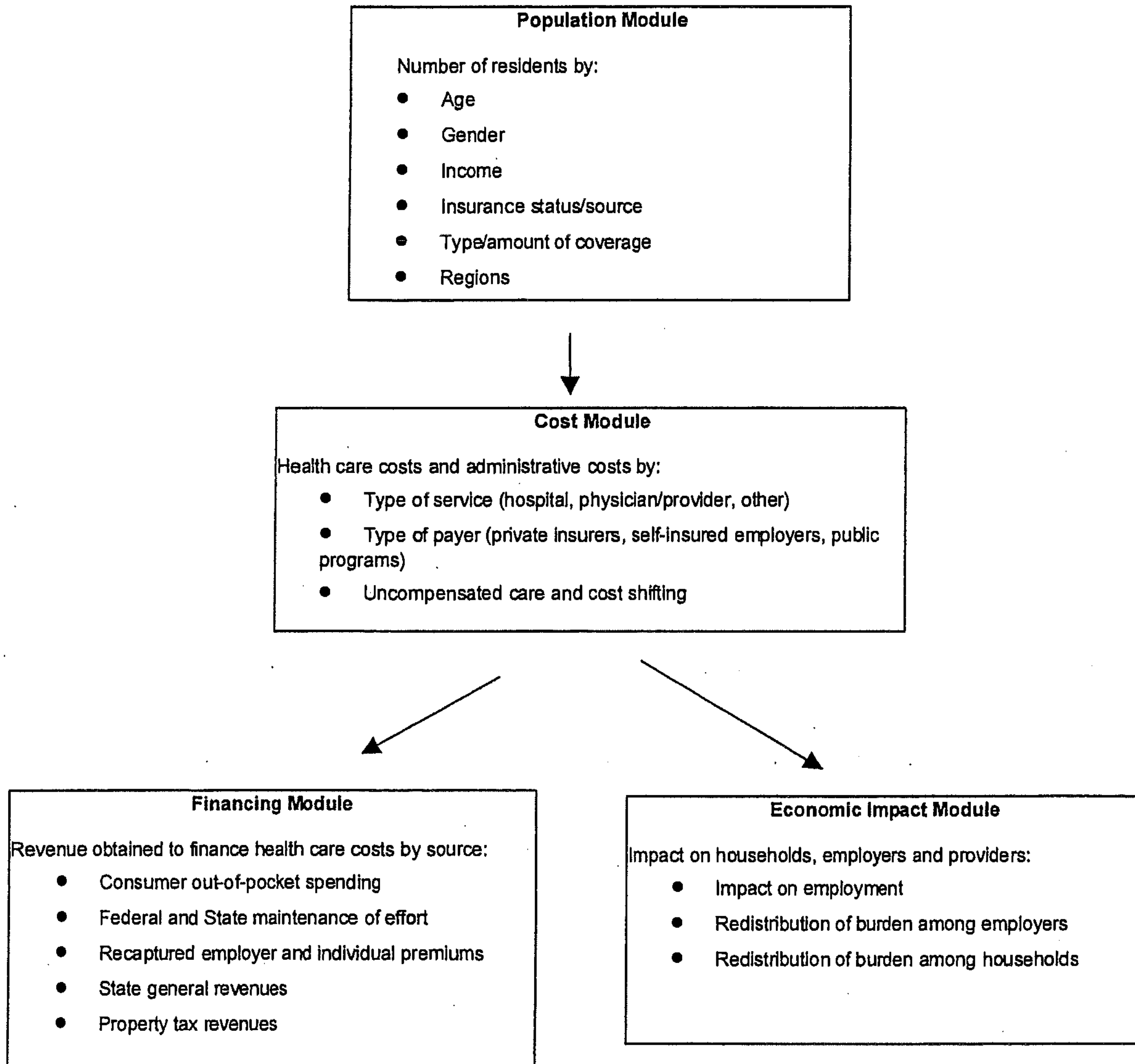
The Board also envisions that the single-payer health plan would utilize certain care management strategies. Currently, the State's MaineCare program uses primary care case management to assist in cost control. The Board directed that the model used by Mathematica assume that primary care case management would continue to be a part of the single-payer health plan. Other care management strategies mentioned in the Board's discussions include risk factor management programs, disease management and care coordination programs, identification and adoption of "best practices" and prior authorization for services using new and emerging technology.

IV. Microsimulation Model Developed by Mathematica

Briefly, the microsimulation model developed by Mathematica is comprised of four modules: (1) a population module used to project the demographic and health insurance coverage characteristics; (2) a cost module used to project health care spending by type of service and the source of spending that includes both medical and administrative costs; (3) a financing module used to project current levels of revenue from current and available sources for funding health care expenditures; and (4) an economic impact module used to project the impact of a single-payer health plan on the State's economy and employment. The complete feasibility study prepared by Mathematica, including documentation of the microsimulation model, its assumptions and sensitivity analyses, and its results projecting the costs of a single-payer health plan, is included as Appendix B.

Table 2 describes the general design of the microsimulation model; it is a reproduction of Figure III.1 from the Mathematica feasibility study.

Table 2. Information Flow Diagram for the Maine Microsimulation Model



V. Preliminary Findings and Recommendations

While the Board believes additional time is needed to consider the Mathematica feasibility study and develop final recommendations to the Legislature, the Health Security Board makes these preliminary findings and recommendations.

The Health Security Board supports universal coverage for all Maine citizens---every man, woman and child living in this State deserves comprehensive health care coverage.

Consistent with its purpose, the Health Security Board is unified in the belief that all Maine citizens should have access to comprehensive health coverage that emphasizes preventive care, quality, cost containment, choice of provider and long-term care. Clearly, that is not the case under Maine's current health care system. Based on estimates from the Mathematica study, nearly 96,000 people or 7.4 % of Maine's population will be uninsured in 2004. [1] In addition, the Mathematica study estimates that 22% of those privately insured in the individual market and 11% of those insured by small group employer coverage (2-99 employees) are underinsured. [2] Further, evolving evidence suggests that employers and employees are being faced with double digit premium increases and those cost increases are resulting in an additional erosion of coverage. To the members of the Health Security Board, health coverage is a right of all Mainers. The Health Security Board is committed to ensuring that universal coverage becomes a reality. Soon.

The Health Security Board finds that maintaining the "status quo" for Maine's health care system cannot be sustained.

In 1999, it was estimated that Maine spent about $5 billion for total health care spending.[3] Without reform, the Mathematica study has projected total spending to increase to $8.4 billion in 2004, a 37% increase over 2001 spending projections. By 2008, total spending is expected to increase to almost $11 billion, another increase of over 31%. On a per capita basis, health care spending will account for $6478 in 2004 and $8291 in 2008. [4] Over the long term, these cost increases cannot be sustained by any participant in Maine's health care system whether individual citizen, employer, insurer or federal, state or local government. The Health Security Board believes the current system needs reform. Without policy reform, problems of cost and access will continue to escalate and the current health care system will collapse.

While additional information and further analysis is needed, the Health Security Board finds that a single-payer health care system providing universal coverage appears to be financially feasible.

In its enabling legislation, the Health Security Board was directed to study the feasibility of a single-payer health plan and develop a plan that achieved a savings of 5% over current

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[1] The estimates used in the Mathematica model of Maine's uninsured population are lower than estimates provided in other published studies that rely on only Current Population Survey (CPS) data from the Census Bureau. In consultation with the Board, Mathematica adjusted the CPS numbers projecting the uninsured population at 11% to account for the fact that the MaineCare population is undercounted in the CPS.

[2] For modeling purposes, "underinsured" has been defined by Mathematica as coverage under a health insurance policy with a deductible of $2500 or higher.

[3] See "The Cost of Health Care in Maine," Year 2000 Blue Ribbon Commission on Health Care, Report to Governor Angus S. King, November 2000.

[4] See Mathematica Report, Feasibility of a Single-payer Health Plan Model for State of Maine, Ch. IV.B, p.32 and Table IV.3, p. 35.

spending. The Board interpreted this charge to mean the development of a plan that saved 5% compared to the base line projections for total health care spending in either 2004 or 2008. Based on the results of the Mathematica study, the model's estimates indicate that one plan developed by the Board (plan 3A) will save 2% over base case spending in 2004 and 8% in 2008. Under Plan 3A, individuals would be asked to contribute a maximum of $1000 and $2000 annually for individual and family coverage respectively through cost sharing; those individuals or families with incomes at or below 200% of poverty would be exempt from the cost sharing requirement. A more detailed outline of the benefits under Plan 3A is included in Table 1. The model also suggests that even greater savings could be achieved through more aggressive managed care and cost containment strategies, through changes in benefit design or through increased cost sharing requirements.

Further, the financing estimates project that if the current level of public sector effort at the federal and state level is maintained but insurance premiums are discontinued, the total additional financing required for a single-payer system with universal coverage is between $3.2 and 4.9 billion in 2004 (or 49-52% of the total) depending on the single-payer benefit design. To finance that additional effort in the absence of premium contributions, the Mathematica study uses a payroll tax to model the funding needs for a single-payer system. Depending on the plan's benefit design and cost sharing requirements, the model projects that a payroll tax rate of 11.1% to 16.8% in 2004 and 9.7% to 15.5% in 2008 would provide the necessary funding. Mathematica estimates that private employers currently providing health insurance coverage, on average, contribute approximately 10% of wages and salaries for covered employees in the current premium-based system. [5]

While the Mathematica model suggests a single-payer plan is financially feasible compared to the "status quo", the unanimous endorsement of a single-payer plan by the Health Security Board at this time is premature. There are many complex issues and questions related to the financing, operation and economic impact of a single-payer system that are unresolved. The Health Security Board views the feasibility study conducted by Mathematica with cautious optimism---it suggests that a single-payer health care system may be one feasible approach to achieving universal coverage in Maine.

The Health Security Board recommends that the Legislature authorize the Board to continue its work until January 1, 2004 to refine and extend the financial feasibility study and to develop a transition and implementation plan for achieving universal coverage through a single-payer health care system in Maine.

In the Board's opinion, the Mathematica feasibility study provides an excellent foundation to evaluate the likely impact of a single-payer health care system on health care spending and financing in Maine. It also provides an initial assessment of how a single-payer system will affect Maine's economy. However, the microsimulation model has limitations that would benefit from additional analysis and refinement. In addition, the model and the feasibility study does not address many practical and policy issues affecting the operation

[5] See Mathematica study, Chapter IV. C, p. 43.

of a single-payer system. The Health Security Board believes it is critically important to evaluate these issues before making its final recommendations to the Legislature.

In relation to the microsimulation model, the Health Security Board has identified these unanswered questions:

- What is the economic impact of an alternative financing strategy, which requires broad participation and is more progressive than the current premium system? Does a financing mechanism with these features make Maine a more or less attractive place to do business?
- Can the model's estimates of the financing and economic impact of a single-payer system be integrated?
- Can the distributional impact on Maine's businesses and individuals be modeled?
- Can the model's estimates be improved by incorporating updated population data?
- Can the administrative cost savings assumptions for plans and providers be refined to reflect current costs and experience of Maine plans and providers?
- What is the potential for "adverse selection" through in migration of residents from other states if Maine establishes a single-payer plan? What is the potential for out migration if individuals, businesses and providers leave Maine? What financial impact could that have on the State? What impact would the loss of providers, especially specialty providers, have on the delivery and quality of health care?
- How well does the Watson Wyatt PreView™ model predict Maine's health care costs when applied retroactively?
- How do the single-payer benefit designs used in the model compare with current benefit packages offered by large and small employers?
- What level of financial reserves would be required for implementation of a single-payer plan?
- What are the costs of a transition to a single-payer system?

With regard to the transition to a single-payer health care system, the Health Security Board has not fully addressed all of the operational and policy issues. The Board has discussed many of these issues to some extent, but has not been able to reach consensus as a group. The unresolved questions that need further discussion and consideration by the Health Security Board include but are not limited to:

- What steps are necessary to transition from the current health care system to a single-payer system? How will the costs of transition be paid? What is the timeline necessary for transition? Should coverage under a single-payer system be phased in for certain coverage groups or populations?
- How will a single-payer system be governed? What entity will oversee and administer a single-payer system? How will that entity be structured? Will administration of the system be performed by state government or by contracting with a private entity?
- Can federal maintenance of effort be achieved? What steps are necessary to obtain necessary waivers?

- How will eligibility for coverage under a single-payer system be determined? What standards will be used?
- How will the global budget for a single-payer system be prepared? How will it work? Is there a role for certificate of need?
- How will providers participate in a single-payer system? How will they be reimbursed? At what level? Can regional differences in the cost of health care technology and procedures, for example, between Maine and Massachusetts, be addressed?
- How will the adequacy of a provider network be evaluated? Can the current supply of providers in Maine meet an anticipated increased demand for services?
- What mechanisms can be used to evaluate and ensure the quality of health care services provided under a single-payer plan?
- What health care services will be provided? Will rationing of services be necessary?
- What specific benefit design should be recommended?
- How should a single-payer system be financed? Through a payroll tax? Through a combination of payroll and other taxes?

Without additional time to consider these issues, the Health Security Board cannot adequately meet its charge from the Legislature. An extension will allow the Board time to thoughtfully consider and evaluate the work done by Mathematica. It will allow the Board time to completely respond to the questions outlined above. It will allow the Board time to coordinate its effort with the research and analysis being done on comprehensive system reform through the federally funded state health planning grant. Most importantly, it will allow the Board time to solicit public comment and input on the feasibility study and the work it has completed to date. If additional time is available, the Board plans to schedule public hearings throughout the State and to seek additional funding for consultative expertise. The Board also intends to draft legislation to implement its recommendations for consideration by the 121st Legislature.

Conclusion

The Health Security Board hopes that this report and the microsimulation model will provide a foundation for informed and constructive dialogue among policymakers and others interested in reforming Maine's current health care system. The results of the feasibility study suggest that a single-payer health care system appears to be a feasible approach to achieving universal coverage but more information and analysis is needed. With additional time and resources, the Health Security Board believes it can help develop a blueprint for universal coverage. We look forward to reaching the goal of universal coverage.

APPENDIX A

Enabling Legislation Establishing the Health Care System and Health Care Security Board

Public Law 2001, chapter 439, Part ZZZ

PART ZZZ

Sec. ZZZ-1. Health Care System and Health Security Board.

1. Board established. The Health Care System and Health Security Board, referred to in this section as the "board," consists of 19 members as follows:

A. The Commissioner of Human Services or the commissioner's designee;

B. The Executive Director of the State Employee Health Commission or the director's designee;

C. The State Tax Assessor or the assessor's designee;

D. Two members of the House of Representatives appointed by the Speaker of the House of Representatives with preference to members of the joint standing committee of the Legislature having jurisdiction over health and human services matters, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over banking and insurance matters;

E. Two members of the Senate appointed by the President of the Senate with preference to members of the joint standing committee of the Legislature having jurisdiction over health and human services matters, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over banking and insurance matters;

F. A representative of each of the following, appointed by the President of the Senate:

(1) A statewide organization that advocates universal health care;
(2) A statewide organization that defends the rights of children;
(3) A statewide organization representing health insurers and health maintenance organizations;
(4) Health care economists;
(5) A statewide organization of physicians; and
(6) Small hospitals in the State; and

G. A representative of each of the following, appointed by the Speaker of the House:

(1) A statewide organization that represents Maine senior citizens;
(2) A statewide labor organization;
(3) A statewide organization of nurses;
(4) Large hospitals in the State;
(5) The business community; and
(6) An organization representing the self-employed.

2. Chairs. The first-named Senate member is the Senate chair and the first-named House member is the House chair of the board.

3. Appointments; convening board. All appointments must be made no later than 30 days following the effective date of this Part. The chairs shall call and convene the first meeting of the board within 30 days of completion of all appointments.

4. Purpose. The purpose of the board is to develop recommendations to provide health care coverage to all citizens of this State through a plan or plans that emphasize 24-hour coverage, quality, cost containment, choice of provider and access to comprehensive, preventive and long-term care.

5. Duties of board. The board has the following duties.

A. As its first priority, the board shall undertake a review to:

(1) Determine what percentage of health care benefits are paid from automobile insurance, general liability insurance and workers' compensation insurance;

(2) Assess what, if any, savings are associated with a simplified billing system;

(3) Assess what, if any, savings would be realized by schools and correctional facilities with a single-payor system based on their current expenses for services related to health care such as occupational therapy, physical therapy and speech therapy; and

(4) Assess what, if any, savings are associated with a single-payor system by comparing hospitals of similar size in the State and other states; and

(5) In its assessment, the board shall examine prior studies conducted in Maine and other states.

B. In developing proposals to implement a single-payor plan to provide health care coverage to all citizens of this State, the board shall make recommendations related to standards for:

(1) Eligibility for coverage under the plan for residents of the State, including a requirement that residents must apply for an identification card to enroll in the plan, responsibility for collection from individuals and insurance companies and reimbursement for providers in the State;

(2) The types of health care services covered under the plan. The plan must provide coverage for health care services from a provider within this State if those services are determined medically necessary by the provider for the patient, except that the plan may not provide cosmetic services. Copayments may be charged only as charged under current Medicaid coverage. Deductibles may not be charged to plan enrollees. The plan must be at least as inclusive as Medicaid coverage. This subsection does not preclude supplementary benefit insurance for services that are not medically necessary. Covered health care must include all services and providers for which coverage is mandated under the Maine Revised Statutes, Title 24-A and must include all coverage offered by the Medicaid program;

(3) A system for the delivery of health care services throughout the State. Covered health care services must be provided to plan enrollees by participating providers who are located within the State and who are chosen by the plan enrollees. The plan must pay for health care services provided to a plan enrollee while the enrollee is temporarily outside the State. The maximum period of time a plan enrollee may be covered while out of state is 90 days per year. A plan enrollee may qualify to begin services out of state but, in order to receive continued treatment, may be required to receive treatment within the State. Reimbursement for services rendered out of state must be at rates set by the board. A participating provider may not charge plan enrollees or 3rd parties for covered health care services in excess of the amount reimbursed to that provider by the plan. A participating provider may not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status; and

(4) The role of other health care programs including, but not limited to, the following programs: the Medicare program of the federal Social Security Act, Title XVIII; the Medicaid program of the federal Social Security Act, Title XIX; the civilian health and medical program as referred to in 10 United States Code, Sections 1071 to 1106; the federal Indian Health Care Improvement Act, 25 United States Code, Sections 1601 to 1682; other 3rd-party payors who may be billable for health care services; and any state and local health programs, including, but not limited to, workers' compensation and employers' liability insurance pursuant to the Maine Revised Statutes former Title 39 and Title 39-A.

The board shall also examine issues related to the implementation of a single-payor plan for universal coverage and access such as: promoting the purposes of the plan; setting reimbursement rates for participating providers; rules necessary to implement the plan; systems for enrollment, registration of providers for participation, rate setting and contracts with providers of services and pharmaceuticals; developing budgets with hospitals and institutional providers; administration of revenues of the plan; employment of staff as necessary to implement the plan; development of plans and funding for training and assistance for workers in the health care sector displaced by moving to a single-payor health care system; addressing the unique issues related to the delivery of a single-payor health care system among the State's border communities and the impact on health care practitioners, providers and residents of those communities; and conducting public hearings annually or more frequently regarding resource allocation, revenues and services.

C. The board shall examine funding for the single-payor plan from a combination of sources, including payments from government sources, including federal, state and other governmental health care and aid programs; payments from workers' compensation, pension and health insurance employee benefit plans; payments from state, county and municipal governmental units for coverage; payments from tobacco settlement funds; and payments from any taxes or fees based on the results of the feasibility study required under paragraph D.

D. The board shall conduct a feasibility study of the economic impacts on individuals and businesses of a single-payor plan that guarantees a minimum 5% savings over existing health care costs and the impact on individuals and businesses of payment options and benefits should those options be necessary, including but not limited to increasing corporate and individual

income tax rates; increasing sales tax rates; eliminating sales tax exemptions and exclusions; and establishing a payroll or other tax dedicated to funding the plan. The board shall also address the potential positive or negative impact of the plan on the State's economy.

E. The board shall stress prevention of disease and maintenance of health in developing proposals to implement the single-payor plan and shall attempt to retain and strengthen existing health facilities whenever possible in developing those proposals.

F. The board may examine any other issues or gather information necessary to fulfill its purpose and duties.

The board may choose to organize subcommittees of its members to carry out the duties described in this subsection, except that a subcommittee may not take any action without a final decision by the entire board. Any action or decision of the board must be made by majority vote.

6. Staff assistance. The board may contract with and retain staffing and technical assistance from a health policy organization.

7. Funding. The board may seek and accept outside funding through the public or private sector to advance its work.

8. Compensation. Those members of the board who are Legislators are entitled to receive the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2 and reimbursement for travel and other necessary expenses related to their attendance at meetings of the board.

9. Report. Based on its review, the board shall develop recommendations regarding the implementation of a single-payor plan to provide health care coverage to all citizens of this State and shall submit its report, together with any necessary implementing legislation, to the Second Regular Session of the 120th Legislature by March 1, 2002. If the board requires an extension of time to make its report, it may apply to the Legislative Council, which may grant the extension. Upon submission of the report, the board may not take further action unless further action is authorized by law.

Sec. ZZZ-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

2001-02

LEGISLATURE
Health Care System and Health Security Board

Personal Services $660
All Other 10,000

Provides funds for the per diem and expenses of legislative members of the Health Care System and Health Security Board, to conduct public hearings, to contract for staffing and technical assistance and to print the required report.

LEGISLATURE ___________
TOTAL $10,660

Sec. ZZZ-3. Allocation. The following funds are allocated from Other Special Revenue to carry out the purposes of this Part.

2001-02

LEGISLATURE
Health Care System and Health Security Board

All Other $500

Provides funds as a base allocation in the event that outside sources of revenue are received by the Health Care System and Health Security Board.

APPENDIX B

(NOT INCLUDED)

APPENDIX C

Proposed Draft Legislation Recommended by Health Care System and Health Security Board

An Act to Extend the Authority of the Health Care System and Health Security Board

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, it is essential for the effective operation of the Health Security Board that certain changes be made immediately in the terms of the initial appointees and that the Board be authorized to continue its work; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. Public Law 2001, chapter 439, Sec. ZZZ-1, subsection 1, ¶¶ D and E amended to read:

D. Two members ~~of the House of Representatives~~ appointed by the Speaker of the House of Representatives who are serving in the House of Representatives at the time of their appointment with preference to members of the joint standing committee of the Legislature having jurisdiction over health and human services matters, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over banking and insurance matters;

E. Two members of the Senate appointed by the President of the Senate who are serving in the Senate at the time of their appointment with preference to members of the joint standing committee of the Legislature having jurisdiction over health and human services matters, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over banking and insurance matters;

Sec. 2. Public Law 2001, chapter 439, Sec. ZZZ-1, subsection 2 is amended to read:

2. Chairs. The first-named Senate member is the Senate chair and the first-named House member is the House chair of the board. The Senate and House chair may continue to serve until a successor is appointed.

Sec. 3. Public Law 2001, chapter 439, Sec. ZZZ-1, subsection 3 is amended to read:

3. Appointments; convening board. All appointments must be made no later than 30 days following the effective date of this Part. Appointed members may continue to serve until their successor is appointed. The chairs shall call and convene the first meeting of the board within 30 days of completion of all appointments.

Sec. 4. **Public Law 2001, chapter 439, Sec. ZZZ-1, subsection 8** is amended to read:

8. Compensation. Those members of the board who are Legislators or were Legislators at the time of their appointment are entitled to receive the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2 and reimbursement for travel and other necessary expenses related to their attendance at meetings of the board. If funds are available, public members of the board who are not otherwise compensated by their employers or other entities whom they represent may apply for reimbursement of travel and other necessary expenses related to their attendance at meetings of the board held after January 15, 2003.

Sec. 5. **Public Law 2001, chapter 439, Sec. ZZZ-1, subsection 9** is amended to read:

9. Report. Based on its review, the board shall develop recommendations regarding the implementation of a single-payor plan to provide health care coverage to all citizens of this State and shall submit its final report, together with any necessary implementing legislation, to the Second Regular Session of the 121st Legislature by January 1, 2004. The board shall submit an interim report, together with any necessary implementing legislation, to the First Regular Session of the 121st Legislature by January 15, 2003. ~~Second Regular Session of the 120th Legislature by March 1, 2002. If the board requires an extension of time to make its report, it may apply to the Legislative Council, which may grant the extension.~~ Upon submission of the final report, the board may not take further action unless further action is authorized by law.

Sec. 6. Retroactivity. This Act is retroactive to September 21, 2001.

Emergency clause. In view of the emergency cited in the preamble, the Act takes effect when approved.

Summary

This bill extends the authority for the Health Care System and Health Security Board to continue its work and submit a final report by January 1, 2004. The bill requires that the Board submit an interim report by January 15, 2003. The bill also allows members appointed when they were Legislators to continue to serve until a successor is appointed.

The bill is retroactive to the date when the legislation creating the Health Security Board was first enacted.

APPENDIX A:

Public Law 2003, chapter 492

CHAPTER 492

H.P. 27 - L.D. 20

An Act to Extend the Authority of the Health Care System and Health Security Board

Be it enacted by the People of the State of Maine as follows:

Sec. 1. PL 2001, c. 439, Pt. ZZZ, §1, sub-§1, first ¶ is amended to read:

1. Board established. The Health Care System and Health Security Board, referred to in this section as the "board," consists of ~~19~~ 20 members as follows:

Sec. 2. PL 2001, c. 439, Pt. ZZZ, §1, sub-§1, ¶¶D and E are amended to read:

D. Two members ~~of the House of Representatives~~ appointed by the Speaker of the House of Representatives who are serving in the House of Representatives at the time of their appointment with preference to members of the joint standing committee of the Legislature having jurisdiction over health and human services matters, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over banking and insurance matters;

E. Two members ~~of the Senate~~ appointed by the President of the Senate who are serving in the Senate at the time of their appointment with preference to members of the joint standing committee of the Legislature having jurisdiction over health and human services matters, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over banking and insurance matters;

Sec. 3. PL 2001, c. 439, Part ZZZ, §1, sub-§1, ¶G is amended to read:

G. A representative of each of the following, appointed by the Speaker of the House:

(1) A statewide organization that represents Maine senior citizens;

(2) A statewide labor organization;

(3) A statewide organization of nurses;

(4) Large hospitals in the State;

(5) The business community; ~~and~~

(6) An organization representing the self-employed~~.~~; and

(7) The public.

Sec. 4. PL 2001, c. 439, Pt. ZZZ, §1, sub-§§2 and 3 are amended to read:

2. **Chairs.** The first-named Senate member is the Senate chair and the first-named House member is the House chair of the board. The Senate and House chairs may continue to serve until successors are appointed.

3. **Appointments; convening board.** All appointments must be made no later than 30 days following the effective date of this Part. Appointed members may continue to serve until their successors are appointed. The chairs shall call and convene the first meeting of the board within 30 days of completion of all appointments. The board may hold up to 4 meetings after June 30, 2003, all of which must be in the Augusta area.

Sec. 5. PL 2001, c. 439, Pt. ZZZ, §1, sub-§§6 to 9 are amended to read:

6. **Staff assistance.** The board may contract with and retain staffing and technical assistance from a health policy organization. Upon approval of the Legislative Council, the Office of Policy and Legal Analysis may provide necessary staffing services to the board.

7. **Funding.** The board may seek and accept outside funding through the public or private sector to advance its work and support its activities. Funds may not be appropriated from the General Fund to support any activity of the board, nor may expenses exceed available funding.

8. **Compensation.** Those members of the board who are Legislators are entitled to receive the legislative per diem as

defined in the Maine Revised Statutes, Title 3, section 2 and reimbursement for travel and other necessary expenses related to their attendance at meetings of the board. Public members not otherwise compensated by their employers or other entities whom they represent are entitled to receive reimbursement of necessary expenses and, upon demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at meetings of the board.

9. Report. Based on its review, the board shall develop recommendations regarding the implementation of a single-payor plan to provide health care coverage to all citizens of this State and shall submit its final report, together with any necessary implementing legislation, ~~to the Second Regular Session of the 120th Legislature by March 1, 2002~~ for presentation to the First Regular Session of the 122nd Legislature by November 1, 2004. ~~If the board requires an extension of time to make its report, it may apply to the Legislative Council, which may grant the extension.~~ The board shall submit an interim report, together with any implementing legislation, to the First Regular Session of the 121st Legislature by January 15, 2003. Upon submission of the final report, the board may not take further action unless further action is authorized by law.

Sec. 6. Appropriations and Allocations. The following appropriations and allocations are made.

LEGISLATURE

Health Care System and Health Security Board

Initiative: Provides an allocation of Other Special Revenue funds for expenses of the board.

Other Special Revenue Funds	**2003-04**	**2004-05**
Personal Services	$1,100	$0
All Other	5,202	0
Other Special Revenue Funds Total	$6,302	$0

Sec. 7. Retroactivity. This Act is retroactive to September 21, 2001.

APPENDIX B:

Additional Questions and Issues Identified in Preliminary Report

HEALTH CARE SYSTEM AND HEALTH SECURITY BOARD
PRELIMINARY REPORT JANUARY 15, 2003

ISSUES NEEDING FURTHER STUDY AND DISCUSSION

Operational and Policy Issues Related to Single-Payer System:

- What steps are necessary to transition from the current health care system to a single-payer system? How will the costs of transition be paid? What is the timeline necessary for transition? Should coverage under a single-payer system be phased in for certain coverage groups or populations?

- How will a single-payer system be governed? What entity will oversee and administer a single-payer system? How will that entity be structured? Will administration of the system be performed by state government or by contracting with a private entity?

- Can federal maintenance of effort be achieved? What steps are necessary to obtain necessary waivers?

- How will eligibility for coverage under a single-payer system be determined? What standards will be used?

- How will the global budget for a single-payer system be prepared? How will it work? Is there a role for certificate of need?

- How will providers participate in a single-payer system? How will they be reimbursed? At what level? Can regional differences in the cost of health care technology and procedures, for example, between Maine and Massachusetts, be addressed?

- How will the adequacy of a provider network be evaluated? Can the current supply of providers in Maine meet an anticipated increased demand for services?

- What mechanisms can be used to evaluate and ensure the quality of health care services provided under a single-payer plan?

- What health care services will be provided? Will rationing of services be necessary?

- What specific benefit design should be recommended?

- How should a single-payer system be financed? Through a payroll tax? Through a combination of payroll and other taxes?

Additional Analysis through Microsimulation Model:

- What is the economic impact of an alternative financing strategy, which requires broad participation and is more progressive than the current premium system? Does a financing mechanism with these features make Maine a more or less attractive place to do business?

- Can the model's estimates of the financing and economic impact of a single-payer system be integrated?
- Can the distributional impact on Maine's businesses and individuals be modeled?
- Can the model's estimates be improved by incorporating updated population data?
- Can the administrative cost savings assumptions for plans and providers be refined to reflect current costs and experience of Maine plans and providers?
- What is the potential for "adverse selection" through in migration of residents from other states if Maine establishes a single-payer plan? What is the potential for out migration if individuals, businesses and providers leave Maine? What financial impact could that have on the State? What impact would the loss of providers, especially specialty providers, have on the delivery and quality of health care?
- How well does the Watson Wyatt PreView™ model predict Maine's health care costs when applied retroactively?
- How do the single-payer benefit designs used in the model compare with current benefit packages offered by large and small employers?
- What level of financial reserves would be required for implementation of a single-payer plan?
- What are the costs of a transition to a single-payer system?

APPENDIX C:

Draft Legislation to Implement Board's Recommendation

Proposed Draft Legislation Recommended by
Health Care System and Health Security Board

Resolve, to Continue the Health Care System and Health Security Board

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the Health Security Board has determined that additional time is needed to monitor current health care reform efforts before making a final recommendation on a single-payer health care plan; and

Whereas, the Board has already completed substantial work to determine the feasibility of a single-payer health care plan for this State; and

Whereas, the Board intends to make recommendations to implement a single-payer health plan if other reform efforts are not successful;

Whereas, the Board has adequate funds to support its activities; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it resolved by the People of the State of Maine as follows:

Sec. 1. Board reestablished. The Health Care System and Health Security Board, established in Public Law 2001, chapter 439, part ZZZ and referred to in this resolve as the "board", is reestablished. The board consists of 20 members as follows:

A. The Commissioner of the Department of Health and Human Services or the commissioner's designee;

B. The Executive Director of the State Employee Health Commission or the director's designee;

C. The State Tax Assessor or the assessor's designee;

D. Two members of the House of Representatives appointed by the Speaker of the House of Representatives with preference to members of the joint standing committee of the Legislature having jurisdiction over health and human services matters, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters;

E. Two members of the Senate appointed by the President of the Senate with preference to members of the joint standing committee of the Legislature having jurisdiction over health and human services matters, the joint standing committee of the Legislature having

jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters;

F. A representative of each of the following, appointed by the President of the Senate:

(1) A statewide organization that advocates universal health care;
(2) A statewide organization that defends the rights of children;
(3) A statewide organization representing health insurers and health maintenance organizations;
(4) Health care economists;
(5) A statewide organization of physicians; and
(6) Small hospitals in this State.

G. A representative of each of the following, appointed by the Speaker of the House:

(1) A statewide organization that represents Maine senior citizens;
(2) A statewide labor organization;
(3) A statewide organization of nurses;
(4) Large hospitals in the State;
(5) The business community;
(6) An organization representing the self-employed; and
(7) The public.

2. Chairs. The first-named Senate member is the Senate chair and the first-named House member is the House chair of the board. The Senate and House chair may continue to serve until a successor is appointed.

3. Members; appointments; meetings. Those members serving on the board as of November 1, 2004 shall continue to serve unless they submit their resignation to the chairs. All appointments for vacancies to the board as of November 1, 2004 must be made no later than 30 days following the effective date of this resolve. Appointed members may continue to serve until their successor is appointed. The chairs shall call and convene meetings of the board as necessary.

4. Board purpose. The purpose of the board is to develop recommendations to provide health care coverage to all citizens of this State through a single-payer health care plan that emphasizes access to comprehensive, preventive and long-term care, quality, cost containment and choice of provider.

5. Duties of the board. The board has the following duties.

A. In developing a proposal to implement a single-payer plan to provide health care coverage to all citizens of this State, the board shall make recommendations related to standards for:

(1) Eligibility for coverage under the plan for residents of this State, including a requirement that residents must apply for an identification card to enroll in the plan, responsibility for collection from individuals and insurance companies and reimbursement for providers in the State;

(2) The types of health care services covered under the plan. The plan must provide coverage for health care services from a provider within the State if those services are determined medically necessary by the provider for the patient, except that the plan may not provide cosmetic services. Copayments may be charged only as charged under current Medicaid coverage. Deductibles may not be charged to plan enrollees. The plan must be at least as inclusive as Medicaid coverage. This subsection does not preclude supplemental insurance coverage for services that are not medically necessary. Covered health care must include all services and providers for which coverage is mandated under the Maine Revised Statutes, Title 24-A and must include all coverage offered by the Medicaid program;

(3) A system for the delivery of health care services throughout the State. Covered health care services must be provided to plan enrollees by participating providers who are located within the State and who are chosen by plan enrollees. The plan must pay for health care services provided to a plan enrollee while the enrollee is temporarily outside the State. The maximum period of time a plan enrollee may be covered while out of state is 90 days per year. A plan enrollee may qualify to begin services out of state but, in order to receive continued treatment, may be required to receive treatment within the State. Reimbursement for services rendered out of state must be at rates set by the board. A participating provider may not charge plan enrollees or 3rd parties for covered health care services in excess of the amount reimbursed to that provider by the plan. A participating provider may not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status;

(4) The role of other health care programs including, but not limited to, the following programs: the Medicare program of the federal Social Security Act, Title XVIII; the Medicaid program of the federal Social Security Act, Title XIX; the civilian health and medical program as referred to in 10 United States Code, Sections 1071 to 1106; the federal Indian Health Care Improvement Act, 25 United States Code, Sections 1601 to 1682; the statewide plan provided through Dirigo Health; other 3rd party payers who may be billable for health care services; and any state and local health programs, including, but not limited to, worker's compensation and employers' liability insurance pursuant to the Maine Revised Statutes, Title 39-A; and

(5) Other issues such as: promoting the purposes of the plan; setting reimbursement rates for participating providers; rules necessary to implement the plan; systems for enrollment, registration of providers for participation, rate setting and contracts with providers of services and pharmaceuticals; developing budgets with hospitals and institutional providers; administration of revenues of the plan; employment of necessary staff to implement the plan; development of plans and funding for training and assistance of health care workers displaced by moving to a single-payer health plan; addressing the unique issues related to the delivery of a single-payer health plan among the State's border communities and the impact on providers residents of those communities; and conducting public

hearings annually or more frequently regarding resource allocation, revenues and services.

B. The board shall examine funding for the single-payer plan from a combination of sources, including payments from government sources, including federal, state and other governmental health care and aid programs; payments from worker's compensation, pension and health insurance employee benefit plans; payments from state, county and municipal governmental units for coverage; payments from tobacco settlement funds; and payment from any taxes or fees based on the results of the feasibility study prepared under contract with the board in December 2002.

C. The board shall stress prevention of disease and maintenance of health in developing proposals to implement the single-payer plan and shall attempt to retain and strengthen existing health care facilities whenever possible in developing those proposals.

D. The board may evaluate current health care reform efforts, including but not limited to Dirigo Health, and examine any other issues or gather information as necessary to fulfill its purpose and duties.

6. Staff assistance. Upon approval of the Legislative Council, the Office of Policy and Legal Analysis may continue to provide necessary staffing services to the board. The board may also contract with and retain staffing and technical assistance from a health policy organization.

7. Funding. The board may seek and accept outside funding through the public or private sector to advance its work and support its activities. Any unexpended funds allocated to the board as of November 1, 2004 must be carried forward for use by the board and may not lapse. Funds may not be appropriated from the General Fund to support any activity of the board, nor may expenses exceed available funding.

8. Compensation. Those members of the board who are Legislators are entitled to receive the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2 and reimbursement for travel and other necessary expenses related to their attendance at meetings of the board. Public members not otherwise compensated by their employers or other entities whom they represent are entitled to receive reimbursement of necessary expenses and, upon demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at meetings of the board.

9. Report. The board shall develop recommendations regarding the implementation of a single-payer plan to provide health care coverage to all citizens of this State and shall submit its final report, together with any necessary implementing legislation, to the Second Regular Session of the 122nd Legislature by November 1, 2006. If the board requires an extension of time to make its report, it may apply to the Legislative Council, which may grant the extension. Upon submission of the final report, the board may not take further action unless further action is authorized by law.

Sec. 2. Retroactivity. This Act is retroactive to November 1, 2004.

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

Summary

This bill continues the Health Care System and Health Security Board through the next biennium of the Legislature. The bill requires that the Board submit a final report by November 1, 2006 to the 122nd Legislature. The bill allows those members serving on the Board as of November 1, 2004 to continue as members. It also preserves any unexpended funds allocated to the Board for use to pay future expenses.

The bill is retroactive to the date when the Health Security Board submitted its final report to the 121st Legislature.

APPENDIX D:

Summaries of Board Meetings

Health Care System and Health Care Security Board
Summary of Meeting on April 2, 2004

The Health Care System and Health Care Security Board met on Friday, April 2nd in Room 427, State House. Rep. Marilyn Canavan chaired the meeting. She was appointed last July as the new House chair. Paul Volenik, the Board's former House chair, has been appointed by the Speaker as the 20th member to represent the public.

Board resignations

Howard Buckley, who was appointed by the Speaker of the House to represent large hospitals, has resigned from the Board. With Mr. Buckley's resignation, the Board now has 3 vacancies: a position for a member of the Senate held previously by former Sen. Mary Small; a member who is a health care economist held previously by Beth Kilbreth, who resigned in January 2003; and a member representing large hospitals. Both Senate and House staff have indicated that these vacancies will be filled by the President and the Speaker after adjournment of the legislative session. If anyone wants to submit recommendations for these vacancies, they should speak to the chairs or to House and Senate staff directly.

Budget/Funding

The Board has a budget balance of $6299. These funds should be adequate to cover the costs of 4 meetings, including a public hearing. Budgeted expenses include per diem and expenses for legislative members, mailing and printing costs. Expenses have also been made available for public members of the Board who are not reimbursed for attendance at meetings by their employer or any organization they represent. Any members interested in submitting a request for reimbursement of expenses should contact board staff for more information.

Budget funds will not be sufficient to contract for additional consulting services. The Board did submit concept letters to the Maine Health Access Foundation (MeHAF) in February 03 and December 04 as part of the Foundation's request for grant proposals. MeHAF did not ask the Board to submit grant proposals in either round. The additional consulting services and analysis outlined in the Board's preliminary report, along with necessary modifications to the microsimulation model to provide public access, were estimated by Mathematica at approximately $148,000.

Briefing on Dirigo Health

Adam Thompson of the Governor's Office of Health Policy and Finance briefed the Board on the status of the overall Dirigo Health reform law. He spoke on behalf of Trish Riley who was unable to attend. Adam gave the Board a sense of the cost containment efforts underway in the Governor's Office, including the status of the draft State Health Plan (due May 2004) and the various study commissions. Tom Dunne, Executive Director of the Dirigo Health Agency, outlined the planned CareWorks benefit plan and

the schedule for the request for proposals from carriers. He told the Board that the CareWorks benefit plan should be launched sometime this summer. Mr. Dunne explained the innovative features of the CareWorks plan, including the sliding scale deductibles and out of pocket maximums based on income; subsidies for premium assistance; and financial incentives for health risk assessments. In the event that private carriers do not participate, the Dirigo Health Board is preparing a contingency plan to establish a nonprofit corporation if needed. Legislative approval of a nonprofit corporation is required.

Several handouts were distributed.

Future Role of Health Security Board

The Board discussed its future role. Given the enactment of the Dirigo Health law, a majority of members expressed the opinion that the Board should "hibernate" until Dirigo Health may be evaluated more fully. Several felt that Dirigo Health signals that the political will and support for a single-payer health plan has eroded and the role of the Board has diminished. While a few members expressed a willingness to suspend the Board's activities immediately, others suggested that the Board defer making any final decisions about its future until the fall when Dirigo Health may be evaluated again before the Board's November 1 deadline. Some members advocated that the Board continue its work to develop a single-payer health plan on parallel with Dirigo Health in the event that the Dirigo Health insurance products fails to meet expectations. They felt strongly that a single-payer plan is the solution to the State's health care problems.

In the end, the Board agreed that a final decision about its future should wait until fall. They decided to hold off on another meeting until late September or October. Since Dirigo Health is expected to be offering coverage by summer, the Board will invite Trish Riley and Tom Dunne to make another update on Dirigo's status. Then, the Board hopes to be able to make some decisions about making its final report to the Legislature on November 1st and any recommendation to continue its planning for a universal coverage, single-payer health plan.

Next Meeting

As explained above, the next meeting of the Board will be held in September or October when called by the chairs. At that meeting, the Board will get an update on Dirigo Health and make some final decisions about its future role in preparation for submitting its report to the Legislature on November 1, 2004.

Health Care System and Health Care Security Board
Summary of Meeting on September 22, 2004

The Health Care System and Health Care Security Board met on Wednesday, September 22nd in Room 427, State House. Sen. John Martin and Rep. Marilyn Canavan chaired the meeting. Other members attending were: Bob Downs, Jerome Gerard, Tammy Greaton, Patricia Philbrook, Violet Raymond, Leo Siegel and Paul Volenik.

Briefing on Dirigo Health

Ellen Schneiter, Deputy Director of the Governor's Office of Health Policy and Finance briefed the Board on the Dirigo Health Reform Act. She gave the first-year progress report on Dirigo Health, which went into effect on September 13, 2003. She highlighted the following accomplishments by the Governor's Office and Dirigo Health Agency pursuant to the law:

- DirigoChoice health plan, in partnership with Anthem, will begin enrollment on October 1st; coverage begins on January 1, 2005. Small businesses and self-employed individuals may enroll in the first quarter of operation; individuals may enroll beginning in March 2005. As you may recall, discounts on premiums, deductibles and out-of-pocket expenses will be available on a sliding scale to employees and individuals with incomes below 300% of the federal poverty line. Expected enrollment in the first year is 31,000 enrollees eligible for subsidized premiums;
- Interim State Health Plan was issued in July 2004. The State Health Plan's goal is to improve the allocation and coordination of the State's health care resources. A biennial State Health Plan will be issued in July 2005;
- Capital Investment Fund rule issued; Certificate of Need (CON) process strengthened. The Capital Investment Fund establishes an annual limit on the dollar amount of 3rd year operating costs of capital expenditures and new technology investments that may be approved under CON. The CIF was initially established through emergency rulemaking. The Legislative will review the major substantive rule next session. In addition, the State Health Plan set priorities and criteria to be used in evaluating CON applications; and
- Maine Quality Forum. The Forum has been established as part of the Dirigo Health Agency to pursue initiatives to improve the quality of health care delivered in Maine. The Forum works with an advisory group of health care providers, insurers, consumers and business representatives.

The first-year progress report (handout) was distributed.

Future Role of Health Security Board

The Board discussed its future role. The consensus of the members was that no further action of the Board is necessary at this time. Given the progress with DirigoChoice and the other Dirigo reform efforts, members expressed their hope that universal access can

be achieved over time with this approach. However, the members also agreed that it is worthwhile for the Board to seek continued authority to meet in the event that DirigoChoice is not successful. The members decided that legislation should be drafted for consideration by the Legislature that will authorize the Board to meet, as needed, through the next biennium.

Next Steps

No additional meetings of the Board are expected. Staff will soon distribute a draft of a short final report, along with recommended legislation to extend the Board's authority for 2 more years. Board members will review the draft report and legislation so that it can be finalized prior to the November 1 reporting deadline. The legislation will be considered by the Legislature during the upcoming legislative session (sometime between January and April 2005).