NON-CONFIDENTIAL

STATE OF MAINE

DIRIGO HEALTH AGENCY

BOARD OF DIRECTORS

IN RE:	)	**MEAHP EXHIBIT 1**
	)	
DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE FOURTH ASSESSMENT YEAR (2009)	)	PREFILED TESTIMONY OF JACK P. BURKE

July 9, 2008

Q. Would you please state your name and your professional affiliation?

A. My name is Jack P. Burke. I am a principal and consulting actuary with Milliman, the leading provider of independent actuarial consulting services to the health care industry. My resume is attached as Burke Exhibit 1.

Q. What is the purpose of your testimony in this proceeding?

A. The Maine Association of Health Plans ("MEAHP") has retained me to review and comment on the *Report to the Dirigo Health Agency, Dirigo Health Reform Act: Aggregate Measurable Cost Savings (AMCS) for Year 4* (updated June 26, 2008) (the " srHS Report"), prepared by schramm/raleigh Health Strategy and Dr. Kenneth Thorpe. The srHS Report identifies a level of aggregate measurable cost savings ("AMCS") of $190.2 million. I have been asked to prepare a critique of the srHS Report and will address the hospital savings/cost per CMAD, Bad Debt and Charity Care and Medical Loss Ratio intiatives, as well as the Overlap calculation. My critique is attached as Burke Exhibit 2. As I note in my critique, it is my opinion that the AMCS caculation contained in the Report is not reasonably supported because it is based on unreasonable, unsupported and improper assumptions, and depends on faulty, unreasonable calculations.

Q. Please summarize the basis for your opinion by intiative.

A. With respect to the hospital savings CMAD calculation, my opinion is based on a number of grounds, including without limitation and as set forth in detail in my report::

1) failure to reasonably account for specific, credible explanations for the pattern of slower cost growth post-Dirigo other than Dirigo;

2) developing a CMAD estimate in the absence of Dirgo and failing to compare it to actual cost growth in the presence of Dirigo, but instead developing and comparing two flawed estimates – one with and one without Dirigo;

3) unreasonbaly equating the "absence" and "presence of Dirgo" with pre-SFY 2004 and post SFY-2003; or another time period if more covenient for the result;

4) failure to account for numerous fluctuations in hospital costs which are caused by factors completely unrelated to the so-called Dirigo initiatives (including national trends in hospital costs and patient volume);

5) failure to use pre-Dirigo actual cost –per-CMAD data that is consistent with that used in last year's srHS report, which unreasonably inflates the cost per CMAD reduction attributed to Dirigo;

6) failure to calculate what portion of this component of the AMCS determination is reasonably recoverable by payors from providers, despite clear precedent to consider this point in last year's decisions by the DHA Board and the Superintendent.

A. With respect to the Bad Debt and Charity Care and Overlap initiatives, my opinion is based on a number of grounds, including without limitation and as set forth in detail in my report::

1) reliance on an unreasonable projection to 2008 of the actual uninsurance rate for 2006;

2) unreasonably including 2003 in the "post-Dirigo" period, which unreasonably inflates the projected reduction in the uninsurance rate due to Dirigo;

3) failure to explain with specific reasons why the actual decrease in the uninsurance rate in Maine since 2003 was due to anything other than three identified events and erroneously attributing additional reductions in the uninsurance rate in Maine to "global" effects on health insurance premium increases due to Dirigo;

4) failure to calculate what portion of this component of the AMCS calculation is reasonbly recoverable by payors from providers, including failure to adjust the calculation for induced utilization, increased variable costs and the"savings per insured" figure from Dr. Thorpe to account for those assisted by governmental or other assistance programs that become insured;

5) failure to adjust for the overlap between this calculation and the cost per CMAD calculation.

A. With respect to the Medical Loss Ratio intiative, my opinion is based on a number of grounds, including without limitation and as set forth in detail in my report:

1) failure to make reasonable assumptions about the nature of the refunds in question, the fact that they are not recoverable, and that any such "savings" would overlap the other savings intitatives.

Q. Last year you provided in your report and live testimony alternative assumptions and calculations for both the hospital savings and Bad Debt and Charity Care initiatives. Do you offer similar alternate assumptions and calculations this year?

A. Yes. In my report I provide alternative assumptions and calculations for both of these intitatives again this year, which I believe are reasonable, and consistent with the key points in the pre-filed testimony of Dr. Dobson and Mr. Maffei in this year's proceeding, as well as Jack Keane's testimony in the year 3 proceeding, and prior years' decisions.

Q. Does this conclude your testimony?

A. Yes, it does.

Biography of Jack Burke FSA, MAAA

Principal, Consulting Actuary

Current Responsibility

Jack is a principal and a consulting actuary with the Philadelphia office of Milliman. He joined the firm in 1999.

Experience

Jack has extensive experience in all aspects of the small employer managed care market, including operations, systems, product design and development, legislation, underwriting, pricing, management of distribution systems, and overall business strategy.

Since joining Milliman, Jack has been involved in a variety of projects involving small and large group commercial products and Medicare. He has also developed expertise in consumer driven products, including HSAs and analysis of single payer legislative proposals.

Prior to joining Milliman, Jack worked at Aetna and United Healthcare. While at United Healthcare, he was vice president in charge of product management of health plan products, including the open access product. Prior to that, Jack was vice president of small group, responsible for growing United Healthcare's share of the small employer market.

Prior to working at United Healthcare, Jack spent 13 years at Aetna, where he gained broad management experience, including running a 180-person production unit and managing a large HMO system development project. At Aetna Health Plans, Jack was the CFO for, and ultimately head of, a 600-person, $1.6 billion strategic business unit selling group insurance and managed care to small employers.

Professional Designations

- Fellow, Society of Actuaries
- Member, American Academy of Actuaries

Education

BS, Math and Computer Science, University of Notre Dame

Burke - Exhibit 2

Report to the Dirigo Health Agency

Dirigo Health:
Aggregate Measurable Cost Savings
(AMCS) for Year 4

July 9, 2008

Jack P. Burke, F.S.A
Principal & Consulting Actuary

Milliman

Milliman Report in Support of Testimony Regarding
Aggregate Measurable Cost Savings – Year 4

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Milliman Report in Support of Testimony Regarding
Aggregate Measurable Cost Savings – Year 4

I. Introduction

Milliman was asked by the Maine Association of Health Plans to review and comment on the "Report to the Dirigo Health Agency – Dirigo Health Reform Act: Aggregate Measurable Cost Savings (AMCS) for Year 4" (srHS Report). In addition, Milliman reviewed other information related to the Year 4 calculation, and much of the reports, testimony, decision and supporting material related to Years 1, 2, and 3. Our comments regarding the srHS Report and the methods, calculations, and conclusions are included herein.

The intended use of this report is to be filed as testimony by Jack Burke for consideration by the Dirigo Health Board regarding the calculation of Aggregate Measurable Cost Savings for Year 4, as used to develop the Savings Offset Payment. Our analysis and results may not be appropriate for any other use.

In performing this analysis, we relied on data and other information. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

This report has been prepared for the use of and is only to be relied upon for the purpose stated. The report must be considered in its entirety.

It is certain that actual experience will not conform exactly to the assumptions used in this analysis. To the extent that actual experience is different from the assumptions used in the projections, the actual results will also deviate from the projected amounts.

II. Background

In the past, the srHS Report used the reduction in CMAD trend from pre-Dirigo to post-Dirigo years to imply that "savings" were due to the Dirigo law itself.

Last year, we provided a variety of other explanations for a reduction in trend, including reversion to the mean.

The Superintendent agreed, saying "the passage of time makes the failure to control for other factors affecting costs increasing problematic for the method, and at the same time makes other methods which control for these factors, such as multi-variate multi-state analyses, more feasible. While small random fluctuations in cost will occur in any year, the more serious threats to the persuasive power of this method would be raised by specific, additional credible explanations for the pattern of slower cost growth post-Dirigo." (Superintendent's Year 3 decision at 12)

III. The srHS Report's Choice of Multi-Variate Analysis

While the Superintendent wasn't clear about what type of multi-variate analysis to do, the method chosen in the srHS Report was not a reasonable one, for several reasons:

- The primary reason is that it didn't develop an estimate of CMAD and then compare it to actual. It instead developed two of its own flawed estimates – with and without Dirigo – and determined savings to be the difference between its estimates.

- In addition, despite repeatedly saying that they directly measured the savings due to each initiative, they only tried to differentiate one thing in the two estimates: whether the clock struck midnight on 6/30/2003 or not. And despite their testimony saying that it is the "absence of Dirigo" versus the "presence of Dirigo" (always underlined), it is not that at all. It is whether we crossed over from SFY 2003 to SFY 2004.

- Dobson/DaVanzo has shown that the srHS Report's notion of "the presence of Dirigo" can produce savings in most of the states using their analysis; often huge savings. That result demonstrates that this analysis does not adequately control for all the necessary factors to ensure, or even suppose, that it is projecting "Dirigo" savings. This defeats the purpose of the multi-variate analysis.

- It also highlights a point made in other testimony: that the srHS Report does not demonstrate any causal relationship between the variables tested and the results. To illustrate, we could construct a variable that reflects which of two teams, Yankees or Red Sox, had last won the World Series by the end of a calendar year. If, at the end of the calendar year, the Yankees had last won the World Series, the variable would be 0. If, by the end of the year, the Red Sox had last won the World Series, it would change to a 1. It stays a 1 until the Yankees change it back by winning the World Series.

This variable would have the following values for the years related to the CMAD calculation:

Calendar Year	Value
2000	0
2001	0
2002	0
2003	0
2004	1
2005	1
2006	1
2007	1

If this variable was tested in the CMAD calculation instead of the "Dirigo" variable, it also would have produced the same savings estimates. That is, the methodology used in the srHS Report would demonstrate that the reduction in case mix adjusted costs per hospital discharge was "due to" the Red Sox last winning the World Series (when compared to the Yankees). And the conclusion would be that such savings are likely to continue as long the Yankees do not reclaim it.

The reason the savings would be exactly the same is that the variable (0,0,0,0,1,1,1,1) is the same for this variable as for the Dirigo variable. This illustration is intended to clarify why the regression test used by the srHS Report does not show relationship or causality, since it is clear to all but the most diehard Sox fans that hospital costs per CMAD are unlikely to rest on the fortunes of the baseball team.

- Like it did in prior years, I believe the savings produced by this result are primarily a function of the high rate of growth in the early part of this decade, and as before, can be explained by reversion to the mean.

- The fact that the reported "ACTUAL" CMAD history changed substantially since last year is troubling. In the Year 3 srHS Report (Appendix E. CMAD Calculations), a calculation that was verified by Roland Mercier, the Net Total Cost (carefully developed removing the impact of non-acute stays) and the case mix adjusted discharges are all clearly shown. Appendix E, page 39 from the Year 3 srHS Report, is attached as Burke Exhibit 3. The 2000 to 2001 increase of 4.6% consisted of the following data: a) overall Net Total Costs going up 7.4% (from $1.396 billion to $1.500 billion), divided by b) overall case-mix adjusted inpatient and imputed outpatient discharges increasing 2.6% (from 286,056 to 293,585). It's unclear how that jumped to 11.3% for the 2000 to 2001 change in this year's work. The extra 6.4% would seem to imply another $89 million increase in costs that were not reported last year. Primarily by increasing this 2000 to 2001 CMAD trend, this changed version of history produces a bigger pre/post-difference, which is driving the current regression results to project "savings." If, for example, the pre-2004 trend in Maine averaged 5.5%, as shown in last year's report, then the decrease to post-2004 trend of 4.5% would only be 1%, which is below the US average decrease of 1.5% and the same as the rest of New England.

Despite this inconsistency, using any three-year period to lock in a high CMAD increase rate that is forever projected into the future to represent what would have happened is unreasonable. The pre-SFY 2004 period is a small period that does not represent an underlying fundamental Maine specific "force of CMAD cost growth trend."

- Last, they do not consider what portion of it is "recoverable" by their own admission despite the Superintendent explicitly ruling last year that this is appropriate in the AMCS determination. (Superintendent's Year 3 decision at 10).

The actual post SFY 2003 CMAD cost is higher and is actually increasing faster (4.5%) than New England (3.9%) and the US (3.9%) rate of growth. Using the peak of a cycle as the basis for projecting forward is not reasonable. Paradoxically, if Maine's CMAD continues to grow faster than the U.S., this method could produce higher savings, as long as the difference in growth is within a range of a few percent.

As I testified last year, I would expect a high annual increase to moderate – to revert to the mean – in the years after a sharp growth. In the case of cost per CMAD, if the hospitals costs increased early in the decade, then there would be that much less pressure to continue to increase in the next few years.

As noted by the Superintendent last year, however, "it is appropriate to consider the extent to which the calculated savings are attributed to hospitals with negative or poor margins." Similarly, hospitals may not be able to pass on savings due to the ongoing impact of MaineCare reimbursement cuts. The cuts do not need to be an absolute dollar decrease to have an impact as asserted by the srHS Report. The MaineCare reimbursement is already low (roughly 76% of cost).

Also, as reported in Jack Keane's testimony of last year and cited by the Superintendent, the CMAD calculation can inflate admissions when the outpatient utilization and charges grow faster than the inpatient cost per case, thereby deflating the average CMAD growth. This phenomenon is still a problem in the current calculation. By all accounts, outpatient charges have increased faster than inpatient, especially in Maine (See Burke Exhibit 4) (2 pages).

Actual potential reasons for the previously high CMAD growth and the subsequent slowing may include:

- Hospital margins were too low, but started to catch up to needed levels in 2001 and 2002, then the pressure was off for further rate hikes especially for outpatient charges;

- The influence of overall employment growth on uninsurance and the use of medical services;

- Hospital cost drivers: such as physician and other staffing levels and salaries, equipment cost, and building expense increased due to cyclical pressures.

In summary, I believe the new CMAD methodology presented in the srHS Report is not reasonable based on the methodology chosen and its misuse of the underlying data. Its construction is so difficult to support that no small adjustments can be made to create a reasonable and supportable estimate of savings.

Because the srHS Report again has created a method to develop unreasonably high savings estimates, and because no reasonable multi-variate calculation is available to demonstrate how changes ascribed to Dirigo directly impact actual CMAD savings, I have created an alternative calculation drawing on the historical decisions and data. Essentially, I would start with the "rough justice" decision from Year 3 that $25 million is deemed to be reasonable, and then adjust it for:

a) The impact of the excess Maine growth from 2006 to 2007: Maine CMAD growth of 3.3% outpaced the U.S. growth of 3.0% (srHS Year 4 Report page 54). It outgrew the Cluster 1 states CMAD change by about 2%. If we assume that Maine lost 0.3% (3.3% less 3.0%) to the national average, this would remove roughly $19 off the excess CMAD (of $253) used in the Year 3 calculation, or 7.5%.

b) The change in adjusted discharges used in each year's srHS report.

See Attachment I for this calculation. The result of these two adjustments are $21.2 million as a rough estimate of Year 4 CMAD savings. This is only offered as a reasonable result in the absence of other reasonable calculations. This also passes the check of a reasonable comparison to past year's findings.

Nothing in my testimony should be construed as suggesting that the methodology put forth by srHS reflects cost savings that are actually due to Dirigo. To the contrary, as set forth more fully in the testimonies from Dr. Dobson and Mr. Maffei, the srHS model is fraught with conceptual, variable and data problems and does not provide reasonable support for any CMAD savings for the Fourth Assessment Year. The alternative approach I have outlined above reflects only my effort to provide the Board with a methodology that can be supported by starting with an estimate of CMAD savings approved by the Superintendent in the last proceeding and updating it using known data.

IV. Bad Debt/Charity Care (BD/CC)

Maine's actual bad debt and charity care reported has grown yet the srHS Report's analysis reports between $17 and $42 million in "savings." Like the CMAD calculation, srHS does this by making an unreasonable estimate of what it would have been absent Dirigo. Unlike the CMAD calculation, srHS compares it to an "actual" figure, although not "actual bad debt and charity care," but actual uninsured rates. Again, not actual "actual," the srHS Report compares it to an unreasonable projection of the actual uninsurance rate for 2006 forward to 2008.

The srHS Report uses the actual-to-expected uninsurance rates as a proxy for the bad debt and charity care. But it unreasonably over-estimates the "expected" uninsurance rates and over-values its worth. Also, it doesn't develop it from direct Dirigo activity.

1. The srHS Report stops "pre-Dirigo" at 2002 for this calculation, instead of SFY 2003 as in the CMAD calculation. This is done because CY 2003 had a significant drop in uninsured rates, and this enables "post-Dirigo" to take credit for it. If the methodology in DHA Exhibit 18, column VII was used but with calendar year 2003 considered as pre-

Dirigo, the savings would drop by approximately 75%, from $30.3m to $7.2m, consistent with the level of last year's determination.

2. The srHS Report further projects the estimate of uninsurance to come down from 10.7% in 2006 to 9.65% in 2008. It does this by using the historical rate of decline (from 2003) and assuming it will continue. However, the decrease in that period can be explained by three specific activities.

The Medicaid expansion programs and the DirigoChoice enrollment of previously uninsured people provide specific reasons to explain the decrease in uninsured rates. These explanations are more direct and a counter-argument to the DHA global, umbrella argument that, in addition to the reductions due to these programs, Dirigo has also caused a reduction in the rate of insurance premium increases, thereby causing meaningfully fewer Maine people to be uninsured. The direct approach is also consistent with the BD/CC methodology approved by the Board in the Year 3 savings determination.

In particular, since 1999 the total reduction in uninsured has been 23,924, and 16,954 since 2002. The big drops were in 2003 (-12,712) and 2006 (-7,837). See Table 1 below. These two events can be explained entirely or more by:

- The MaineCare expansion (effective October 2002) to cover the non-categorical adults contributed to an increase in MaineCare enrollees from July 1, 2002 to July 1, 2003 of 36,347 (See Burke Exhibit 5) (3 pages).

- The MaineCare expansion to Parents of Children (150% FPL to 200% FPL) around 2005 added about 5,000 enrollees.

- The DirigoChoice program added about 12,000 enrollees of whom 35% were previously uninsured, which equals about 4,200 enrollees (See Burke Exhibits 6 & 7).

Table 1				
Year	**Maine Uninsurance Rate**	**Maine Population**	**Actual Uninsured**	**Implied Reduction**
1999	**13.25%**	1,103,652	146,220	
2000	**12.40%**	1,126,144	139,670	6,549
2001	**12.07%**	1,081,270	130,501	9,169
2002	**13.04%**	1,067,611	139,250	-8,749
2003	**11.79%**	1,073,084	126,538	12,712
2004	**11.64%**	1,087,397	126,538	2
2005	**11.67%**	1,114,873	130,133	-3,598
2006	**10.67%**	1,146,038	122,296	7,837
Source: srHS Report, pg. 70, plus calculations				

The total of these 3 initiatives (36,347+5,000+4,200) is over 45,000 enrollees, which more than explains the two significant drops and allows for population growth. Moreover, more than 36,000 of these newly enrolled are due to the MaineCare expansion that was enacted in the year before the Dirigo Act became law.

Unless another MaineCare expansion or growth in Dirigo enrollment happened in 2007 or 2008, then any projection of a continued decrease in uninsured (rates or absolute decreases) is unwarranted.

V. Recoverability

The srHS Report admits that its calculation makes no attempt to project the portion of savings that is reasonably recoverable, which is a key component of the AMCS determination, as reflected in both the Board's and Superintendent's decisions last year.

The savings per insured of $893 is derived from an analysis done by Family USA. It includes 36% that is paid for by federal, state and local programs. If these members become insured, that 36% savings will accrue to government sponsors, not the carriers. All calculations should be reduced by 36% (to $572), since the $893 figure is used in all savings estimates. This revised figure is fairly consistent with the average of $426 per uninsured/underinsured person and $533

per Medicaid expansion person, trended one more year, in the Year 3 calculation that led to the $6.3 million uninsured/underinsured Superintendent's decision.

As covered in previous testimony in prior years, an increase in utilization caused by coverage of uninsured will cause variable costs to increase. Only the excess of payments over variable expenses could be used for other purposes. The calculations shown in Section F below update similar calculations shown in the Year 3 testimony.

VI. Overlap

Any reduction in bad debt at the hospital would in theory reduce the pressure on the cost per case for the remaining, paying customers, and would thus be reflected in the CMAD calculation (if the calculation was directly measuring the cost per case); to the extent they would otherwise be recoverable. Thus, any hospital portion of the BD/CC has been accounted for. According to the Hadley/Holleran sources used as the basis for the calculation, 66% of uncompensated care is for hospital care. The remainder is physicians (14%) and community health clinics (20%).

Since both the hospital cost per CMAD and the BD/CC methodologies are attempts at estimates of macro measures of changes in the economy, rather than any direct savings from Dirigo, I consider them to be unreasonable and the related calculations to be without any reasonable support. Nonetheless, if the projected savings are preserved in any amount for either of these initiatives, the "savings" attributed to the reduction of bad debt should be reduced by 66% to reflect the overlap with the CMAD calculation.

The "rough justice" approach above includes an explicit adjustment for overlap in the Superintendent's Year 3 decision. My alternative hospital cost per CMAD calculation above is built upon that adjustment. Thus, I will not make a second explicit adjustment for it here.

VII. Direct Measure of BD/CC Savings Due to MaineCare Expansion

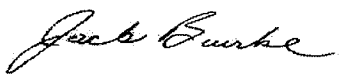
See Attachment II for a direct calculation of available savings for calendar year 2008. This calculation borrows from and is an abbreviated presentation of the approved savings decision for Year 3. (See Burke Exhibit 8) (8 pages) I updated the number of enrolled members and trended the net savings forward one year at 7%. The result decreased from $6.3 million to $6.1 million because the Dirigo enrollment declined from an average of 14,185 to 12,050; more than offsetting the MaineCare expansion increase in enrollment from 5,100 to 5,597.

VIII. Medical Loss Ratio

For a large carrier like Aetna with a reasonable expense ratio, a medical loss ratio (MLR) law raises the cost to carriers, and thus premiums, because it creates an expense during the favorable part of a pricing cycle, but has no offsetting return during the unfavorable part of the cycle. On average, a small risk charge is needed to cover this cost.

The "expense" is a reimbursement to certain customers when prices are over-estimated. This reimbursement is thus not available to the carrier to reduce premiums.

Any argument that MLR reimbursements are savings is unreasonable because they impose an additional cost on the carrier, not savings. This cost is not recoverable. If any of the gap is due to unexpected lower costs, they are not only unrecoverable, but may overlap with the CMAD or BD/CC savings estimates.



Jack P. Burke, F.S.A.
Principal & Consulting Actuary
July 9, 2008

Attachment I
Review of Aggregate Measurable Cost Savings
CMAD
Adjustment to 2007 Approved Savings Calculation

		Dirigo		Notes
		2006	2007	
Average CMAD	a	$ 6,481		From Year 3 srHS Report, Burke Exhibit 3
Actual 2006 to 2007 Maine Trend	b		3.3%	From srHS Report, page 54 (*$7,470/$7,233*)
Actual 2006 to 2007 US Trend	c		3.0%	From srHS Report, page 54 (*$7,235/$7,034*)
Excess of Maine vs. US	d		0.3%	= b - c
Estimated Reduction in Excess CMAD	e		19	= a x d
2007 Excess CMAD Used in Report	f	$ 253		From Year 3 srHS Report, Burke Exhibit 3
2008 Imputed CMAD	g		$ 233	= f - e
Case Mix and Outpatient Adj. Discharges	h	296,298	272,041	From Year 3 Burke Testimony, Burke Exhibit 8, and srHS Report, page 54
Year 3 Calculated "Savings"	i	$ 74,895,149		From Year 3 srHS Report, Burke Exhibit 3 (or f x h)
Reduction for error, offsets, overlap, and reasonableness	j	33.4%	33.4%	= k / i
Reasonably Determined Savings - Year 3	k	$ 25,000,000		From Year 3 Superintendent's decision.
Reasonably Determined Savings - Year 4	l		$ 21,187,761	= g x h x j

Attachment II
Review of Aggregate Measurable Cost Savings
Bad Debt/Charity Care
Available Savings Calculation for Calendar Year 2008

		Dirigo		MaineCare		
		Uninsured	Underinsured	Expansion	Total	Notes
Enrolled	a	12,050	12,050	5,597	29,697	From Burke Exhibit 6
Previously Uninsured	b	30.2%	25.8%	57%		From Year 3 Burke testimony, Burke Exhibit 8
Previously Underinsured						
Percent Months Uninsured/Underinsured	c	58.4%	58.4%	58.4%		From Year 3 Burke testimony, Burke Exhibit 8
New Average Enrollment to System	d	2,124	1,814	1,863	5,801	= a x b x c
Average Member Months	e	25,489	21,763	22,358	69,610	= d x 12
2007 Increase in Revenue	f	$ 195.09	$ 81.02	$ 93.50		From Year 3 Burke testimony, Burke Exhibit 8
2007 Increase in Expenses	g	$ 61.37	$ 35.71	$ 35.83		From Year 3 Burke testimony, Burke Exhibit 8
2007 Excess of Revenue over Expenses	h	$ 133.72	$ 45.31	$ 57.67		= f - g
2008 Excess of Revenue over Expenses	i	$ 143.08	$ 48.48	$ 61.71		h trended to 2008 at 7%
Available for Other Uses	j	$ 3,646,971	$ 1,055,123	$ 1,379,615	$ 6,081,710	= e x i

DOCUMENTATION FOR CMAD SAVINGS CALCULATION (CONT'D)

Appendix E. CMAD Calculations

Virtual Hospital Statewide	2006	2005	2004	2003	2002	2001	2000	1999
Overall Total Cost	$ 2,314,380,959	$ 2,170,976,582	$ 2,003,928,030	$ 1,850,943,460	$ 1,721,418,238	$ 1,536,036,499	$ 1,430,900,519	$ 1,295,507,823
RHC Total Cost	$ 40,289,958	$ 31,775,964	$ 24,096,994	$ 16,720,492	$ 10,611,613	$ 9,351,005	$ 7,824,458	$ 6,058,477
Gain (Loss) Due to Hospital Allocation Tax	$ (8,666,303)	$ (5,387,619)	$ (2,096,891)	$ -	$ -	$ -	$ -	$ -
SNF Total Cost	$ 21,804,040	$ 19,367,026	$ 19,797,990	$ 18,440,269	$ 14,573,152	$ 12,481,769	$ 11,260,276	$ 12,023,858
NF Total Cost	$ 7,891,320	$ 7,728,726	$ 7,212,569	$ 6,955,448	$ 9,894,811	$ 11,114,770	$ 12,351,904	$ 9,938,701
Other Long Term Care Total Cost	$ 3,581,408	$ 3,172,665	$ 3,067,820	$ 3,162,117	$ 3,031,812	$ 3,176,315	$ 3,051,766	$ 2,815,913
Hospital Tax Allocation	$ 51,842,150	$ 47,706,721	$ 15,793,938	$ -	$ -	$ -	$ -	$ -
Net Total Cost	$ 2,197,638,386	$ 2,066,613,099	$ 1,936,055,611	$ 1,805,665,135	$ 1,683,306,851	$ 1,499,912,640	$ 1,396,412,115	$ 1,264,670,874
Total I/P Charges	$ 2,430,552,681	$ 2,340,891,455	$ 2,210,450,347	$ 2,045,132,599	$ 1,882,547,942	$ 1,729,700,983	$ 1,614,269,457	$ 1,446,602,401
SNF I/P Charges	$ 15,205,362	$ 14,698,281	$ 14,890,680	$ 15,111,062	$ 11,588,912	$ 10,980,284	$ 10,467,324	$ 10,838,216
NF I/P Charges	$ 9,199,721	$ 8,908,009	$ 8,518,766	$ 8,100,055	$ 10,103,958	$ 9,998,782	$ 9,967,585	$ 9,296,094
Other Long Term Care I/P Charges	$ 3,338,575	$ 3,031,671	$ 2,947,559	$ 3,021,177	$ 2,884,173	$ 2,788,954	$ 2,682,810	$ 2,642,394
Net I/P Charges	$ 2,402,809,024	$ 2,314,253,495	$ 2,184,093,342	$ 2,018,900,306	$ 1,857,970,900	$ 1,705,932,963	$ 1,591,151,737	$ 1,423,825,697
Total O/P Charges	$ 2,362,739,164	$ 2,126,008,622	$ 1,861,122,901	$ 1,622,555,412	$ 1,400,748,291	$ 1,191,323,265	$ 1,051,187,934	$ 873,798,369
RHC O/P Charges	$ 20,007,968	$ 20,160,478	$ 9,123,407	$ 4,897,481	$ 221,572	$ 607,452	$ 390,241	$ 117,335
SNF O/P Charges	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
NF O/P Charges	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Long Term Care O/P Charges	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Net O/P Charges	$ 2,342,731,196	$ 2,105,848,144	$ 1,851,999,494	$ 1,617,657,931	$ 1,400,526,720	$ 1,190,715,813	$ 1,050,797,693	$ 873,681,033
Case Mix and outpt adj discharges	343,009	335,475	326,942	314,651	302,139	293,585	286,056	276,629
Total discharges, MHDO	155,668	157,459	158,667	156,895	154,976	156,120	154,446	154,662
Case Mix Adjusted Discharges	191,234	192,196	192,400	188,937	185,319	184,616	184,060	181,726
Cost per CMAD incl newborn w/ Prev. Unins.	$ 6,407	$ 6,160	$ 5,922	$ 5,739	$ 5,571	$ 5,109	$ 4,882	$ 4,572

Virtual Hospital - SFY06 Adjustments Summary	Statewide	Medicaid CAH	Non-CAH Medicaid O/P	Medicare	Net Adjusted Statewide
Overall Total Cost	$ 2,314,380,959	$ 56,162,534	$ 108,490,328	$ 112,771,757	$ 2,036,956,341
RHC Total Cost	$ 40,289,958	$ -	$ -	$ -	$ 40,289,958
Gain (Loss) Due to Hospital Allocation Tax	$ (8,666,303)	$ -	$ -	$ -	$ (8,666,303)
SNF Total Cost	$ 21,804,040	$ -	$ -	$ -	$ 21,804,040
NF Total Cost	$ 7,891,320	$ -	$ -	$ -	$ 7,891,320
Other Long Term Care Total Cost	$ 3,581,408	$ -	$ -	$ -	$ 3,581,408
Hospital Tax Allocation	$ 51,842,150	$ -	$ -	$ -	$ 51,842,150
Net Total Cost	$ 2,197,638,386	$ 56,162,534	$ 108,490,328	$ 112,771,757	$ 1,920,213,768
Total I/P Charges	$ 2,430,552,681	$ 33,600,951	$ -	$ 45,169,358	$ 2,351,782,372
SNF I/P Charges	$ 15,205,362	$ -	$ -	$ -	$ 15,205,362
NF I/P Charges	$ 9,199,721	$ -	$ -	$ -	$ 9,199,721
Other Long Term Care I/P Charges	$ 3,338,575	$ -	$ -	$ -	$ 3,338,575
Net I/P Total	$ 2,402,809,024	$ 33,600,951	$ -	$ 45,169,358	$ 2,324,038,715
Total O/P Charges	$ 2,362,739,164	$ 78,601,150	$ 235,960,910	$ 137,327,120	$ 1,910,849,984
RHC O/P Charges	$ 20,007,968	$ -	$ -	$ -	$ 20,007,968
SNF O/P Charges	$ -	$ -	$ -	$ -	$ -
NF O/P Charges	$ -	$ -	$ -	$ -	$ -
Other Long Term Care O/P Charges	$ -	$ -	$ -	$ -	$ -
Net O/P Charges	$ 2,342,731,196	$ 78,601,150	$ 235,960,910	$ 137,327,120	$ 1,890,842,016
Case Mix and outpt adj discharges	343,009	12,165	-	34,428	296,298
Total discharges, MHDO	155,668	3,724	-	8,678	143,265
Case Mix Adjusted Discharges	191,234	3,452	-	8,045	179,737
Cost per CMAD incl newborn w/ Prev. Unins.	$ 6,407				$ 6,481

Recommended Savings

schrammraleigh Health Strategy Methodology - HMBI Trend - 00/04 Adjusted
2004 and Approved Yr. 1 Savings in the Base

Approved 04 CMAD Savings	$ 33,700,000
2004 Case-Mix and Outpatient Adjusted Discharges	326,942
Approved Savings per CMAD	$ 103
Actual 04 CMAD + Approved Savings	$ 6,025

SFY	CMAD	HMBI Trend	SFY00 CMAD trended to SFY04	Rate above inflation	Estimated SFY06 CMAD	Total Savings per CMAD	Discharges	Total Savings
2000	$ 4,882	1.041						
2001	$ 5,109	1.040						
2002	$ 5,571	1.039						
2003	$ 5,739	1.038						
2004	$ 6,025	1.043	$ 5,703	1.382%				
2005	$ 6,160	1.043						
2006	$ 6,481	1.038			$ 6,733	$ 253	296,298	$ 74,895,149

statehealthfacts.org
Your source for state health data

Burke - Exhibit 4

HOME | 50 STATE COMPARISONS | INDIVIDUAL STATE PROFILES | SEARCH | TOOLS

Choose a different category...

Providers & Service Use

Providers & Service Use

Hospitals
- Total Hospitals
- Hospitals by Ownership
- Beds
- Beds by Ownership
- Admissions
- Admissions by Ownership
- Emergency Room Visits
- Emergency Room Visits by Ownership
- Inpatient Days
- Inpatient Days by Ownership
- Outpatient Visits
- Outpatient Visits by Ownership

Hospital Trends
- Total Hospitals, 1999-2006
- Hospitals by Ownership, 1999-2006
- Beds, 1999-2006
- Beds by Ownership, 1999-2006
- Admissions, 1999-2006
- Admissions by Ownership, 1999-2006
- ER Visits, 1999-2006
- ER Visits by Ownership, 1999-2006
- **Inpatient Days, 1999-2006**
- Inpatient Days by Ownership, 1999-2006
- Outpatient Visits, 1999-2006
- Outpatient Visits by Ownership, 1999-06

Medical Errors
- Mandatory Quality Reporting Requirement
- Hospital-Based Infection Reporting Req.

Nursing Homes
- Number of Nursing Home Residents
- Residents by Primary Payer Source
- Number of Nursing Homes
- Nursing Homes by Ownership Type
- Number of Nursing Home Beds
- Beds by Certification Category
- Number of Special Care Beds
- Nursing Home Occupancy Rates
- Nurse Hours per Resident Day
- Avg # of Nursing Home Deficiencies
- % of Homes w/ Serious Deficiencies
- % of Nursing Homes with No Deficiencies

Inpatient Days per 1,000 Population, 1999-2005

Bar Graph | Table | Map | Map & Table

Rank by: State name (alphabetical)

Rank Order:

	1999	2000	2001	2002	2003	2004	2005	2006
United States	704	682	681	683	676	673	665	657
Alabama	825	806	799	724	788	810	798	775
Alaska	399	468	479	468	443	435	461	450
Arizona	499	484	476	468	478	485	493	490
Arkansas	861	781	756	780	766	746	722	692
California	517	514	516	531	531	512	504	504
Colorado	480	459	477	483	495	467	451	454
Connecticut	631	620	637	647	582	643	660	659
Delaware	654	643	631	678	741	774	760	785
District of Columbia	1,896	1,577	1,578	1,645	1,623	1,771	1,711	1,674
Florida	737	707	704	737	704	696	696	689
Georgia	722	666	653	676	694	683	678	666
Hawaii	649	699	718	698	653	694	670	658
Idaho	555	515	516	483	511	479	452	463
Illinois	682	658	656	662	646	661	647	632
Indiana	673	647	644	662	645	652	601	603
Iowa	871	851	850	834	806	799	783	763
Kansas	841	773	806	798	788	774	754	735
Kentucky	832	823	815	830	824	817	811	770
Louisiana	794	799	837	865	862	856	755	838
Maine	696	679	699	687	624	624	643	648
Maryland	585	564	554	560	575	573	570	565
Massachusetts	682	674	685	677	681	691	682	689
Michigan	638	620	611	627	617	622	635	618
Minnesota	847	829	823	828	812	786	784	767
Mississippi	1,053	1,028	1,047	958	935	955	921	931
Missouri	777	762	749	747	759	765	763	742
Montana	1,316	1,157	1,168	1,177	1,143	1,125	1,095	1,030
Nebraska	1,094	1,028	1,063	998	917	923	1,000	945
Nevada	553	488	487	512	496	534	526	525

Burke - Exhibit 4

Choose a different category...
Providers & Service Use

Providers & Service Use
- **Hospitals**
  - Total Hospitals
  - Hospitals by Ownership
  - Beds
  - Beds by Ownership
  - Admissions
  - Admissions by Ownership
  - Emergency Room Visits
  - Emergency Room Visits by Ownership
  - Inpatient Days
  - Inpatient Days by Ownership
  - Outpatient Visits
  - Outpatient Visits by Ownership
- **Hospital Trends**
  - Total Hospitals, 1999-2006
  - Hospitals by Ownership, 1999-2006
  - Beds, 1999-2006
  - Beds by Ownership, 1999-2006
  - Admissions, 1999-2006
  - Admissions by Ownership, 1999-2006
  - ER Visits, 1999-2006
  - ER Visits by Ownership, 1999-2006
  - Inpatient Days, 1999-2006
  - Inpatient Days by Ownership, 1999-2006
  - **Outpatient Visits, 1999-2006**
  - Outpatient Visits by Ownership, 1999-06
- **Medical Errors**
  - Mandatory Quality Reporting Requirement
  - Hospital-Based Infection Reporting Req.
- **Nursing Homes**
  - Number of Nursing Home Residents
  - Residents by Primary Payer Source
  - Number of Nursing Homes
  - Nursing Homes by Ownership Type
  - Number of Nursing Home Beds
  - Beds by Certification Category
  - Number of Special Care Beds
  - Nursing Home Occupancy Rates
  - Nurse Hours per Resident Day
  - Avg # of Nursing Home Deficiencies
  - % of Homes w/ Serious Deficiencies
  - % of Nursing Homes with No Deficiencies

Outpatient Visits per 1,000 Population, 1999-2005

Bar Graph | Table | Map | Map & Table

Rank by: State name (alphabetical)

Rank Order:

	1999	2000	2001	2002	2003	2004	2005	2006
United States	1,817	1,848	1,889	1,932	1,937	1,946	1,971	2,007
Alabama	1,793	1,789	1,743	2,243	1,976	1,826	1,659	1,748
Alaska	1,666	2,025	2,193	2,085	2,227	2,023	2,513	2,621
Arizona	1,034	1,026	957	944	1,202	942	1,138	1,063
Arkansas	1,550	1,645	1,669	1,788	1,680	1,761	1,791	1,810
California	1,351	1,322	1,406	1,524	1,355	1,324	1,356	1,488
Colorado	1,588	1,551	1,561	1,558	1,536	1,511	1,582	1,524
Connecticut	2,077	1,974	1,891	1,920	1,968	2,002	2,041	2,225
Delaware	1,788	1,859	1,866	2,417	2,471	2,248	2,219	2,158
District of Columbia	2,665	2,330	2,478	2,681	2,848	2,933	2,834	2,748
Florida	1,304	1,358	1,270	1,347	1,296	1,287	1,255	1,260
Georgia	1,392	1,366	1,431	1,461	1,481	1,502	1,511	1,475
Hawaii	2,055	2,034	2,586	1,583	1,536	1,471	1,499	1,473
Idaho	1,743	1,660	1,998	1,778	2,026	1,742	1,903	1,847
Illinois	1,972	2,018	2,019	2,106	2,152	2,229	2,250	2,314
Indiana	2,207	2,320	2,349	2,288	2,419	2,491	2,626	2,621
Iowa	2,984	3,127	3,206	3,178	3,309	3,280	3,405	3,463
Kansas	1,893	1,952	1,997	2,093	2,184	2,144	2,163	2,230
Kentucky	2,015	2,148	2,133	2,114	2,074	2,144	2,123	2,097
Louisiana	2,176	2,243	2,253	2,397	2,409	2,303	2,176	2,324
Maine	2,217	2,543	2,734	2,882	2,998	3,131	3,262	3,198
Maryland	1,149	1,133	1,164	1,186	1,183	1,246	1,208	1,251
Massachusetts	2,544	2,627	2,934	2,962	3,058	2,971	2,932	3,037
Michigan	2,268	2,497	2,597	2,576	2,695	2,745	2,589	2,784
Minnesota	1,351	1,487	1,718	1,772	1,814	1,870	1,842	1,961
Mississippi	1,249	1,302	1,436	1,394	1,387	1,453	1,407	1,455
Missouri	2,678	2,641	2,519	2,629	2,740	2,810	2,969	2,799
Montana	2,877	2,932	2,923	2,920	2,982	3,124	3,059	3,065
Nebraska	1,802	1,988	1,995	2,007	2,116	2,260	2,213	2,296
Nevada	1,175	1,086	1,015	1,136	1,019	1,048	1,083	958

=9%

=31%

MaineCare CASELOAD

	Traditional Medicaid	SCHIP Medicaid Expansion	SCHIP "Cub Care"	Medicaid Expansion Parents ≤ 150% FPL	Non-Categorical Adults ≤ 100% FPL	Medicaid Expansion Parents >150% FPL	SUBTOTAL	DEL\Maine RX Drug Programs	TOTAL
Jan-02	166,222	7,963	4,137	12,665	0	0	**190,987**	109,384	**300,371**
Feb-02	167,920	8,194	4,218	13,060	0	0	**193,392**	110,143	**303,535**
Mar-02	169,974	8,484	4,346	13,543	0	0	**196,347**	110,898	**307,245**
Apr-02	171,777	8,698	4,401	13,800	0	0	**198,676**	111,401	**310,077**
May-02	173,222	8,913	4,243	13,922	0	0	**200,300**	112,140	**312,440**
Jun-02	173,613	9,029	4,130	14,052	0	0	**200,824**	111,726	**312,550**
Jul-02	174,393	9,208	4,069	14,330	0	0	**202,000**	112,071	**314,071**
Aug-02	175,329	9,199	4,065	14,425	0	0	**203,018**	112,430	**315,448**
Sep-02	176,047	8,442	4,061	13,147	0	0	**201,697**	112,897	**314,594**
Oct-02	181,134	8,294	4,079	13,500	2,846	0	**209,853**	111,811	**321,664**
Nov-02	184,050	8,328	4,307	14,245	5,571	0	**216,501**	110,778	**327,279**
Dec-02	185,859	8,415	4,449	14,379	7,774	0	**220,876**	109,864	**330,740**
Jan-03	190,665	7,954	4,575	13,727	10,036	0	**226,957**	108,851	**335,808**
Feb-03	190,905	8,414	4,619	14,665	11,535	0	**230,138**	107,025	**337,163**
Mar-03	192,472	8,504	4,684	14,778	12,845	0	**233,283**	102,669	**335,952**
Apr-03	193,887	8,413	4,752	14,778	13,719	0	**235,549**	98,551	**334,100**
May-03	195,694	8,023	4,697	14,387	14,591	0	**237,392**	94,175	**331,567**
Jun-03	195,499	7,943	4,720	14,400	15,007	0	**237,569**	90,373	**327,942**
Jul-03	196,151	7,944	4,701	14,300	15,538	0	**238,634**	86,277	**324,911**
Aug-03	196,291	8,221	4,709	14,396	15,853	0	**239,470**	82,078	**321,548**
Sep-03	198,110	8,056	4,808	14,195	16,248	0	**241,417**	80,212	**321,629**
Oct-03	200,419	7,940	4,890	12,064	16,854	0	**242,167**	80,055	**322,222**
Nov-03	199,704	8,011	4,853	12,900	17,176	0	**242,644**	79,810	**322,454**
Dec-03	198,172	8,281	4,804	13,639	17,458	0	**242,354**	79,806	**322,160**
Jan-04	201,189	8,225	4,693	13,542	18,344	0	**245,993**	102,052	**348,045**
Feb-04	201,928	8,369	4,712	14,110	19,086	0	**248,205**	103,667	**351,872**
Mar-04	201,924	8,916	4,577	15,428	19,859	0	**250,704**	104,290	**354,994**
Apr-04	202,258	9,169	4,491	15,952	20,262	0	**252,132**	101,574	**353,706**
May-04	202,690	9,408	4,449	16,393	20,552	0	**253,492**	99,767	**353,259**
Jun-04	202,923	9,483	4,484	16,681	20,901	0	**254,472**	98,977	**353,449**
Jul-04	203,722	9,634	4,481	16,942	21,376	0	**256,155**	98,914	**355,069**
Aug-04	203,765	9,684	4,489	17,054	21,712	0	**256,704**	98,879	**355,583**
Sep-04	204,625	9,816	4,397	17,486	22,194	0	**258,518**	98,761	**357,279**
Oct-04	205,195	9,985	4,454	17,657	22,623	0	**259,914**	98,662	**358,576**
Nov-04	205,862	10,011	4,420	17,904	23,072	0	**261,269**	98,588	**359,857**
Dec-04	207,217	10,064	4,372	17,821	23,669	0	**263,143**	98,515	**361,658**
Jan-05	207,966	10,150	4,225	18,116	24,383	0	**264,840**	98,514	**363,354**
Feb-05	208,138	10,087	4,127	17,972	24,925	0	**265,249**	98,611	**363,860**
Mar-05	209,545	10,067	4,000	18,078	24,460	0	**266,150**	98,942	**365,092**
Apr-05	210,550	10,040	3,899	18,070	23,333	0	**265,892**	96,318	**362,210**
May-05	210,394	10,165	3,816	18,270	22,021	611	**265,277**	95,006	**360,283**
Jun-05	210,096	10,047	3,942	18,354	20,556	1,631	**264,626**	92,697	**357,323**
Jul-05	209,973	10,073	4,076	18,339	19,248	2,442	**264,151**	90,084	**354,235**
Aug-05	209,974	10,145	4,200	18,319	18,029	3,075	**263,742**	90,018	**353,760**
Sep-05	209,806	10,106	4,262	18,447	16,895	3,766	**263,282**	91,875	**355,157**

Prepared by the Office of Fiscal and Program Review from DHHS-OMS Data
g:\ofpr\humserv\medicaid\MaineCare Caseload\MaineCare Caseload Summary

Burke - Exhibit 5

MaineCare CASELOAD

	Traditional Medicaid	SCHIP Medicaid Expansion	SCHIP "Cub Care"	Medicaid Expansion Parents ≤ 150% FPL	Non-Categorical Adults ≤ 100% FPL	Medicaid Expansion Parents >150% FPL	SUBTOTAL	DEL\Maine RX Drug Programs	TOTAL
Oct-05	210,191	10,220	4,360	18,587	15,933	4,040	**263,331**	93,247	**356,578**
Nov-05	210,502	10,254	4,498	18,607	15,087	4,288	**263,236**	89,773	**353,009**
Dec-05	210,666	10,200	4,505	18,453	13,634	4,340	**261,798**	90,360	**352,158**
Jan-06	211,114	10,417	4,504	18,669	12,972	4,545	**262,221**	89,237	**351,458**
Feb-06	212,099	10,408	4,482	18,671	12,462	4,749	**262,871**	88,944	**351,815**
Mar-06	213,767	10,111	4,568	18,500	11,824	4,907	**263,677**	86,548	**350,225**
Apr-06	213,195	10,276	4,504	18,749	11,430	5,010	**263,164**	85,735	**348,899**
May-06	213,410	10,235	4,489	18,776	11,058	5,091	**263,059**	84,463	**347,522**
Jun-06	213,643	10,270	4,509	18,876	10,795	5,108	**263,201**	84,780	**347,981**
Jul-06	212,833	10,325	4,483	18,920	10,872	5,048	**262,481**	84,119	**346,600**
Aug-06	212,515	10,310	4,504	18,824	16,123	5,100	**267,376**	78,888	**346,264**
Sep-06	212,686	10,264	4,505	18,730	18,091	5,005	**269,281**	76,213	**345,494**
Oct-06	212,938	10,343	4,530	18,891	19,249	5,090	**271,041**	74,707	**345,748**
Nov-06	212,796	10,292	4,533	18,918	20,249	5,129	**271,917**	73,691	**345,608**
Dec-06	213,104	10,216	4,609	18,955	20,910	5,194	**272,988**	73,640	**346,628**
Jan-07	213,955	10,298	4,638	19,051	20,356	5,249	**273,547**	74,479	**348,026**
Feb-07	214,345	10,075	4,632	18,959	19,483	5,342	**272,836**	75,210	**348,046**
Mar-07	215,380	9,913	4,615	18,806	20,134	5,414	**274,262**	75,302	**349,564**
Apr-07	215,513	9,922	4,601	18,985	19,351	5,377	**273,749**	75,634	**349,383**
May-07	215,876	9,991	4,600	19,246	18,491	5,524	**273,728**	75,862	**349,590**
Jun-07	216,185	10,087	4,543	19,325	20,852	5,596	**276,588**	73,297	**349,885**
Jul-07	216,342	9,910	4,573	19,117	19,936	5,606	**275,484**	73,810	**349,294**
Aug-07	216,693	9,695	4,504	19,018	20,744	5,593	**276,247**	68,765	**345,012**
Sep-07	216,928	9,777	4,395	18,973	20,864	5,537	**276,474**	68,130	**344,604**
Oct-07	216,836	9,684	4,374	18,924	20,773	5,533	**276,124**	68,261	**344,385**
Nov-07	215,722	9,780	4,409	18,883	20,332	5,558	**274,684**	68,564	**343,248**
Dec-07	215,383	9,778	4,409	18,833	19,398	5,545	**273,346**	69,135	**342,481**
Jan-08	216,870	9,667	4,526	18,607	18,512	5,642	**273,824**	69,554	**343,378**
Feb-08	218,150	9,342	4,556	18,207	17,669	5,685	**273,609**	69,919	**343,528**
Mar-08	218,304	9,362	4,566	18,179	16,651	5,679	**272,741**	71,426	**344,167**
Apr-08	217,789	9,341	4,588	18,121	15,633	5,616	**271,088**	73,038	**344,126**
May-08	217,582	9,327	4,604	17,943	14,742	5,597	**269,795**	74,033	**343,828**

DHHS Eligibility Descriptions:

- Traditional Medicaid includes adults and children in receipt of a financial benefit (TANF, IV-E); aged and disabled persons in receipt of a financial benefit (SSI, SSI Supplement), institutionalized persons (NF), and others not included below.
- SCHIP (State Child Health Insurance Program) Medicaid Expansion Children (M S-CHIP) (effective July 1998) are children with family incomes above 100% and up to and including 150% of the Federal Poverty Level
- SCHIP "Cub Care" Children (effective July 1998) are children with family incomes above 150% and up to and including 200% of FPL.
- Medicaid Expansion Parents are persons who function as the primary caretakers of dependent children and whose income is above 100% and up to and including 150% of FPL (effective September 2000); and beginning May 2005, up to and including 200% of FPL.
- Non-Categorical Adults (effective October 2002) are persons who are over 21 and under 65, not disabled, not the primary caretakers of dependent children, and whose income is not more than 100% of FPL.
- DEL\MaineRX Drug Programs include persons eligible for Medicaid, but not for "full benefits" (e. g., QMB, SLMB, QI) who meet the criteria for participation in DEL and/ or Maine Rx; and persons who meet ONLY the criteria for participation in DEL and/ or Maine Rx.

Burke - Exhibit 5

DEL/ Me Rx Caseload
Department of Health and Human Services

	MaineCare Eligible				NOT MaineCare Eligible				Grand Total			
	ME Rx only	DEL and Me Rx	DEL only	TOTAL	ME Rx only	DEL and Me Rx	DEL only	TOTAL	ME Rx only	DEL and Me Rx	DEL only	TOTAL
July 2005	233	8,405	3	8,641	47,997	33,444	2	81,443	48,230	41,849	5	90,084
August 2005	767	8,023	1	8,791	48,027	33,196	4	81,227	48,794	41,219	5	90,018
September 2005	147	8,705	1	8,853	49,734	33,285	3	83,022	49,881	41,990	4	91,875
October 2005	5	9,101	0	9,106	50,518	33,620	3	84,141	50,523	42,721	3	93,247
November 2005	1	9,112	1	9,114	47,698	32,958	3	80,659	47,699	42,070	4	89,773
December 2005	0	9,183	0	9,183	48,441	32,736	0	81,177	48,441	41,919	0	90,360
January 2006	0	9,364	0	9,364	48,524	31,349	0	79,873	48,524	40,713	0	89,237
February 2006	0	9,847	0	9,847	48,276	30,821	0	79,097	48,276	40,668	0	88,944
March 2006	0	10,554	0	10,554	46,637	29,356	1	75,994	46,637	39,910	1	86,548
April 2006	0	11,686	0	11,686	46,366	27,682	1	74,049	46,366	39,368	1	85,735
May 2006	0	13,265	0	13,265	45,722	25,475	1	71,198	45,722	38,740	1	84,463
June 2006	0	14,281	1	14,282	46,295	24,201	1	70,497	46,295	38,482	2	84,779
July 2006	0	14,717	0	14,717	45,729	23,672	1	69,402	45,729	38,389	1	84,119
August 2006	0	15,042	0	15,042	40,506	23,339	1	63,846	40,506	38,381	1	78,888
September 2006	0	15,229	0	15,229	37,700	23,283	1	60,984	37,700	38,512	1	76,213
October 2006	0	15,482	0	15,482	36,147	23,078	0	59,225	36,147	38,560	0	74,707
November 2006	0	15,691	0	15,691	35,124	22,876	0	58,000	35,124	38,567	0	73,691
December 2006	0	15,863	0	15,863	34,836	22,941	0	57,777	34,836	38,804	0	73,640
January 2007	1	16,070	0	16,071	35,617	22,791	0	58,408	35,618	38,861	0	74,479
February 2007	1	16,214	0	16,215	36,404	22,591	0	58,995	36,405	38,805	0	75,210
March 2007	0	16,960	0	16,960	35,987	22,355	0	58,342	35,987	39,315	0	75,302
April 2007 [1/]	0	30,701	0	30,701	36,639	8,294	0	44,933	36,639	38,995	0	75,634
May 2007	0	30,552	1	30,553	37,217	8,092	0	45,309	37,217	38,644	1	75,862
June 2007	0	30,460	1	30,461	34,928	7,908	0	42,836	34,928	38,368	1	73,297
July 2007	0	30,529	1	30,530	35,527	7,753	0	43,280	35,527	38,282	1	73,810
August 2007	0	29,905	0	29,905	32,426	6,434	0	38,860	32,426	36,339	0	68,765
September 2007	0	30,219	0	30,219	31,449	6,462	0	37,911	31,449	36,681	0	68,130
October 2007	1	30,519	0	30,520	31,354	6,387	0	37,741	31,355	36,906	0	68,261
November 2007	1	30,824	0	30,825	31,449	6,290	0	37,739	31,450	37,114	0	68,564
December 2007	2	31,119	0	31,121	31,855	6,159	0	38,014	31,857	37,278	0	69,135
January 2008	2	31,435	0	31,437	32,074	6,043	0	38,117	32,076	37,478	0	69,554
February 2008	1	31,668	0	31,669	32,346	5,903	1	38,250	32,347	37,571	1	69,919
March 2008	1	32,047	0	32,048	33,482	5,896	0	39,378	33,483	37,943	0	71,426
April 2008	4	32,472	1	32,477	34,855	5,706	0	40,561	34,859	38,178	1	73,038
May 2008	4	32,724	1	32,729	35,978	5,325	1	41,304	35,982	38,049	2	74,033

Please Note:

[1/] Due to the change in DEL eligibility guidelines (particularly converting many DEL eligibles to Qualified Medicare Beneficiary (QMB – "Quimby") status; i.e. increasing the income disregard) there are significant (anticipated) count changes this month compared to prior months in the DEL-related columns on the MaineCare Caseload report and the DEL/Me Rx Caseload report.

The Qualified Medicare Beneficiary program (QMB), Specified Low-Income Medicare Beneficiary program (SLMB), and Qualified Individual program (QI), help Medicare beneficiaries of modest means pay all or some of Medicare's cost sharing amounts (ie. premiums, deductibles and copayments). To qualify an individual must be eligible for Medicare and must meet certain income guidelines which change annually. The income guidelines change April 1 each year.

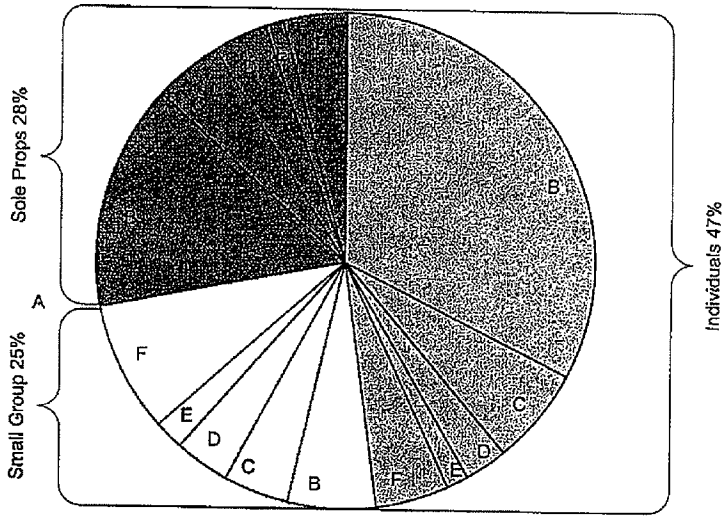
Burke - Exhibit 5

DHA Board
7/7/08

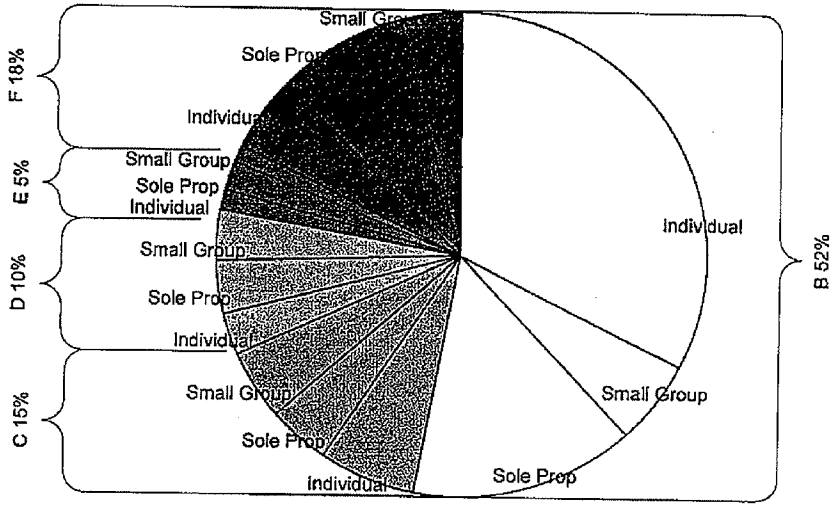
Dirigo Health Monthly Numbers June 2008
Dirigo Health Agency 07/02/2008

Total Members Served, DC + Parents	28,745
New DC Members (un/subsidized)	81 (29/52)
HCTC Members	78
Total Enrolled DC Members	12,050
New DC Small Groups	4
Total Enrolled DC Small Groups	637
Total Enrolled Parents	5,597
New Parents	0
CY 2008 Member / Employee Share of coverage cost	$ 17,446,174.08 (48%)
CY 2008 Dirigo Share of coverage cost (subsidy)	$ 19,202,837.59 (52%)
CY 2008 total coverage cost	$ 36,649,011.67 (100%)
CY Member Months	77,742 (100.16% to projected)
CY Subsidy PMPM	$247.01 (95.14% to projected)
FY 2008 Member / Employee Share of coverage cost	$34,834519.60 (46%)
FY 2008 Dirigo Share of coverage cost (subsidy)	$40,133,369.82 (54%)
FY 2008 total coverage cost	$74,967,889.42 (100%)
FY Member Months	178,223
FY Subsidy PMPM	$225.19

Members by Employer Type



Members by Discount Level



Notes:

1. Total Members Served refers to the total number of members ever enrolled (beginning 01/01/2005) for any period of time in the DirigoChoice or MaineCare Parent Expansion programs
2. Total New Members refers to the number of new members enrolled in the reporting month.
3. Total Enrolled Members refers to the number of members currently enrolled in the reporting month.
4. Annual subsidy PMPM is the average "per member per month" annual cost for the Agency in 2008.

Burke - Exhibit 6

STATE OF MAINE
DIRIGO HEALTH AGENCY
211 WATER STREET, 53 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0053

Burke - Exhibit 7

JOHN ELIAS BALDACCI
GOVERNOR

KARYNLEE HARRINGTON
EXECUTIVE DIRECTOR

TO: Joint Committee on Insurance and Financial Services

FROM: Karynlee Harrington, Dirigo Health Agency

CC: Trish Riley, Governor's Office of Health Policy and Finance
Dr. Robert McAfee, Chair of the Dirigo Health Agency Board of Directors
Colleen McCarthy Reid, Esq.

DATE: ~~December~~ January 24, 2008

RE: Colleen McCarthy Reid's January 15, 2008 e-mail specific to follow up questions from the Committee on Insurance and Financial Services.

Please find outlined below the specific question Colleen raised in her January 15, 2008 e-mail along with the Agency's response. Once you have had a chance to review please do not hesitate to contact me with additional questions.

1. What are the CY 2007 administrative/operating costs for the agency? What is the Maine Quality Forum's operating expenses?

Response: The Agency's (Agency includes quality and access) CY2007 operating costs totaled $3,728,226 of which $804,333 is specific to the costs associated with the Quality Forum.

2. Please provide the average per member per month enrollee share.

Response: The average per member per month member/employee share of monthly coverage cost in CY2007 is $191.87.

3. Please provide more information on the subsidies provided to small groups. What is the total number of subsidized small groups v. non-subsidized?

Response: As of December 2007 there are 713 small employers (defined as employers with 2-50 employees) participating in DirigoChoice of which 175 small employer groups do not have employees/dependents eligible for subsidy and 538 small employers groups do have employees/dependents eligible for subsidy.

4. The total percentage of un/underinsured is listed as 60.6%. If possible, please provide a breakdown of percentage uninsured and percentage underinsured.

Response: The breakdown of the 60.6% reported in the December 2007 Monthly Numbers report reflects the percentage of un/underinsured DirigoChoice members through June 2006 (as note number five in the report indicates) is as follows. 34.81% previously uninsured; 25.79% underinsured.

5. Please provide a copy of the Agency's contract with Harvard Pilgrim Health Care.

Response: A hard copy of the Dirigo Health Agency-Harvard Pilgrim Health Care Group Health Insurance Agreement has been forwarded to you via interoffice mail.

Burke - Exhibit 8

Attachment IIa
Review of Aggregate Measurable Cost Savings
Uninsured/Underinsured Initiative
Available Savings Calculation for Calendar Year 2007

Dirigo Population

	I. Enrollment Assumptions	Total Dirigo	Previously Uninsured	Previously Underinsured	Notes & Calculations
(1)	Projected CY07 Member Months	170,224			Per Attachment IIIa
(2)	% Previously Uninsured/Underinsured		0.302	0.258	see Muskie, p. 10
(3)	% Months Uninsured/Underinsured		0.584	0.584	Per Attachment IIIa
(4)	Adjusted CY07 Member Months	170,224	29,974	25,620	(1) x (2) x (3)
	II. Development of Increased Payments to Providers				
(5)	Cost Relative to Fully Insured		55%	80%	Per Attachment IIIa
	Prior to Dirigo				
(6)	CY06 Allowed Annual Cost	$4,403.24	$2,719.09	$3,955.04	Insured PMPM x (5)
(7)	Paid by Plan	$3,016.23	$0.00	$2,570.77	(6) x (24)
(8)	Paid by Other Sources	$155.41	$679.77	$237.30	(6) x (25)
(9)	Paid by Member	$828.88	$1,006.06	$791.01	(6) x (26)
(10)	Net Paid to Provider	$4,000.52	$1,685.83	$3,599.08	(7) + (8) + (9)
(11)	Uncompensated	$402.72	$1,033.25	$355.95	(6) - (10)
(12)	Induced Utilization		1.500	1.200	Per Attachment IIIa
	In Dirigo				
(13)	CY06 Allowed Annual Cost	$4,761.69	$4,078.63	$4,746.04	(14) / (27)
(14)	Paid by Plan	$3,760.67	$3,221.21	$3,748.31	Total Dirigo Experience (a)
(15)	Paid by Member	$761.87	$652.58	$759.37	(13) x (28)
(16)	Net Paid to Provider	$4,522.54	$3,873.79	$4,507.68	(14) + (15)
(17)	Uncompensated	$239.15	$204.85	$238.37	(13) - (16)
	Estimated Increase in Payments to Providers				
(18)	CY06 Annual Increase	$522.02	$2,187.95	$908.60	(16) - (10)
(19)	Years of Trend		1	1	Per Attachment IIIa
(20)	Trend		7%	7%	Per Attachment IIIa
(21)	CY07 Annual Increase	$558.56	$2,341.11	$972.20	(18) x (1 + (20)) ^ (19)
(22)	CY07 PMPM	$46.55	$195.09	$81.02	(21) / 12
(23)	CY07 Dollars	$7,923,333	$5,847,698	$2,075,634	(22) x (4)
	Source of Payments to Providers				
	Prior to Dirigo				
(24)	Plan		0%	65%	Per Attachment IIIa
(25)	Other Sources		25%	6%	Per Attachment IIIa
(26)	Member		37%	20%	Per Attachment IIIa
	In Dirigo				
(27)	Plan		79%	79%	Per Attachment IIIa
(28)	Member		16%	16%	Per Attachment IIIa

(a) Incurred CY06 Dirigo experience, per the Report to the Dirigo Health Agency - Dirigo Health: Aggregate Measurable Cost Savings (AMCS) for Year 3, July 3, 2007, schramm-raleigh Health Strategy, Appendix H.

Burke - Exhibit 8

Attachment IIa
Review of Aggregate Measurable Cost Savings
Uninsured/Underinsured Initiative
Available Savings Calculation for Calendar Year 2007

Dirigo Population

IIIa. Development of CY07 Variable Expenses for Uninsured

	Type of Service	Allocation (a)	Additional Allowed PMPM (b)	% Variable (c)	Variable Expenses	Calculations
	Inpatient	20.9%	$25.32	40.0%	$10.13	
	SNF	0.2%	$0.20	40.0%	$0.08	
	Outpatient	33.6%	$40.68	40.0%	$16.27	
	Physician: Lab/Pathology	1.5%	$1.85	40.0%	$0.74	
	Physician: Radiology	2.8%	$3.37	40.0%	$1.35	
	Physician: DME	0.6%	$0.74	98.0%	$0.73	
	Physician: Other	22.8%	$27.60	40.0%	$11.04	
	Prescription Drugs	17.7%	$21.47	98.0%	$21.04	
(29)	Total	100.0%	$121.23		$61.37	
(30)	Total Variable Expenses for Uninsured				$1,839,512	(29) x (4)

IIIb. Development of CY07 Variable Expenses for Underinsured

	Type of Service	Allocation (a)	Additional Allowed PMPM (b)	% Variable (c)	Variable Expenses	
	Inpatient	20.9%	$14.73	40.0%	$5.89	
	SNF	0.2%	$0.12	40.0%	$0.05	
	Outpatient	33.6%	$23.67	40.0%	$9.47	
	Physician: Lab/Pathology	1.5%	$1.08	40.0%	$0.43	
	Physician: Radiology	2.8%	$1.96	40.0%	$0.78	
	Physician: DME	0.6%	$0.43	98.0%	$0.42	
	Physician: Other	22.8%	$16.06	40.0%	$6.42	
	Prescription Drugs	17.7%	$12.49	98.0%	$12.24	
(31)	Total	100.0%	$70.53		$35.71	
(32)	Total Variable Expenses for Underinsured				$914,793	(31) x (4)
(33)	Total Variable Expenses for Uninsured and Underinsured				$2,754,305	(30) + (32)

IV. Total CY07 Available Savings

(34)	Total Increase in Payments to Providers	$7,923,333	(23)
(35)	Total Variable Expenses	$2,754,305	(33)
(36)	Total Available Savings	$5,169,027	(34) - (35)

(a) Based upon Dirigo CY 2006 experience.
(b) Line (13) - Line (6), trended to 2007 for Total Dirigo.
(c) Per Attachment IIIa.

- Preliminary Draft -
- Not Yet Thoroughly Checked -

EXHIBIT 4

Burke - Exhibit 8

Attachment IIb
Review of Aggregate Measurable Cost Savings
Uninsured/Underinsured Initiative
Available Savings Calculation for Calendar Year 2007

MaineCare Expansion

	I. Enrollment Assumptions	Total MaineCare	Previously Uninsured	Notes & Calculations
(1)	Projected CY07 Member Months	61,206		Per Attachment IIIb
(2)	% Previously Uninsured		0.570	Muskie,k p. 12
(3)	% Months Uninsured		0.584	Per Attachment IIIb
(4)	Adjusted CY07 Member Months	61,206	20,363	(1) x (2) x (3)

	II. Development of Increased Payments to Providers			
(5)	Cost Relative to Fully Insured		55%	Per Attachment IIIb
	Prior to MaineCare			
(6)	06-07 Allowed Annual Cost	$2,077.43	$1,343.77	Insured PMPM x (5)
(7)	Paid by Plan	$1,467.32	$0.00	(6) x (24)
(8)	Paid by Other Sources	$111.77	$335.94	(6) x (25)
(9)	Paid by Member	$279.54	$497.19	(6) x (26)
(10)	Net Paid to Provider	$1,858.63	$833.14	(7) + (8) + (9)
(11)	Uncompensated	$218.80	$510.63	(6) - (10)
(12)	Induced Utilization		1.500	Per Attachment IIIb
	In MaineCare			
(13)	06-07 Allowed Annual Cost	$2,300.97	$2,015.65	(14) / (27)
(14)	Paid by Plan	$2,070.87	$1,814.09	Total MaineCare Experience (a)
(15)	Paid by Member	$161.07	$141.10	(13) x (28)
(16)	Net Paid to Provider	$2,231.94	$1,955.18	(14) + (15)
(17)	Uncompensated	$69.03	$60.47	(13) - (16)
	Estimated Increase in Payments to Providers			
(18)	06-07 Annual Increase	$373.30	$1,122.05	(16) - (10)
(19)	Years of Trend		0.75	Per Attachment IIIb
(20)	Trend		0%	Per Attachment IIIb
(21)	CY07 Annual Increase	$373.30	$1,122.05	(18) x (1 + (20)) ^ (19)
(22)	CY07 PMPM	$31.11	$93.50	(21) / 12
(23)	CY07 Dollars	$1,904,034	$1,904,034	(22) x (4)
	Source of Payments to Providers			
	Prior to MaineCare			
(24)	Plan		0%	Per Attachment IIIb
(25)	Other Sources		25%	Per Attachment IIIb
(26)	Member		37%	Per Attachment IIIb
	In MaineCare			
(27)	Plan		90%	Per Attachment IIIb
(28)	Member		7%	Per Attachment IIIb

(a) Incurred 4/06 - 3/07 MaineCare experience, per the Report to the Dirigo Health Agency - Dirigo Health: Aggregate Measurable Cost Savings (AMCS) for Year 3, July 3, 2007, schramm-raleigh Health Strategy, Appendix H.

EXHIBIT 4

Burke - Exhibit 8

Attachment IIb
Review of Aggregate Measurable Cost Savings
Uninsured/Underinsured Initiative
Available Savings Calculation for Calendar Year 2007

MaineCare Expansion

	III. Development of CY07 Variable Expenses for Uninsured					
	Type of Service	Allocation (a)	Additional Allowed PMPM (b)	% Variable (c)	Variable Expenses	Calculations
	Inpatient	18.9%	$10.58	53.0%	$5.61	
	SNF	0.1%	$0.08	53.0%	$0.04	
	Outpatient	30.4%	$17.01	53.0%	$9.01	
	Physician: Lab/Pathology	1.4%	$0.77	50.0%	$0.39	
	Physician: Radiology	2.5%	$1.41	50.0%	$0.70	
	Physician: DME	0.6%	$0.31	98.0%	$0.30	
	Physician: Other	20.6%	$11.54	50.0%	$5.77	
	Prescription Drugs	25.5%	$14.29	98.0%	$14.00	
(29)	Total	100.0%	$55.99		$35.83	
(30)	Total Variable Expenses for Uninsured				$729,661	(29) x (4)

	IV. Total CY07 Available Savings		
(31)	Total Increase in Payments to Providers	$1,904,034	(23)
(32)	Total Variable Expenses	$729,661	(30)
(33)	Total Available Savings	$1,174,373	(31) - (32)

(a) Based upon Dirigo/MaineCare CY 2006 experience.
(b) Line (13) - Line (6), trended to 2007 for Total MaineCare.
(c) Per Attachment IIIb.

Burke - Exhibit 8

DirigoChoice Member Survey

A Snapshot of the Program's Early Adopters:
April 1, 2005 – August 31, 2005

Prepared by:

Taryn Bowe
Deborah Thayer

Institute for Health Policy
Muskie School of Public Service
University of Southern Maine
Portland, Maine

August 2006

small business members/sole proprietors heard about DirigoChoice through an insurance agent, and 14.1 percent learned of the program through another source, such as a health care provider, family member, friend or colleague.

Prior Health Insurance Status

One of the goals of DirigoChoice is to increase access to affordable health care and decrease the number of uninsured within the state of Maine. In order to get a clearer picture of the types of Maine citizens that are selecting DirigoChoice, respondents were asked about their prior insurance status, specifically whether or not they were covered by any health insurance plan, including HMOs, government plans, or MaineCare, at the time they enrolled in DirigoChoice.

Insurance Status During Prior Year

Because an individual's insurance status is often dynamic, respondents were asked to report on their coverage for the entire year preceding DirigoChoice enrollment. Two survey questions were used to determine (a) the number of respondents who were insured when they enrolled in DirigoChoice, but who were without health insurance some time during the previous year and (b) the number of respondents who were uninsured at the time they enrolled in DirigoChoice, but had access to coverage some time during the previous year. The results are shown in Table 4.

For those who enrolled in DirigoChoice as an individual, half (50.2 percent) were insured for the full 12 month period preceding enrollment and half (49.8 percent) were uninsured or insured for only part of the year. For small business members and sole proprietors, rates of prior insurance were higher. Nearly two thirds (63.0 percent) of small business members and sole proprietors were insured for the entire year prior to enrollment, while 37.0 percent were uninsured or only insured for part of the year.

Table 4: Insurance Status of Respondents during the Year Prior to DirigoChoice Enrollment (N=1737)[i]

Insurance Status During the Entire Year Prior to Enrollment	**Respondents**					
	Individuals N=964		Small Business/Sole Prop. N=773		All Respondents N=1737	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Insured for entire year	484	50.2	487	63.0	971	55.9
Uninsured at some time during prior year	480	49.8	286	37.0	766	44.1
- Insured at enrollment, but uninsured at some time during prior year	75	7.8	56	7.2	131	7.5
- Uninsured at enrollment, but insured at some time during prior year	173	17.9	69	8.9	242	13.9
- Uninsured for all of the previous 12 months	232	24.1	161	20.8	393	22.6
Total	**964**	**100.0**	**773**	**100.0**	**1737**	**100.0**

Note:

i. A small number of don't know and not applicable responses were not included when calculating percentages.

Insurance Status at Time of Enrollment

The survey also gathered information on the insurance status of respondents and their dependents at the time of DirigoChoice enrollment. These results are shown in Table 5. For those who enrolled in DirigoChoice as an individual, 57.7 percent said they were covered by health insurance at the time of enrollment, while 42.1 percent reported being uninsured at this time. For small business members and sole proprietors, levels of prior insurance were significantly higher with 70.2 percent of these respondents citing coverage at the time of enrollment and 29.7 percent reporting that they were uninsured at this time.

Dependent Insurance Status

Compared with respondents, a larger portion of dependents had health insurance at the time of enrollment. Of the 338 dependents associated with individual contract holders, 70.7 percent had health insurance at the time they enrolled in DirigoChoice, while 29.3 percent were uninsured at this time. Of the 663 dependents associated with small business members and sole proprietors, 79.2 percent were insured when they enrolled in DirigoChoice, whereas 20.5 percent were uninsured at this time. One explanation for the higher rate of prior insurance among dependents is that respondents with dependents were more likely to have been insured at the time of enrollment than respondents without dependents. [The results of this analysis can be found in Table B-1 in the Appendix.]

Table 5: Insurance Status of Respondents and Dependents at the Time of DirigoChoice Enrollment (N=2748)

Insurance Status at the Time of Enrollment	**Respondents**		**Dependents**		**Total Enrollees Represented by Survey**	
	Individuals N=969	Small Business/Sole Prop. N=778	Individuals N=338	Small Business/Sole Prop. N=663	Individuals N=1307	Small Business and Sole Prop. N=1441
	Percent	Percent	Percent	Percent	Percent	Percent
Insured	57.7	70.2	70.7	79.2	61.1	74.3
Uninsured	42.1	29.7	29.3	20.5	38.8	25.5
DK or NA	0.2	0.1	0.0	0.3	0.2	0.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Prior Insurance Status by Discount Group

Further analysis reveals that respondents and dependents from lower income groups were more likely to have gone without insurance during the 12 months prior to DirigoChoice enrollment when compared with enrollees who came from the highest income group, where no DirigoChoice discount is applied. About 43 percent of enrollees (respondents and dependents) who received discounts through DirigoChoice were uninsured at some point during the year prior to enrollment compared with 30.7 percent for enrollees for whom no discounts are applied. Table 6 presents these results.

Table 6: Percentage of Respondents and Dependents who were Uninsured during the Year Prior to DirigoChoice - by Discount Level (N=2669)[i]

	Rates of Uninsurance in Year Prior to DirigoChoice					
	Subsidized (Discount Groups A-E)		Non-Subsidized (Discount Group F)		Total	
	Freq.	%	Freq.	%	Freq.	%
Respondents	659	46.8	107	32.5	766	44.1
Dependents[ii]	268	34.7	43	27.0	311	33.4
Total Enrollees	927	42.5	150	30.7	1077	40.4

Notes:

i. A small number of don't know and not applicable responses were not included when calculating percentages.

ii. Dependents that were uninsured some time during the 12 months prior to enrollment may be understated. Fifty-nine dependents who were insured at enrollment were not assigned to a category because the respondents associated with these dependents were administered an earlier version of the survey in which they were not asked to comment on their dependents insurance status during the 12 months prior to enrollment.

Prior Health Insurance Type

Respondents who were insured at the time they enrolled in DirigoChoice were asked to specify their prior insurance type. In addition, respondents with one or more dependent currently enrolled in DirigoChoice were asked to indicate their dependents' prior insurance coverage if their dependents were covered at the time of enrollment. This information was elicited from respondents to better understand the types of health plan coverage DirigoChoice enrollees switch from, as well as the components of DirigoChoice that might be attractive to persons who are already insured.

About 74 percent of respondents who were insured at the time of enrollment reported that their prior insurance was through a private health plan. Approximately sixty percent were insured by Anthem/Blue Cross/Blue Shield, while 7.7 percent and 2.2 percent were covered by Aetna and Cigna respectively. An additional 4.4 percent were covered by MegaLife, the health plan offered through the National Association for the Self-Employed (NASE).[2]

Individuals and members of small businesses who were insured by private insurers at the time of enrollment (N=936) were asked whether their prior coverage was obtained through an employer. Approximately forty percent of these respondents said that their prior coverage was obtained through an employer, and of this group (N=380), 59.5 percent said that the employer who sponsored their previous health plan was the same as their current employer.

[2] All respondents that specified that they were covered by MegaLife or NASE were assigned to this category.