**Discussion Document**
**Dirigo Board of Trustees**
**August 17, 2009**

**Introduction**

**PL 2009 Chapter 359 Sec. 6. - Changes to Dirigo Health.**

The Board of Trustees of Dirigo Health, or "the board," shall:

**1. Develop products, procedures.** Develop more affordable products and procedures that can reach uninsured and underinsured residents of the State to reduce uncompensated care;

**2. Maximize federal initiatives.** Use subsidies to maximize federal initiatives, including Medicaid and any national health reform;

**3. Asset tests.** Determine the impact of asset tests on determining eligibility;

**4. Voucher program.** Consider offering a voucher-based program to provide health insurance benefits; and

**5. Redesign.** Redesign the DirigoChoice product or products.

The board shall report to the Joint Standing Committee on Insurance and Financial Services regarding changes that will be made to the Dirigo Health Program consistent with this section by January 1, 2010.

**Direction of the Board as of July 28, 2009**

1) Asset Test and Subsidy Level determinations:

    a. Implement the Agency's 2006 proposed asset test (see attachment A)
        i. Sliding scale
        ii. Excludes retirement and educational accounts
        iii. Self declaration with an audit

    b. Without proof of Medicaid denial, the greatest premium subsidy an applicant is eligible for is 60%.

    **The Agency recommends that this change be effective July 1, 2010 (as accounts renew).**

2) DirigoChoice subsidy will not be available to Medicare eligible members as of the first of the month the member is eligible for Medicare (see attachment B).

    **The Agency recommends that this change be effective October 1, 2009 (see attachment B for implementation timing).**

3) Social Security will be counted as income in the Agency's income determination.

**The Agency recommends that this change be effective October 1, 2009 (as accounts renew).**

Note: the Agency will need to coordinate with Harvard Pilgrim to implement the changes recommended for October 2009. Based on that activity actual implementation dates may shift.

**Outstanding Eligibility Issue**

Should eligibility be limited to the uninsured or underinsured?

## Plan Options - Designs to Lower Costs and Increase Membership

All membership figures assume savings from Board decisions relative to eligibility above and annual $38 million of anticipated revenue.

| Option | Maximum Annual Benefit | Deductible/Coinsurance | Benefit Structure | RX Benefit | Actuarial Value | Estimated Premium Savings | Estimated Membership Projection | Growth over status quo |
|---|---|---|---|---|---|---|---|---|
| Option 1 | $100,000 | $1000 deductible for B $2000 deductible, 30% coinsurance, 5000 OOP Max for all others | • 100% preventative care<br>• everything else subject to deductible and coinsurance | copay | 0.71 | -9% | 12,250 | 22.5% |
| Option 2 | No limit | $2000 deductible, 30% coinsurance, up to $5000 OOP | • 100% preventative care<br>• three PCP/SCP visits 25/40 copay<br>• ER copay<br>• everything else subject to deductible and coinsurance | copay | 0.69 | -13% | 12,800 | 28.0% |
| Option 3 | $100,000 | $1000 deductible for B $2000 deductible, 30% coinsurance, 5000 OOP Max for all others | • 1 routine/preventative office visit covered at 100%<br>• everything else subject to deductible and coinsurance | copay | 0.67 | -14% | 13,000 | 30.0% |
| Option 4 | No limit | $2000 deductible, 30% coinsurance, up to $5000 OOP | • 1 routine /preventative office visit covered at 100%<br>• 3 PCP/SCP visits 25/40 copay<br>• 1 eye exam<br>• ER copay<br>• everything else subject to deductible and coinsurance | copay | 0.64 | -17% | 13,750 | 37.5% |
| Option 5 | No limit | $2000 deductible, 30% coinsurance, up to $5000 OOP | • 100% preventative care<br>• everything else subject to deductible and coinsurance | copay | 0.64 | -18% | 14,000 | 40.0% |
| Option 6 | No limit | $2000 deductible, 30% coinsurance, up to $5000 OOP | • 1 routine/preventive visit at 100%<br>• everything else subject to deductible and coinsurance | copay | 0.61 | -21% | 14,800 | 48.0% |
| Option 7 | No limit | $2000 deductible, 30% coinsurance, up to $5000 OOP | All services apply to deductible and coinsurance | deductible and coinsurance | 0.56 | -28% | 17,000 | 70.0% |
| Option 8 | $100,000 | $2000 deductible, 30% coinsurance, up to $5000 OOP | All services apply to deductible and coinsurance | deductible and coinsurance | 0.50 | -36% | 21,250 | 112.5% |

Preventative care (for these examples) includes mammography, pap smear, routine GYN, copay first prenatal visit, then 100%, postpartum care, immunizations, colonoscopy, Well Child visits, adult routine visits, and prostate cancer screening

## Cost Sharing Under Plan Design Options

| | **Cost Sharing Options 1, 3** | | **Cost Sharing Options 2, 4-8** | |
|---|---|---|---|---|
| | Fixed Premium | Variable OOP (Risk) | Fixed Premium | Variable OOP (Risk) |
| | **% income** | **% income** | **% income** | **% income** |
| B | 16.59% | 16.34% | 16.59% | 81.68% |
| C | 11.83% | 29.05% | 11.83% | 29.05% |
| D | 13.27% | 22.38% | 14.16% | 22.38% |
| E | 14.06% | 18.77% | 11.88% | 18.77% |

Note: the variable (OOP) costs in the table relate to the OOP and deductible limits specified in the plan. Plans with maximum annual benefits (1, 3, and 8) would expose members to unlimited risk above the maximum annual benefit.

## Relationship of Subsidy PMPM Reduction to Growth in Membership

Assumes savings from Board decisions relative to eligibility above and annual $38 million of anticipated revenue.

| % savings | Premium PMPM | Subsidy PMPM | Estimated Membership | Growth % |
|---|---|---|---|---|
| **STATUS QUO (no eligibility changes)** | | | | |
| 0 | $ 633.97 | $ 341.54 | 10,000 | 0% |
| **STATUS QUO (eligibility changes)** | | | | |
| 0 | $ 633.97 | $ 341.54 | 11,220 | 12.20% |
| **PLAN CHANGES → PMPM CHANGES** | | | | |
| 1 | $ 627.63 | $ 338.92 | 11,323 | 13.23% |
| 2 | $ 621.29 | $ 335.50 | 11,431 | 14.31% |
| 3 | $ 614.95 | $ 332.07 | 11,541 | 15.41% |
| 4 | $ 608.61 | $ 328.65 | 11,653 | 16.53% |
| 5 | $ 602.27 | $ 325.23 | 11,768 | 17.68% |
| 6 | $ 595.93 | $ 321.80 | 11,885 | 18.85% |
| 7 | $ 589.59 | $ 318.38 | 12,005 | 20.05% |
| 8 | $ 583.25 | $ 314.95 | 12,127 | 21.27% |
| 9 | $ 576.91 | $ 311.53 | 12,252 | 22.52% |
| 10 | $ 570.57 | $ 293.69 | 12,201 | 22.01% |
| 11 | $ 564.23 | $ 288.95 | 12,401 | 24.01% |
| 12 | $ 557.89 | $ 284.22 | 12,607 | 26.07% |
| 13 | $ 551.55 | $ 279.49 | 12,821 | 28.21% |
| 14 | $ 545.21 | $ 274.76 | 13,042 | 30.42% |
| 15 | $ 538.87 | $ 270.03 | 13,270 | 32.70% |
| 16 | $ 532.53 | $ 265.30 | 13,506 | 35.06% |
| 17 | $ 526.19 | $ 260.57 | 13,752 | 37.52% |
| 18 | $ 519.85 | $ 255.84 | 14,006 | 40.06% |
| 19 | $ 513.51 | $ 251.10 | 14,270 | 42.70% |
| 20 | $ 507.17 | $ 246.37 | 14,544 | 45.44% |
| 21 | $ 500.83 | $ 241.64 | 14,829 | 48.29% |
| 22 | $ 494.49 | $ 236.91 | 15,125 | 51.25% |
| 23 | $ 488.15 | $ 232.18 | 15,433 | 54.33% |
| 24 | $ 481.82 | $ 227.45 | 15,755 | 57.55% |
| 25 | $ 475.48 | $ 222.72 | 16,089 | 60.89% |
| 26 | $ 469.14 | $ 217.98 | 16,438 | 64.38% |
| 27 | $ 462.80 | $ 213.25 | 16,803 | 68.03% |
| 28 | $ 456.46 | $ 208.52 | 17,184 | 71.84% |
| 29 | $ 450.12 | $ 203.79 | 17,583 | 75.83% |
| 30 | $ 443.78 | $ 199.06 | 18,478 | 84.78% |
| 31 | $ 437.44 | $ 189.72 | 18,887 | 88.87% |
| 32 | $ 431.10 | $ 185.50 | 19,317 | 93.17% |
| 33 | $ 424.76 | $ 181.28 | 19,766 | 97.66% |
| 34 | $ 418.42 | $ 177.06 | 20,237 | 102.37% |
| 35 | $ 412.08 | $ 172.84 | 20,732 | 107.32% |
| 36 | $ 405.74 | $ 168.62 | 21,250 | 112.50% |
| 37 | $ 399.40 | $ 164.40 | 21,795 | 117.95% |

**Proposed Guiding Principles for Plan Design**

1. Include robust prevention, wellness, and disease management benefits.

2. Include mental health parity.

3. Do not exclude pre-existing conditions.

4. Reduce over-use and under-use of health care by aligning quality and efficiency incentives among providers across the continuum of care so that physicians, hospitals, and other health care providers are encouraged and enabled to work together towards the highest standards of quality and efficiency. For example, provide tiered networks based on quality metrics and/or pay for performance (P4P) incentive models.

5. Adhere to evidence-based best practices and therapies that reduce hospitalization, manage chronic disease more efficiently and effectively, and implement proven clinical prevention strategies. [1]

6. Do not pay for "never" events (see attachment C).

7. Target a medical care ratio of 90% (i.e., at least 90% of every dollar must go toward medical services as opposed to the carrier's administrative costs or profit).

8. Include strong incentives to promote the use of generic medications when available.

9. Promote the use of medical homes and primary care.

[1] Guiding principles 5 and 6 (not including examples) come from the May 11th, 2009 letter to President Obama from America's Health Insurance Plans, the American Hospital Association, the American Medical Association, the Service Employees International Union, Pharma, and AdvaMed outlining the health care industry's commitment to achieving cost savings and quality improvements.

## Attachment A – Agency Asset Test

All DirigoChoice applicants and renewing members will be required to provide asset information if they wish to be enrolled in any subsidy level B-E.

**Which Assets Are Counted?**
Assets counted for Groups B-E are assets owned by the applicant/member and/or spouse or domestic partner who lives with the applicant/member, as well as assets owned jointly with another person.

They include:

- Cashable assets: This includes savings and checking accounts, certificates of deposit (CDs), credit union shares, stocks, bonds, annuities, mutual funds, Keogh or profit sharing plan assets.

- Lump sum payments (for example gifts, inheritances, lottery winnings, insurance settlements such as property damage claims, accidents, injury and death benefits)

- Real estate: You do not have to list the home and land where you live, but list any other property you own (for example, a second home, camp, land not attached to your primary home). Exclusions for real property may include rental property, jointly held real estate when the property cannot be sold because the other owner refuses to sell, or if a good faith effort is being made to sell at a reasonable price. Exclusions for income producing property may include fishing/lobster boat, commercial truck, machinery, livestock.

- Vehicles: List all vehicles you own. Include the estimated value (for example, the "Blue Book" value) as well as any amount you still owe on the vehicle.

- Recreational vehicles: List all types of motorized vehicles (for example, boat, motorcycle, snowmobile, ATV). Include the estimated value (for example, the "Blue Book" value) as well as any amount you still owe on the vehicle.

**How Do Assets Affect the Subsidy Level?** The charts below show how subsidy levels are affected by countable assets. The "1st Stage Level" is the subsidy based on income only. The subsequent table shows how that subsidy is affected based on the value of assets. For example, an applicant whose household size is 1, whose income would qualify for a B level subsidy, and who had $32,000 in assets would have a final subsidy level of D.

B (below 150% FPL)
C (below 200% FPL)
D (below 250% FPL)
E (below 300% FPL)
F (above 300% FPL)

If the applicant has qualified for a subsidy based on income (i.e., an initial placement of B-E), the Agency makes a final placement based on assets as detailed below:

| **Single** | | | | | | **Family** | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Income Level** | **B** | **C** | **D** | **E** | | **Income Level** | **B** | **C** | **D** | **E** |
| *Asset Amount* | | | | | | *Asset Amount* | | | | |
| < $15,000 | B | C | D | E | | < $30,000 | B | C | D | E |
| < $29,999 | C | D | E | F | | < $59,999 | C | D | E | F |
| < $44,999 | D | E | F | F | | < $89,999 | D | E | F | F |
| < $59,999 | E | F | F | F | | < $119,999 | E | F | F | F |
| >= $60,000 | F | F | F | F | | >= $120,000 | F | F | F | F |

**Attachment B (1) - Process for Medicare Eligible DirigoChoice Members**

The Agency will notify all potentially affected DirigoChoice members of the pending change relating to Medicare eligibility. The Agency will send notices to these members by August 24th, 2009.

| DirigoChoice Members… | When subsidies will end | Medicare Enrollment |
|---|---|---|
| Currently on Medicare (parts A, B, D) | October 31st, 2009 | Members are already enrolled in Medicare |
| Currently on Medicare (parts A and B but not D) | October 31st, 2009 | HPHC will issue COC allowing member to enroll in part D outside the general open enrollment period. |
| Over 65 not on Medicare part B | June 30th, 2010 | Members must enroll in Medicare part B during the general open enrollment period January 1, 2010 – March 31, 2010. Medicare coverage begins July 1, 2010. |
| Turning 65 between July 1 2009 and June 30, 2010 | Last day of the month prior to member's 65th birthday | Members may enroll 3 months prior to turning 65 and 3 months after turning 65. Medicare coverage begins the 1st of the month of the member's 65th birthday or the first of the month subsequent to enrollment if the member applies after his/her birthday. |

Members 65 and older who are not eligible for Medicare may inform the Agency, and the Agency will allow these members to keep their existing subsidies.

The ongoing notification process will entail written notification three months in advance of the member's 65th birthday. The member will be provided information on applying for Medicare and the Agency's policy on the subject.

**Attachment B (2) - Medicare Question and Answer Document**

Question #1:
What is the enrollment period for those turning age 65 and entitled to Medicare Part A and Part B?

Answer:
There is an initial enrollment period of 6 months surrounding the period when someone is turning age 65 and entitled to Medicare Part A and Part B. The initial enrollment period is the 3 month period prior to the month someone turns age 65 and ends 3 months after the month someone turns age 65.

Question #2:
Do you need to take steps yourself to sign up for Medicare Part A and Part B?

Answer:
If you are receiving Social Security or Railroad Retirement benefits when turning age 65 you receive your Medicare card in the mail 3 months prior to your 65th birthday. If you keep the card, Part A and Part B benefits automatically begin. The Part B premium is deducted from your monthly Social Security or Railroad Retirement payments. The Part B premium for 2009 for most people is $96.40 per month.

If you are not receiving Social Security or Railroad Retirement benefits when turning age 65 you must sign up during the initial enrollment period outlined in question #1 above.

Question #3:
Is there a penalty if you do not sign up for Medicare Part A and Part B during the initial enrollment period?

Answer:
The cost of your Part B premium increases by 10% for each full 12 month period you could have had Part B but did not sign up for it. You must pay this late enrollment penalty as long as you have Part B.

Question #4:
Are there exceptions to payment of the penalty for failure to sign up when initially offered?

Answer:
Yes, if you are still receiving health benefits from your (or your spouse's) current employer when you are first eligible for Medicare Part B, you have the option of enrolling in Medicare Part B at a later date. When you are ready to sign up for Medicare Part B you must do so during a special enrollment period

Question #5:
When can you sign up for Medicare Part B if you do not sign up during the initial enrollment period?

Answer:
There is a general enrollment period between January 1st and March 31st each year. If you sign up during the general enrollment period your coverage begins on July 1st.

Question #6:
When can you sign up for Part D (for pharmacy benefits) if you do not sign up during the initial enrollment period?

Answer:
There is a general enrollment period between November 1st and December 31st with coverage effective January 1st. However, with a certificate of credible coverage you may apply for Part D outside the annual enrollment period. This should allow you to enroll during what is considered a special enrollment period outside the annual enrollment period.

Question #7:
Who is eligible for Medicare coverage?

Answer:
Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment and you are 65 years or older and a citizen or permanent resident of the United States.

Question #8:
If not eligible for Medicare coverage can you buy into Part A and Part B?

Answer: Yes, as long as if you are age 65 or older and you are a U.S. citizen or a lawfully admitted noncitizen who has lived in the United States for at least five years.

**This information is a summary and not meant to replace information provided by the Social Security Administration or the Centers for Medicare and Medicaid Services. For more information go to www.medicare.gov or www.socialsecurity.gov.**

**Attachment C – National Quality Forum Never Events (2006)**

1. SURGICAL EVENTS

A. Surgery performed on the wrong body part
B. Surgery performed on the wrong patient
C. Wrong surgical procedure performed on a patient
D. Unintended retention of a foreign object in a patient after surgery or other procedure
E. Intraoperative or immediately postoperative death in an ASA Class I patient

2. PRODUCT OR DEVICE EVENTS

A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

3. PATIENT PROTECTION EVENTS

A. Infant discharged to the wrong person
B. Patient death or serious disability associated with patient elopement (disappearance)
C. Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility

4. CARE MANAGEMENT EVENTS

A. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
G. Patient death or serious disability due to spinal manipulative therapy
H. Artificial insemination with the wrong donor sperm or wrong egg

5. ENVIRONMENTAL EVENTS

A. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
D. Patient death or serious disability associated with a fall while being cared for in a healthcare facility
E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

6. CRIMINAL EVENTS

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
B. Abduction of a patient of any age
C. Sexual assault on a patient within or on the grounds of a healthcare facility
D. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility