



A Comparison of MaineCare and “Benchmark” Private Health Insurance Coverage Arrangements

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Introduction

This analysis, prepared for Maine Equal Justice, explores the question of whether, as a cost containment strategy, the state of Maine should consider reducing benefits and coverage for one or more groups of Medicaid-enrolled adults. Specifically, this analysis considers the implications of both across-the-board reductions in coverage, as well as more selective limitations through the use of a special “benefit flexibility” state option under federal Medicaid law, which was added by the Deficit Reduction Act (DRA) of 2005.¹ This option permits states to substitute for traditional Medicaid coverage a “benchmark” health benefit plan structured in accordance with commercial insurance principles. This option can be combined with an additional DRA option,² as modified by the American Recovery and Reinvestment Act of 2009,³ which permits states to impose premiums and cost-sharing for certain populations and services, at higher rates, although rates that are still well below market rates for commercial insurance.

The analysis concludes that in light of the health status of low income adults, across-the-board reductions in benefits and increased cost sharing could significantly impair access to essential health services, particularly services linked to chronic illness and disability. Reduced access in turn could lead to a greater burden of illness, as well as substantial uncovered health care costs for the state’s health care providers.

This analysis also concludes that purchasing “benchmark plan” coverage for certain classes of adult beneficiaries could result in significantly higher costs. A comparison of MaineCare with federally designated benchmark plans shows that coverage is approximately equivalent and thus, that moving from traditional Medicaid to a benchmark would eliminate virtually no service classes. At the same time, a premium support approach to financing coverage would result in a virtual doubling of the state’s per capita costs for the affected populations, given the large price differential between traditional Medicaid and commercial insurance. This estimate does not take into account either the higher costs associated with the limits on costsharing that could be imposed on the Medicaid population, or the costs associated with administering multiple insurance enrollment and coverage arrangements for the Medicaid population. As a result, only a handful of states have pursued benchmark benefit flexibility.

¹ Pub. L. 109-171 §6044, adding §1937 to the Social Security Act. (109th Cong. 2d sess.)

² Pub. L. 109-171, § 6041, adding §1916A to the Social Security Act (109th Cong. 2d sess.)

³ Pub. L. 111-5, §5006 (111th Cong. 1st sess.)

This analysis begins with a brief overview of the health status of low income, non-elderly adults, and the population whose coverage is addressed through MaineCare Basic. The analysis then briefly describes Medicaid and the range of coverage options available to states under federal law, including options to reduce coverage across the board or to use DRA benchmark benefit and costsharing flexibility. The analysis then describes a framework for comparing Medicaid services and benefits against private health insurance products, including those that are designated as benchmark plans under federal law and compares MaineCare Basic to several potential benchmark plans. This “top level” examination shows that in terms of covered benefits and services, MaineCare coverage is, in fact, highly similar to benchmark plans. The analysis concludes with a discussion of the implications of this comparison for coverage of adults under Maine’s Medicaid program.

The Health Status of Low Income Adults

The question explored in this analysis concerns coverage of low income adults; because health status significantly affects the cost of health care, it is important to consider the health of the population to be covered, especially when the use of market-based products such as actuarially designed benchmark plans is under consideration.⁴

MaineCare covers individuals with severe limitations of daily activity based on illness, injury, health condition, or age. The higher health needs of elderly and disabled persons are well understood. In State Fiscal Year 2008, per capita payments for adults with disabilities using MaineCare services averaged nearly \$16,200, while costs for elderly beneficiaries averaged nearly \$10,200.⁵

MaineCare also covers nonelderly adults who have low family incomes, at an annual average cost of approximately \$3800 in State FY 2008. (As of January 2009, income eligibility standards for parents stood at 200%, with a slight differential based on employment status).⁶ Although these adults do not have significant disabilities, substantial evidence suggests that low income alone is associated with fair to poor health, quite apart from whether the health conditions that are present are severe enough to cause a disability within the meaning of the Social Security Act. Furthermore, low income adults also as a group experience an inability to pay more than nominal amounts out-of-pocket for their health care.

Low family income, rather than behavior, race, or age, is a strong predictor of health. Low family income has been shown to nearly treble the proportion of non-elderly adults reporting fair to poor health status (23% in the case of adults with family incomes below 200% of poverty versus 8% among adults with family incomes above this threshold).⁷ Regardless of

⁴ Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Federal Reform Options* (Georgetown University, 2009) <http://www.law.georgetown.edu/oneillinstitute/projects/reform/Discrimination.html> (Accessed March 15, 2009)

⁵ Unpublished data, Muskie School of Public Service, (March 20, 2009)

⁶ Kaiser Family Foundation, *Statehealthfacts.org* <http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4> (accessed March 14, 2009)

⁷ Stephen Zuckerman and Stephen Norton, *Snapshot of America’s Families: Health Status of Adults and Children* (Urban Institute, 1999) http://www.urban.org/UploadedPDF/900864_1997Snapshots.pdf (Accessed March 14, 2009)

race or ethnicity, persistently low family income is a strong predictor of mortality; furthermore, and contrary to widely held beliefs, once income is taken into account, “behavioral risk factors such as smoking, alcohol drinking, sedentary lifestyle, and obesity account for only a small proportion of differences in mortality across sex, race, and age groups.”⁸ Because low income adults suffer significantly greater rates of food insecurity, they also experience significantly greater rates of diabetes.⁹ Low income also elevates the risk for heart disease,¹⁰ as well as the risk of mental illness, with particularly elevated rates of serious depression.¹¹ In sum, even for those members of Maine’s low income adult population who are neither elderly nor disabled, the evidence suggests that a higher burden of poor health is a reality.

These health statistics make access to effective health care particularly important. The evidence also suggests that even modest levels of financial responsibility can impair access to care. Research has shown the effects of both premiums and cost sharing on lower income persons. One multi-state study of participation in public health insurance programs, found that participation dropped by half among eligible low-income individuals when premiums reached 3% of family income. Participation declined by over 90% when premiums exceeded eight percent of a family’s income.¹² Significant research also shows the adverse effects of even modest cost-sharing on access to health care among low income persons, particularly in the case of primary and preventive care.¹³

Thus, the weight of the evidence suggests two things: *first*, the importance of a benefit and coverage design that emphasizes comprehensive primary health care, as well as ongoing management of moderate to severe chronic physical and mental health conditions; and *second*, coverage that is highly affordable, without premiums or enrollment fees and with nominal copayments, at most, at the point of care. The policy goal is broad coverage, particularly for primary and preventive benefits, with either near or total elimination of out-of-pocket payment requirements at the point at which treatment is sought.

⁸ Robert Wood Johnson Foundation, Low Income, Not Race or Lifestyle, is the Greatest Threat to Health. <http://www.rwjf.org/reports/grr/026422.htm> (Accessed March 14, 2009)

⁹ AHRQ, Severe Food Insecurity of Low Income Adults is Linked to an Increased Rate of Diabetes, <http://www.ahrq.gov/RESEARCH/dec07/1207RA19.htm> (Accessed March 14, 2009)

¹⁰ Biomedicine, Lower Income Means Higher Risk for Heart Disease, <http://news.bio-medicine.org/medicine-news-3/Lower-income-means-higher-risk-for-heart-disease-2985-1/> (Accessed March 14, 2009)

¹¹ Bazelon Center for Mental Health, *Data on Adults and Children with Mental Disorders on TANF*, <http://www.bazelon.org/issues/TANF/Final%20TANF%20Fact%20Sheet%20I.pdf> (Accessed March 14, 2009)

¹² Leighton Ku and Teresa Coughlin, “Sliding Scale Premium Health Insurance Programs: Four States’ Experiences,” *Inquiry*, Winter 1999/2000.

¹³ Leighton Ku and Victoria Wachino, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings*, Center on Budget and Policy Priorities, July 7, 2005.

Medicaid

In general

The largest of all means-tested federal programs, Medicaid is the nation's single largest source of health care financing, enabling health care for nearly 60 million persons in 2007.¹⁴ Medicaid finances medically necessary health care in much the way insurance does, through third party payments on behalf of enrolled individuals to participating health care providers and professionals. Medicaid represents the single largest direct federal spending program and often dominates state budget deliberations.

Medicaid is governed by extensive federal requirements related to eligibility, enrollment, coverage, payment, and plan administration. State Medicaid agencies that elect to participate in Medicaid must cover certain categories of individuals and must provide certain classes of "required" services to program enrollees. Where adults are concerned, certain additional classes of benefits and services are considered optional, although whether a service is required or optional is unrelated to its importance in health care (for example, prescribed drugs are an "optional" service).

Like other participating states, Maine covers both required and optional services for adults. Indeed, a rapid comparison of Maine's Medicaid services and benefits against those found in other states suggests that Maine's program is typical in the classes of benefits provided.¹⁵

Although it operates like insurance, Medicaid significantly differs from commercial health insurance products in both benefit and cost sharing design. Because of the health status of the Medicaid population -- one quarter of whose members are elderly persons and persons with significant disabilities -- Medicaid covers considerably more benefits related to long-term management of serious and chronic health conditions, offering such services as extended inpatient rehabilitation care for persons with physical conditions or mental illness. Furthermore, few Medicaid programs operate with annual or lifetime dollar limits on coverage, a feature of many private plans. Thus, for example, while the number of visits or inpatient days may be subject to either soft or hard per admission limit or a monthly use cap, total annual spending is customarily not limited to a fixed, aggregate dollar level.

Similarly, because Medicaid is structured to address the needs of low income persons with higher health needs, federal law generally prohibits the use of premiums and permits only limited costsharing. As with benefit and service design, the cost-shifting features of private health insurance, such as annual or lifetime maximum dollar coverage limits are rare in Medicaid, since the program is specifically designed to support patients, states, and communities in meeting the cost of chronic and lifelong illness.

¹⁴ Kaiser Family Foundation, *The Medicaid Program at a Glance* (November 2008)
http://www.kff.org/medicaid/upload/7235_03-2.pdf (Accessed March 14, 2009)

¹⁵ Kaiser Family Foundation, Online Medicaid Benefit Data Base
<http://www.kff.org/medicaid/benefits/service.jsp?gr=off&nt=on&so=0&tg=0&yr=3&cat=5&sv=32> (Accessed March 14, 2009)

Medicaid's statewideness and comparability requirements; state options for tailoring benefits to certain subgroups of categorically needy populations.

Under the traditional Medicaid program, coverage for categorically needy adults must be in effect on a statewide basis, and coverage among the program's various eligibility categories must be "comparable" in scope.¹⁶ This means that if an optional benefit is reduced or eliminated for one category of adults, it must be reduced or eliminated for all adults including parents, people with disabilities, and the elderly. To take an extreme example, were Maine to decide to eliminate prescription drug coverage for adults, the decision would affect all classes of adults and could not be targeted at only certain subgroups of categorically needy persons.

The Deficit Reduction Act of 2005 (DRA),¹⁷ as amended by the Children's Health Insurance Program Reauthorization Act of 2009,¹⁸ gives states special additional authority to waive statewideness and comparability (as well as certain other provisions identified by the Secretary)¹⁹ in order to provide "benchmark" benefits in lieu of traditional coverage. Under this special state option, Maine could in fact single out one categorical subgroup (e.g., certain parents) and offer them a benchmark plan (or its actuarial equivalent) in lieu of the full complement of traditional Medicaid coverage. However, states using this option must exempt numerous groups from mandatory enrollment: the elderly, Medicare dual enrollees, persons receiving hospice care, women whose eligibility is based on receipt of treatment for breast or cervical cancer, certain pregnant women, parents who continue to be deemed eligible for benefits today as a result of qualifying for the (now repealed) Aid to Families with Dependent Children (AFDC) program, children in foster care, and certain populations deemed by the Secretary to be "medically frail" or have special medical needs.²⁰ Case-specific enrollment procedures would be required to assure compliance with the law's population exemption provisions.

The benchmark statute offers three possible benchmark alternatives: the federal employee health benefit plan; state employee coverage; or coverage offered under the state's most popular commercial HMO product.²¹ In addition, the statute permits states to design an actuarial equivalent to the benchmarks. The statute contains no standards for entities that sell "benchmark plans" to states, leaving the question open as to the qualifying conditions that benchmark plans would be required to meet.

The DRA also authorizes states to utilize "alternative" approaches to premiums and cost sharing that permit the imposition of premiums in the case of certain eligible populations (e.g., beneficiaries with incomes in excess of 150% of the federal poverty level) and somewhat higher cost sharing. Nonetheless, because of the low income that characterizes Medicaid beneficiaries, this alternative premium provision is also subject to a variety of limits and exemptions.²²

¹⁶ 42 U.S.C. §§1396a(a)(1) and 1396a(a)(10)

¹⁷ Section 1937 of the Social Security Act.

¹⁸ Pub. L. 111-3 §611 (111th Cong. 1st sess.)

¹⁹ As of mid-March 2009, no such other provisions have been identified as qualified for waiver by a state.

²⁰ Section 1937 of the Social Security Act.

²¹ Section 1937 of the Social Security Act.

²² Section 1916A of the Social Security Act.

Furthermore, the American Recovery and Reinvestment Act (ARRA) limits states' use of DRA cost sharing options during the special recession adjustment period.²³

The DRA also specifies an aggregate upper limit on alternative cost sharing and premiums and requires that states have mechanisms for assuring that beneficiaries subject to cost sharing are not exposed out of pocket obligations that exceed these limits.²⁴ This aggregate upper limit provision means that adopting states would need to have in place mechanisms that are capable of ending recipients' cost-sharing exposure when the limit is reached, and the mechanism would have to work on a recipient-by-recipient basis.

Thus, within the limitations described above, Maine conceivably could enter into agreements with sellers of "benchmark plan" products for the purchase of alternative coverage for its non-disabled, non-pregnant, non-elderly adult population (predominantly non-exempt parents). These plan products could offer a range of benefits and services that are narrower than those available through a state's traditional Medicaid program, as long as such products satisfied the benchmark (or its actuarial equivalent) methodology set forth in federal law. Because the benchmark plans identified in the statute are group health plans offering relatively robust coverage, federal law would prohibit, for example, the sale of a "bare-bones" product with limited coverage. Similarly, federal law would prohibit the use of high deductibles, copayments and coinsurance.

It is also important to note the cost differential that could arise were the state to switch from traditional Medicaid to premium support for benchmark coverage. In State FY 2008, per-person spending on Maine's adult Medicaid population ranged from about \$3800 in the case of non-disabled adults to slightly more than \$10,000 for elderly adults, to more than \$16,000 in the case of persons with disabilities. For non-disabled, non-elderly adults, the state's FY 2008 annual spending figure translates into approximately \$320.00 per beneficiary per month.

This monthly per-person expenditure figure for non-disabled adults compares to a national average of about \$400 per member per month for group health insurance coverage sold in the employer-sponsored market.²⁵ More notably, in Maine, the average per member per month charge for enrolling a single adult into the state employee point-of-service plan is \$648.00, making private group coverage of working age adults in Maine about twice as expensive as the cost of coverage under Maine's Medicaid program. In other words, despite the reduced health status of low income adults and the restrictions on cost sharing that apply to Medicaid beneficiaries, the monthly cost of Medicaid coverage for a non-disabled working age adult in Maine is about half the cost of covering the same adult through commercial insurance. This differential is understated, since the commercial rate would require further adjustments to reflect poorer health and more limited cost sharing.

This very large price differential is consistent with the literature on cost differences between Medicaid and commercial insurance. For example, one recent study found that

²³ American Recovery and Reinvestment Act PL 111-5, Section 5001(f)

²⁴ Id.

²⁵ Kaiser Family Foundation, *Kaiser HRET Employer Health Benefits Survey* (2008)
<http://ehbs.kff.org/images/abstract/7791.pdf> (Accessed March 14, 2009)

Medicaid offered significantly lower cost for comparable coverage when compared to private health insurance and estimated as much as a 26% cost increase from shifting adults from Medicaid to private health insurance.²⁶

Medicaid versus Private Health Insurance Coverage

Were the state to consider moving toward a benchmark approach for eligible adults, it would be important to understand how the statutory benchmark plans compare to traditional Medicaid coverage. The subject of coverage is complex and encompasses many different issues, only some of which are visible to the naked eye, as are covered benefit classes.²⁷ Indeed, some of the most important dimensions of a full coverage comparison between Medicaid and private health insurance cannot be carried out without extensive analysis of contractual and legal terms and provisions, as well as provider claims and payment manuals and interviews with clinical and utilization management staff. Thus, a comprehensive comparison of Medicaid and private health insurance coverage would address a range of topics extending well beyond covered benefit classes and services.

The need for thoroughness in comparing Medicaid to private insurance is never greater than when an option to move from traditional Medicaid rules to commercial design is under consideration. This is because traditional Medicaid coverage design is governed by principles that differ significantly from the actuarial principles that apply to private health insurance. The most important of these differences are the rules of “reasonableness” and “non-discrimination,”²⁸ which bar the types of fixed, condition-related limitations, caps, and exclusions that characterize private coverage. As a result, even when Medicaid coverage appears similar to that available under private health insurance, the two types of financing arrangements can differ markedly, particularly where coverage of long-term and serious physical and mental health conditions is concerned. The standards of reasonableness and non-discrimination thus stand in stark contrast to the principles of “fair discrimination” that guide private health insurance.²⁹

The following considerations become relevant when fully comparing forms of health insurance coverage, especially when the point of comparison is between Medicaid and commercially available plans:

Benefit classes: The starting point of comparison is covered benefit classes, which delineate the broad categories of services and items that are considered covered. Physician services, hospital services, and prescribed drugs are examples of benefit classes.

²⁶ Leighton Ku and Matthew Broadus, “Public and Private Health Insurance: Stacking Up the Costs,” *Health Affairs* 27:4 w318-w327 (June 2008)
<http://content.healthaffairs.org/cgi/content/full/27/4/w318?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Leighton+Ku&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT> (Accessed March 15, 2009)

²⁷ Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, NY, NY 1997)

²⁸ 42 C.F.R. §440.230 Sara Rosenbaum and David Rousseau, “Medicaid at Thirty-Five,” *St. Louis University Law Journal* (2000) pp. 1-66.

²⁹ Sara Rosenbaum, *Insurance Discrimination Based on Health Status*, supra, n. 2.

Benefit definitions: A second comparison is benefit definitions. A benefit definition can considerably constrain the reach of an otherwise covered class. For example, “speech therapy” can encompass therapies related to treating an acute condition that, with treatment, can be eliminated. Alternatively, the definition can be structured so that the service is available for any condition that medically requires therapy, regardless of whether full recovery is possible.³⁰ Consider an adult patient who has experienced a stroke and is in the process of recovering from its effects; speech therapy can aid in the recovery. By contrast, an adult experiencing multiple sclerosis might benefit from therapy because the therapy averts further loss of speech capacity, even though the adult will never “recover” from the condition. Benefit definitions typically are embedded in the coverage class itself, but they may also be part of the internal operations procedures used by an insurer and thus not subject to easy review.³¹

Coverage definitions: How medical necessity is defined can be critical to coverage. A medical necessity definition may or may not be subject to easy review. Under Medicaid, states have the discretion to define medical necessity but cannot use definitions that are not reasonable or that discriminate in the provision of required services based on a condition.³² By contrast, private health insurers can vary coverage in ways that discriminate, excluding otherwise covered treatments for certain conditions as not being medically necessary. For example, a private health insurer could use treatment standards for mental illness that recognize only short term hospital stays as necessary for mental illness, while permitting longer term treatments for cancer as necessary. Mental health parity legislation enacted in 2008 does not prohibit this practice, since the law does not classify medical management standards as part of the definition of parity³³

Coverage limitations and exclusions. Private insurance may impose condition-related coverage limitations and exclusions, such as dollar caps on an annual or lifetime basis for certain conditions such as AIDS, while exempting other conditions from such limitations. While differential caps are prohibited in the place of mental illness and addiction, they are not prohibited for other conditions. This type of condition specific coverage cap is prohibited by Medicaid’s non-discrimination rule.

Coverage of individual procedures within benefit classes. Perhaps the most important differential comes in the form of payment procedures. While covered benefit classes are visible to the naked eye, insurers can differ strikingly in the covered procedures within any particular class. One plan may permit a broad range of covered procedures according to its own internal treatment guidelines, while another plan may be more restrictive. Medicaid, like private health insurance, can limit covered procedures as long as the limitations are not discriminatory.³⁴ At the same time, because Medicaid is designed to address the situation of adults and children with chronic conditions, it is not unusual for

³⁰ *Bedrick v Travelers Insurance Co.* 93 F. 3d 149 (4th Cir., 1996)

³¹ *Id.* See also *Jones v Kodak Medical Assistance Plan* 169 F. 3d 1287 (10th Cir., 1999)

³² 42 C.F.R. §440.230

³³ 29 U.S.C. §1185 as amended by the Pau. Wellstone and Pete Domenici Mental Health Parity and Addiction Recovery Equity Act, Pub. L. 110-343 Title V, Subtitle B (110th Cong. 2d sess.)

³⁴ *Rodriguez v City of New York* 197 F. 3d 611 (2d Cir., 1999)

Medicaid to cover additional procedures not recognized by private health insurers.³⁵ Thus, maintenance therapies for chronic illness might be payable under Medicaid even as they are excluded by private health insurers because they do not lead to “recovery” to normal functioning.

Despite the value of an extensive analysis, comparison of broad benefit classes can reveal major similarities and differences between Medicaid and commercial insurance. **Table 1** compares MaineCare to the three benchmark plans recognized under federal law (FEHBP standard, Maine State Employees, and HMO Maine). This “top level” examination, using a specially prepared comparison tool that was made available to the author for this analysis, shows that in terms of broad categories of services, MaineCare is, in fact, highly similar to the three benchmark plans. Indeed, in certain key respects, MaineCare is less generous, while simultaneously more generous in ways that are consistent with its role in serving low income adults with limited health status, including the elderly and those with significant disabilities.

For example, 2 of the 3 benchmarks cover clinical trials in certain situations, while MaineCare does not. Dental coverage under MaineCare is more limited than in the case of at least one of the benchmarks. Annual admission limits are placed on coverage of inpatient hospital care for adults without children under MaineCare (although these limits may be waived in cases of medical need); similar limits do not appear under the private plans. Surgical limits also are readily apparent in MaineCare, compared to the 3 benchmarks.

By contrast, MaineCare appears to covers a greater range of mental health treatment (something which may or may change under mental health parity, since commercial insurers can continue to entirely exclude certain conditions from any coverage under the 2008 parity law) The greater level of coverage available under the Maine Medicaid program is consistent with data on the greater burden of serious mental illness borne by low income adults.

Similarly, occupational, speech, and physical therapy appear somewhat more broadly covered in the case of MaineCare, allowing a greater level and duration of treatments, as well as treatments for conditions that are subject to rehabilitation even if not total recovery. This more generous level of coverage is consistent with the higher burden of chronic mental and physical illness borne by the Medicaid population.

Discussion and Implications

This analysis suggests that compared to private health insurance, MaineCare represents the most efficient and cost-effective means of extending coverage to a low income population that bears a greater burden of illness and lacks the ability to pay more than a nominal amount toward the cost of care. Maine might elect to scale back benefits and coverage across the board for all categorically needy adults, but such a decision inevitably would fall most heavily on persons with disabilities and the elderly as well as the health care providers and programs that

³⁵ Anne Markus, Sara Rosenbaum, Ruth Stein, and Jill Joseph, *From Benefit Design to Individual Coverage Decisions (Policy Brief 6)*
http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/SCHIP_brief6.pdf (Accessed March 15, 2009)

serve them. Federal comparability requirements preclude a policy approach that shrinks benefits for one population without reducing coverage for all similarly situated populations.

Alternatively, Maine might consider taking advantage of the DRA benchmark plan option under which it can selectively re-design coverage for certain populations who are not exempt from the terms of the law. This option could be combined with somewhat higher costsharing for certain services.

However, Table 1 suggests that little would be gained from such an approach in Maine, because in fact, benchmark coverage is comparable (and in some cases superior) to traditional Medicaid. MaineCare tends to be more generous where chronic illness management is concerned, offering what appears to be more extensive mental health and rehabilitation coverage than that found in the commercial market. This differential makes sense, since commercial plans are built on actuarial principles and are designed to limit their reach to a healthy working population.

While a full comparison of coverage lies beyond the scope of this analysis, even a top-level review shows great similarities and important differences. Furthermore, even though MaineCare in fact is comparable to private benchmark plans, financial data suggest that switching to a benchmark strategy would be highly costly, even before taking into account the additional costs that would flow from running multiple enrollment and coverage arrangements for the adult beneficiary population, and from having to adjust the cost of coverage to reflect a sicker population and lower permissible cost sharing. Indeed, even without taking these additional costs into account, the evidence suggests that the monthly individual premium for a commercial plan in Maine costs twice as much as the monthly expenditure under traditional Medicaid for a non-disabled adult. Furthermore, were the state to move to benchmark coverage, it appears that important coverage for chronic physical and mental health services could be lost, resulting in a major cost shift onto Maine's public programs and long-term care providers.

In sum, it appears that MaineCare, in its traditional Medicaid format and structure, represents the most efficient and cost-effective means of achieving coverage for the population. Reductions in coverage would affect both low-need and high-need adult populations, and the benchmark option would not only result in higher monthly costs but also would appear to reduce coverage for serious and chronic conditions. These reductions can be readily viewed from a comparison of benefit classes; the extent of the potential coverage reductions resulting from adoption of benchmark coverage may be far greater under a more granular analysis that takes into account the impact of tighter definitions, limitations and exclusions, as well as limitations on covered procedures within benefit classes.