

Dirigo Health

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Maine's pioneering Dirigo Health program aims at reducing health care costs, improving quality, and increasing access by providing health insurance coverage to all of Maine's currently uninsured population. State senators Sharon Treat and Michael Brennan and co-author Ann Woloson provide an overview of the components, structure and financing of the program. They discuss some of the challenges and opportunities posed in Dirigo Health's implementation, and give an insider's perspective on the process by which the program was enacted. In their commentaries, Godfrey Wood, CEO of the Portland Regional Chamber, and Deborah Cook, executive director of the Maine Small Business Alliance, discuss Dirigo Health from the viewpoint of small businesses, whose employees and families, along with the self-employed, represent the largest proportion of uninsured in Maine's population. Both note that rising costs of health care and insurance are a major threat to the viability of small businesses. While Cook and Wood are both supportive of Dirigo Health's goals, Wood raises some concerns about the program's assumptions, its cost to employers and employees, and its financing. 

INTRODUCTION

With the passage of Dirigo Health, Maine has launched a first-in-the-nation plan to significantly reduce health care costs and make health insurance available to every Maine resident. Over the next five years, the goal of Dirigo Health is to provide coverage to the estimated 136,000-180,000 Mainers currently without health insurance. Equally important, Dirigo Health aims to control the growth of health care costs for everyone. In short, by utilizing an innovative blend of private and public resources, Maine has launched itself to the forefront of progressive health care reform.

As legislators, we frequently hear from our constituents—both businesses and individuals—about the high cost of health insurance and the lack of access to needed health care. In previous years, the Maine State Legislature took steps to expand coverage programs serving low-income families and those that provide assistance in accessing prescription drugs for Maine's elderly, uninsured and disabled. While these programs have been helpful to those who qualify, those who don't continue to seek affordable alternatives for coverage.

The legislature also has made some attempt to control health care costs through targeted legislative initiatives. For example, cost and quality were addressed through the Certificate of Need (CON) process. Enacted in 1977, with several amendments since that time, this regulatory program requires health care providers (i.e., hospitals, nursing homes, and others) to obtain formal approval from the state before constructing or renovating health care facilities, purchasing or leasing certain medical equipment, or making certain changes in the array of health care services provided. The primary objectives of the CON review process are to reduce increases in health care costs by reducing unnecessary duplication of health care facilities and services, and to ensure that high quality health services are provided. Similarly, in the insurance area, as part of a 1997 bill creating a "patient bill of rights," the legislature established a consumer health division within the state's Bureau of Insurance, which provides a consumer hotline and a consumer complaint procedure.

Although these incremental steps helped, health care costs continue to increase at unsustainable rates; likewise, insurance rates also continue to rise, while the number of uninsured has held steady or even increased.

A statewide poll conducted in 2000 revealed that health care was of bigger concern than the environment, taxes, growth or crime (Carrier 2000). The poll results showed that 69% of respondents were very concerned about the cost of health insurance, placing that issue at the top of the list of concerns. The cost of medical care came in second, followed by prescription drug costs and the cost of caring for the elderly.

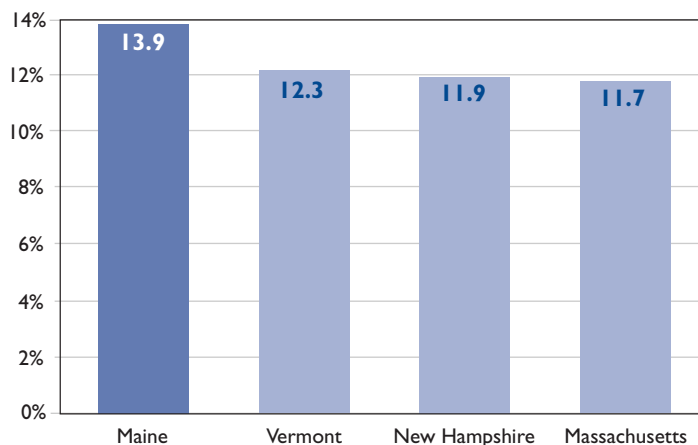
A survey of Maine small businesses also released in 2000 revealed that they too were concerned about the rising cost of providing health insurance to workers. Eighty-one percent of respondents indicated that health insurance was important in their efforts to attract and retain employees (St. John et al. 2000). However, the number of small business employers offering insurance in Maine had declined. While over three-quarters offered insurance to employees at some time during the three years prior to the survey, only two-thirds were offering coverage at the time of the survey—even though the number of businesses indicating that it was important to offer coverage as a matter of principle had risen.

Increasingly, businesses also have been forced to reduce coverage to their employees. Employers are increasing the employee share of the cost of premiums and co-pays, reducing coverage for dependants, or moving to catastrophic policies or medical savings accounts. As a result, the number of the underinsured has grown as well. Small businesses, which make up more than 95% of businesses in Maine and employ nearly 50% of our workers, are in crisis. They want to provide coverage for their



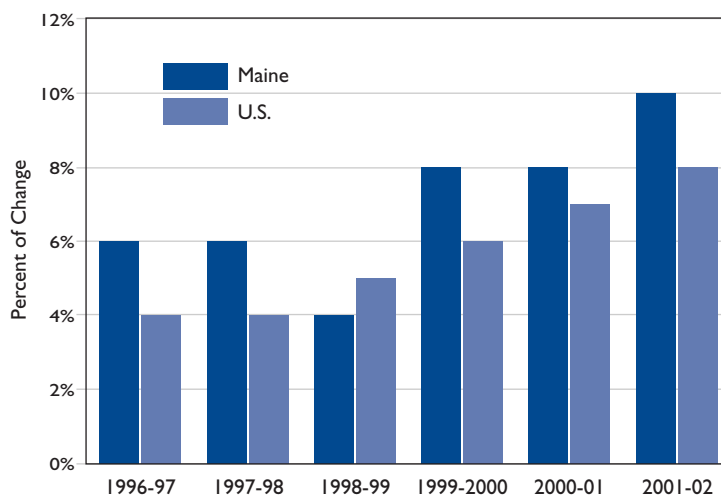
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FIGURE 1: Percentage of Non-Elderly Uninsured in New England, 1998-99



Source: U.S. Government Accounting Office (GAO) 2001

FIGURE 2: Percentage Change in Hospital Expenses (Inpatient and Outpatient) in Maine and the United States



Source: *Almanac of Hospital Finance and Operating Indicators*, 2002-2003

workers, and they have made it clear to legislators that they need relief sooner rather than later.

The experiences of Maine businesses have been borne out by the data. Mainers have been subject to annual double-digit increases in health insurance premiums. Nationally, it is projected that when the numbers are in, employers will have experienced an average increase of 15% in 2003 (Kaiser Family Foundation and Health Research and Education Trust 2002). Maine small businesses experienced a cumulative 58% increase in the average cost for managed care coverage between 1996 and 2001 (Maine Health Access Foundation 2000). Annual small-group health insurance premium costs increased 31% and 16% in Fiscal Years 2002 and 2003, respectively (personal correspondence from the Maine Bureau of Insurance).

Given that Maine has been faced with even greater increases in premiums, and continues to be confronted by a slowing economy, employers will be challenged to maintain their current level of employer-based coverage (Wolf 2003). Workers continue to bear more of the cost of coverage, either in the form of higher co-payments or higher deductibles. Many forgo wage increases in an effort to maintain coverage. In the worst case scenario, good paying jobs are being cut and major employers are closing, putting more individuals and families into the ranks of the uninsured.

Maine has many other challenges that need to be recognized and addressed in attempts to improve access to quality health care. The state has the highest percentage of uninsured people in New England (Figure 1), and our rates of preventable illness exceed national averages (AARP 2001). While Maine is the poorest state in New England, its health care spending ranks among the highest in New England and in the nation (Riley 2003; Wolf 2003).

Moreover, increases in Maine hospital costs over time tend to be higher than the average for the United States (Figure 2). Maine hospitals cite the aging population, the high prevalence of preventable disease, and low Medicare reimbursement rates as factors for the higher hospital costs. Overall, however, Maine hospitals remain the most profitable in New England (*Almanac of Hospital Financial and Operating Indicators*,

2002 2003). Hospital costs make up about 34% of Maine's annual health care expenditures, and represent the fastest growing category of health care expenditures, outstripping even the recent growth in expenditures on prescription drugs (Governor's Office on Health Care Policy and Finance 2003).

DIRIGO: THE PROCESS

Coming into the 121st session, legislators were prepared to take action to address Maine's health care crisis. But they faced a significant roadblock—a billion dollar budget shortfall. Like so many other states, Maine's revenue shortfall is caused by the country's shaky economy, reduced revenues as a result of tax cuts at both the state and federal level, and increased costs, especially in health care.

Given this situation, many wondered if it was really possible to move ahead and expand health care to more people. While the factors that contribute to high health care costs pose major challenges to reform in Maine, many members of the legislature recognized that continued increases in the cost of health care could not be sustained over time. With no relief expected from the federal government to help the uninsured, and strong support from many in the business, labor and health care communities, Maine legislators moved forward to provide health coverage to all of Maine's uninsured over time.

At the same time, health care reform was a major theme of Democratic Governor John Baldacci's campaign. After being elected, he took immediate steps to carry out this campaign pledge. He created the Office of Health Policy and Finance and staffed it with national experts. He also created the Health Action Team, consisting of 30 members representing health care providers, including nurses, doctors, and hospitals; businesses; organized labor; consumers; policymakers; and legislators who met regularly to assist in the development of a plan. The plan was introduced and legislation was submitted to:

- provide affordable coverage to small business;
- control health care costs for an initial period of

one year; and

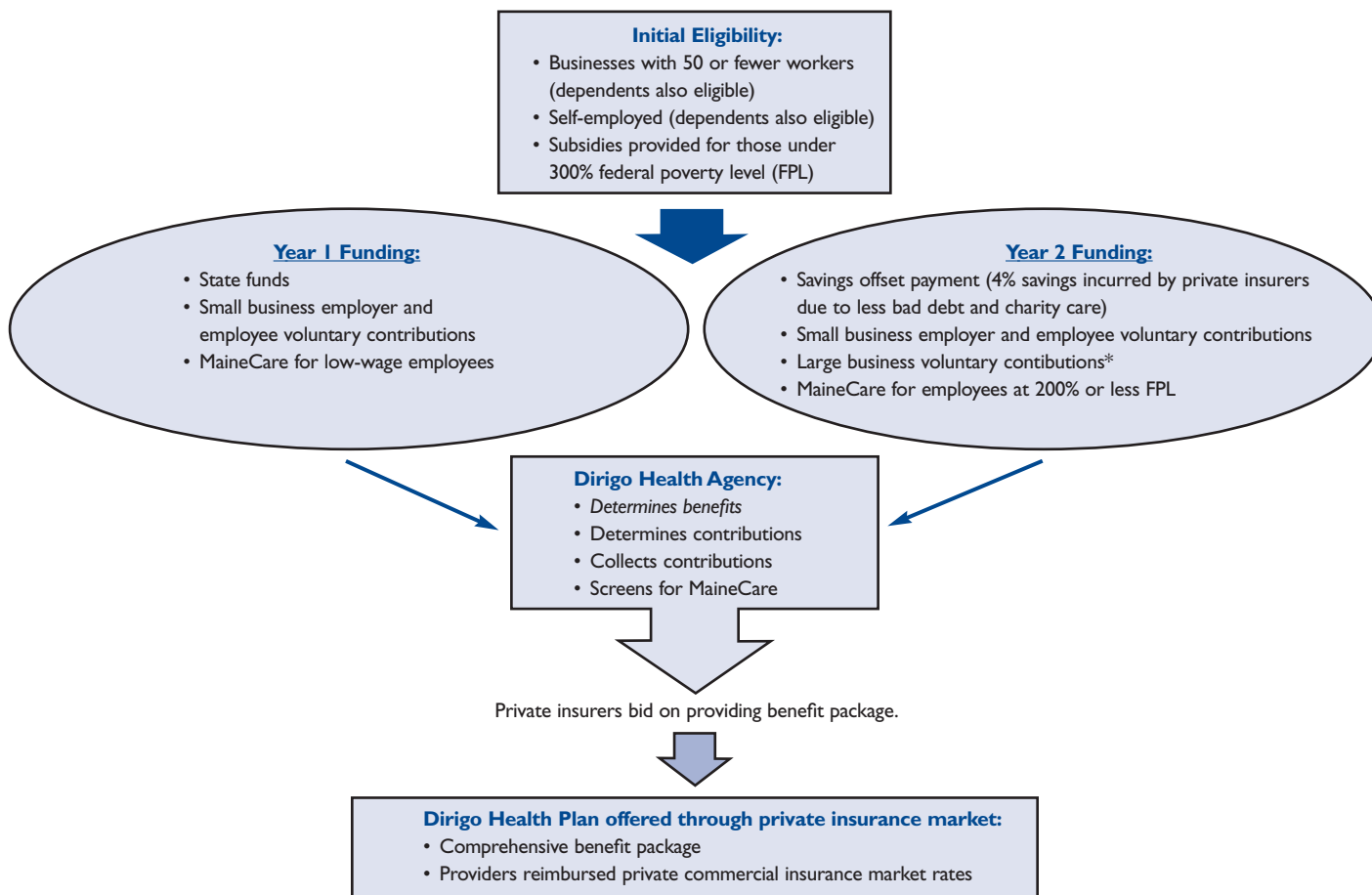
- improve state health planning to prepare for the future.

Legislative leadership established a Joint Select Committee on Health Care Reform to consider the legislation. The bipartisan committee was comprised of members from the legislature's joint standing committees on Health and Human Services, Insurance and Financial Services, and Appropriations and Financial Affairs. The committee held an extended hearing that went into the evening hours, where public comment on the proposal was presented by small and large businesses, medical associations, consumers, insurers and labor unions.

The hearing was followed by weeks of lengthy work sessions. Members of the Joint Select Committee on Healthcare Reform worked with stakeholders to ensure that the goals of the original proposal were maintained while concerns regarding various aspects of the proposal were being addressed through intense negotiations between stakeholders, the governor's office, and the bipartisan committee. In the end, the legislation was unanimously supported by the Joint Select Committee on Health Care Reform. The legislation creating Dirigo Health was passed by a vote of over two-thirds of the members of both the House and the Senate. The Dirigo Health Reform Act, Public Law 469, was signed by the governor in May 2003. Initial steps are currently underway to implement the plan so it can be fully operational by late summer/early fall of 2004.

KEY ELEMENTS OF DIRIGO HEALTH

Trish Riley, Director of the Governor's Office of Health Policy and Finance, indicated in her testimony supporting Dirigo Health that "cost, quality and access are interrelated and one cannot be achieved or sustained without affecting the others... access cannot be sustained without cost containment; access without quality is not worth having." The legislation deals with all three components of Maine's health care system, each of which is described below.

FIGURE 3: **How Dirigo Health Works**

*After one year of operation, the Dirigo Health Board of Directors may, by rule, expand the definition of eligible business to include larger public or private employers.

IMPROVING ACCESS TO AFFORDABLE COVERAGE

In the long run, Dirigo Health is designed to rely not only on employer/employee premiums for financing but also on savings that are expected to accrue to Maine's health care system by reducing the amount of health care currently provided to the uninsured. It also includes the use of voluntary employer contributions to draw down federal funds to provide subsidies for low-

income workers and to reduce overall premium costs for small businesses. (Figure 3 outlines the major components of Dirigo's insurance process.)

The primary objective of Dirigo Health over the first six months of 2004 is to develop the benefit plan to be made available through the private insurance market. The plan will offer a competitively priced, comprehensive benefit package for small businesses, self-employed individuals, and households with incomes under 300% of the federal poverty level.

Ensuring a balance between affordability and benefits will be critical to the success of Dirigo Health.

Health care providers who provide services to enrollees under Dirigo Health will be reimbursed the same rates paid by private insurers—services often previously provided without any reimbursement when many of the uninsured required care under Maine’s mandatory “charity care” provisions. Ideally, Dirigo Health will provide more financial resources to Maine’s health care industry, and providers will send fewer patients to collection agencies. Although coverage through Dirigo Health initially will be limited to the three groups identified above, larger businesses may be able to participate after one year of operation. Dirigo Health does not try to accomplish too much, too quickly, allowing time to plan before expanding to larger businesses.

The incremental approach to achieving universal access to health insurance in Maine that has been adopted by Dirigo Health can be seen in its specific objectives, which include:

- Insuring at least 31,000 individuals in year one, beginning no later than October 2004, and progressing toward universal access by covering at least an estimated additional 110,000 individuals by 2009.
- Offering affordable premiums and providing subsidies to individuals and families on a sliding scale based on ability to pay. For example, an individual with an annual gross income up to \$27,000 or a family of four with a gross income of \$55,000 would qualify for a subsidy toward monthly premiums. Enrollees should benefit from lower and more stable rates provided by participation in a larger group.
- Offering coverage through private health insurance carriers who will provide a comprehensive benefit package and pay providers at private insurance market rates.
- Expanding the definition of eligible business to include larger public or private employers after one year of operation.

IMPROVING HEALTH PLANNING AND QUALITY

Dirigo Health calls for the development of a State Health Plan every two years to identify health care needs and resources based on access and quality goals. The Maine Quality Forum has been established to collect and provide information about the overall quality of care in the state. More reliable information about quality and prices will be available to consumers, allowing them to make better health care decisions. Other health planning initiatives included in Dirigo Health include a Task Force on Veterans’ Health Services, charged with assessing the needs of veterans, and the Commission to Study Maine’s Hospitals, which will provide analysis and policy recommendations regarding both hospital roles and needs, and hospital costs and reimbursement. (See Figure 4 and the sidebar, pages 18-19, for an outline and description of the various entities established under Dirigo Health.)

Containing Costs

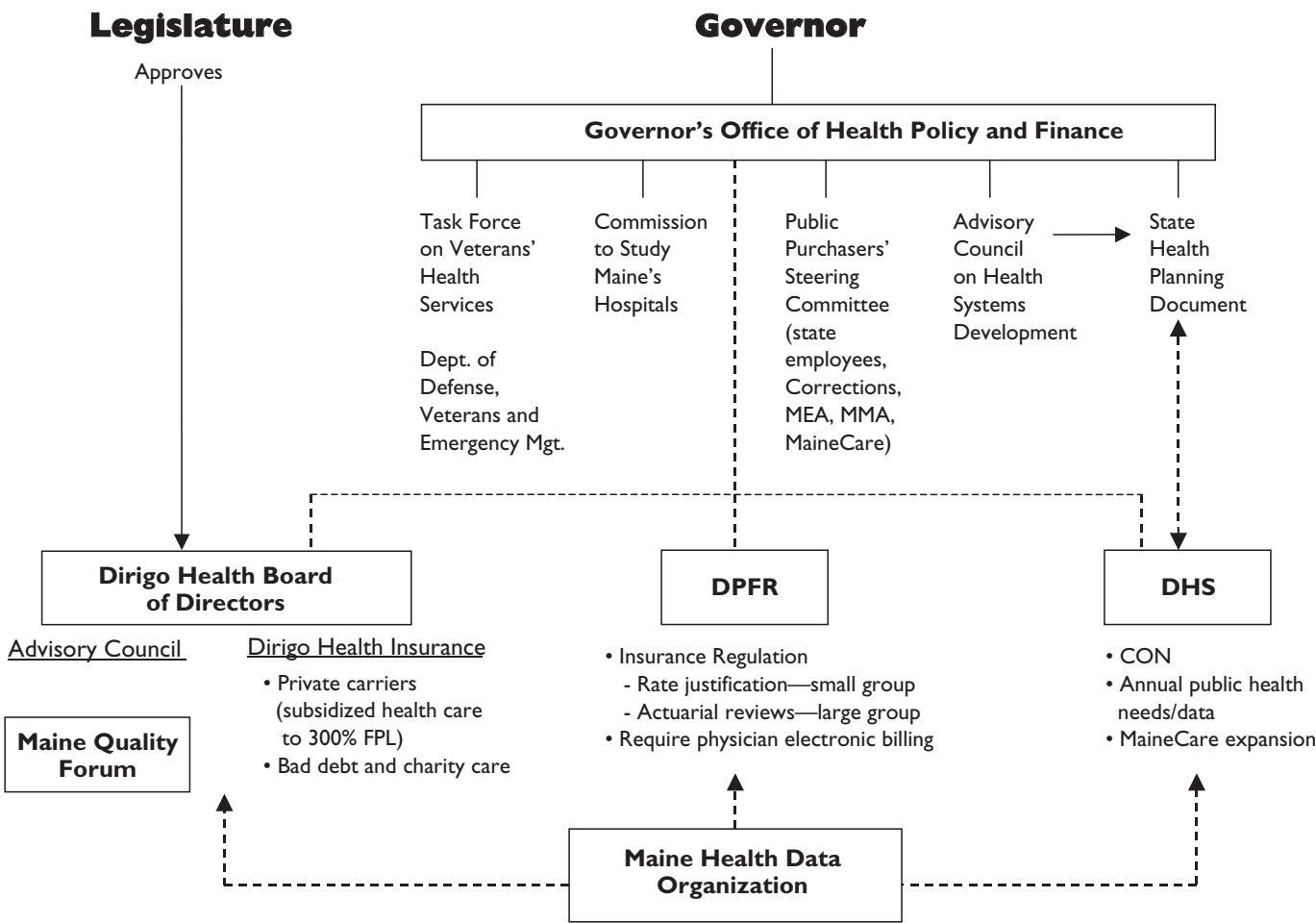
Dirigo Health has several cost-containment measures, which are critical to the success of the program over time.

Insurance costs. In the past, only premium rate increases proposed for individual policyholders were regulated by the state. Now, increases in small and large group premium rates (generally purchased by businesses) must be submitted to the superintendent of insurance, and will be subject to public hearings or actuarial reviews to justify the need for increases. This provision alone provides Maine businesses with an effective and long-overdue tool to control costs. In fact, recent small group health insurance premiums filed with the Bureau of Insurance in the first quarter of fiscal year 2004 represent only a single digit price increase of 9% (personal communication from Maine Bureau of Insurance). If this level of rate increase remains the same throughout this fiscal year, it will be the first time in nearly 10 years that the yearly increase in small-group insurance premiums has been under 10%. While we cannot judge Dirigo’s impact on insurance rates based on only first-quarter data, we believe the recent figure suggests that insurance companies are at least anticipating the provisions of Dirigo Health.

FIGURE 4:

DIRIGO HEALTH

Health Reform for Maine



Hospital Costs. As we have noted, hospital costs make up a significant part of Maine's annual health care expenditures and represent one of the fastest-growing components of Maine's health care expenditures. Dirigo Health takes a comprehensive approach to containing hospital costs for an initial time-limited period. It also sets up a mechanism for examining those costs and for planning on how to address such costs in the future. Specific efforts include:

- Voluntary caps on cost and operating margins for hospitals during the first year.
- Requiring hospitals to maintain price lists and provide them to patients upon request.
- The creation of a Capital Investment Fund to guide the Certificate of Need (CON) process by placing health care capital expenditures on an annual budget. This will include:

DIRIGO HEALTH ADVISORY GROUPS AND COMMITTEES

Advisory Council on Health System Development: guides the Governor's Office in establishing the State Health Plan and Capital Investment Fund, and in conducting hearings and synthesizing data and research. The council will work with existing organizations such as the Maine Health Data Organization in coordinating and streamlining health data and research activities.

Commission to Study Maine's Hospitals: charged with conducting a comprehensive analysis of hospital costs, roles, reimbursement, and capital needs and making policy recommendations. The commission's report and any

suggested legislation are to be submitted by November 1, 2004 to the legislature's joint standing committees of Health and Human Services and Insurance and Financial Services.

Maine Quality Forum: an independent watchdog group to provide more information to the public about the quality of health care in Maine. It will collect, report and disseminate research, adopt quality and performance measures, promote evidence-based medicine and best practices, encourage the adoption of electronic technology, and make recommendations for the State Health Plan.

Public Purchasers' Steering Group: charged with establishing and coordinating a collaborative purchasing program to ensure cost-effective and quality health care purchased with public funding.

Task Force on Veterans' Health Services: charged with reviewing and assessing the needs of Maine veterans relative to health care services. The task force report of findings and recommendations, including proposed legislation, is to be submitted by January 1, 2005 to the legislature's joint standing committees of Veterans Affairs and Health and Human Services.

- A one-year moratorium on CON, with exceptions for approvals made prior to enactment of the legislation and requests already received.

- Expanding the CON process to include ambulatory surgery centers (non-hospital based service providers and doctors offices) for investments in new technologies costing more than \$1.2 million and capital expenditures (expansions) costing over \$2.4 million.

- A minimum of 12.5% of the Capital Investment Fund to be made available to non-hospital service providers for the first three years of implementation of the plan.

- The creation of the Commission to Study Maine's Hospitals to provide a systematic analysis of hospital costs, including resources and opportunities for maintaining affordable, accessible hospital services throughout Maine.

In addition to enhanced insurance rate monitoring and the initiatives regarding hospital costs, other Dirigo Health cost containment measures include:

- Requiring health care practitioners to notify patients in writing of their charges for common services.
- Asking health insurance carriers to limit underwriting gains to 3% for the first year the legislation is in effect.
- Permitting health insurance carriers to offer their enrollees financial incentives to travel further to undergo non-emergency surgical procedures if the carriers can demonstrate cost-effectiveness and the quality of care is equal to or better than those in the more distant location(s).
- Requiring the superintendent of insurance to study medical malpractice cases and malpractice insurance rates in Maine.

DIRIGO HEALTH STRUCTURE AND ADMINISTRATION

The enacted legislation created the Dirigo Health Agency, a quasi state agency governed by a five-member volunteer board of directors nominated by the governor and approved by the legislature (see Figure 4). The agency will oversee administration of Dirigo Health and coordinate various aspects of the plan with the Bureau of Insurance, the Department of Human Services and the Governor's Office of Health Policy and Finance. Staff of the Dirigo Health Agency also will be responsible for promoting Dirigo Health to businesses and the public, assisting in the enrollment process, collecting contributions from enrollees, and working with insurers in distributing benefits.

Several advisory groups and commissions were established as part of Dirigo Health to investigate, report, and make recommendations on various aspects of Maine's health care system (see sidebar). The Dirigo Health Agency will staff and coordinate the work of these various advisory groups and commissions. Information gathered by these entities will identify needs and resources, collect and provide information about quality, and give Maine the ability to plan effectively for the future.

FINANCING

The first year of Dirigo Health will be funded with voluntary contributions from individuals and small businesses, federal matching funds for low-income families (those below 200% federal poverty guidelines), and with about \$53 million in state funds.

In the second year of operation, the Maine Quality Forum and premium subsidies will be funded by a "savings offset payment" from health insurers. The payment will be based on savings to Maine's health care system resulting from a reduction in the amount of bad debt and charity care currently provided to the uninsured.

- The "savings offset payment" by insurers and third-party administrators will be made after the first year of operation in proportion to cost savings achieved. If there are no savings, there will be no payment required. Savings

will result from cost controls such as the CON moratorium, the voluntary price controls and decreases in bad debt and free care costs.

- Health insurance carriers and health care providers will demonstrate that they have made reasonable efforts to recover the "savings offset payments" by negotiating reduced reimbursement rates that take into account decreases in bad debt and charity care costs and other aggregate savings.
- Health insurance premiums must reflect cost savings attributable to decreases in bad debt and free care. Currently, it is estimated that the cost of bad debt and free care is \$275 million per year, which is passed through to those who have health insurance, accounting for about 16% of the costs of insurance premiums.
- Health insurance carriers choosing to file rates without a public hearing will be required to refund excess premiums to policyholders if their payout for medical claims falls below 78% of premiums collected.
- If, after three years, average premiums and the rate of uninsured in Maine exceed average premium rates and the average rate of uninsured among 31 states with high-risk pools, legislation will be introduced for a high-risk insurance pool in Maine.

CHALLENGES AND OPPORTUNITIES

We believe that alternate proposals for improving access and slowing the growth of health care costs in Maine do not offer consumers the improved access or cost-savings provided by Dirigo Health. Proposals that rely on trimming benefits and implementing higher out-of-pocket expenses are not the answer. Many in Maine, especially individual policyholders and the self-employed, are already paying more for less. For example, it is not uncommon for people to be paying for coverage they will never use because, in

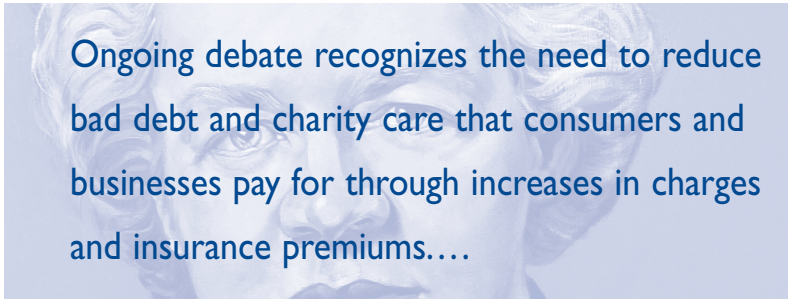
an effort to trim monthly premiums, they have policies with high annual deductibles (\$5,000-\$10,000). Dirigo Health will provide many of these people with an affordable option that will allow them to access health care prevention and other medically necessary care that they now forgo because of high deductibles.

Similarly, high-risk pools, often touted as the solution for bringing younger, healthier people into the market, make coverage more expensive and difficult to maintain for sicker or older people. Because high-risk pools are composed of consumers with high health care needs, premiums are expensive for those in the pool. Frequently, people who need health care the most end up losing their coverage. In some states, such pools have created another escalating financial burden on state budgets, which are relied upon to fund the pool. Whether to create a high-risk pool in Maine was hotly debated during the Dirigo Health negotiations. As an interim measure, a bipartisan compromise was reached during the final stage of negotiations that requires the State of Maine to explore the development of a high-risk pool in Maine if Dirigo Health is not successful over time in reducing the number of uninsured.

The assessment on insurers to help fund Dirigo Health was probably the most debated aspect of the plan. Many legislators feared that such an assessment would be passed on to policyholders. Instead, the assessment is intended to reflect the savings accrued to insurers from Dirigo Health as the costs of bad debt and charity care are reduced. In other words, the assessment reflects a portion of the hidden tax now paid by everyone through increased insurance rates and increased provider charges.

The Dirigo Health plan ultimately adopted by the legislature compromised on this provision, while maintaining the basic premise of the assessment. By covering the uninsured, Dirigo Health will reduce bad debt and charity care costs. However, instead of allowing insurance companies to collect a windfall in additional revenues from these savings, Dirigo Health identifies a portion of the money saved—referred to in the final law as the “saving offset payment”—no more than 4% of the cost of each policy, and uses it to help fund health insurance costs for businesses and individuals. The insurance industry and businesses were heavily

involved in negotiating these terms, which clearly spell out that no payment from insurers will be required unless savings are clearly recognized. In this way, policyholders are protected from pass-throughs by the insurance industry. While this compromise will extend the full implementation of the Dirigo Health program to five years and require the use of \$53 million in one-time funds to jump-start the program, it resolved the concerns of many policyholders and allowed the program to move ahead with broad-based support.

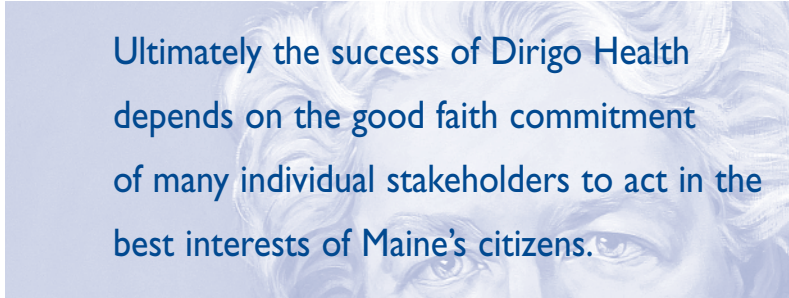


Ongoing debate recognizes the need to reduce bad debt and charity care that consumers and businesses pay for through increases in charges and insurance premiums....

Finally, there has been significant debate about the role hospitals will continue to serve as health insurance coverage expands through the public and private mechanisms of Dirigo Health. Ongoing debate recognizes the need to reduce bad debt and charity care that consumers and businesses pay for through increases in charges and health insurance premiums, but it also fuels discussion about increased utilization and capacity. Hospitals are important to Maine's economy and in providing safety net services throughout Maine. Some are doing well, but others, especially smaller rural hospitals, indicate that they are struggling—operating either near or in the red. However, we believe that by initially restraining hospital costs while simultaneously providing a mechanism for examining the drivers of hospital costs in Maine, Dirigo Health can provide an opportunity for preserving the viability of many of the state's smaller and more rural hospitals.

Ultimately the success of Dirigo Health depends on the good faith commitment of many individual stakeholders to act in the best interests of Maine's citizens. We believe there is early evidence of this commitment. Insurance rates, for example, while still

increasing, are increasing at much smaller percentages than in the previous three years. Where most policyholders were seeing annual increases in the 15-30% percent range or even higher, rate increases requested recently remain in the single digits. As a result, a number of businesses have reported that with some modification of their policies, they have been able to avoid passing along any additional costs to employees this year. This is a positive signal that we hope reflects the good faith commitment of insurers to the success of Dirigo Health.



Ultimately the success of Dirigo Health depends on the good faith commitment of many individual stakeholders to act in the best interests of Maine's citizens.

In conclusion, the Maine State Legislature in partnership with Governor Baldacci chose to act, and act decisively, believing that this state faces a health care crisis and knowing that no one else is likely to step in to resolve it—not the private sector, and not the federal government. We know there is still much work ahead of us, and we assume there will continue to be new challenges as we implement Dirigo Health. However, by improving access to more affordable coverage, slowing the growth in health care costs, and promoting greater quality in our health care system, Dirigo Health takes an innovative and common sense approach to solving Maine's health care crisis sooner rather than later. 🐟

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(D-Kennebec County) was elected to the Maine Senate in 1996 after three terms in the House, and serves as Senate majority leader. She previously served as assistant majority leader, and has chaired the Health and Human Services, Natural Resources, and Judiciary committees. Senator Treat was the lead Senate sponsor of the Dirigo Health legislation and has sponsored numerous bills relating to health care and prescription drug policy.



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(D-Cumberland County) served four terms in Maine's House of Representatives prior to being elected to the Senate in 2002. He serves as the chair of the Joint Select Committee on Health Care Reform. He also is Senate chair of the Joint Standing Committee on Health and Human Services and is a member of the Joint Standing Committee on Education.



Ann Woloson is special assistant for the Senate Majority Office. She previously worked for years as a health policy analyst and advocate in Maine's nonprofit sector, and as a policy writer for the state Medicaid program. She has served as a member of several boards and commissions related to health care, and most recently as a representative of the Senate majority on the governor's Health Action Team.