ISSUE BRIEF

The Massachusetts Health Policy Forum

Dirigo Health - A Universal Health Care Coverage Plan in Maine: Implications for Massachusetts

Omni Parker House Hotel
Tremont and School Streets
Boston

Thursday, October 23, 2003
9:00 to 9:30 - Registration and Breakfast
9:30 to 11:30 - Presentation and Discussion

Featuring: **Trish Riley**
Senior Health Policy Advisor to Governor John Baldacci
Executive Director, National Academy for State Health Policy

Moderated by: **Stuart H. Altman, Ph.D.**
Sol C. Chaikin Professor of National Health Policy
Schneider Institute for Health Policy at The Heller School for Social Policy and Management, Brandeis University

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This issue brief was prepared by Michael Miller, MPP and Brian Rosman, JD of Community Catalyst and Health Care For All. These organizations are committed to expanding access to health care at the state and national level.

On June 18th, Maine governor John Baldacci signed into law a comprehensive health care initiative know as Dirigo Health. Dirigo is Latin for "I lead", the state motto. Dirigo is often referred to as Maine's new universal coverage law. The law seeks to achieve universal access to coverage by integrating access, cost, and quality initiatives.

While Dirigo responds to and takes advantage of particular circumstances in Maine, it has naturally drawn a great deal of interest from other states seeking to deal with similar problems. This issue brief provides an overview of Dirigo Health and outlines areas that might inform the health policy debate in Massachusetts (and perhaps other states as well).

Antecedents

While the campaign, and ultimate election of Governor John Baldacci in 2002 catapulted the health care issue into the forefront of the political debate, the roots of Dirigo precede the campaign. Perhaps the most important factor prior to the election that created the atmosphere necessary for the passage of Dirigo was not a sharp increase in the number of uninsured, but a sharp increase in health insurance costs, particularly for small businesses. Between 1996 and 2001 health insurance premiums for small businesses rose 58%.[1]

With small businesses dominating the Maine employment scene, this rise in premiums threatened to substantially undermine existing coverage arrangements. Maine small businesses faced a number of barriers to obtaining affordable health insurance. Rising health care costs were taking place in an environment with limited competition between hospitals and among health insurers.[2]

The campaign for governor highlighted the problems of the uninsured and of rising costs. As a candidate, future Governor Baldacci made a pledge to address the problems of the health care system within four months of taking office. On his first day he announced creation of his Office of Health Policy and charged it with implementing his vision of a comprehensive health plan for the state of Maine.

In addition to the market and political factors that helped shape Dirigo, another important factor is the state's 1115 Medicaid waiver. Although Dirigo itself does not require any additional federal Medicaid waivers, Maine already had a waiver that allowed it to extend Medicaid to 125% FPL for adults without dependent children. (However, because of budget constraints Maine had only used this authority to extend coverage to 150% FPL

[1] Dirigo Health: Health Reform for Maine, Governor's Office of Health Policy, May 5, 2003 available at http://www.state.me.us/governor/baldacci/healthpolicy/reform_proposals/annotated_summary.htm, 10/17/03

[2] ibid

for parents and 100% FPL for other adults prior to Dirigo) This waiver is an important base for the Dirigo coverage expansion. The state also plans to submit a state plan amendment to cover parents up to 200% FPL.

Basic Description

The goal of Dirigo is to reform the health care system, meet cost and quality goals and achieve universal health insurance coverage in Maine within five years. Dirigo seeks to achieve this though a voluntary system of subsidies targeted to individuals and small businesses combined with efforts to reduce price growth and improve health care quality. Dirigo will provide a full range of benefits to those joining including wellness, quality initiatives and diseases management and will arrange for the provision of health care.

Eligibility

In Phase I of Dirigo (beginning 10/1/04), individuals and families eligible for subsidies include those who are:

- self employed,
- unemployed[3],
- work for a small business (2-50 employees) that does not offer health insurance and
- those with income up to 300% of the FPL not eligible for the state's Medicaid program

are eligible for health insurance subsidies through Dirigo. Workers who dropped coverage or whose employers terminated their health insurance program within the preceding 12 months may be excluded. Individuals with incomes above 300% FPL may also enroll in Dirigo if they are otherwise eligible, but do not receive any state subsidy toward the cost of their insurance. Employees of firms with more than fifty employees may also be eligible for state subsidies even though they are not Dirigo enrollees.

Small employers can also enroll in Dirigo. To enroll, they must employ between two and fifty workers and agree to make payments to Dirigo equivalent to up to 60% of the cost of private insurance for their employed individuals and their families who are to be enrolled in Dirigo.[4] They must also cover at least 75% of their employees that work at least 30 hours per week and do not have other health insurance coverage.

Subsidies will be on a sliding scale. Although the subsidy schedule has yet to be determined, preliminary documents have suggested employee costs ranging from $24 to $96 per month for individuals between 200 and 300% FPL and $64 to $254 for a family plan. Medicaid eligibility is extended to the full income level permitted under the Maine 1115 waiver (see above) and non-Medicaid eligible enrollees with income below 200% FPL would pay no or nominal premiums (It is important to emphasize that these are

[3] Unemployed is defined as not working more than 20 hours per week for a single employer (and not self-employed)

[4] The Dirigo board has the authority to increase the size of eligible firms after the initial year of operation

preliminary planning estimates only and the actual premium scale could differ significantly).[5]

Although individuals can enroll without their employer, the state subsidy will not fully replace employer contributions. Subsidies for individuals who enroll without an employer may be limited to 40% of premium and cannot exceed what is available to employees whose employer is participating. If there were no difference in what employees received regardless of their employer's decision to join Dirigo, there would be little incentive for employers to join. This need to provide incentives to employers exposes a tension within the plan between its voluntary nature and the goal of universality. If an employer chooses not to participate, the state subsidy to workers may not be adequate to allow them to afford coverage, but if the worker is held harmless regardless of an employer's choice, there would be less employer participation and higher cost to the state.

Benefits

The Dirigo board, consisting of five members appointed by the governor and three ex-officio state officials with responsibility for health care and finance in the state, will establish a benefit package and will contract with one or more private health insurers to deliver the Dirigo benefit package.[6] If no private insurer bids to offer coverage through Dirigo, the state may, subject to a vote of the legislature, decide to administer the Dirigo benefit package directly or through a new non-profit entity. Dirigo will pay rates comparable to the private sector. In addition to arranging for coverage, Dirigo will provide a range of services to members including but not limited to disease management, health promotion and prevention services.

Role of Public and Private Sector

One of the crucial aspects of Dirigo is that it reasserts a prominent role for the public sector in guiding the health care system after years of leaving most decisions to the market. This public sector role includes not only offering subsidized coverage, but also increased oversight of capital expansion and insurance premium rates and an active public role in quality enhancement. This renewed interest in public sector intervention is largely a response to the factors noted at the outset such as rising prices and growing market concentration within the health care and health insurance sectors. Nonetheless, Dirigo preserves a prominent role for the private sector in the financing, organization and delivery of care. Voluntary employer and employee payments, rather than taxes are the principle source of financing, and care is organized and delivered through one or more private health plans.

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[5] Health Access Small Business Edition, Consumers for Affordable Health Care, Fall 2003, available at www.mainecahc.org/foundation/default.htm, October 17, 2003

[6] There is little specific guidance on the benefit package within the statute but both the statute and public statements and planning documents make reference to a comprehensive benefit package assumed to be similar to a comprehensive private plan. See for example statement of Trish Riley, Director of the Governor's Office of Health Policy and Finance to the Joint Committee on Health Care Reform, May 15, 2003.

Financing

The subsidies and Medicaid expansion are financed through a mix of federal and state funds, along with employer contributions cycled through Dirigo Health. The new state funds come from an assessment on insurers, called "savings offset payments." Insurers, employee benefit excess insurance carriers, and third-party administrators acting for self-insured employers are required to make payments to Dirigo Health beginning July 1, 2005, a year after Dirigo Health begins operations.

The assessment is calculated by the Dirigo Health board, based on the insurer's savings due to two factors: the decline in rate of growth of health spending and savings through declines in charity care and bad debt. The statute calls for the payments to be based on "aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State, as a result of the operation of Dirigo Health and any increased enrollment due to an expansion of MaineCare eligibility." Other cost savings are expected to come from the Certificate of Need moratorium and voluntary cost increase limits.

The maximum allowable assessment is 4% of premiums. In contrast, the Uncompensated Care Pool in Massachusetts assesses insurers and hospitals a combined $315 million, which is about 2.3 % of the total spending by employer-provided health insurance plans in 2002, according to the 2002 LECG report to the Massachusetts legislature.[7]

This model assumes that provider savings due to increased enrollment and declining uncompensated care will be captured by insurers as declining provider payments. The law requires both insurers and providers to demonstrate that their "best efforts" were made in rate negotiations to allow the insurer to recover the provider's savings. This is enabled by a requirement that providers share data on decreased costs with insurers as part of rate negotiations. Insurers are then required to use their best efforts to lower premiums to reflect these savings.

In the original proposal for Dirigo, the insurer assessment was to begin immediately. However, the final bill delayed the assessment until the second year of Dirigo's operation. This shortfall was made up by the use of the state's economic stimulus funds provided through an increase in the Medicaid federal matching percentage as part of the 2003 tax cut bill.

Cost Containment

The Dirigo statute includes a number of ambitious provisions to reduce the rate of growth of health care costs in Maine. The provisions include both mandatory controls on new capital spending and voluntary cost-increase targets based on state health planning.

[7] The Feasibility of Consolidated Health Care Financing and Streamlined Health Care Deliver In Massachusetts, LECG, August 30, 2002.

With the introduction of the bill, the governor imposes a one-year moratorium on new capital spending that requires a Certificate of Need (CON, similar to the Massachusetts Determination of Need process) from the state. During that year, the Governor will develop a State Health Plan that includes a prioritization of the total capital investments to be made in the state's health care infrastructure. After the moratorium expires, all CONs must be issued in conformity with the limits imposed by the State Health Plan. It is also stipulated that CONs must not result in increases in inappropriate care, according to the evidence-based guidelines of the Maine Quality Forum. The plan also includes the development of a Capital Investment Fund, a global capital budget and the extension of CON to certain physician equipment.

The bill also aims to reduce cost increases by facilitating price comparisons. Hospitals and ambulatory surgery centers are required to publicly disclose the average per diem and ancillary charges for the 15 most common inpatient conditions and the 20 most common outpatient surgical and diagnostic procedures. The information will be available to consumers at provider sites as well as online.

The Maine legislature also included a request for voluntary price restraints from providers and insurers. The bill asks all health care practitioners to limit net revenue growth to 3%. Hospitals are asked to restrain cost increases to 3.5% in the coming year, and to limit it operating margin to under 3%. Health plans are asked to limit underwriting gains to 3%.

Insurance Regulation

The Dirigo statute requires insurers in the small group market to get approval if their anticipated loss ratio (the ratio of medical expenses to premium revenue) is under 78%. The Bureau of Insurance is also authorized to direct insurers to refund consumers if actual loss ratios end up below 78% over a 3-year period despite projections that they would exceed that amount.

Quality Provisions

The Dirigo health legislation includes several components aimed to improve the quality and cost-effectiveness of health care. The Maine Quality Forum will develop measures to compare healthcare quality and produce reports on an annual basis. The Forum's public education mission includes both dissemination of information on best medical practices to providers and direct consumer education on health and health care. The Quality Forum also makes recommendations with respect to new technologies for the purposes of capital planning. The Forum will work in collaboration with the Maine Health Data Organization. Dirigo expands the role of MHDO in collecting and disseminating data on the quality (as well as price) of services.

Issues Challenges and Lessons for Massachusetts

What can Massachusetts learn from the Maine experience so far? To what extent is the Maine experience transferable and to what extent is it a product of the unique circumstances in Maine? One factor, perhaps particular to Maine, was the way the crisis in health insurance costs for small business affected the debate. In an environment with heavily concentrated insurance and provider sectors and weak managed care, there was less business opposition to expanding the role of government in health care than might have otherwise been the case.

The chief political lesson seems to be that a chief executive committed to reform who also has a collaborative relationship with the legislature is essential to success. This does not describe the current Massachusetts political landscape. Less obvious, but equally important, certain provision contained in Dirigo, both in its original design and as it was amended during the legislative debate, may have been necessary to secure its passage but ultimately may increase the difficulty of successful implementation.

The fact that the plan relies on the voluntary participation of employers makes it difficult to project its actual impact on the rate of uninsured. During the legislative process the Baldacci administration made several key compromises to secure passage of Dirigo, for example, delaying the collection of savings offset payments and making those collections contingent on demonstrated savings.

The projected differences in employee premium share illustrate just how important employer participation is to the success of the plan. At 200% FPL, early projections suggest that an individual with an employer contribution would pay about $24 per month if their employer enrolls in Dirigo, but $204 per month with no employer contribution.[8]

Therefore, the willingness of employers who do not offer insurance today to voluntarily contribute to the cost of their employees' health care is critical to the success of the program both in terms of expanding coverage and financial stability, since much of financing comes from the savings offset payments. These savings will not fully materialize if enrollment of the uninsured lags. Furthermore, the fact that savings offset payments are contingent on demonstrated savings adds to the uncertainty of the financing and could increase the administrative burden of implementation.

Questions for Massachusetts

What does this mean for Massachusetts? Can we follow suit in expanding federal matching funds? Maine has several advantages in this regard. The Maine expansion—parents to 200% FPL, non-parents to 125%-- generally exceeds current income thresholds in Massachusetts. Maine also benefits from a higher federal matching rate than Massachusetts. Also could Massachusetts modify its existing premium assistance

[8] Health Access Small Business Edition, Consumers for Affordable Health Care, Fall 2003, available at www.mainecahc.org/foundation/default.htm, October 17, 2003

program within the structure of its existing waiver, or would additional waiver authority be necessary?

Beyond the innovative approach to drawing down federal matching funds, what else in Dirigo might make sense for Massachusetts? Does Dirigo represent an effective approach to universal coverage? Will the voluntary system succeed in attracting large number of employers who do not now offer insurance? Will people who do not gain employer sponsored care be able to afford insurance? What about the increased role of government in capital planning for the health care system? Is there a need for this type of intervention here? Will the Maine Quality Forum and the Maine Health Data Organization have a significant impact on medical practice?

Given all the uncertainties that surround the plan at this initial stage, it is difficult to assess what influence Dirigo will have on Massachusetts or other states. Perhaps Maine is a harbinger of a return to more activist government in health policy. Perhaps beyond any specific transfer of policy ideas, the most significant immediate contribution of Dirigo to the health care debate in Massachusetts and elsewhere is that Maine is moving forward at a time when Massachusetts and so many other states are having difficulty maintaining benefit and eligibility levels.