

# Issue Brief

## Dirigo Health Reform - An Overview and Progress Report

“It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments ....”

- Justice Louis Brandeis

### I. What is Dirigo Health Reform?

In 2003, Federal health care reform was well settled in a stalemate of inaction. Meanwhile, costs were spiraling out of control. Working people were losing their insurance. Businesses found themselves burdened in international competition.

Maine had a choice: either to sit still and wait for national reform, meanwhile allowing more of its citizens to suffer from high costs and lost health care, or to build on work already underway here, and take the next big step to achieve affordable, quality health care for all. Maine’s action could never be a full substitute - national health care reform, needed then, is still needed now. No one state can solve this problem alone. But Maine could help its citizens out, and serve as a “laboratory of democracy.”

Thanks to a bold Governor and Legislature, Maine’s health care reform became law in September 2003. Named “Dirigo,” after the state motto meaning “I Lead,” the program was a first-of-a-kind effort in the nation. The country took notice. The New York Times editorialized, “it is encouraging that Maine, which led most states in efforts to control prescription drug costs, has

now taken a new tack toward solving the nation’s health care problems.”

The reform proposed a comprehensive set of actions to: (1) reduce health care costs; (2) expand health insurance coverage; (3) improve public health; and (4) improve the delivery and quality of services.

Overall, Dirigo has three strategies to assure all Mainers have access to affordable, quality health care.

- Address health care system costs and quality reforms to assure those who now have private coverage can continue to afford it.
- Use MaineCare – the state’s Medicaid program – to provide coverage to the lowest income Mainers by capturing just under \$1.81 in federal funds for every \$1 the state provides.
- Create DirigoChoice, an insurance program for small businesses, the self-employed and individuals who are not eligible for MaineCare. Sliding scaled subsidies are available to individuals and families with household incomes up to 300% of the federal poverty level (\$61,950 for a family of four and \$30,630 for a single adult).

### II. What Problems is Dirigo Designed to Address?

The US spends about twice as much per capita as other developed nations (see chart next page).<sup>1</sup>

#### Fast Facts

- The U.S. spends twice what other developed nations spend - and Maine spends more per capita than the U.S. - but we don’t cover everyone and don’t get better quality or health.
- Health care spending in Maine -- \$8.3 M (2005) is about 18% of our economy.
- Dirigo Health Reform is comprehensive health reform – assuring costs are controlled; making Maine a healthier state; improving the efficiency and effectiveness of health care and offering subsidized insurance coverage for those least able to afford it.
- Dirigo Health Reform has, to date, covered over 29,000 Mainers statewide, most with incomes below 200% Federal Poverty Level (about \$21,000) through DirigoChoice and MaineCare parent expansion including over 700 small businesses; and saved over \$150 M in health care spending.

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Those nations spend less but get more. They cover all their citizens and have better health outcomes. Health insurance premiums across the US and in Maine increase about 2-3 times faster than inflation, making insurance increasingly unaffordable for businesses and families, increasing the ranks of the uninsured and underinsured, and creating a drag on the economy. Health care spending in Maine was estimated at \$8.3 billion in 2005, about 18-19% of the economy.

Much of our spending on health care is driven by our health and can thus be lowered by becoming healthier. Almost 40% of healthcare spending increases is caused by five largely preventable diseases: heart disease, cancer, lung disease, diabetes, and mental health issues.<sup>2</sup>

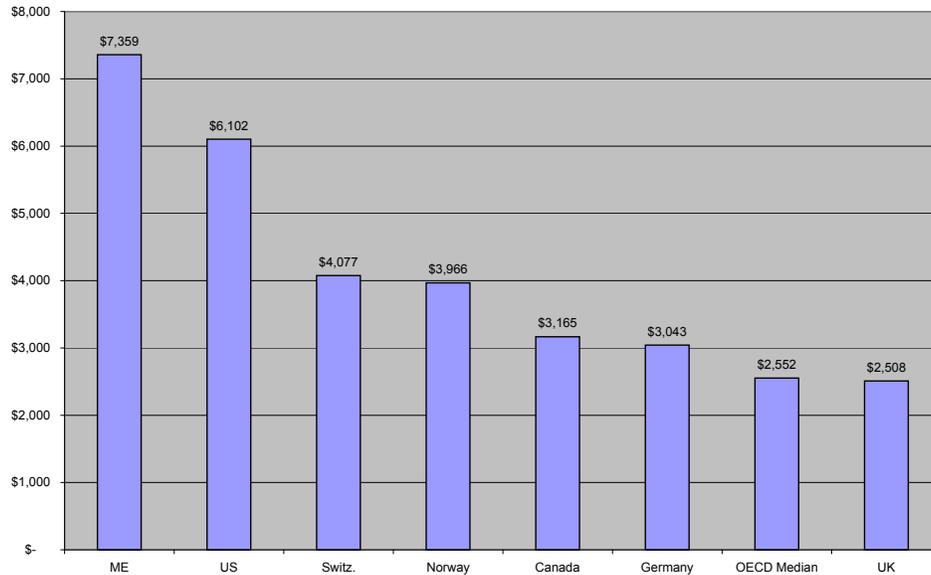
But a significant portion of our spending is driven simply by variation in how care is delivered across the state and lack of good public information to help patients understand their conditions and treatment options. In fact, one national study found that up to one third of Medicare spending goes to services that do not help people improve their health,<sup>3</sup> while another study found that only about half of the care we receive is care we should receive based on accepted best practices,<sup>4</sup> and that the system tends to over-use costly acute care and under-use inexpensive, preventative care that can improve health and save costs down the road.

Dirigo Health Reform's goal is to lower the growth in health care spending through strategies that address the health system's multiple cost drivers and inefficiencies, including reducing the cost shift to private payers from the uncompensated care costs of those without adequate health coverage. The focus of the Reform is improving cost, quality, and access simultaneously, because health reform is not sustainable unless we affect all three. Dirigo Health Reform also asks all the players in the health care system – hospitals, doctors, insurance companies, employers, state government, and consumers – to play a role in health reform.

The original proposal, which was rejected, was to finance Dirigo Health by a fee on insurers and third party administrators<sup>5</sup>

that could not be passed on to consumers, and to give those payers tools, like global budgets to make hospital expenditures more predictable and contained, and to provide coverage for the un- and under-insured to reduce uncompensated care, with payers using those savings to pay for the cost of the assessment.

Per Capita Total Health Care Spending 2004



The Dirigo program was originally designed, then, to be self-sustaining – that is, access expansions and the Maine Quality Forum would be financed and cost no more than payers would otherwise have paid in the absence of these reforms.

In enacting the bill, some of the

original cost containment provisions were rejected and replaced by voluntary measures. The final Dirigo Health Reform Act included, as a compromise, the Savings Offset Payment (SOP), an assessment on paid claims which can only be assessed if there are measurable cost savings in the system that are validated by an independent review by the Superintendent of Insurance. The amount of the assessment cannot exceed those measurable savings or 4% of all health care paid claims, whichever is less. The compromise secured strong bipartisan support for the program but, coupled with other implementation compromises, resulted in lower revenues than originally projected and, therefore, are slowing enrollment to comply with the lower budget.

### III. Strategies to Address Health Care Costs

#### *Making Maine the Healthiest State, with an Efficient and Effective, High-Performing Health System: The State Health Plan*

How we use health services and how healthy we are affects premiums. Becoming healthier and addressing the chronic illnesses that drive costs will lower the growth in our health care costs.

To improve our health and make Maine the healthiest state, the Dirigo Health Reform Act requires the Governor – advised by a

citizen and stakeholder council known as the Advisory Council on Health System Development (ACHSD) – to issue the State Health Plan every two years.

The first biennial Plan was released in April 2006 after extensive public input from hundreds of citizens at “Tough Choices in Health Care” in spring 2005; focus groups in summer 2005; meetings with multiple stakeholder groups in summer/fall 2005; a statewide “Listening Tour” in fall 2005; and public hearing and legislative review of a draft State Health Plan. Development of the plan was funded in part by the Maine Health Access Foundation (MeHAF) and others.

The goal of the State Health Plan is to make Maine the healthiest state and bring down growth in health care costs in large part by addressing chronic disease and other health conditions, and to create a better health system by: preventing illness, disability and improving health; helping people with chronic illness improve the care they get; strengthening the rural health system; expanding the use of telemedicine to ensure that all citizens in Maine have access to needed diagnostic and treatment options; and providing guidance for the state’s Certificate of Need program (discussed later).

The State Health Plan is an action plan that sets specific goals for specific issues and brings the stakeholders together to work on each issue. For instance, working with employers to encourage them to offer wellness programs to improve their employees’ health which will reduce the growth in their premiums; promoting transparency with provider data to raise awareness specific to variation and improve quality with use of “evidence-based” care; helping public and private payors to support best practices in their reimbursement models and prevention in their benefit designs; and creating ways to encourage individuals to practice good health.

A Public Health Work Group, created by the State Health Plan, has achieved a long sought after goal in Maine: building a public health system for the state. It has been done within existing resources. Eight public health districts now exist, served by Maine CDC staff out-stationed to the districts from the central office; Regional Coordinating Councils are developing measurable regional health improvement plans; Healthy Maine Partnerships have been strengthened and over 500 different grants have been streamlined to 125 grants to the new infrastructure; and, working with the Maine Municipal Association, local health officers roles will be clarified and better integrated with and supported by CDC. As envisioned, the system will coordinate with existing emergency management and bioterrorism efforts and build on the strengths of Maine’s two city health departments. A statewide coordinating council will ad-

vice Maine CDC to assure a seamless local, district state public health system that assures the essential public health services are available statewide.

In 2007, the Legislature updated the ACHSD’s responsibilities to include reporting to the Legislature on health care cost drivers, along with recommendations to slow the rate of growth of health care spending in Maine. The second biennial Plan was released in April 2008. Among other things, it laid out a plan for the cost driver report. The first cost driver report was included in the State Health Plan and Data Book.<sup>6</sup> Under the direction of the Dirigo Health Agency’s Maine Quality Forum (see discussion of MQF later in this report), a more focused study on costs will be presented to the ACHSD. The Council will then issue a final report to the Legislature’s Health and Human Services and Insurance and Financial Services Committees in the spring of 2009. It also created a stakeholder group that is looking at the causes of and solutions to Maine’s emergency department use third highest in the nation, behind only Alaska and West Virginia.<sup>7</sup> The stakeholder group’s report and recommendations are expected in spring 2009.

The ACHSD oversees implementation of the State Health Plan to ensure that the Plan’s goals, tasks, and benchmarks are met, including reporting to the Legislature’s Health and Human Services Committee.

### *Strengthening the Certificate of Need Program*

The purpose of the state’s Certificate of Need (CON) program is to ensure that the health care infrastructure meets the needs of the population. Numerous studies have shown that, unlike in traditional economics where demand drives supply, the opposite has been shown to be true in health care. That is, if a service is there, people will use it and pay for it whether they really need it or not,<sup>8</sup> driving costs -- and ultimately premiums -- up. By making sure that investments only occur when there is a demonstrated need for a service, CON programs can help prevent unnecessary increases in health care spending.

The Dirigo Health Reform Act strengthened the CON program, which requires certain hospital and other capital investment projects to get state approval before investment can occur (for instance, before a hospital buys an MRI or a builds new wing). Maine is one of 36 states with a CON program. Roughly one-third of hospital capital expenditures in Maine are subject to CON review.

Dirigo made three important changes to CON:

- **Established limits on how much investment Maine can afford.** The Capital Investment Fund (CIF) is one of the

only cost containment tools available in state law. The CIF is one of the only cost containment tools available in state law. It places a cost limit on how much may be added to the health care system each year by capital investments approved under the CON program. The CIF establishes a measure of affordability against which CON decisions about need can be made. It balances need and affordability, recognizing that supply of health care services increases utilization and that increased utilization does not necessarily improve health outcomes.

- **Guided CON decisions through a State Health Plan.** To ensure that capital investments are made efficiently and effectively to meet Mainers' health needs.
- **Leveled the playing field: any major health investment – no matter who makes it – must meet the plan's goals.** CON now covers large capital expenditures made by providers other than hospitals (for instance, building a new ambulatory surgical center or a doctor's office acquiring a costly new technology).

In 2008, GOHPF and the ACHSD worked closely with stakeholders – hospitals, consumers, employers, insurers, and others – to revise the CIF rule to make it a more effective cost containment and health system planning tool than it was in its first several years. The Legislature will review this rule during the 2009 legislative session.

#### *Facilitating Collaboration Between Providers*

The Legislature followed the recommendation of the Hospital Study Commission that was created by the Dirigo Health Reform Act by amending the Hospital Cooperation Act to make it easier for hospitals and other providers to voluntarily collaborate and to share services to achieve cost saving efficiencies and/or quality improvements, without violating anti-trust laws. The Act is currently being used for the first time by MaineHealth and the Southern Maine Medical Center. The process includes the active involvement of DHHS, the Attorney General's office, and GOHPF.

#### *Reducing Cost Shifting from the Uninsured and Underinsured*

The debt that hospitals accumulate when the uninsured and underinsured are unable to pay for services received, is shifted to the privately insured through increases in the cost of services, that ultimately results in increased premiums. In 2006, hospitals provided \$87 million in free care and incurred approximately \$125 million in bad debt for a total of \$212 million. These costs are shifted to the privately insured as bad debt and charity care expenses.

Bad debt and charity care (BDCC) is driven primarily by two things:

- The number of people who are uninsured and underinsured (a 2004 survey conducted jointly by GOHPF and the Maine Hospital Association found that approximately 30% of hospital bad debt is from insured people, likely those with high deductible policies), and
- Hospitals' charity care policies. State law requires hospitals to provide free care to people up to 100% of the federal poverty level. MaineCare provides coverage to this level. All but two hospitals have voluntarily extended their policies to more people, with 28 hospitals increasing their charity care eligibility policies between September 2003 and November 2005. As of September 2007, 24 hospitals provided free care up to 200% FPL and one up to 250%.

By bringing down growth in the number of uninsured and underinsured, Dirigo Health Reform reduces cost-shifting.

#### *Reducing Paperwork for Providers and Insurers*

Medical claims have historically been submitted on paper, creating an administrative burden for both insurers and providers. The Dirigo Health Reform Act requires providers to submit their claims to insurers in a standardized electronic format to lower administrative costs throughout the system. The Superintendent of Insurance may grant an exemption for providers with 10 or fewer full-time-equivalent health care practitioners and other employees based upon hardship.

#### *Regulating Premium Increases in the Small Group Market*

For the first time, Dirigo Health reform regulates premiums in the small group market (where employers with up to 50 employees get insurance, covering almost 115,000 people in 2005), requiring that insurers operating in the state spend at least 78 cents of every dollar of premiums over any given three-year period on medical expenses, limiting administration, marketing, tax payments, and profit to 22 cents of each premium dollar. As a result of this provision, in 2008 Aetna refunded \$6.6 million to small employers for premiums paid from July 2004 through June 2007.

#### *Increasing Transparency of Cost and Financial Data*

Dirigo made several changes to how providers and insurance companies report their cost and financial data to make it easier for the public to understand how premium dollars are spent.

- **Price posting.** To assist consumers in making apples-to-apples comparisons of what different providers charge

for services, Dirigo Health Reform required hospitals and doctors offices to maintain and make readily available to the public a list of what they charge for a standardized list of the most common procedures performed across the state. This will be improved in 2009 by a web-site where consumers can look up price estimates for specific services at hospitals and doctors offices across the state.

- **Standardized reporting for insurance companies.** To solve the problem of insurance companies reporting data in different ways – which made it difficult for the public to understand insurance company information, such as how premiums are set and how much insurance companies profit from different lines of business – Dirigo Health Reform requires insurance companies to file annual reports on a standardized template with the Bureau of Insurance (BOI), which then summarizes this information for the public at the BOI web-site.<sup>9</sup> The reports include information on how much insurance companies collect in premiums, pay in claims, spend on administration, and keep as profit for each of their lines of business.
- **Standardized reporting for hospitals.** To solve the problem of hospitals reporting financial data in different ways – which made it difficult for the public to understand hospital financial health and operations – the Legislature acted on a recommendation of Dirigo’s Hospital Study Commission by requiring hospitals to give the Maine Health Data Organization (MHDO, an independent state agency) their financial information on a standardized template. The MHDO summarizes this information in a report posted at its website to help the public better understand the financial situation of Maine’s 39 non-profit hospitals. The first posting – 2005 and 2006 data – was posted in 2008,<sup>10</sup> and 2007 data will be posted in early 2009.

#### *Voluntary Targets for Hospitals and Insurance Companies*

- **Hospitals.** Dirigo asked hospitals to voluntarily limit their profits to 3% and their growth in spending per patient to 3.5%. The voluntary limits were later renewed for another three years by the Legislature at the recommendation of a Dirigo’s Hospital Study Commission.<sup>11</sup>
- **Insurance Companies.** Dirigo asked insurance companies to voluntarily limit their profits to 3% for the first year after Dirigo was passed. Anthem (including MainePartners), Mega Life and Health, and United Healthcare abided by the limit. The targets were not renewed.

#### *Reviewing Medical Malpractice in Maine*

Medical malpractice is frequently brought up when discussing health care costs, so the Dirigo Health Reform Act asked the Bureau of Insurance to review medical malpractice lawsuits and insurance rates in Maine. BOI found that medical malpractice rates in Maine have not been experiencing the kind of inflation seen in other states. In 2005, malpractice coverage in Maine was less than half the cost seen nationally and among the lowest in the country.

#### *Enhanced Public Purchasing*

The Dirigo Health Reform Act also created the Public Purchasing Group, a group representing public purchasers, including state employees, the University system, Maine Education Association, Maine Municipal Association, Maine School Management Program, some large municipalities, MaineCare, and Dirigo Choice. The group’s charge is to coordinate and collaborate where feasible in the purchase of cost effective, quality health care services. The group has issued three reports which detail the purchasing power of public entities, including a finding that public entities spent \$2.8 billion in health care expenditures in 2005, a significant portion of total health care spending in the state.

## **IV. Strategies to Address Health Care Quality**

#### *Getting the Right Care at the Right Time: Reducing Variation & Increasing Use of Best-Practices*

Patients in certain Maine communities are up to three times more likely to get some expensive procedures than an identical patient in another community, even when there is no evidence that the procedure is what’s known as a “best practice” for a given medical condition.<sup>12</sup> This variation – which can be high or low – is unrelated to underlying differences in the population (such as differences in age, for example, or the prevalence of disease), but instead are driven by the capacity of health resources in an area (or lack thereof) and the preferences and training of the medical personnel serving the population. This variation can result in both wasted spending and in decreased quality and patient safety. To help raise awareness and reduce this variation to ensure we get the right care, the right way, at the right time, Dirigo Health Reform created the Dirigo Health Agency’s Maine Quality Forum (MQF). MQF collects and analyzes data on medical practice around the state and serves as a clearinghouse of the latest information on best, and evidence-based practice, all of which helps providers improve their performance, reducing costs and improving quality.

#### *Establishing the Maine Quality Forum*

The Maine Quality Forum (MQF) was created within the Dirigo Health Agency to be a forum where providers, employers,

consumers, and insurers can work together to produce information to improve health care quality. The duties of the Maine Quality Forum are:

- Research Dissemination
- Quality and Performance Measures
- Data Coordination
- Public Reporting
- Consumer Education
- Technology Assessment
- Health Information Technology
- State Health Plan
- Health Care Associated Infection Surveillance and Prevention

As discussed above, MQF's work will help to reduce unnecessary medical spending by reducing variation in medical service use and increasing use of best practices.

MQF's accomplishments include:

- Completed analysis and website posting of hospital quality metrics (Chapter 270 data)
- Began cost driver study based on paid claims database
- Received expanded grant under Robert Wood Johnson Foundation Aligning Forces for Quality Initiative, now \$1.5 million over 3 years for extension of AF4Q activities into hospital quality improvement (with emphasis on disparities in care and consumer engagement)
- Selected as a demonstration site for CMS electronic health record initiative which has the potential to bring to the state up to \$29 million in reimbursement for providers selected for the project
- Increased number of primary care practices and physicians assessed in the Voluntary Practice Assessment Initiative (109 of desired 150 physicians)
- Developed comprehensive statewide primary care provider database
- Facilitated development of the Maine Critical Access Hospital Safety Collaborative
- Facilitated the development of the Maine Patient-Centered Medical Home Pilot, including exploration of reimbursement models, practice selection, and evaluation components

- Continued to support In a Heartbeat activities including community awareness, development of Emergency Medical System (EMS) capabilities, and hospital performance analysis
- Supplied quality analysis of five CON project applications for CON Unit of DHHS
- Developed collaborative partnership (with Quality Counts, Maine Health Management Coalition, and HealthInfoNet) to apply for Chartered Value Exchange status from U.S. Department of Health and Human Services, awarded February 2008
- Recommended that 2008-2010 State Health Plan emphasize healthcare-associated infection, health information technology, patient-centered medical home, and health care services variation analysis
- Led formation of the Maine Infection Control Consortium
- Led multi-organization reassessment of performance of the Northeast Healthcare Quality Foundation as Medicare Quality Improvement Organization for Maine (and as a result supported NEHQF proposal to accomplish Medicare QIO 9th Scope of Work)
- Supported and helped organize:
  - MMA/MHA joint quality conference on subject of unwarranted variation
  - Quality Counts 2008 annual conference on population-based care management
  - 2008 Governor's Summit of the Maine Cardiovascular Health Council on patient-centered medical home
  - 2008 Hanley Forum on patient-centered medical home and public policy
  - Team STEPPS conference on patient safety (with Maine DHHS and Maine Medical Center)
  - 2008 Maine Center for Public Health Focus conference on patient-centered medical home

### *Building a Statewide, Interconnected Electronic Medical Record System*

The majority of medical records in the US are kept in paper files, making it difficult for doctors and hospitals to share records to guarantee the best patient care. If you are in a car accident and taken unconscious to an emergency room at a hospital far from home, the doctor won't know important information about you, such as what medications you are on, what medical conditions you may have, and so on, putting you at risk and

subjecting you to duplicative, time consuming, costly tests and procedures.

There is an emerging consensus around the US that an interconnected electronic medical record (EMR) system will improve patient safety and quality of care, as well as saving millions of dollars each year.

With the help of the Maine Quality Forum, Maine is leading the way among the states in developing a statewide interconnected health information system. In early 2006, following a year of feasibility studies and organizational development, HealthInfoNet (HIN) – an independent not-for-profit organization governed by a board of directors comprised of 19 representatives from the medical community, private business, state government, and related advocacy organizations – was created to build an electronic health care superhighway for sharing patient information, with care to assure confidentiality.<sup>13</sup> HIN has received backing from philanthropic and private business organizations (e.g. the Maine Health Access Foundation and KeyBank). HIN’s 24-month pilot will go live later this year. It includes participation by Maine’s four largest health care delivery systems (MaineHealth, MaineGeneral, Eastern Maine Healthcare Systems, and Central Maine Medical Family), Franklin Memorial Hospital, Martin’s Point Healthcare and the Maine Center for Disease Control and Prevention. These organizations account for 52% of annual inpatient discharges and more than 40% of annual outpatient visits across Maine.

**Creating Incentives to Use Higher Quality Providers**

The Dirigo Act amended Maine law to allow insurers to offer financial incentives to encourage patients to use providers that have been identified as providing higher quality.

**V. Strategies to Increase Health Care Access**

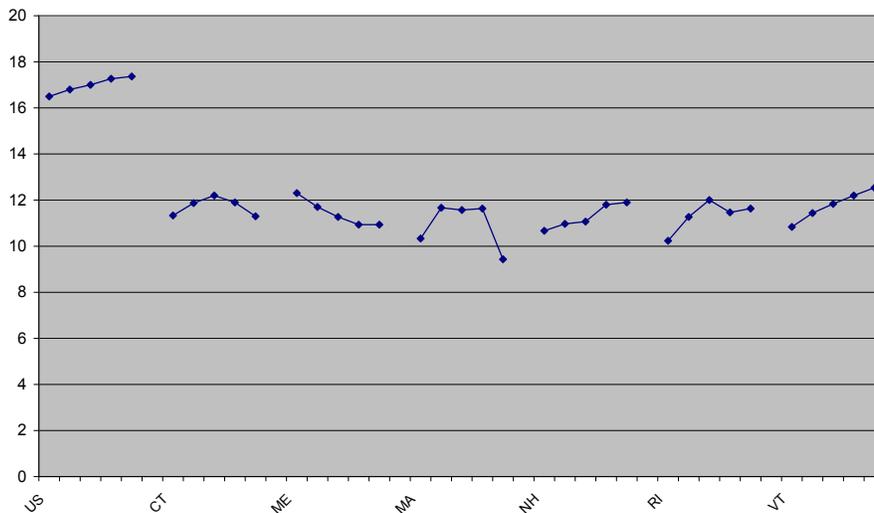
**MaineCare – Maine’s Medicaid Program**

Medicaid is a state-federal partnership for low income individuals through which states get roughly \$1.72 for every \$1 the state spends. States participating in the program – all 50 states do – have to meet certain federal standards defining who to cover and what benefits to offer, but states then can implement optional expansions.

The Dirigo Health Reform Act included two modest MaineCare expansions. It expanded coverage of parents of MaineCare eligible children from 150% to 200% of the federal poverty level (FPL) (from \$25,755 to \$34,340 for a family of three in 2006). Enrollment began in May 2005 and as of November 2008 covered 5,526 parents. The Dirigo Health Reform Act also authorized expanded MaineCare coverage for childless adults from 100% to 125% FPL (from \$10,210 to \$12,763 for an individual); however, this expansion was never implemented due to a federal cap on funding and was eliminated by the legislature.

As seen below,<sup>14</sup> before Dirigo Reforms, Maine had the highest rate of uninsurance in New England, but from then on Maine consistently bucked national trends. Due in large part to MaineCare, Maine’s uninsured has fallen while the nation’s has risen, and as a result, by 2006 Maine had the lowest rate in New England. Maine was replaced by Massachusetts in 2007 as a result of that state’s reforms that included mandates for individuals to buy coverage; for employers to participate in coverage costs; and for the state to finance through a unique Federal waiver that allowed them to use about \$400M of existing federal funds other states do not receive to pay for the expansions.

**Percent Uninsured (under age 65)**  
Three Year Averages 2001-02-03 through 2005-06-07



The table below compares how Mainers and Americans age 0-64 got coverage in 2007 (the most recent years for which data are available).<sup>15</sup>

	US	ME
<b>Employer</b>	60.9%	61.5%
<b>Individual</b>	5.5%	5.6%
<b>Medicaid</b>	13.9%	19.6%
<b>Other Public</b>	2.5%	2.7%
<b>Uninsured</b>	17.2%	10.6%

### DirigoChoice

Most of Maine’s uninsured and underinsured work in small businesses or are self-employed. DirigoChoice is an insurance program for small businesses, the self-employed, and individuals. DirigoChoice was designed as a public/private partnership administered through the Dirigo Health Agency and, originally, through Anthem Blue Cross and Blue Shield of Maine. In 2007, when the renewal bid from Anthem proved unaffordable, the Dirigo Health Agency contracted with the non-profit Harvard Pilgrim Health Care (HPHC) effective January 1, 2008. HPHC has been consistently ranked the number one health plan by US News and World report and the National Committee on Quality Assurance. DirigoChoice offers comprehensive coverage, with a strong preventive focus, and a subsidy program that reduces premiums and deductibles. Sliding scale subsidies are available to individuals and families with household incomes up to 300% of the federal poverty level (\$61,950 for a family of four and \$30,630 for a single adult). DirigoChoice pays providers commercial reimbursement – not Medicaid reimbursement – rates.

The connection between MaineCare and DirigoChoice is important. Currently, if you are on MaineCare and are given a raise, or you work more hours; that additional income could disqualify you from the MaineCare program. You fall off the cliff of eligibility, unable to afford private health insurance, but earning too much to qualify for MaineCare. DirigoChoice discounts are based on a sliding scale to eliminate that cliff.

DirigoChoice enrollment began January 1, 2005. By November 2008, over 29,000 people had been covered by DirigoChoice and Dirigo financed MaineCare expansions. However, on-going challenges to the funding of the program reduced revenues and required the program to close to new DirigoChoice enrollment over a year ago. As of November 2008, 10,663 DirigoChoice members and over 600 small businesses were enrolled and nearly 2,000 people are on a waiting list, should funding be available again. Twenty-six percent of DirigoChoice enrollees came in through small business, 29% were sole proprietors, and 45% were individuals. The map in the appendix shows that Dirigo enrollment is statewide and has been since its inception.

A more complete discussion of DirigoChoice, including definitions of the discount groups, costs for each discount group, how enrollment breaks out by income level, and more, is available at the Dirigo Health web-site.<sup>16</sup>

## VI. Financing Dirigo Health Reform- The Savings Offset Payment (SOP) & Beyond

Dirigo Health reform was designed as a comprehensive solution to Maine’s growing health care crisis. It set forth a number of strategies to reduce the rapid growth of health care costs and stated that savings should offset the cost of any coverage expansions. In a compromise that helped win unanimous bipartisan Committee support and a 2/3 majority vote in each chamber of the Legislature, a savings offset payment (SOP) was created. The SOP can be assessed only if there are measurable savings in the system, as validated by an independent review by the Superintendent of Insurance. The amount of the assessment cannot exceed the measurable savings or 4% of all claims, whichever is less. An initial state appropriation of \$53 million started the program and was used to support in the first three years.

Controversy has followed the financing of the program. The state argues that SOP includes savings from the full range of Dirigo’s reforms, including bad debt and charity care (BDCC) reductions from covering the uninsured and under-insured, the voluntary hospital targets, Certificate of Need changes, increases in MaineCare payment to reduce MaineCare cost shifting, and other Dirigo reform strategies.

For the most part, insurance companies and employers argue that savings should be limited to bad debt and charity care reductions from covering the uninsured and that other savings were not tangible, so they would have to raise premiums to pay for the SOP. The intent of Dirigo was to create adequate reductions in the growth of health care costs to assure that the program would be self supporting – would cost no more than would otherwise have been spent.

Modifications made to the SOP in PL 2005, Ch 400, Part A effectively allowed those who paid the SOP 27 months to pay an annual assessment. The Dirigo Health Agency recognized that this amendment would create cash flow problems for the program and sought revisions to the financing structure over the years.

In July 2006, Governor Baldacci appointed a Blue Ribbon Commission to develop alternatives to the SOP. The Commission’s final report was presented to the Governor in January 2007. That year the Governor presented a bill to the Legislature with an alternative financing strategy that was rejected. Efforts continued with Legislative leadership, the Governor’s office

and stakeholders, and in 2008 the Legislature enacted a bill that (1) addressed high costs in the individual market, and (2) enacted recommendations of the Blue Ribbon Commission to stabilize program funding and eliminate the cash flow problem caused by delayed SOP payments. Specifically, the bill: reformed the individual market to significantly reduce premium growth for many and hold premiums steady for the older and sicker; developed pilot programs to test lower cost products for younger people; reduced the SOP from 4% of claims allowed in law to a fixed 1.8%; and added Commission-supported taxes on soda, beer, and wine. The bill was enacted, achieving important reforms in the individual market for those who must buy coverage on their own without an employer contributing to the costs, and ending the contentious SOP, replacing it with new funding, recommended by the Blue Ribbon Commission. Importantly, these reforms solved the cash flow problems with the current SOP.

A People's Veto, largely financed by the beverage industry, secured enough signatures to put the new law before the voters in November 2008. A well financed campaign, "Fed Up With Taxes", succeeded in repealing the new law and financing.

As a result the Dirigo Health Agency will continue to rely on the SOP and if necessary defend itself in court against challenges to the SOP. Legislative action will again be required to assure the Agency receives annual funding over a one-year period, not the current 27-month payment cycle now required by law.

Adjudicatory hearings were held by the Superintendent of Insurance in 2005, 2006, 2007 and 2008 to determine the amount of savings. Three different superintendents have concluded that the savings from Dirigo's first four years totaled over \$150 million.

Insurers and several employer groups filed suit against the state over the SOP. The Superior Court ruled that the SOP was constitutional and reasonable and was not a tax. The case was appealed to the Law Court which upheld the decision of the Superior Court. However, the most recent year's savings determination is again being appealed in the courts.

## VII. Conclusion

When enacted in 2003, Governor Baldacci's Dirigo Health Reform Initiative was widely heralded as the first to seek universal coverage. It was the first major health reform to be enacted in any state in over a decade. Dirigo Health Reform was named a top government innovation for 2006 by Harvard University's Ash Institute and the Council for Excellence in Governance.

In the years since passage of Dirigo Health Reform, other states have followed suit. Many include provisions of Dirigo, and, while none initially took on the comprehensive approach of Dirigo to address cost, quality, and access, Massachusetts and Vermont have revitalized strategies enacted in the 1980's – though ultimately repealed – to require employers to offer coverage or pay a fee, and Massachusetts has mandated individual coverage.

States remain the laboratories of democracy, testing new ideas to solve problems like health care. Dirigo Health Reform is a work in progress requiring providers, business, insurers, labor, consumers and government to work together. With legislative direction and support, and the collaboration of stakeholders, Dirigo Health Reform will continue to evolve to better meet its goals of assuring all Maine citizens have access to affordable, quality health care and is a platform ready to launch reforms that may be enacted at the national level, as promised by President Obama.

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13. For more information see [www.hinfont.org](http://www.hinfont.org).
14. US Census Dept. Census instructs (page 21 of document at [www.census.gov/hhes/www/p60\\_235sa.pdf](http://www.census.gov/hhes/www/p60_235sa.pdf)) that to compare states to each other three-year averages should be used. The three-year averages computed in these charts are calculated using data from table HIA-6 Health Insurance Coverage Status and Type of Coverage by State-- Persons Under 65: 1999 to 2007 at [www.census.gov/hhes/www/hlthins/historic/index.html](http://www.census.gov/hhes/www/hlthins/historic/index.html).
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## Appendix 1 DirigoChoice Enrollees

