Issue Brief

Dirigo Health Reform – An Overview and Progress Report

I. What is Dirigo Health Reform?

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 about $1.72 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 ($58,050 for a family of four and $28,710 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, but we get less for our spending (appendix 1). 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 forty percent (40%) of health-care spending increases is caused by five largely preventable diseases - heart disease; cancer; lung disease; diabetes; and mental health issues.[1]

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 1/3 of Medicare spending goes to services that do not help people improve their health,[2] while another study found that only about 1/2 the care we receive is care we should receive based on accepted best practices,[3] and that the system tends to over-use costly acute care and under-use inexpensive, preventive 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 by addressing the health system's multiple cost drivers and inefficiencies and linking the reductions in growth (savings) to reinvestment in access. The original proposal, which was rejected, was to finance Dirigo Health by a fee on insurers and third party administrators[4] that could not be passed on to consumers. That original bill included tools to restrain cost

Fast Facts

- Health care spending in Maine was estimated at $8.3 billion in 2005, about 18-19% of the economy.
- In 2005, hospitals provided $77 million in free care and incurred approximately $126 million in bad debt for a total of $204 million. These costs are shifted to the privately insured as bad debt and charity care expenses.
- In 2005, malpractice coverage in Maine was less than half the cost seen nationally and among the lowest in the country.
- DirigoChoice enrollment began January 1, 2005. As of December 1, 2006, 13,290 people and over 700 small businesses were enrolled.

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growth to assure savings that would make the Dirigo program 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. 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 demonstrated savings in the system. The amount of the assessment cannot exceed demonstrated savings or 4% of all claims, whichever is less.

Dirigo Health Reform focuses on 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.

III. Strategies to Address Health Care Costs

Making Maine the Healthiest State: 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 cost 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, expand 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).

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.

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. Eight public health regions will be served by regional offices of the Maine CDC; Regional Coordinating Councils will develop measurable regional health improvement plans; comprehensive community health coalitions will be strengthened; 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.

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,[5] 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 20% of hospital capital expenditures are subject to CON review.

Dirigo made three important changes to CON:

- **Establishes limits on how much investment Maine can afford.** An annual limit—called the Capital Investment Fund—assures Mainers have access to new equipment and facilities they need but not more.

- **Guides CON decisions through a State Health Plan.** To ensure that capital investments are made efficiently and effectively to meet Mainers' health needs.

- **Levels 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).

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.

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, are shifted to the privately insured through increases in the cost of services, that ultimately results in increased premiums. In 2005, hospitals provided $77 million in free care and incurred approximately $126 million in bad debt for a total of $204 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 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 December 2005, 25 hospitals provided free care up to 200% FPL and two up to 250%.

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

In addition, the Governor has committed to reducing the cost shift caused by lower or delayed MaineCare payments and has committed to increasing payments to physicians and hospitals.

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 Premiums 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.

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 comparison of what different providers charge for services, Dirigo Health Reform requires 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.

- **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 website.[6] 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 will summarize this information in a report to be posted at its website to help the public better understand the financial situation of Maine's 39 non profit hospitals. MHDO's board will discuss the report's format and content at its March 2007 meeting, and hopes to have the first report complete before the end of 2007.

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.[7]

- 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 two reports which detail the purchasing power of public entities, including a finding that public entities spent $2.5 billion in health care expenditures in 2004, a significant portion of total health care spending in the state. Updated reports will be available early in 2007.

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.[8] 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.

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:

- ***In a Heartbeat*** - A hospital collaborative to improve heart attack care all across the state to reduce the deaths from this disease.

- **Make hospitals safer** - Using the Agency for Healthcare Research and Quality's patient safety indicators and inpatient quality indicators to help hospitals identify possible targets for quality improvement. The MQF Hospital Safety Star recognizes and promotes hospitals' full adoption of the National Quality Forum's Safe Practices.

- **Make sure best practices are in every physician's office** - Working with physicians to measure the quality of patient care in independent practices.

- **Provide tools to the public to improve quality** - Created the MQF website[9] dedicated to public reporting of healthcare quality information to help the people of Maine make better informed decisions about the care they receive and to help providers improve the care they deliver.

- **Reduce inappropriate and costly variation in how care is delivered** - Published a variation analyses for a range of services showing that care is delivered very differently in different parts of the state - and that raises cost and quality concerns.

- **Make sure quality of care is a criterion for spending on new services and technology** - Collaborates with the Department of Health and Human Services in reviewing Certificate of Need applications.

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 savings 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.[10] HIN has received backing from philanthropic and private business organizations (e.g. the Maine Health Access Foundation and Key Bank).

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 MaineCare expansions: it expanded coverage of parents of MaineCare eligible children from 150% to 200% of the federal poverty level (FPL) (from $24,135 to $32,180 for a family of three in 2006); enrollment began in May 2005 and covered 5,129 parents in December 2006. The Dirigo Health Reform Act also authorized expanded MaineCare coverage for childless adults from 100% to 125% FPL (from $9,570 to $11,963 for an individual); however this expansion was never implemented due to a federal cap on funding.

Maine is one of only 7 states in U.S. to reduce uninsured between 2000 and 2004; even while the cost of insurance has risen across the country and the percentage of people with employer sponsored insurance has fallen. This is due in large part to MaineCare. Maine is the only state in New England to lower its rate of uninsured between 1999/2000 and 2004/2005. Currently,

Maine has one of the lowest rates of uninsured in the country at 12% (compared to 18% nationally).

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. It is a public/private partnership administered through the Dirigo Health Agency and Anthem Blue Cross and Blue Shield of Maine. DirigoChoice offers comprehensive coverage 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 ($58,050 for a family of four and $28,710 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 ability to pay to eliminate that cliff.

DirigoChoice enrollment began January 1, 2005. As of December 1, 2006, 13,290 people and over 700 small businesses were enrolled. The map at appendix 4 shows that Dirigo enrollment is statewide. As of December 1, 2006; 27% of enrollees came in through small business, 27% were sole proprietors, and 46% were individuals.

Since the beginning of the program, a total of 22,653 people have been enrolled in either DirigoChoice or the MaineCare parent expansion. 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 website.[11]

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 demonstrated savings in the system. The amount of the assessment cannot exceed the demonstrated 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 3 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 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 and would cost no more than would otherwise have been spent.

Adjudicatory hearings were held by the Superintendent of Insurance in 2005 and 2006 to determine the amount of savings and whether those savings are "recoverable" by insurance companies. The Superintendent ultimately ruled that the savings form Dirigo's first two years were $78 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 has been appealed to the Law Court.

In July, Governor Baldacci appointed a Blue Ribbon Commission to develop alternatives to the SOP. The Commission's final report will be presented to the Governor in January 2007.

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 take on the comprehensive approach of Dirigo to address cost, quality, and access, other states have revitalized strategies

enacted in the 1980's - though ultimately repealed - to require employers to offer coverage or pay a fee, and several states are advancing new initiatives to mandate 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.

References

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4. This is the term for organizations that assist self-insured employers (employers that bear the risk of insuring their employees rather than contracting with an insurance company to provide coverage) in administering their plans.

5. See, for instance, Wennberg JE and Cooper MM. The Dartmouth Atlas of Health Care in the United States. Dartmouth Medical School, Center for the Evaluative Clinical Sciences. 1996.

6. http://www.state.me.us/pfr/ins/financial_results_health_insurers.htm and http://www.state.me.us/pfr/ins/financial_results_health_insurers_formula_version.htm.

7. In renewing that the cost increase target, the target changes each year based on the rate of medical inflation.

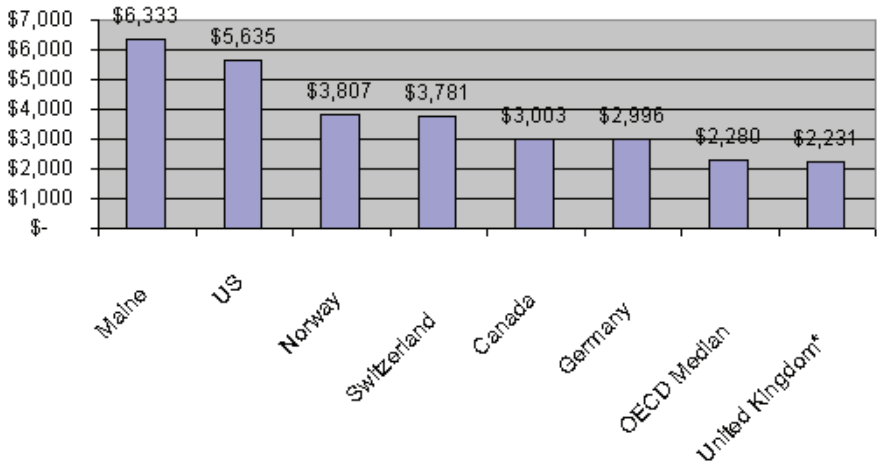
8. www.mainequalityforum.org

9. www.mainequalityforum.com

10. For more information see www.healthinfonet.org.

11. www.dirigohealth.maine.gov/BRC/9-18/Agency%20Fact%20Sheet%20Final%20091506.pdf

Appendix 1. 2003 Per Capita Health Care Spending in Maine, the US, and Other Industrialized Countries



Sources: Anderson GF, Hussey PS, Frogner BK and Waters HR. Health Spending in the United States and the Rest of the Industrialized World. Health Affairs 24(4), 903-914, for data on US and OECD nations. Maine figures calculated using data from the CMS Office of the Actuary.

Appendix 2. How Mainers Age 0-64 Get Coverage, 2004/2005

Employer	59%
Individual	5%
Medicaid	21%
Other Public	3%
Uninsured	12%

Source: Kaiser State Health Facts Online
- "Other public" includes military-related and other coverage non-Medicaid public programs
- The Census Dept uses two year blended data for states to counter the effect of small sample size in Census's annual data collection effort.
- All Americans age 65 and over are covered by the federal Medicare program.

Appendix 4. DirigoChoice Enrollees