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**Health Policy in Maine:  
Recurrent Themes and Dramatic Change**

by

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Introduction

There is an ancient Chinese curse, “May you live in interesting times,” or so they say. We, here in Maine, are certainly living in interesting times in the arena of health policy – but I hate to disappoint the traditionalists – I think it is great. I think the outlook for the future has great promise. With the passage of the Dirigo Health Act, Maine this year, stands alone among states in taking on the challenge of assuring access to health care for all citizens of the state.

How Maine, a state with a more limited tax base than many, got to this position of leadership in the arena of health policy is a long story. More than can be covered in an hour’s discussion. I want to start, by talking about the critical decisions governing health care made by the federal government, because, for much of the past fifty years, the federal role in health care has inalterably changed the landscape for both state governments and those who work in the health care field.

Let’s go back and look at what health care was like in the late ‘50s and early ‘60s when Marcus Welby typified the family doctor. Some of the most dreaded diseases were polio, pneumonia and tuberculosis. Children lined up at the local elementary school every year to get a polio vaccine. Measles and mumps were considered a normal scourge of childhood. Doctors carried the tools of their trade in small black bags and made house calls. They worked singly, in small offices, with maybe one assistant, usually a nurse, who managed both clinical support services and all administrative functions. Children’s shoe stores used as marketing gimmicks, x-ray devices that allowed you to view a green image of the bones of your foot without a thought to radiation exposure. The Marlborough Man was in his hey-day as the icon for the quintessential, self-reliant, self-confident, strong, and of course, healthy, American.

Impact of Early Federal Health Policy

In Maine, as in other states, the role of state government in health care was limited. The state funded and ran large institutions for mentally ill or mentally retarded persons. The Department of Health oversaw the quality of drinking water and monitored food handling practices in restaurants. But policy initiatives at the federal level were already pushing the State into a higher level of engagement with the health care system. The Hill Burton Act, passed in 1946, stimulated an unprecedented spurt of hospital construction that carried through the ‘60s. States had to develop surveys and plans for locating new hospitals, and were given \$75 million a year – collectively -- to aid hospital construction. Federal policy

also promoted the expansion of the nursing home industry and community mental health centers.

These federal initiatives contributed to a realignment of the health care delivery system in Maine. To give you some idea of the impact, at the height of the hospital expansion push, around the 50s and 60s, there were something like 80 hospitals operating in Maine, compared to the current 39.

The other major federal initiative of the post-WWII era was funding medical research. Between 1941 and 1960, federally funded medical research grew from \$ 3 million to \$400 million. This emphasis on research and new technology promoted the growth of major academic medical centers and encouraged the proliferation of medical specialties.

There is no question that this burgeoning new hospital-based health industry made major advances in the treatment of important diseases. The overall age-adjusted death rate in the U.S. in 1950 was about 145 deaths per 10,000. Now, the rate has dropped to 87/10,000. The mortality rate from heart disease alone – the number one killer in America, has dropped by more than half.

What has this explosion in resources and spending meant in Maine? Well, certainly a major increase in access to care in a largely rural state. The number of physicians practicing in the state has more than doubled in the past 30 years. We've seen the introduction into the state of advanced treatment options for heart disease, cancer, childhood cancers, organ transplants and huge advances in the treatment and care of high risk, low birth weight babies.

But all this advancement in medical technology – all this federal largesse – has its down-side. Researching cures for diseases, has a lot of razzle-dazzle – it even dangles the possibility of a Nobel Prize down the line -- no wonder policymakers and the public, alike, are so supportive of it. I read that when the announcement came that the Salk vaccine worked against polio, all around the country people rang church bells, blew factory whistles, closed schools for the day, and took the rest of the day off from work to celebrate.

But with all the attention and resources flowing to research and building the high tech medical infrastructure, some fundamental needs were neglected. Like assuring access to basic medical services.

#### The Impact of Medicare and Medicaid

The issue of universal health insurance for this country is not new: it has been debated by Congress four times and, of course, defeated four times. Instead, we have relied, for the most part on private insurance coverage, largely made available as a work-related benefit. This system – never intended to meet everyone's needs – had troublesome gaps from the start. In 1960, about 78 percent of *full-time* workers were covered. But among retired persons, only 43 percent were insured. Among housewives – coverage was just 32 percent.

It was primarily the plight of the elderly –that finally galvanized action.

Medicare was enacted in 1964 – Ironically, it was the efforts of the American Medical Association and others to limit the program to a means-tested system for low-income elderly, that resulted in the enactment of Medicaid – not *instead* of Medicare – but in addition to Medicare.

In my view, the enactment of these two programs is the single most important policy decision in health care in the last fifty years. They set all sorts of things in motion. First and foremost, of course, these programs extended a safety-net to some of our most vulnerable citizens. Early studies of the impact of Medicaid, for example, found that poor children, whose access to and use of health services before Medicaid was abysmally low, quickly caught up with well off and insured children once they enrolled in Medicaid. The Medicare program had a comparable impact on the elderly. This, clearly, was a significant victory in the struggle to assure adequate health care to everyone.

But an important side effect of Medicare and Medicaid was that these programs thrust everyone – states, health care providers, hospitals, patients – into a new relationship with the federal government.

The American Medical Association had seen this coming. They fought tooth and nail against the passage of Medicare and Medicaid, precisely because they feared their freedom to practice as they chose would be compromised. To give you a flavor of the AMA-led fight, listen to this: It's an excerpt from an AMA-sponsored recording sent to physicians' spouses all around the country in 1962, to urge them to write Congress opposing Medicare. The tape ends this way:

Write those letters now...If you don't, this program, I promise you, will pass... and behind it will come other federal programs that will invade every area of freedom as we have known it in this country. Until one day... We will awake to find that we have socialism. And if you don't do it... One of these days you and I are going to spend our sunset years telling our children and our children's children what it was like in America when men were free.

By the way, the person who recorded that on behalf of the AMA in 1962, was actor whose name will be familiar to you – Ronald Reagan.

Well, Medicare and Medicaid didn't open the door to Socialism in America, but they did insert the government into shaping our health care system – but not at first. Initially, the federal government swore off any interference with the practice of medicine and agreed to pay for medical services on the basis of what was reasonable and customary. This was a bit like an indulgent parent handing a credit card to a teenager and saying, "I won't review or second guess what you use this card for and it has no credit limit. But please, be reasonable with it."

But you don't usually find constraint in markets where there are not some kind of externally or internally imposed constraints – and the health sector was no exception. When you combined the impetus already given to hospital-centered, high tech medicine with this major new revenue source for payment of patient services, the results were astounding. Health care became the Godzilla that ate the national budget. In 1960, total health care spending in

this country was about 5 percent of the economy. Now, it is more than 14 percent. Let me point out what this means in more personal terms. While in 1960, we spent, on average, \$126 per person on health care, now, the average spent per person was \$4,370.

Medicaid had another, unanticipated impact on state governments everywhere, including Maine. Medicaid is a large and complex program that is state-administered. It requires state government to screen eligibility, track enrollments and disenrollments, pay medical claims, review the credentials of participating physicians, oversee the quality of nursing homes, and manage an enormous budget. This last year, Maine Medicaid, or MaineCare, provided health coverage to almost 343,000 individuals. Total program expenditure exceeded \$1.2 billion dollars. The program processed around 6 million provider claims, excluding bills for pharmacy services.

State government has grown enormously in the last 50 years -- from an entity with little infrastructure and few program administrative responsibilities -- to a large organization with the capacity to manage complex programs and maintain a sophisticated understanding of a variety of policy areas. Medicaid was one of the primary engines that fueled this change.

#### Cost Containment Policies

The start-up of the Medicare and Medicaid programs also ushered in what I think of as the modern era in health policy. Health policy in this era has been overwhelmingly dominated by the two issues of controlling costs and trying to assure access to care. The demon twins that keep coming back to bite us.

This is the era where Maine, I think, really starts to stand out among states for trying innovative policy responses.

The cost problem was the first to catch the attention of policymakers everywhere. It took only 10 years with Medicare in place, for national health care spending to grow from \$42 billion to well over \$100 billion. Suddenly, the enthusiasm for funding hospitals and training more doctors began to fade. The health care economy, we discovered, did not follow the laws of most economic markets. Increased competition among a larger number of providers did not reduce prices. Instead, increased capacity just seemed to generate increased use. Demand for health care services seemed insatiable.

Maine first addressed this issue in 1978 by starting a state health planning process and instituting a Certificate of Need program. The State Health Plan tried to establish objective population-based measures of need for services and facilities, and to determine which areas in Maine were under-served and which over-served. Certificate of Need, or CON, gives the State regulatory authority over new hospital services and hospital capital expenditures exceeding a specified cost threshold.

With its second cost-containment initiative, Maine joined a small cadre of states trying more aggressive strategies for taming health inflation. This second strategy was the establishment of the Maine Health Care Financing Commission in 1984. The MHCFC was a regulatory agency that had the authority to establish limits on each hospital's revenues on an annual basis.

The MHCFC regulated hospitals for nine years. During this period, comparative analyses with other states indicate that the system had some success in slowing the rate of growth of hospitals costs. However, the regulatory structure made the hospitals extremely unhappy. They felt the system was too rigid and cumbersome and that it inadequately recognized the changing environment and costs hospitals had to contend with. Many hospitals spent considerable time and resources locked in disputes with the regulatory agency – appealing rulings and trying to make cases for exceptions to the MHCFC’s formula-driven standards.

### Access Strategies

While the struggle for cost containment was underway, Maine was also one of the states providing leadership in efforts to expand access to care. These two issues, of course, are inextricably linked. The more health care costs rise, the more insurance premiums rise. With each hike in costs, the fewer people can afford it. Coverage started to erode in the aftermath of exuberant cost increases in the ‘60s and ‘70s . Overall, the number of Americans without any insurance coverage had held steady at about 26 million during the 1970s, then began to climb. It was 32 million by 1985, 36 million when Clinton introduced his health reform bill, and, has continued to climb at a rate of about a million persons a year, where it is now up to 42 million. Maine’s current share of those uninsured is about 136,000. We have had these increases despite expansions in public coverage through the Medicaid program. Where we are seeing the decline is in private coverage.

Maine policymakers were out in front in trying to address the access issues arising from declining private coverage. As early as 1974, the Maine Legislature enacted a Catastrophic Illness program designed to provide resources to individuals who exhausted insurance and other resources due to a major illness. The program operated until 1984 and, at its height, was serving about 2,500 people a year.

In 1986 the Legislature commissioned a study to look at the scope and causes of medical indigence, and to propose various responses. The next step on the arduous journey toward comprehensive coverage in Maine, was a High Risk Insurance Program, enacted in 1987. This program, modeled on similar initiatives in other states, offered health insurance coverage to individuals who could not obtain private insurance at normal premium costs because of pre-existing medical conditions. This aspect of our insurance system, now remedies through insurance regulation, generated some of the most heart rending stories about barriers to care. Imagine someone who works for a small business, this person has faithfully paid health premiums throughout his or her working career. Then they get some really costly illness like cancer. The next year, when the small business must renew their health insurance contract, they find that the premiums are being hiked up by 100 percent, maybe 200 percent. Either, the whole business has to drop coverage, or the individual with the illness who was responsible for the claims that drove up the renewal rate, has to drop out of the employer’s plan so that everyone else can afford coverage. These incidents were not uncommon in the 1980s.

In 1988, the State sponsored a three year demonstration project to try to expand health coverage among small businesses in Maine. The legislature appropriated \$3 million dollars to cover the costs of subsidizing the premiums of low-income workers in businesses of fewer than 15 and the self-employed, on a sliding scale based on income.

In 1989, we reached a kind of tipping point both on access issues, and in the growing frustration of hospitals with the regulatory system. Hospitals had been gathering support in the legislature for deregulation. Their arguments were bolstered by the fact that all around the country, managed care was in vogue and the hopes were high that competition among managed care plans would rein in prices and stimulate efforts to improve quality in health care -- removing the need for regulatory controls.

Second, momentum was building in Maine for a more comprehensive response to the health care access issue for low wage workers and others. A bill was put forward in the legislature for a state-funded program that would cover everyone in the State whose income was below 150 percent of the federal poverty level. The public hearing on this bill drew a crowd so large that the hearing had to be held at the Augusta Civic Center. All day, citizens came forward to tell their stories about the hardships caused by not having health insurance.

Legislators put these two issues – hospital deregulation and access expansion – together in a single bill: the Maine Health Program was enacted and The MHCFC was dismantled. The total package was funded at \$20 million for the first year with two-thirds of the funds ear-marked for the Maine Health Program and one-third set-aside as a fund to help hospitals that could show hardship related to bad debt and charity care and because of under-payments by Medicare and Medicaid.

Now, think about this for a minute. The health care system in Maine was infused with a new \$20 million in funds at the same moment that hospitals were deregulated. Managed care entities made a valiant effort to get a toe-hold in the state, to change utilization patterns and bargain down prices – but they largely failed. So what happened, in retrospect, seems inevitable. It is, in many ways, on a mini-scale, similar to what happened when Medicare was enacted. Utilization increased and prices soared.

The Maine Health Program only lasted through 1992. The combination of higher than expected costs, a down-turn in the economy, and soaring state budget deficits doomed it.

#### Momentum toward Dirigo Reform

So this brings us to the “pre-Dirigo” period. Throughout the decade of the 90s, -- the era of unfettered health care markets in Maine – we saw consolidation in both the health insurance industry and in health care networks. Thirty-one of Maine’s thirty-nine hospitals affiliated with one of four hospital networks. Physician specialty practices have consolidated. Several insurers left the State or were purchased by larger insurance companies so that now has only three insurers with any measurable share of the market. The largest insurer holds 95 percent of the individual insurance market and 54 percent of the overall insurance market.

Health care costs, on a per capita basis rose faster in Maine than in any other state in the country over the past decade. The State, which is 37<sup>th</sup> in average income in the country, rose to 10<sup>th</sup> in average health care spending. These increases have been showing up in employers’ and individuals’ insurance premiums. One of Maine’s large employers had increases in health benefits costs of 60 percent over three years. Here at the University, costs rose by 49 percent at the end of a two year contract. Small businesses have been seeing comparable

increases. And individuals who have to buy their own coverage have been the hardest hit. Comprehensive policies in Maine now cost families \$20,000 to \$25,000 a year.

These are the circumstances that, once again, galvanized Maine to step into the leadership on health reform – this time to take on health care costs and expanded access to care simultaneously. Just within these last couple of years, the stage was set for the Dirigo initiative by a growing level of discussion and action, both by policymakers and by the public. In 2000, Governor King established a Blue Ribbon Commission to Study Health Care Costs. In 2001, the Maine People’s Alliance sponsored a referendum campaign in Portland advancing the “Creation of a System of Universal Health Care.” The initiative was widely debated, drew fire from Anthem Blue Cross, and finally passed. Later that year, the Legislature created an appointed Board to study the feasibility of a single payer universal health care system and to develop recommendations for its design and implementation. The Speaker of the house sponsored a successful piece of legislation to develop a program to assist small businesses and their employees in securing health coverage. And the President of the Senate sponsored a reform bill based on consumer choice and purchasing pools – which also passed.

Health reform was clearly back on the front burner and Governor Baldacci, as a candidate, pledged to make this a priority of his administration. His first act, as Governor, was to create a Governor’s Office of Health Policy and Finance, charged with developing a proposal that would encompass universal access, cost controls, and measures to enhance quality. The Governor convened a task force – the Health Action Team – with representation from consumers, providers, the insurance industry, business, and labor to provide a sounding board for ideas on reform strategies. He brought a comprehensive proposal before the Legislature within 100 days of taking office and the Legislative leadership convened a special select committee to work the bill. Features of the bill were controversial and negotiations for change and compromise were intense between the Governor’s office, and various interested parties including representatives of hospitals, physicians, the insurance industry, business groups and consumer advocacy groups. However, these various interest groups were able to agree on a proposed amended bill that encompassed changes to meet the various concerns. Once all these constituent groups signed on, bi-partisan support was possible in the legislature. The bill was moved out of Committee with a unanimous recommendation of ought to pass.

#### Dirigo – A Description

So, what will the Dirigo Health Act do? A lot. Here are some of the most salient features. The Act creates a new independent, Dirigo Health agency as an entity of State Government. This Agency is run by a Board appointed by the Governor with Senate confirmation. The agency will sponsor a program that offers health insurance, disease management and possibly some other services to eligible businesses and individuals. All businesses with fewer than 50 full-time employees and self-employed individuals are eligible to enroll. Individuals who work for employers who do not offer insurance coverage are eligible as long as they have not had employer coverage available for 12 months or longer. Employers will be required to pay some portion of the participation fees – the exact level will be determined by the Board. Low-income enrollees will be eligible for subsidization of their portion of the costs either through MaineCare, if they are eligible, or through a Dirigo-funded sliding scale subsidy.

The program also encompasses a variety of measures to help reduce the rate of increase in health care costs. Some of these measures ask for voluntary cooperation from providers and insurers, and some, including a newly expanded and more rigorous Certificate of Need process, are set in place by the new law. The law also calls for the development of a new State Health Plan and creates a Maine Quality Forum which will build on efforts already underway in the state to enhance patient safety, evidence-based medicine, and health care quality.

In the first year, program administrative expenses and costs of the subsidies will be paid through a one-time appropriation of \$53 million. In future years, funds will come from an assessment on all insurance premiums in the State. So as not to trigger another round of health inflation, the assessment will be set at a level equivalent to measured savings in the health care system from reduced bad debt and charity care and other reductions in the growth of spending. And under no circumstances, can the assessment rise above 4 percent.

This is a complex program – I have tried to capture, in a nutshell, some of the most important features. I think there are two major take-away points regarding the Dirigo plan. The first is that it should dramatically increase the availability of affordable health coverage, particularly for low-wage workers and small business employees. The second, is that the system requires everyone *trying* to make it work – for it to work. Program funding is set specifically to ensure that the new money put into the system goes to provide broader coverage, and not to fuel inflation in the health sector. The Dirigo Program will need the hard work of providers and insurers to help make sure this happens. And consumers. We all have to do what we can to stay healthy without resorting to medical care, and then use the health care system responsibly when we need it. But one of the ingenious features of the program is that it creates a win-win situation. To the extent that costs are controlled, businesses and individuals who are already insured benefit. But it is also these savings to the system that will help support coverage for some of Maine’s uninsured citizens. In other words, the more we bring down costs, the more people we will be able to insure. I promise you, all eyes are on Maine. If we succeed in this endeavor, Maine will be the model for the country. The elusive goal of universal access and controlled costs is the brass ring – no one yet, in this country, has snagged it.

#### Reasons for Maine’s Policy Leadership

So what is it about Maine allows – stimulates – this creativity in health policy?

I think there may be several reasons. The first might be what I call Maine’s intimate style of politics. Maine is a cohesive enough community so that all the players in an issue area like health care, know each other and negotiate on issues, time after time. Health policy is complex and it brings many stakeholders to the table. The more stakeholders, the harder it is to reach consensus. Unlike many other states – or at the national level, in Maine, all the stakeholders fit around the same table – they can hear each other out. Plus, it’s foolish to make enemies when you may need someone’s cooperation the next time around.

A second reason, in my view, is that Maine has a vibrant consumer advocacy community and has, for many years. Consumers are organized, they form coalitions, they conduct grass-roots outreach, and they have been persistent. These organizations have assured that legislators are acutely aware of how health policy decisions affect their constituents. And the

organizational representatives are savvy negotiators on behalf of their constituents in Augusta. Their voice is respected.

Governor Baldacci deserves a great deal of credit for the leadership he provided. He moved fast, his message was clear and consistent, and he held the line firmly on principles that were important to him – like universal access. He created a framework for negotiations that allowed give and take but established some fundamentals that guided the legislative process.

Finally, I would say that the years of trying things – incremental reforms, prior efforts at comprehensive reform – were not wasted. We’ve learned as we went along. There’s an institutional memory, there were some things we could scratch off the list, others that were worth revisiting. You know what they say – if at first you don’t succeed, try, try again.

As we look to the future, I would say our number one challenge is to try to make these new reforms work. Simply, we need to continue to try to balance an economically robust health sector with the need to restrain costs so that all can afford the care that they need. It would be so nice if we could get beyond the little matter of an insurance card in every pocket to focus all our energies on health promotion, disease prevention, and improvements in the quality of care.

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