MAINE'S DIRIGO HEALTH REFORM ACT – IS IT WORKING?

D. Michael Frink, Esq.
George M. Linge, Esq.
207.774.9000

As reported in the winter 2004 issue of this Journal,[1] in 2003 the Maine Legislature enacted An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs.[2] Commonly referred to as the "Dirigo Health Reform Act" (hereinafter the "Act"), this ambitious law, proposed by Governor John Baldacci, has been touted as a comprehensive, system-wide strategy to improve Maine's health care system. The Act includes three interrelated approaches: a new state-sponsored health insurance product ("Dirigo Choice") to achieve universal access to coverage; new and improved systems to control health care costs; and initiatives to ensure the highest quality of care statewide.[3]

Our previous article focused on the expansion of access to health coverage through the voluntary, market-based offering of the Dirigo Choice insurance product. This new product is made available to the previously uninsured through premium subsidies funded by a "savings offset payment" ("SOP") paid by insurance carriers, self-funded plans and third-party administrators. The increases in enrollment in this new subsidized product, coupled with expansions in state Medicaid eligibility, are in theory intended to produce savings by reducing the amount of cost shifting in Maine to the insured and self-insured market. Thus, the "savings" from reduced cost shifting are to be "offset" by "payments" by those that pay for insurance coverage already. The law provides that the SOP cannot exceed these savings, so theoretically policy premiums (even with the SOP assessment) do not increase beyond what they otherwise would have been but for the Dirigo program.

In judging the success of this new program, three fundamental questions were identified in the previous article as being of great concern to the insurance industry, and to the employers in Maine, both large and small, that provide coverage through fully-insured and self-funded plans:[4] (1) will the product succeed in the marketplace? (2) are there any real savings to insurers and other payors from the offering of Dirigo Choice?, and (3) will the Dirigo Choice product and the overall Dirigo reforms contain healthcare costs?

Now, after eighteen months of experience with this program, we are beginning to see more clearly how the Dirigo experiment is working. We also are seeing more activity in other states that are moving to enact similar reforms.[5] It appears that, however laudable the goals of the Dirigo Health Reform Act, the actual enrollment in Dirigo Choice has been much less than projected, thereby having a much less than anticipated effect on reducing the amount of costshifting.[6] Insurers and self-funded plans have reported no significant reduction in medical cost trends since the Dirigo programs took effect.[7] These facts raise serious questions about the effectiveness of the Dirigo model, which contains only voluntary limits on healthcare spending by providers.[8] Finally, the SOP-based funding mechanism for the premium subsidies to expand access to coverage has proven to be fundamentally flawed and unsustainable and must be replaced with a broader-based approach.

At the heart of the Dirigo reforms is the tenet that by reducing the number of uninsured people through the offering of a subsidized insurance product and by expanding state Medicaid eligibility, hospitals and physicians will experience less bad debt and charity care, and will accordingly reduce the extent of cost-shifting to the insured and self-funded market. In Maine, with nearly 50% of those with coverage being covered under Medicare and Medicaid, the degree of cost shifting is among the highest in the nation, driving insurance premiums to levels significantly higher than other more densely populated states. Thus, in theory, the Dirigo reforms attack the heart of the problem. In practice, however, with enrollment in Dirigo Choice lagging far behind projections, there simply is no credible evidence that significant reductions in cost shifting or medical cost trends have yet occurred in Maine. Moreover, as discussed below, insurers and employers have challenged the validity of portions of the Act itself and how it has been interpreted by the Dirigo Health Agency Board in calculating the "Aggregate Measurable Cost Savings" ("AMCS")[9] supposedly produced by that Agency. (These are the "savings" that fund the savings offset payments to Dirigo.) A key part of this challenge includes the way that these alleged savings are counted to determine the amount of the "savings offset payment."

The Dirigo Act established a complex, three-part process for determining the amount of AMCS attributable to the operations of Dirigo Health and the expansion of Medicaid eligibility. First the Board of the Dirigo Health Agency,

which is the agency responsible for offering the Dirigo Choice insurance product and overseeing the Maine Quality Forum, is charged under the Dirigo Act with the responsibility for determining each year the amount of AMCS. This determination then goes to the Maine Superintendent of Insurance, who conducts a hearing to review the determination to ensure it is reasonably supported by the evidence. The Superintendent's decision then goes back to the Board for an assessment of a "savings offset payment" ("SOP"), which cannot exceed the amount of the AMCS (as set by the Superintendent of Insurance), or 4% of paid claims, whichever is less.[10]

As has been argued in various phases of the ongoing litigation relating to this three-step process, the DHA Board has an inherent conflict of interest in determining the amount of AMCS, as it relates directly to the amount of funding DHA may collect to support its programs. This situation has been exacerbated by the lack of clear standards in the Act for determining what initiatives are to be included in the AMCS calculation and how the savings produced by each such measure is to be calculated.[11] DHA itself provided a vivid demonstration of the potential for over-reaching in its initial attempt to claim $250 million in savings in the first year of Dirigo's operations. The Superintendent reduced this figure to $43.7 million, but expressly declined to engage in any legal interpretation of the Act. He therefore did not consider the claims of various litigants that the Board had improperly included various categories of savings that did not relate to the "operations of Dirigo Health," such as enhanced payments to providers under Medicaid, discussed below. The Superintendent also did not control for other factors that influence savings, such as national cost trends, patient volume and regularly occurring variations in costs for healthcare providers.[12] The Superintendent's decision also did not fully review and analyze the reasonableness of DHA's assumption that hospital and physician providers, which have been long overdue for increased and more timely Medicaid reimbursement, would pass on to payors the full amount of the alleged savings created by enhanced Medicaid payments to them, even if those were assumed to be the result of the "operations of Dirigo Health."[13]

The Maine Association of Health Plans and its member companies, as well as the Maine State Chamber of Commerce, representing large Maine employers with fully-insured and self-funded health plans, have been engaged in litigation to challenge the constitutionality of the Act itself (on vagueness grounds and as an improper delegation of the taxing authority of the Legislature) and the Board's and the Superintendent's decisions on the methodology and calculation of AMCS and the SOP. Given the possible precedent that may be created in these cases, this issue has drawn careful scrutiny by the health insurance industry's national association, America's Health Insurance Plans. The outcome of the litigation remains uncertain, and at this time there are ongoing legislative negotiations to attempt to replace the AMCS/SOP with another funding mechanism.

Regardless of the outcome of the litigation and the legislative negotiations, however, several key lessons can be learned from the "Dirigo experiment." First, reducing bad debt and charity care (and associated cost-shifting) through expanded coverage to the previously uninsured and expanded Medicaid eligibility can work, but the net impact of such efforts on medical cost trends that drive the prices paid by insured and self-funded plans has yet to be significant. In fact, it appears that the actual savings will never be sufficient to form the sole basis for funding such programs through "savings offset payments."

Second, the Dirigo Board has not developed a credible and sustainable methodology for determining AMCS and the SOP. In fact, as suggested above, it is probably not feasible to develop such a methodology that would provide a long-term basis for funding this program at the level needed for the Baldacci administration to achieve the goals it has set. The result is an ongoing lack of support and continued legal challenges from the health plans, major employers and other payors in Maine. The prospects for a legislative resolution are complicated by the fact that the debate has continued into a gubernatorial election year. Governor Baldacci has embraced this program as a centerpiece of his administration's priorities since the enactment of the Act, making it a critical factor in his re-election campaign.

A legislative resolution has been further complicated by a bill, under active consideration, that would prohibit insurers from passing the SOP through to policyholders.[14]

As laudable as the goals and original intent of the Dirigo health reforms may be, it is a flawed approach which should be modified in several key respects, as other states appear to have recognized. First, the funding for increased insurance and Medicaid coverage must be as broad-based as possible, and the methodology must be fair and transparent. Those with insurance and those companies that provide coverage through fully-insured or self-funded plans should not be paying for the expansion of coverage for the uninsured. The employers that do not

provide coverage for their employees should be assessed instead, as is the case in Maryland and in a plan recently adopted by the Legislature in Massachusetts.[15] Further, increased general fund appropriations are needed for Medicaid expansions and to supplement employer contributions for subsidies.

Second, a mandate for coverage for both individuals and employers is probably needed, subject to income and affordability/subsidy guidelines, although this element will likely involve complex governmental oversight, guidelines and regulation.[16]

Third, even with these additional reforms, it will be difficult to achieve significant reductions in medical cost trends absent meaningful controls on hospital prices. Maine hospitals correctly point out that Maine's high percentage of Medicare and Medicaid patients (for whom the federal and state governments pay only a portion of the cost of care) produces an abnormally high cost shift. A state statutory requirement that Maine hospitals, all of which are not-for-profit institutions, must provide care to every person regardless of ability to pay also serves to exacerbate an already unfavorable situation. Expanding insurance coverage is therefore a good starting point, but it is not likely to address the crippling cost of coverage and health care generally until a mixture of price controls and higher governmental reimbursement levels can be included in the equation.

One thing is certain. Maine will continue to struggle to achieve the ambitious goals of the Dirigo Health Reform Act. To lead on this issue, true to the State's motto (Dirigo means "I lead" in Latin), Maine will need to consider what certain other states are doing and adopt some of those ideas in order to develop a more credible and sustainable approach for funding healthcare reform.

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[1] FORC Quarterly Journal of Insurance Law and Regulation, vol. XV, Edition VII.

[2] The insurance code provisions of the Dirigo Health Reform Act are codified at 24-A M.R.S.A. ch. 87, §§ 6901-6971 (Supp. 2005). The Act was originally enacted as Public Law 2003, ch. 469 (effective Sept. 13, 2003), as amended by Public Law 2005, ch. 400 (effective Sept. 17, 2005).

[3] The Act also amended three other titles in the Maine Revised Statutes, in addition to the major revisions to the Maine Insurance Code, including the statutes regulating public health and welfare, Title 22. Part A established the Maine Quality Forum, to collect and disseminate research regarding health care quality, evidence-based medicine and patient safety to promote best practices. 24-A M.R.S.A. § 6951-52. Part B established a capital investment fund to limit the amount of new capital expenditures by hospital and non-hospital providers. 22 M.R.S.A. § 101-05. Part F, an unallocated and non-codified part of the Act, established voluntary limits on hospital costs and on insurance companies underwriting gains for one year.

[4] These questions were identified in interviews with representatives of the Maine State Chamber of Commerce and the National Federation of Business. These organizations taken together represent over 10,000 Maine businesses, both large and small.

[5] The Maryland law entitled the "Fair Share Health Care Fund Act" is set to take effect January 1, 2007. Chapter 3 of the Acts of the General Assembly of 2006. The Massachusetts law entitled the "Health Care Access and Affordability Act" took effect on April 12, 2006. Chapter 58 of the Acts of 2006.

[6] Based on reports from the Dirigo Health Agency, total enrollment was by now to approach 30,000, when in fact only approximately 7,500 people have enrolled.

[7] Actuaries and network contracting and marketing representatives from several insurance companies including Anthem Blue Cross Blue Shield, CIGNA and Aetna have appeared as witnesses in the first year AMCS proceedings before the Superintendent of Insurance. All concur that no significant reduction in medical cost trend has been experienced in Maine as a result of the Dirigo Health Reforms.

[8] *See* Dirigo Health Reform Act, Part F, *supra*.

[9] *See* note 11 below for the statutory definition of AMCS.

[10] 24-A M.R.S.A. § 6913(1-3).

[11] The only guidance in the Act as to what constitutes AMCS and how it is to be calculated is contained in the following provision: "After an opportunity for a hearing conducted pursuant to Title 5, chapter 375, subchapter 4, the board shall determine annually not later than April 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. §6913(1)(A).

[12] The full text of the Superintendent's decision can be viewed at www.state.me.us/pfr/ins/ins05700dirigo.htm
[13] *Id*.
[14] Legislative Document 1935, "An Act to Protect Health Insurance Consumers."
[15] Chapter 3 of the Acts of the General Assembly of 2006; Chapter 58 of the Acts of 2006.
[16] The Massachusetts law as passed by both houses contains both of these mandates. Chapter 58 of the Acts of 2006.