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HEALTH CARE REFORM - INSURANCE COVERAGE EXPANSION:

Maine's Experience in the National Context

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As reported in the summer 2006 issue of this journal, An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs was enacted by the Maine State Legislature in 2003. 1 Commonly referred to as the "Dirigo Health Reform Act" or "Dirigo Health," this legislation was meant to decrease health care costs, improve clinical quality and provide universal access to health coverage for all Maine citizens. The Act sought to achieve these goals using a three-pronged approach, including a state-sponsored insurance product ("DirigoChoice") to achieve universal access to coverage as well as several health care cost containment and quality improvement initiatives. This article will provide an update on health care reform efforts and related obstacles encountered to date in Maine and in other states and suggest key strategies necessary to achieve meaningful reform.

The Impasse Continues in Maine

Legislative Gridlock

Slower than anticipated enrollment, a flawed funding mechanism that assesses a "savings offset payment" on those currently insured to subsidize coverage expansion of the uninsured through the DirigoChoice product, and an ongoing ideological debate over government sponsored versus private market solutions to health care access triggered a political firestorm during this past session of the Maine Legislature. Re-elected in November and facing legal action from groups such as the Maine Association of Health Plans, the Maine State Chamber of Commerce and others, as well as significant pushback from providers, Governor John Baldacci proposed An Act to Make Health Care Affordable, Accessible and Effective for All, dubbed ("Dirigo 2.0") in May, 2007. 2

Dirigo 2.0 contained many of the measures discussed in our previous article. It included several new features, among them an employer and individual mandate and a broader based funding source for expansions in insurance programs covering the uninsured, and made permanent the voluntary hospital cost containment targets set to expire this year. The legislature adjourned, however, without taking action on this plan or on three alternatives put forth by the legislature's Insurance and Financial Services Committee, leaving Dirigo Health and its funding mechanism untouched.

Litigation Over Dirigo Health-Related "Savings" Continues

Although the Maine Law Court upheld the Dirigo Health Agency's ("DHA") broad authority to interpret the ambiguous Dirigo Health Reform Act in determining the amount of "aggregate measurable cost savings" ("AMCS")³, the Maine Insurance Superintendent, in this the third year of administrative hearings to set the amount of AMCS, dramatically reduced the actual savings figure from the \$98 million sought by DHA to \$32.8 million. He also directed DHA in future years to develop a new way of measuring hospital savings - the

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lion's share of the AMCS figure. These decisions still leave many questions unanswered, and the cloud of non-support for the funding approach still hovers over this program as it has for the past three years. Enrollment in DirigoChoice has not met expectations and there is no conclusive evidence that Dirigo Health has produced "savings" in the form of a significant reduction in healthcare costs, nor in the rate of cost growth.

Maine's Experience in the National Context

Many of the reform elements proposed in Maine's 2007 legislative session and likely to re-surface in 2008 mirror those under consideration or currently in place in other states. Over the past few years, a number of states have enacted health reform laws to increase access to health care by expanding insurance coverage, with the goal, as in Maine, of attaining universal coverage. Other similarities among the various state health reform efforts include employer or individual mandates, cost containment measures, quality initiatives, health promotion programs, Medicaid expansions, and health information system development. Below is a brief summary of states that are most actively engaged in health care reform.

Massachusetts

Undoubtedly the most widely publicized reform was passed by the Massachusetts legislature and signed by then Governor Mitt Romney on April 26, 2006.⁴ The most controversial feature of the law was an individual mandate that went into effect July 1 of this year. With all citizens required to carry health coverage, the law also needed to ensure affordable coverage was available. Therefore, it created the Commonwealth Health Insurance Connector to offer a range of affordable plans and help "connect" businesses and individuals to coverage. This concept is in stark contrast to Maine's single DirigoChoice product, which costs as much as most comparable commercial plans. Like in Maine, the Commonwealth Care Health Insurance Program provides subsidies for those living at up to 300% of the federal poverty level ("FPL") with premiums waived for those at 100% of FPL and lower. The Massachusetts bill also includes an expansion of MassHealth, the state's Medicaid Program. Unlike Maine, the Massachusetts reform also contained a "play or pay" provision or employer mandate, collecting an annual "fair share" contribution (which many consider to be far too low to be meaningful) of \$295 per employee from employers with 11 or more employees that do not offer health coverage. Program funding comes from redirected federal Medicaid uncompensated care funds, generally paid to hospitals, along with employer contributions and general fund revenues.

Vermont

Vermont passed a package of reforms in May of 2006 with the goal of insuring 96% of Vermonters by 2010 and addressing similar priorities as the Dirigo Health Reform Act.⁵ The state's Catamount Health Insurance Product became active on Oct 1, 2007 and is being touted as an affordable and comprehensive plan for those who have been uninsured for 12 months or more. In Maine, one is eligible for subsidized DirigoChoice coverage with only one day of being uninsured in the year prior to enrollment. Vermont's product is much like DirigoChoice, offering a non-group product but requiring less cost sharing than DirigoChoice along with generous subsidies for individuals and families living at 300 percent of the FPL. The state will also offer financial assistance to low-income citizens to pay their employer coverage premiums.

Vermont chose not to impose an individual mandate, but will explore the idea in 2011 if the 96% threshold is not reached. Instead of a pure employer mandate, Vermont will require employers that do not provide coverage to pay an assessment for every full time employee. Employers who do provide coverage must pay the assessment only on workers who are ineligible to participate in the plan and uninsured workers who refuse the employer's coverage plan. The plan will be funded by an increased tobacco tax, the employer assessment, enrollee premiums and federal funding from a Medicaid waiver. The reform legislation also contained support for public health and chronic disease management through the Vermont Blueprint for Health, a public-private

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partnership that will work to help the chronically ill manage their disease. Like Maine, Vermont has also put a particular emphasis on the development of an integrated health information system for chronic disease and population health management.

California

Although Maine, Massachusetts and Vermont are the first states to pass truly comprehensive reform, a number of other states, California chief among them, have put forth similar proposals. Governor Schwarzenegger unveiled his proposal to reform California's health care system in January 2007 and after some revision and work with the state legislature, the Health Care Security and Cost Reduction Act has now been passed by the California Assembly and is scheduled for hearing in the state Senate in January 2008.⁶ The proposal included an individual mandate, guarantee issue regardless of age or medical history, broadly shared responsibility for funding, price and quality transparency requirements for providers, pay-for-performance initiatives, a minimum of 85% of premium to be spent by insurers on patient care, expanded access to public programs for children and low income adults, and a new state administered subsidized purchasing pool for those living at 101-250% of the FPL. It would provide incentives for participation in wellness programs and chronic disease management services. It places a greater emphasis than other states on information technology in health care, proposing to mandate e-prescribing by 2012.

Proposed funding includes accessing over \$4 billion in federal funds previously unavailable due to lack of state matching funds, a 4% hospital fee, employer contributions, tobacco revenues, and contributions from insured individuals within existing premium levels. California voters will be asked to approve the funding mechanism for this bill on the November 2008 ballot.

Maryland

Maryland also tried to pass legislation with similar reforms including public program expansions, wellness incentives funded by assessments on providers and an increased tobacco tax. But none of these proposals has been able to garner the support needed to pass. Maryland received notable attention following a February 2, 2007 ruling that struck down the so called "Wal-Mart Bill," which mandated that employers with 10,000 or more employees provide employee health care coverage. The law was struck down by a Fourth Circuit Court of Appeals ruling that it violated the federal Employee Retirement Income Security Act ("ERISA").⁷

Synthesis

While many states are attempting to implement comprehensive or incremental health care reforms, only Maine, Massachusetts and Vermont have done so, though if the bill pending before the California legislature passes, that bill would include many of the key provisions needed for sustainable health care reform as well. These New England states share several characteristics that may create the climate needed to enact significant reforms. When compared to the rest of the country, these states: already have generous Medicaid programs and low rates of uninsured; were able to pass legislation with at least some bi-partisan support, although we are seeing much of that erode in the Maine Dirigo Health debate; and have many high profile lobbying and advocacy groups supporting the notion of universal health coverage and other insurance and health service industry reforms.

From the enactment of Dirigo Health in 2003, there has been dramatic erosion of support for the funding mechanism among the key stakeholders, most notably the insurance industry, people currently insured who are required to pay the savings offset payment in addition to regular premiums, employers who offer fully-insured and self-funded insurance plans, and hospitals. Since its creation, Dirigo Health has been narrowly controlled by the Governor and the agency created under the act, the Governor's Office of Health Policy and Finance. Many of the problems surrounding Dirigo Health stem from the failure to include a

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funding mechanism that fairly distributes the cost among all stakeholders, including the Maine taxpayers, and a failure to meaningfully address the rate of growth and the high cost of health care and health insurance in Maine. While there has been some compromise, there has been significant reluctance to examine and accept the hard trade-offs necessary to implement successful reform. Lower costs will mean not only more affordable insurance plans with a narrower menu of benefits and provider choice, but also tighter regulation of hospital costs.

Lessons Learned in Maine

The Need for a Sustainable Funding Source

The most immediate lesson learned from Dirigo Health (and one that applies nationwide) is the need for a sustainable source to fund expansions of coverage for the uninsured. Insurers, providers, businesses and consumers all have very powerful and well-financed lobbies that have blocked many proposals here in Maine and in other states. That is why in more recent reform proposals introduced in Massachusetts, Vermont, California and others there has been a strong emphasis on the shared responsibility principle and a spreading of costs among all crucial players. The 2007 Maine legislative session ended without any agreement on a more equitable funding mechanism, leaving the insurance industry and insured individuals to pick up the tab.

Limited Access to Federal Funding

While Maine has used the savings offset payment to fund the program going forward, it was first funded by a one time \$53 million federal Disproportionate Share Hospital payment. Massachusetts redirected federal uncompensated care funding - which will not continue - to pay for coverage expansions. Also like Maine, other states are using Medicaid waivers to expand Medicaid coverage to previously ineligible populations. However, Maine recently received notice that the federal DHHS denied this waiver request because the federal Medicaid match was not available when the state "seed" money came from "savings offset payments" made by privately insured individuals, as opposed to Maine general fund revenue. Without adequate general fund revenue, most states will attempt to use federal dollars to get health reform off the ground. In light of recent experience, however, this funding may also be unavailable or may be available only for the start-up period.

Impact of Medicaid and Medicare on a Rural Healthcare System

Although expanding coverage in theory would provide savings to the health care system through reductions in cost-shifting, Maine has failed to adequately address some of the largest drivers of health care and insurance cost increases. Medicaid expansions have not been adequately funded, the state still owes millions to state hospitals, and many physician practices are closed to Medicaid patients because of low reimbursement levels; this increases cost shifting to those insured in commercial plans. Also, Maine is an isolated, rural market, with a high percentage of Mainers covered under Medicaid and Medicare, which do not pay even the full cost of providing care by hospitals and which causes more cost-shifting. As a result, many of Maine's hospitals have higher charges than their regional and national counterparts.

Impact of Technology and Chronic Disease

Nationwide, the cost of technology and supplies is increasing at an alarming rate and will require close attention to supply chain management and cost benefit analysis in technology acquisition. So far, Maine's efforts at health system planning have been slow and met with much opposition. Maine also has a high incidence of chronic disease, especially among the Medicaid and low-income uninsured populations. Any health care reform must coincide with a bolstered public health presence and social marketing program to change behaviors such as smoking, poor diet habits and alcohol and drug abuse. The involvement of all

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stakeholders is necessary to address these factors.

Role of Mandates

Of course, getting all those players to the table on a voluntary basis would be virtually impossible, and thus many of the reforms contain elements like employer and individual mandates, provider taxes, cost containment measures and regulatory controls. Mandates can work because they force equal participation and help stabilize insurance risk pools as younger, healthier people are brought into the market. In 1974, Hawaii enacted its Prepaid Health Care Act⁸ and gained a Congressional exemption from ERISA to enable the state to mandate that employers provide health coverage to employees working more than 20 hours per week. This mandate has resulted in Hawaii having one of the lowest uninsured percentages in the country.

Funding Must be Broad-Based

Cost containment measures and regulatory controls on hospitals and insurers, such as price transparency requirements, force them to find ways to operate more effectively. To expand coverage, many states are expanding their Medicaid programs and creating quasi-government agencies to administer subsidized plans. All of these elements together may be able to work as long as the most important elements of reform involve all players in the game. Any successful reform will be financed from a variety of sources, forcing everyone - consumers, providers, insurers, employers and taxpayers - to contribute to the cause. A broad-based solution will, unlike Maine's "savings offset payment," contain many funding mechanisms including employer assessments, general fund revenues, federal funds, provider and insurer taxes or assessments, tobacco taxes, savings from cost containment measures and more.

Conclusion

It is clear that the country faces a growing crisis in the way health care is structured, delivered and financed. It is also clear that the only solution at the state or national level must be broad-based and must force all players to sacrifice and compromise to reach consensus. Here in Maine, the health care debate is not unlike the income tax debates of the early 1970's when then-Governor Kenneth Curtis⁹ managed to pass the state's income tax in his first of two terms. He was able to do this by reaching across the aisle, keeping all stakeholders informed and involved, and perhaps most importantly by communicating the potential collapse of the state's economy and future development into the modern era absent this much-needed although extremely unpopular change.

Will a collapse have to occur in Maine's health care and insurance markets to spur true broad-based reform? This is not just a question for Maine and its policymakers, but for all states and the nation as a whole. Most of the presidential candidates running in 2008 have already come out with draft plans for overhauling our health care system. Some say we cannot afford to wait for a collapse, but many believe it will be the only way to put the pieces back together in a way that will truly achieve the goals of making health care available and affordable to all Americans.

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1. Public Law 2003, ch. 469 (effective Sept. 13, 2003), as amended by Public Law 2005, ch. 400 (effective Sept. 17, 2005).
2. L.D. 1890, H.P. 1322 (May 4, 2007).
3. *Maine Assoc. of Health Plans v. Superintendent of Insurance*, 2007 ME 69; 923 A.2d 918.
4. An Act Providing Access to Affordable, Quality, Accountable Health Care, Chapter 58 of the Acts of 2006, State of Massachusetts (later codified as ALM GL ch. 118H, §§ 1-6).
5. Act 190, An Act Relating to Catamount Health, and Act 191, An Act Relating to Health Care Affordability for Vermonters (May 25, 2006) (later codified as 33 V.S.A. §§ 1981-1986).
6. Governor's Health Care Proposal (January 7, 2007) was amended to the California Health Care Security and Cost Reduction Act (October 9, 2007). The bill currently before the state Senate is California Assembly Bill X1 1, the Health Care Security and Cost Reduction Act.
7. *Retail Industry Leaders Assoc. v. Fielder*, 475 F.3d 180 (2007).
8. HRS §§ 393-398 (2007).
9. Kenneth M. Curtis was Maine's Governor from 1968-1974. He was later appointed by President Jimmy Carter to serve as the United States Ambassador to Canada from 1979-1981. He was a founding member of the firm, Curtis Thaxter Stevens Broder & Micoleau LLC.