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FUNDING HEALTH INSURANCE EXPANSION PROGRAMS:

Maine's Quandary & The Need For A Federal Solution

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Maine was one of the first states in the nation to enact comprehensive health care reform with the passage of the Dirigo Health Reform Act of 2003 (the "Act").[1] As reported previously in this journal, the laudable goals of this ambitious program include improving the quality of and access to health care and controlling costs. A centerpiece of the improving access-to-care component is the expansion of health insurance coverage through a subsidized state-sponsored insurance plan called DirigoChoice, which is administered by the Dirigo Health Agency ("DHA"). This coverage expansion was also intended to control cost growth by reducing cost-shifting. Certain other intiatives under the broad auspices of the Dirigo Health Program have made noteworthy progress. Medicaid eligibility has been greatly expanded, giving more Mainers access to care and coverage and resulting in Maine having one of the lowest rates of uninsured people in the nation. Moreover, various quality improvement programs have been launched with early signs of success. As will be discussed below, however, Maine's experience in funding the DirigoChoice insurance coverage expansion - for those who do not qualify for Medicaid and either have no employer-sponsored coverage or cannot afford commercial insurance plans for individuals - has been plagued with financial, political and legal problems. This experience sheds light on the problems of other states and on the challenges facing the Obama administration as it addresses the crisis in health care and health insurance at the federal level.

Maine's Model for Funding Coverage Expansion - The Savings Offset Payment

The funding for the subsidy of DirigoChoice policies is provided through an assessment on insurers and those who pay for health insurance, including employers and employees covered under fully-insured and self-funded plans. In theory, decreasing the rolls of the uninsured decreases cost shifting, and this dynamic produces "savings." The Act provides for an annual, administrative two-step hearing process to determine the amount of these savings (called "Aggregate Measurable Cost Savings" or "AMCS" under the Act).[2] These savings are supposed to "offset" the assessment to be paid by insurance carriers and others and provide an upper bound for the amount of the assessment, called the "Savings Offset Payment" or "SOP."[3] The DHA Board is charged under the Act with making a recommended determination of AMCS, and then the Superintendent of Insurance is charged with reviewing the proposed determination and approving or disapproving it, in whole or in part, based on whether the determination is reasonably supported in the record. [4]

A Contentious History and a Failed Attempt to Replace the SOP Through New Taxes

In each of the last three years the insurance industry through the Maine Association of Health Plans ("MEAHP"), the major employers of the state through the Maine State Chamber of Commerce ("Chamber"), and a variety of organizations providing coverage through self-funded plans including the Maine Automobile Dealers Association Insurance Trust ("Trust"), have challenged AMCS figures proposed by the DHA that have ranged from $42 to $230 million. Initially, these groups challenged the DHA's interpretation of the AMCS provision in the Act on the grounds that the plain meaning of section 6913(1)(A) and the underlying legislative intent limited "savings" to cost reductions relating to reduced bad debt and charity care attributable to the DirigoChoice program. In their challenge to the Year 1 AMCS determination through the Maine courts, these parties claimed that DHA had gone far beyond the plain meaning of the language in section 6913(1)(A)

and the legislative intent in developing "savings" methodologies that went beyond the Dirigo Choice product to encompass other Dirigo Health initiatives. These included, among others, per-unit cost reductions by hospitals allegedly due to the voluntary cost growth limits in the Dirigo Act.[5]The Maine Supreme Court found the AMCS provision to be "ambiguous,"[6] but nonetheless upheld the DHA's broad authority to interpret this provision, deferring to the DHA's interpretation on this key point.[7] Two more annual rounds of highly contentious AMCS hearings followed, with repeated claims that DHA was exceeding its authority to interpret an ambiguous statutory provision in proposing huge AMCS amounts.

This year, because of significantly eroded support for the SOP funding approach, the Legislature enacted a replacement funding mechanism that consisted of a flat 1.8% of paid claims assessment on insurers, plus a variety of taxes on soft drinks, juices, beer and wine. Some thought this was the end of the annual AMCS/SOP hearings. This new enactment did not sit well with Maine voters, however, who took advantage of a "Peoples' Veto" provision in Maine law, whereby sufficient signatures were collected to place the question on the November 2008 ballot.[8] The measure passed overwhelmingly, knocking out the replacement funding mechanism and forcing a reversion to the SOP vehicle.

The Year 3 AMCS Hearings

This unusual action resulted in another round of the annual AMCS/SOP "two step": the DHA Board held a hearing resulting in proposed savings of $149 million; and, as in each of the prior three years, the Superintendent of Insurance dramatically reduced the AMCS figure this year to $48.7 million.[9] Moreover, based on direction from the Superintendent in the Year 3 case, the DHA developed a new AMCS methodology to calculate hospital savings based on a multi-state multivariate regression analysis. DHA also developed an entirely new model for calculating savings relating to the reduction in bad debt and charity care, again based on a complex multi-state, multivariate regression analysis. Further, much to the dismay of the so-called "payor intervenors" (the MEAHP, the Chamber and others), DHA expressly declined to consider whether any of the "savings" were recoverable by insurers from hospitals in the form of lower charges. To the payor intervenors, recoverability of savings is critical to "savings" being able to offset payment of the SOP assessment and is the keystone of this funding mechanism. The Superintendent declined to review the DHA's latest interpretation of the Act on this point, deferring to the DHA Board.[10]

Further Legal Challenges to the AMCS Model on Constitutional Grounds

The Superintendent's decision on this critical point directly contradicted the DHA and Superintendent's rulings in the Year 3 case,[11] and it caused these intervenors to file suit challenging the AMCS provision in the Act itself on constitutional grounds.[12] In essence, these parties have asserted that the Act contains no meaningful definition of AMCS or standards or guidelines to reasonably limit the discretion of the DHA and the Superintendent in interpreting the Act in calculating AMCS each year. The Act does not define AMCS, but directs the Board to:

> determine annually not later than August 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).

The variety of new and different categories of alleged savings initiatives,[13] the wildly inflated proposed AMCS figures and dramatic reduction each year,[14] and the direct contradiction on a key point - recoverability - between years 3 and 4 as noted above, have all been cited in support of the claims that this provision of the Act as applied is unconstitutionally vague and constitutes an unauthorized delegation of the power of taxation

by the Legislature to the Executive Branch agencies.[15] As noted above, in the Year 1 case, these same parties appealed the AMCS decision of the Superintendent to the Maine Supreme Court, but did not challenge the Act on these constitutional grounds. Nonetheless, one Justice wrote a lengthy and spirited dissent in which he both captured the gravity of the issue and foretold that this constitutional challenge would eventually be made:

> when such vague and ambiguous statutory terminology gives an agency license to act based on preferences or criteria so subjective that they are virtually unreviewable, [the Law Court] has held that such subjective license is an improper delegation of legislative authority to the executive. *See Maine Association of Health Plans et al v. Superintendent of Ins., et al*, 2007 ME 69, ¶71, 923 A.2d, 918, 936.

Lessons Learned In Maine

A decision by the Superior Court and a very likely subsequent appeal to the Maine Supreme Court means that a final decision from Maine's highest court is not likely until the fall or winter of 2009. Although the arguments in favor of declaring the AMCS provision unconstitutional are very strong, this is a highly-charged political question that makes it difficult to predict the outcome. Nevertheless, there are several observations worth noting, based on the Maine experience with implications for other states and at the national level, relating to the extremely difficult issue of how to finance coverage expansions.

In Maine, as noted above, the Legislature enacted a flat-rate assessment on insurers, coupled with a variety of other taxes, and this package was soundly rejected by voters across the state. Governor Baldacci's administration is not likely to propose another broad-based tax to replace the controversial and legally challenged AMCS/SOP assessment mechanism. This policy void leaves the program with no currently viable funding options should the courts strike down this provision. Even with the current AMCS/SOP funding mechanism, enrollment in DirigoChoice has been frozen for two years due to operating deficits. Moreover, although hospital cost growth has slowed since the Dirigo Act was enacted, this has been true in many states that have no program like Dirigo Health in place. Finally, there has been no significant reduction in hospital charges, and insurance premiums continue to rise rapidly.

Similar Trends in Other States

In 2006, Massachusetts enacted health care and insurance reforms that included coverage expansion under the "connector" component of the Commonwealth Care Health Insurance Program. This program resembles the Maine experiment and has signed up nearly 450,000 people for health insurance (although it is reported that as many as 80,000 were simply put on Medicaid and 176,000 more on government-subsidized plans like DirigoChoice). By contrast, DirigoChoice has never insured more than 20,000 new, previously uninsured enrollees. However, in Massachusetts it is reported that the program will survive only with continued and increasing federal subsidies involving tax dollars from residents from other states,[16] an approach that will be controversial.

Maine, Massachusetts and Vermont were among the first to enact similar, comprehensive health care reform legislation that included coverage expansion as a key provision. Since then, several other states, including California, have debated these reforms but have had less success in enacting such measures. Quite often, the biggest stumbling block is how to fund coverage expansion. This obstacle seems to have only become greater in the past several months with the downturn in the economy and the various financial sector and other bailout and stimulus packages being debated. Controlling health care and health coverage costs also presents practical and political roadblocks at the state level, especially since 46% of health care spending in the entire U.S. comes from the federal government in Medicare and Medicaid and other programs. [17] These programs are the major causes of cost-shifting, because they do not pay the full cost of providing care to hospitals and doctors.

This funding shortfall not only has created access to care issues but creates a problem of insurmountable proportions at the state level for any state.

What the Experience of the States Tells Us About Health Insurance Reform at the Federal Level

At the federal level, as the Obama administration begins its work, the United States devotes 16 percent of its gross domestic product to medical care, more per capita than any other nation in the world. Yet, numerous measures indicate the country lags in overall health: it ranks 29th in infant mortality, 48th in life expectancy and 19th out of 19 industrialized nations in preventable deaths.[18] Maine's experience and that of other states clearly indicate that finding ways to fund coverage expansion cannot be done meaningfully at the state level. This is especially true now, with enormous budget deficits in states across the country. It also seems clear that meaningful controls on health care costs must come from the federal government, given its already predominant share of overall health expenditures and its ability to centralize controls in a uniform way. In a prior article, I posed the question of whether a collapse of our health care and health insurance systems will be the only way to put the pieces back together in a way that will truly achieve the goals of making healthcare available and affordable for all Americans. The federal budget deficit is already skyrocketing with more tax cuts, stimulus packages and spending plans coming. Nonetheless, given Maine's and other states' experience in the past year, and the course of events at the national level, it seems more likely that the crisis in health care and health insurance will continue to build so that a national solution will be the only way forward.

Endnotes

1. Public Law 2003, ch. 469 (effective Sept. 13, 2003), as amended by Public Law 2005, ch. 400 (effective Sept. 17, 2005).

2. *See generally* 24-A M.R.S.A. § 6913(1)(A) -(C).

3. 24-A M.R.S.A. § 6913(2)(C). The SOP may not exceed the lesser of AMCS or 4% of paid claims. Id. § 6913(3)(B).

4. 24-A M.R.S.A. § 6913(1)(C).

5. These voluntary cost growth limits on hospitals in Maine are currently codified at 22 M.R.S.A. § 1722.

6. *Maine Association of Health Plans et al v. Superintendent of Ins., et al*, 2007 ME 69 ¶37, 923 A.2d 918, 928.

7. *MEAHP*, 2007 ME 69 ¶46-59, 923 A.2d at 930-34.

8. The provisions of Maine's "people's veto referendum" are codified at 21-A M.R.S.A. § 901 *et seq*.

9. INS-08-900 at 3 (Superintendent's Decision). The Superintendent's decision in the Year 4 case will be available shortly at http://www.maine.gov/pfr/insurance/laws_rules.htm#decisions at docket number INS-08-900.

10. *See* INS-08-900 at 4 and 37.

11. In the four years of AMCS hearings since their inception in 2003, there have been three different Superintendents ruling on the DHA board's proposed AMCS determination: Superintendent Allessandro Iuppa

in Years 1 and 2, and recently appointed Superintendent Mila Kofman in Year 4. Acting Superintendent Eric Cioppa presided over the hearing in Year 3.

12. *See Maine Automobile Dealers Association Insurance Trust, Maine State Chamber of Commerce, Maine Association of Health Plans and Anthem Health Plans of Maine, Inc. v. Superintendent of Insurance and Dirigo Health Agency*, Docket Nos. AP-08-71 to -74 (consolidated) (Kennebec County Superior Court).

13. In addition to the new and extremely complex multi-state, multivariate regressions models for hospital savings and uninsured intiatives, DHA has, over the first four years, proposed additional savings categories including: payment of overdue Medicaid reimbursement to hospitals and physicians, certificate of need and capital investment fund intiatives, voluntary underwriting gain limit initiatives, and in Year 4 a medical loss ratio initiative. It is beyond the scope of this article to explore each of these initiatives, but they are mentioned to demonstrate the breadth of the DHA's interpretation of the AMCS provision. Moreover, DHA has struggled to define AMCS consistently, sometimes defining it as refunds to certain policyholders (medical loss ratio initiative), at other times as savings to the Maine health care system as a whole (uninsured initiatives), and yet others as a subset of the Maine healthcare marketplace (hospital savings) without regard to whether a projected reduction in the rate of hospital cost growth by a mythical virtual hospital was - or even could be - passed on to the purchasers of health insurance policies.

14. In Years 1 through 4 the DHA Board proposed AMCS in the following amounts, followed by the amount actually approved by the Superintendent: Year 1- $136.8 M reduced to $43.7M; Year 2 - $41.8M reduced to $34.3 M; Year 3 - $78.1M reduced to $32.8M; Year 4 - $149.6M reduced to $48.7 M. Moreover, in Year 4 the Superintendent, with significant assistance from outside expert consultants, found that even with substantial revisions to the Year 4 DHA hospital savings methodology, it still carried a $350 million margin of error. INS-08-900 (Decision of Superintendent) at 14.

15. The Maine Constitution explicitly includes the doctrine of separation of powers, using both all-encompassing language and also more specific forms. Article III, Section 2 provides that: "No person or persons, belonging to one of these departments, shall exercise any of the powers belonging to either of the others, except in the cases herein expressly directed or permitted." Article III, Section 1 creates "three distinct departments, the legislative, executive and judicial." Two other more specific provisions are set forth at Article I, section 22 - "No tax or duty shall be imposed without the consent of the people or of their representatives in the Legislature." Article IX, section 9 provides that "The legislature shall never, in any manner, surrender the power of taxation." Numerous arguments supporting these claims have been advanced, but are beyond the scope of this article. These include, for example, the argument that the SOP is a tax and not a fee or duty, given that the SOP is used to fund a state-wide insurance plan.

16. Pipes, Sally C., President and CEO of the Pacific Research Institute, quoted from an op-ed article in the Wall Street Journal, December 5, 2008, entitled "Obama Will Ration Your Health Care."

17. *Id.*

18. Connolly, Ceci, "Many Experts Say Health-Care System Inefficeint, Wasteful." Washington Post, Nov. 30, 2008.