

## KEY COMPONENTS OF A SUCCESSFUL NATIONAL HEALTH CARE REFORM PACKAGE

### *What Maine's Experience Tells Us*

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As Congress and the Obama administration struggle to enact comprehensive health care reform, comparisons are being made to proposed solutions being offered in Washington with what has happened in several states that have already enacted similar types of reform packages in the past few years. As reported previously in this journal, 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").<sup>1</sup> Just like the various federal initiatives being debated currently, two key goals of Maine's reform package were to improve access to health care through expanding private insurance and public Medicaid coverage and to control costs.<sup>2</sup> Maine has attempted to expand private health insurance coverage through a subsidized state-sponsored insurance plan called DirigoChoice, which is administered by the Dirigo Health Agency ("DHA"). This coverage expansion is funded with a surcharge on insurance premiums paid by individual subscribers and was also intended to control cost growth by reducing cost-shifting. 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.

A review of the track record of the Dirigo reforms over the past five years shows that the funding mechanism for private coverage expansion has been fraught with financial, political and legal problems, and the impact on enrolling previously uninsured individuals in the DirigoChoice product has fallen far short of expectations. Just as stark is the failure of the Dirigo model to reduce the overall cost of health care. A review of this track record will reveal what has not worked and why and points the way to several key components of a successful health care reform plan on the national level.

### **I. Maine's Dirigo Health Reforms - The Track Record**

When signed in 2003, Governor Baldacci's administration promised that by 2009 the program would arrange for coverage of all of the approximately 128,000 of Maine's then-uninsured. System-wide controls on hospital and physician costs would hold down insurance premiums. There would be no new taxes to fund the coverage expansion. Providing insurance for all Mainers would also save businesses and patients money by reducing cost-shifting from uninsured and underinsured (including Medicare and Medicaid beneficiaries for whom the federal government pays less than the cost of care to hospitals and physicians) to those insured under private, fully-insured or self-funded plans.

In reality, the cost to taxpayers who also pay for their private health insurance coverage, in the form of the so-called "Savings Offset Payment" ("SOP") surcharge added to their premiums, has totaled \$155 million over the past five years. Annual hearings to set the amount of the SOP and related court challenges have consumed millions of state and private dollars. Instead of 128,000, actual enrollment in the subsidized DirigoChoice product has been far less than projected, hitting a peak of 15,000 enrolled in 2006. That figure has dropped to below 10,000, and, in fact, a majority of these people already had some form of private insurance and chose to drop their prior coverage in favor of the subsidized product. Maine has greatly expanded Medicaid eligibility and coverage over this period, now covering 22% of the population, which is twice the national average and covers families with up to \$44,000 per year in income. Even with this expansion, the total number of

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uninsured in Maine today is only slightly lower than in 2004.<sup>3</sup>

In addition, the promised controls on hospital costs, which were part of the original Dirigo Reform Act legislation, were stripped out in the final hours of legislative negotiations and were replaced by "voluntary" cost targets.<sup>4</sup> Maine has experienced a moderation in the rate of hospital cost growth since 2003, when Maine's cost growth was among the highest in the nation. This "regression to the mean," however, is completely predictable in actuarial circles.<sup>5</sup> Moreover, Maine's overall reduction in the rate of cost growth since 2003 is consistent with the experience in many other states in the country that have not had any similar health reform in place during this period.<sup>6</sup> A stark barometer of the failure of the Dirigo model to control costs is the simple fact that health insurance premiums in Maine continue to be among the highest in the nation.<sup>7</sup>

### **II. What Caused Maine's Track Record to Fall Far Short of Promised Levels?**

First, many of the sickest Mainers - those with the most expensive to treat conditions - crowded into DirigoChoice. This adverse selection makes the premiums so high that even with subsidies fewer than expected low-income people could afford the subsidized product.

Second, the DirigoChoice product offers only one, extremely rich benefit package, making the premium too high even with subsidies, even for healthy individuals. Massachusetts by comparison in its "Connector" program offers a range of coverage and benefit packages on a sliding price scale. As funding through the annual SOP process was far less than projected by DHA, it froze enrollment rather than offering a pared-down range of benefit packages.

Third, in the early 1990's Maine imposed community rating and guaranteed issue requirements on insurers, much like components of several of the federal proposals now being considered. These reforms have driven up health insurance costs to levels significantly higher than in neighboring states. This factor, coupled with Maine's high medical cost growth experience, has caused premiums over the past five years to increase by over 70%.<sup>8</sup>

Fourth, four years of contentious SOP hearings have consistently resulted in decisions by the Maine Superintendent of Insurance that the alleged savings due to the Dirigo program were far less than claimed by DHA. These decisions have left DHA with insufficient funding to provide subsidies for the DirigoChoice product. Therefore, despite the original promise not to impose new taxes to fund this coverage expansion and the other DHA initiatives, the DHA and the Baldacci administration in 2008 sought legislation imposing new taxes on soda, juice, wine and beer to do just that. These taxes were passed by the legislature but then vetoed by a statewide referendum permitted under Maine law.<sup>9</sup>

Fifth, in 2009 DHA and the Baldacci administration were back with legislation to enact a fixed 2.14% of paid claims as a statutory assessment to replace the SOP annual assessment. The legislature enacted this "assessment," which now in perpetuity will be assessed as a surcharge on all those Mainers covered under fully-insured or self-funded plans.<sup>10</sup>

Sixth, Maine unlike the federal government, has a balanced budget requirement in its state constitution. It cannot engage in "deficit spending." Therefore, absent sufficient SOP funding, and even with newly enacted legislation providing for a special assessment on policyholders in Maine, the DHA does not have enough funding to expand eligibility in DirigoChoice. Waiting lists grow longer and the number of uninsured Mainers is not being meaningfully reduced.

Like similarly ambitious programs in Massachusetts and Tennessee<sup>11</sup>, the Maine experiment has proven to be very expensive while achieving very limited success in its original goal of expanding access to care and coverage, mainly through expanding Medicaid eligibility, and has made no significant progress in achieving

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its other key goal, reducing overall the underlying health care costs.

### **III. Key Components of a Successful National Health Reform Package Based on Maine's Experience**

#### a. Reforms must come at the national level.

As noted previously in this journal, the federal government controls a very large segment of the total health care expenditures in the country through its operation of the Medicare and Medicaid programs. Federal matching funding must be secured to enable states to expand their respective Medicaid programs to cover more low-income people. Moreover, to significantly increase Medicaid enrollment it must be done nationally and not left to each state, as there is tremendous variation by state in the Medicaid eligibility requirements (and the percentage of uninsured people). Moreover, Medicare and Medicaid do not even pay the full *cost* to providers (as opposed to the charges of hospitals and doctors). This unmet shortfall is passed on to the insured population and is referred to as "cost shifting." Any comprehensive health care reform package must address the cost shifting problem and only the federal government is in a position to do so.

#### b. Funding must be broad-based.

Special assessments, such as Maine's SOP or the recently enacted legislative assessment, do not raise sufficient funding to cover the cost of providing anything close to universal health coverage. Tax dollars already pay for Medicare and Medicaid. Tax policy is an integral part of all federal options now being considered, such as deductibility of premiums and taxes on high-priced plans. The burden of such major program expansions must be distributed widely throughout the population through the tax structure to be sustainable over the long-term.

#### c. Mandated coverage must be meaningful to be effective.

Massachusetts has enacted a mandate for individuals and employers to obtain coverage as part of its health reform package. The penalty for an employer that does not obtain mandated coverage is far less than the cost to provide coverage, which makes the mandate very ineffective in causing every Massachusetts employer subject to the mandate to obtain coverage for its employees. Likewise, Karen Ignagni, president of America's Health Insurance Plans, the leading health insurance industry advocacy group, has objected to the mandate penalty provision in various proposed federal models as being too lenient, which would not force younger, healthier, currently uninsured people to purchase coverage. This in turn would dilute the insured pool and would undermine the insurers' ability to drive down underwriting costs.<sup>12</sup>

#### d. Insurance reforms will drive up premiums.

Maine has already enacted at least two market reforms - community rating and guaranteed issue - that are currently being debated in Washington. These requirements help to reduce the number of uninsured, but clearly they also have driven up premiums in Maine versus neighboring states.<sup>13</sup> We must expect similar results nationally if such reforms are enacted. There must be true savings in other parts of a national reform package to offset these projected increases.

#### e. Cost Controls - the Pink Elephant.

Noticeably absent from most of the coverage of the federal debate is a sharp focus on the dramatic and steadily increasing amount that this country spends on hospital, physician and pharmacy services, and what specific steps will be included in a national plan to control and reduce these costs. Even the insurance industry, as it reacts to various proposals and is increasingly portrayed as the scapegoat in the debate, seems reluctant to openly call for cost controls. Yet Medicare and Medicaid already control costs by dictating how

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much hospitals, physicians and pharmacies will be paid for services provided to beneficiaries. Ironically, at least one proposal would create "savings" by cutting the amount paid to these providers under Medicare and Medicaid over time. Similar cuts to physicians in the past have been subsequently lobbied out of the law prior to the effective date, but they have propped up the projected savings Congress has promised the taxpayer. To the extent that such cuts in Medicare and Medicaid payments to providers remain in any enacted national reform, they will only add more pressure to the current cost shifting, which will cause private health insurance premiums to increase down the road.

The underlying nemesis to meaningful health reform is how to control the cost of care paid by private insurers to providers on behalf of their subscribers. If the federal government really did control these underlying costs, then insurers could charge less for their coverage. Switzerland has adopted a similar approach, whereby the federal government sets budget limits for hospital care, and then private insurers provide coverage up to these limits. Yet in Maine such controls were stripped out of the Dirigo Health Reform Act. Massachusetts, which is now faced with exploding costs from its new reform package, is trying to push back by proposing widespread controls on hospital costs. This effort is facing fierce opposition from the hospital industry in the state.<sup>14</sup> There appears to be no clearly articulated component of any of the current federal proposals that tackles this issue. Trying to solve the crisis in the cost and availability of health care coverage without meaningful cost controls ignores the underlying costs that the entire health insurance system is designed to cover and cannot succeed over time.

### f. Public Option - now or later?

Maine's DirigoChoice product is not a true public option. Instead it is much like a private health insurance plan with subsidies to help people afford coverage who otherwise could not. Given the much smaller than expected enrollment, and the limited success of voluntary cost limits and reductions in cost shifting due to fewer uninsured in Maine, the Dirigo experiment has not meaningfully reduced the overall cost of health care in Maine. A key element of a true public option should be to grant the authority - like that given to Medicare and Medicaid - to control underlying hospital, physician and pharmacy costs. Senator Snowe from Maine had been quoted as favoring a "wait and see" approach on the public option. She proposed giving the private insurance industry some time to work to control the cost of premiums, and if they are not successful, to then adopt a public option. It is hard to see how the insurance plans can do this without legislation to control the underlying costs that they insure. Such legislation must come at the federal level. Yet such provisions are nowhere to be found in the current proposals being discussed on Capital Hill.

The public option was eliminated from the Senate bill, but was included in the House bill. As the action shifts to conference committee, it bears close watching to see if any meaningful controls on underlying costs are included and ultimately enacted. It is not likely to happen, however, as this would be seen as creating an uneven playing field for any public option versus insurers. It would be better policy but probably not politically feasible to enact such cost controls nationally so that, as in Switzerland, private insurers could benefit from them and pass that benefit along to subscribers in the form of lower premiums.

If we do not adopt a public option with underlying cost controls, it is very likely that these costs will continue to increase dramatically, which will drive up premiums, and we will be faced with a huge tax increase to fund one of the biggest expansions in Medicaid enrollment of all time. As noted in prior articles on this subject in this journal, this crippling increase in premiums and new taxes could over time cause the collapse of the system as we currently know it. If that happens, then the public option will re-surface. Only then the federal government may be forced to run the entire system, like the British government did following World War II. Cost controls would be a key part of such a comprehensive federal program. One way or another the problem of controlling underlying costs will not go away. Our public policymakers are simply deciding when we will be forced to deal with it.

**Endnotes**

1. Public Law 2003, ch. 469 (effective Sept. 13, 2003), as amended by Public Law 2005, ch. 400 (effective Sept. 17, 2005).
2. The third goal of the Act was to improve the quality of health care through the establishment of the Maine Quality Forum, which is charged with undertaking a broad range of initiatives including: collection and dissemination of research on evidence-based medicine and patient safety to promote best practices; adoption of quality and performance measures to evaluate and compare health care quality and provider performance; coordination of collecting health care quality data; collection of comparative health care quality data from providers and insurers in a format usable to consumers, purchasers and policymakers; consumer education; technology assessment to guide the use and distribution of new technology; encouraging the development of electronic data for medical records and claims; making recommendations for the state health plan; providing annual reports to the public and the state legislature including provider-specific performance data and infection prevention activities. *See* 24-A M.R.S.A. § 6951(1-11).
3. "No Maine Miracle Cure: Another Public Option that Failed," Wall Street Journal, September 17, 2009.
4. *See* 22 M.R.S.A. § 1722 (current statutory codification of original Dirigo Reform Act voluntary cost controls).
5. The Maine Association of Health Plans offered expert testimony on this point from Milliman, an industry leading actuarial consulting firm, in the year 4 administrative hearings to set the amount of the SOP. *See In re: Review of Aggregate Measurable Cost Savings ("AMCS") Determined by Dirigo Health for the Fourth Assessment Year, Docket No. INS. 08-900.*
6. Comparative state-by-state hospital cost growth data was admitted into the record in the year four AMCS administrative hearing. *Id.*
7. For example, family coverage in Maine costs in excess of \$15,000 per year.
8. "No Maine Miracle Cure," Wall Street Journal, September 17, 2009.
9. The authority for Maine's "people's veto referendum" appears in the Maine Constitution, Article IV, section 17, and the related procedures are codified at 21-A M.R.S.A. § 901 *et seq.*
10. *See* Public Law, Chapter 359, An Act to Stabilize Funding and Enable DirigoChoice to Reach More Uninsured, codified at 24-A M.R.S.A. § 6917(1). The 2.14% of paid claims figure was based on the amount approved by the Superintendent in the 2008 AMCS/SOP hearings process. The Maine Association of Health Plans, the Maine Chamber of Commerce and the Maine Automobile Dealers Insurance Trust challenged this decision in court and after the new law was enacted, received a decision vacating the Superintendent's decision and rejecting much of the underlying basis for the amount of the assessment. The matter is on remand to the DHA but will only affect the SOP for one year; the 2.14% assessment in the new law is still in effect for the current and future years.
11. "No Maine Miracle Cure," Wall Street Journal, September 17, 2009.
12. Gregg Hitt and Janet Adamy, "Insurers Push Back as Senate Health Vote Nears," Wall Street Journal, October 13, 2009. In a related public television interview, Ms. Ignagni stated that "...the experience at the

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state level indicates that you have to have everybody participate. .. And what happened in the states was...[those] states that enacted market reform without everyone participating, you had rate shock. You had people leaving the pool who were young and healthy, spiraling up the costs for everyone. This is not a projection. This is what happened at the state level." Quoted from an interview on the NewsHour with Jim Lehrer, October 12, 2009.

13. "No Maine Miracle Cure," Wall Street Journal, September 17, 2009.

14. "Hospitals Attack State Pay Proposal," Boston Sunday Globe, October 4, 2009 (page 1).