



# The Dirigo Health Reform Act: A Case Study of Small Group Market Reform in Maine

August 2008

Prepared by  
Elizabeth Kilbreth and Kimberley Fox  
University of Southern Maine, Muskie School of Public Service

for  
The Nelson A. Rockefeller Institute of Government  
Health Policy Research Center

with funding from  
The New York State Health Foundation



## **Acknowledgments**

This report was prepared by the University of Southern Maine, Muskie School of Public Service, for the Nelson A. Rockefeller Institute of Government's Health Policy Research Center (HPRC). Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, or staff.

The primary authors of this case study are Elizabeth Kilbreth and Kimberley Fox. The case study is one of three conducted as part of a project examining states' experiences with private insurance market reforms. Guidance on the report contents were provided by the project director, Courtney Burke, director of the Rockefeller Institute's Health Policy Research Center. Guidance and valuable feedback were also provided by Frank Thompson of the Rutgers Center for State Health Policy and James Fossett of the Rockefeller Institute's Health Policy Research Center. Layout and editing support were provided by HPRC's Barbara Stubblebine. Michael Cooper, the Rockefeller Institute's director of publications, proofread this report.

The authors would like to express their gratitude and acknowledge their indebtedness to the many individuals with substantial knowledge of the health care system in Maine who agreed to be interviewed for this study and whose expertise and perspectives greatly aided the authors.

## **About the Report**

The paper is intended to provide national policymakers with insight about the administrative structure, effects, and implementation challenges of health reform efforts in Maine. It also provides lessons about program reform, administration, and implementation for New York State policymakers.

## **About the Rockefeller Institute and the New York State Health Policy Research Center**

The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York. The New York State Health Policy Research Center (HPRC), a program of the Rockefeller Institute, provides relevant, nonpartisan research and analysis of state health policy issues for New York State and national policymakers. With funding support from the New York State Health Foundation and other foundations, HPRC uses its in-house health policy experts, as well as national experts, to build on the Rockefeller Institute's strength in analyzing the role of state and local governments in financing, administering, and regulating state health care systems.

## **About the Muskie School of Public Service**

Through its teaching, research, and public service, the Edmund S. Muskie School of Public Service of the University of Southern Maine educates leaders, informs state and national policy and practice, and works to strengthen civic life. The Muskie School's Institute for Health Policy conducts nationally recognized research and policy analysis to identify and promote solutions to complex health care challenges. The Institute links leading scholarship with policy and practice to improve health care and human services.

## Table of Contents

Acknowledgments.....	2
Executive Summary.....	4
I. Introduction .....	7
II. The DirigoChoice Program .....	7
Program Eligibility .....	7
Subsidy Program .....	8
Overview of DirigoChoice Program Structure.....	9
Subsidy Administration .....	10
DirigoChoice Marketing and Outreach .....	10
DirigoChoice Program Funding .....	10
DirigoChoice Program Experience.....	11
DirigoChoice Program Costs.....	12
How Has the Cost Performance of the DirigoChoice Program Been Viewed? .....	13
DirigoChoice Plan Mid-Course Corrections.....	14
III. Dirigo Reform Cost Containment Measures .....	16
Regulatory Constraints.....	16
Voluntary Benchmarks and Improvements in Transparency.....	16
Health Planning .....	16
Experience With Cost Containment Measures, to Date .....	17
IV. Lessons From the DirigoChoice Experience .....	18

## Executive Summary

### Overview

In 2004, Maine passed the Dirigo Health Reform Act, which is designed to expand affordable coverage to the uninsured, curb growth in health care spending, and provide state leadership to improve health care services. In an effort to improve coverage, the law expands Medicaid eligibility and provides subsidies for low income uninsured. In the DirigoChoice Program, a state sponsored insurance product available to employers in the small group market, employers contribute 60 percent of the cost of each employee's premium. After 30 months of operation, the program is providing coverage for over 15,000 people, including employers and employees in 720 small businesses. In the three years prior to the enactment of the Dirigo Reform law, premiums in the small group market in Maine increased, on average, 26 percent per year, compared to, on average, 10.25 percent per year in the four years since enactment. The program has increased hospital and insurance industry performance transparency and possibly affected cost containment. The early experience of the DirigoChoice program led to modifications in 2008 to the program design, administrative mechanisms, and funding strategies.

### Administration

The DirigoChoice Program, which is aimed at increasing insurance coverage, is a public/private collaborative jointly administered by a newly created state agency — the Dirigo Agency — and a private insurance carrier. The insurance carrier is selected through competitive bid. Premiums are negotiated by the Dirigo Agency with the carrier and subsidy levels are determined by the board of trustees. The Maine Quality Forum also was developed as a result of the Dirigo Health Reform Act to oversee cost and quality initiatives. The Forum is a public entity that monitors variation in utilization rates and quality, educates the public, and works with providers on quality improvement initiatives.

### Eligibility

There are two categories of eligibility for the DirigoChoice Program: businesses with fewer than 50 employees (including sole proprietors); and individual residents who work 20 hours or fewer per week for any one employer, or who work for a business of fewer than 50 that does not offer health insurance coverage, or are retired but not yet eligible for Medicare.

### Effects of Reforms on Private Insurance Coverage

At the time DirigoChoice was implemented, there were approximately 49,000 working uninsured (and their dependents) in businesses of fewer than 50. After 30 months of operation, the DirigoChoice program had enrolled approximately 15,000 members (this includes 720 small businesses). These small businesses comprise 23 percent of enrollment, while sole proprietors comprise 28 percent, and individuals, 49 percent. Approximately 63 percent of DirigoChoice members were either uninsured or underinsured prior to enrolling. The uninsured constituted 40 percent. Overall, the take-up rate for small businesses is about 11 percent for the pool of uninsured small business workers.

### Lessons

*Program design and employer resistance to coverage may have resulted in lower uptake rates in the small group market* – To date, many eligible persons and businesses have chosen not to enroll in the Maine DirigoChoice program. It appears that the lack of enrollment may derive from uncertainty about the DirigoChoice program's future, high employee turnover, alternative sources of coverage for some

workers, and instances in which neither employers nor their employees can afford the full premium cost for part time employees. Many small employers in Maine not already providing health benefits expressed reluctance to cover the employer share of the premium, and major disappointment was expressed that the subsidy was targeted to enrollees and not to the employers' contributions.

*It is difficult to maintain consensus and bipartisan support during program implementation* – The DirigoChoice Act was passed with bipartisan support in a political environment where public support for policy action on health care costs and access was high. The level of public investment needed for a major access initiative, however, immediately put the DirigoChoice initiative in competition with other state spending priorities. Unrealistic expectations with regard to the rate of change in health care costs and the number of uninsured quickly eroded support in the business community. The Dirigo Agency was limited in its ability to communicate to the public its successes with incremental steps and to correct misinformation because of an insufficient budget for marketing and public education.

*Public consensus is helpful in determining which populations should be assisted by coverage initiatives* – Currently, there is no consensus on how much individuals at different income levels should contribute to their own coverage and who should be entitled to coverage discounts made available through public resources. Even if political consensus is reached on a clearly demarcated line between the private market and those entitled to public subsidies, the line has to be redrawn frequently or new “gap” groups emerge. Publicly sponsored programs like DirigoChoice that open enrollment to higher income businesses and individuals put themselves in direct competition with the private insurance industry. However, if they do not extend eligibility to these individuals and businesses, they preclude enrollment of small businesses with low income and uninsured workers, where the employer and firm management have incomes above the income eligibility threshold. The tradeoffs of these decisions are difficult to manage.

*Complex programs are difficult to administer and market; this may affect take up rates* – The DirigoChoice premium subsidy structure is administratively complex. Private insurers' administrative and billing systems are not designed to accommodate variable pricing based on household income or to match funding streams from two sources (public and private) for premium payments. This complexity limits the state in the number of potential contract partners and could impede expanding the program. In addition, it makes marketing the program to small businesses more difficult because of the need to explain the premium structure and the additional paperwork necessary to process subsidy applications.

*Cost control issues are difficult to separate from coverage initiatives* – High health care costs led to significant resistance in Maine to the establishment of any funding source for coverage expansions that would result either directly or indirectly in an increased cost to the business community. Tying program funding to demonstrated savings was a mechanism to try to ensure that new state dollars did not stimulate more inflation in the health economy, but also was politically necessary to gain support from key stakeholders.

*Changing the rate of growth in health care spending is extremely difficult and measurement of the change even more challenging* – Savings from reductions in bad debt and charity care are real, but are not a dollar for dollar offset against expenditures of newly insured individuals in state programs. Additional savings from state planning efforts, tightened certificate of need (CON) controls and enhanced public health will be realized over the course of many years, but do not provide immediate cost reductions. Even immediately realized and substantial cost reductions, such as hospital compliance

with cost saving benchmarks turned out to be difficult to measure and required an assessment of actual spending against expected (and unmeasurable) spending in the absence of state reforms.

*The biggest challenge in the maintenance of a health access initiative is the rate of increase in health care spending* – State budgets are countercyclical, with the greatest demand for public services happening during economic downturns when revenues are at their lowest. The ultimate sustainability of access initiatives may be affected by successful cost containment measures that provide relief to employers and taxpayers on their health care costs and federal support to states that helps compensate for differences in state fiscal capacity.

*Coverage initiatives are likely to encounter challenges, but can be fine tuned to make them more sustainable* – Maine's DirigoChoice is the first program that has attempted to link program funding to *measured* savings and to make funding contingent upon the demonstration of such savings. The Dirigo Health Reform offers valuable lessons to states considering responses to the health care crisis. It demonstrates some successes, illustrates a number of administrative and political challenges, and reiterates that sustained funding is the greatest challenge facing states striving for the goal of universal coverage.

## I. Introduction

H.P. 1187, the Dirigo Health Reform Act, passed by the Maine legislature in 2004, is a comprehensive initiative designed to expand affordable coverage to the uninsured in the state, curb the rate of growth of health care spending, and provide state leadership in efforts to improve the quality of health care services.

The law authorized a strategy that combined Medicaid eligibility expansion with state subsidies for low and moderate income uninsured people as a means to expand access to health coverage. Specifically, under the Dirigo Reform Law, Maine has:

- Expanded eligibility under MaineCare (Maine’s Medicaid and State Children's Health Insurance [SCHIP] programs) for parents of eligible children from 150 percent up to 200 percent of the federal poverty level (FPL)<sup>1</sup>; and
- Implemented DirigoChoice – a state sponsored health coverage program with subsidies on a sliding scale for non-MaineCare eligible individuals and families with incomes up to 300 percent FPL who meet program eligibility criteria.

The cost containment initiatives of the Dirigo Reform Act include negotiated benchmarks with Maine’s hospital industry, strengthened regulations affecting the provider community and insurance industry, and the introduction of a comprehensive health planning function.

The law authorized the creation of the Maine Quality Forum, a public entity that monitors variation in utilization rates and quality, educates the public, and works with providers on quality improvement initiatives.

This report describes health care access and cost containment initiatives, as implemented by the state of Maine. Section 2 describes the structure of the DirigoChoice program and reports on program experience to date. Section 3 describes the cost containment initiatives and presents preliminary findings with regard to impact. Section 4 presents the study conclusions and lessons from Maine’s experience.

## II. The DirigoChoice Program

### Program Eligibility

Eligibility for the DirigoChoice program includes the following categories:

- Businesses with 50 or fewer full time employees. The program does not have a crowd out provision and businesses meeting the size criterion are eligible to select the DirigoChoice insurance product regardless of current or prior health insurance status. Consistent with Maine small group market requirements, at least 75 percent of employees working 30 hours or more per week and who do not have other credible coverage must participate.

---

<sup>1</sup> Prior to the enactment of the Dirigo Reform law, Maine had implemented a Medicaid 1115 Waiver that extended Medicaid eligibility to childless adults with incomes up to the federal poverty level. Eligibility for children under Maine’s SCHIP program was at 200 percent of the federal poverty level.

- Sole proprietors are considered businesses of one and are eligible to enroll.
- Maine residents may purchase coverage as individuals through DirigoChoice if they work 20 or fewer hours per week for any one employer; if they work for a business of fewer than 50 that does not offer health insurance coverage; if they are retired but not yet eligible for Medicare benefits and their employer does not contribute to retirement health coverage; or if they are a small business employer who tried to purchase a DirigoChoice group policy but was unable to secure 75 percent participation from eligible employees. Employees working for employers that do not provide employer sponsored health benefits are not eligible until they have been without employer sponsored coverage for 12 months.

#### ***Why Such a Limited Crowd-out Provision?***

Policyholders decided against a crowd-out provision (except for individual enrollees) for three reasons:

1. **Equity:** Policymakers were concerned that small employers that had stretched financially to provide health benefits should not be excluded from a government program that was available to their competitors that had not provided benefits.
2. **Market volatility:** The rate of increase in premiums had been so substantial in the years prior to the implementation of the DirigoChoice plan that policymakers were concerned about involuntary loss of coverage due to unaffordable premiums.
3. **Employee take-up rates:** Policymakers wanted to reach individual employees *within covered businesses* who had remained uninsured because they could not afford commercial coverage.

### **Subsidy Program**

The subsidies of the DirigoChoice program are structured differently for small businesses, sole proprietors, and individuals:

- **Small businesses:** The Dirigo Act requires that enrolled employers contribute a minimum of 60 percent of each employee’s premium. However, employers are not required to contribute toward the coverage cost of dependents. The employer share of the premium is not subsidized. In these groups, enrolled individuals and their dependents whose household income is below 300 percent of the federal poverty level are eligible for state funded subsidies for their share of program costs (their contribution to their own premium costs as well as 100 percent of dependent coverage). There are four tiers of subsidy: an 80 percent, 60 percent, 40 percent, and 20 percent discount (see [Table 1](#)). Employees and employers whose incomes exceed 300 percent of the federal poverty level may enroll in DirigoChoice at full membership cost.
- **Sole proprietors:** Self employed individuals with personal incomes below 300 percent of the federal poverty level are eligible for discounts only on 40 percent of the full premium (the enrollee “share”). Their business is expected to pay the employer’s (60 percent) share of the premium. The subsidy for the 40 percent premium share conforms to the same discount schedule as the employee discount in small businesses.
- **Individual enrollees:** Nongroup enrollees with incomes below 300 percent FPL and not otherwise eligible for MaineCare receive discounts against the entire premium. Thus, while an employee of a business might be eligible for a 20 percent reduction in his/her *share* of the membership costs, a similarly situated individual would receive a 20 percent reduction in the full premium costs.



- **Discounts on deductibles:** Deductibles within the DirigoChoice program are also tiered according to subscriber household income ([Table 1](#)). Three plan choices are available with deductibles of \$1,250, \$1,750, and \$2,500 for a single person, respectively. Premiums vary according to the deductible level with higher deductible plans costing less in premiums. The overwhelming majority of enrollees have selected the lowest deductible plan. [Table 1](#) shows the discount schedule for the deductibles for low income subscribers for the most popular DirigoChoice plan.

**Table 1: DirigoChoice Subsidy Structure (Based on the Dirigo Plan With \$1,250 Deductible)**

<ul style="list-style-type: none"> <li>• Employer/self employed pay 60% of employee premium</li> <li>• Employee/self employed discount based on 40% employee share and 100% of dependents</li> <li>• Individual discount based on 100% of premium</li> </ul>					
Discount Groups Based on Income	<149% FPL	150-199%	200-249%	250-299%	+300%
Discount	80%	60%	40%	20%	None
Deductible					
Single	\$250	\$500	\$750	\$1000	\$1250
Family	\$500	\$1000	\$1500	\$2000	\$2500

***Why offer relatively high deductible plans to low income workers?***

The Dirigo Board of Trustees decided to offer health plans with relatively high deductibles as a means of reducing the total premium cost and thereby reducing the 60 percent share required of employers. The small group market in Maine is moving toward high deductible policies in response to the general rate of increase in health care costs and insurance premiums. Because the DirigoChoice products have deductibles comparable to many other products in the market, the unsubsidized premiums (and employers' share) are within a range to stay competitive with other choices available to small groups. Recognizing that high out of pocket costs for low income workers can create access barriers, the Dirigo Board decided to dedicate a portion of subsidy dollars for deductible discounts as well as premium discounts.

**Overview of DirigoChoice Program Structure**

The DirigoChoice program is a public/private collaborative enterprise jointly administered by a newly created state agency — the Dirigo Agency — and a private insurance carrier. The DirigoChoice insurance products are fully insured by the participating insurance carrier. The selection of the insurance partner is determined through a competitive bid process. Premiums are negotiated by Dirigo Agency staff and board of trustees with the carrier, while subsidy levels are determined by the Dirigo board. The carrier is responsible for premium billing, claims processing and payment, and parts of the enrollment process. The Dirigo Agency maintains responsibility for program oversight, contract management, determining subsidy eligibility of enrollees, administering the subsidy program, program marketing, member services, and public education. The agency is required to report to the legislature on an annual basis with information on program enrollment levels, program cost, prior insurance status of members, and the impact of the reforms on the uninsurance rate in the state.

## Subsidy Administration

The Dirigo Agency developed a complex mechanism for administering discounts in order to protect the confidentiality of enrollees. Although insurance enrollment forms are submitted through the employer, applicants individually and confidentially submit paperwork related to eligibility for discounts. Once enrolled, employers make uniform payroll deductions for all participating employees. Those participants who have been determined to qualify for a discount are reimbursed by the Dirigo Agency, electronically, on the same day as the payroll deduction.

Self employed and individual enrollees are billed by the insurance carrier the discounted amount owed from them, and the Dirigo Agency makes direct payments to the carrier of the difference between the discounted premium payments and the full premium due.

## DirigoChoice Marketing and Outreach

The Dirigo Agency maintains primary responsibility for DirigoChoice program marketing and outreach while, at the same time, cooperating with brokers and producers. The agency periodically sponsors marketing campaigns using multiple media including radio spots, mailers, and television. It maintains a five person call center, staffed with trained individuals who can explain knowledgeable the enrollment options, the discount program, and the application process and then refer individuals to the contracting insurers' producers to complete the paperwork.

### ***Why a Two Tiered Marketing Strategy?***

Insurance company producers' reimbursement is tied to the number of lives they underwrite. The very small businesses targeted by the DirigoChoice program, many that have not previously offered health benefits, require a disproportionate amount of time to close a sale and are an inefficient target for brokers. The complexities of the DirigoChoice subsidy structure increase the time burden for those explaining the program to potential customers. A dedicated staff trained by the Dirigo Agency and paid on a salary basis is a more cost effective means of walking potential customers through the program before they are referred to brokers for enrollment.

## DirigoChoice Program Funding

DirigoChoice program funding has gone through three phases:

- A one-time, "jump-start" general fund appropriation of \$53 million (2005);
- Funding through a "savings offset payment" (2006 through 2007); and
- Funding through a combination of a health insurance assessment of 1.8 percent of claims volume and a dedicated portion of taxes on alcoholic beverages and soft drinks (2008).

### *Savings Offset Payment*

The savings offset payment (SOP) was a funding mechanism intended to realign incentives of health providers, consumers, and payers and to fund coverage for low income persons without unduly burdening private payers. The Dirigo Health Agency was authorized by the legislature to levy an assessment on insurance carriers and third party administrators of up to 4 percent of the value of total annual health claims, contingent upon the agency demonstrating health system savings deriving from the Dirigo law reforms in an amount equal to or greater than the amount of the assessment (see discussion under [Cost Containment Measures](#)). The assessment was made contingent upon system

savings so that this new cost to the insurance industry would not result in a corresponding mark up to the premiums of insured payers who already pay a “hidden tax” in the form of price mark ups to cover bad debt and charity care.

The Dirigo Act was not specific as to how savings should be measured, but procedurally required the Dirigo board to recommend an assessment amount based on its measurement of savings and the superintendent of insurance to rule on the reasonableness of the board’s recommendations. The procedure involved an adjudicatory hearing in which interested parties could testify and present written evidence in support of or in opposition to the Dirigo board’s recommendations. In 2005, 2006, and 2007, the superintendent of insurance ruled that the board had reasonably produced evidence of \$43.7 million in savings in Year 1 of the program, \$34.3 million in Year 2, and \$32.8 million in Year 3. These savings levels resulted in assessments of 2.4 percent of claims volume in Year 1 and 1.85 percent in Year 2.<sup>2</sup>

The SOP as a funding mechanism proved politically unpopular and cumbersome and, ultimately, insufficient as a source of funds to maintain program growth. In 2008, the legislature passed a law establishing a new funding mechanism based on dedicated taxes and a fixed assessment on insurers and third party administrators (see discussion under [Mid-Course Corrections](#)).

### **DirigoChoice Program Experience**

After 30 months of operation, the DirigoChoice program had an enrollment of approximately 15,100 members. Small business enrollees comprised 23 percent of enrollment; sole proprietors, 28 percent; and individuals, 49 percent. The small group enrollment included 720 small businesses (exclusive of sole proprietors).

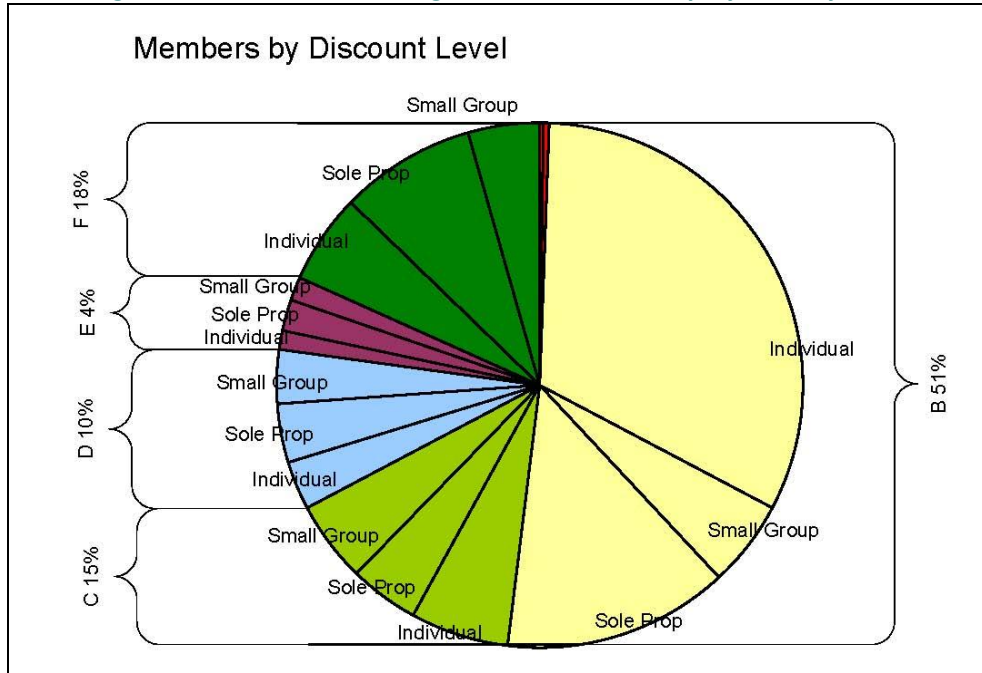
Among DirigoChoice enrollees in the discount program, the average household income was \$15,144 in 2006.<sup>3</sup> Enrollees eligible for the deepest level of discount (80 percent) have consistently been over-represented among the DirigoChoice membership. As of December 2007, 51 percent of the membership was in Group B – the deepest discount group. Eighteen percent of the membership had incomes above the eligibility for subsidies (above 300 percent FPL). Among the other income tiers, numbers of enrollees declined as the level of subsidy declines: 15 percent of members in the 60 percent discount group; 10 percent in the 40 percent discount group; and 4 percent in the 20 percent discount group ([Figure 1](#)).

---

<sup>2</sup> Dirigo Health Agency Annual Report 2005 & 2006: 32-33.

<sup>3</sup> Dirigo Health Agency Annual Report 2005 & 2006.

**Figure 1. Distribution of DirigoChoice Membership by Subsidy Level**



**Key**  
 Group B: 80% Discount                      Group D: 40 % Discount                      Group F: No Discount  
 Group C: 60% Discount                      Group E: 20% Discount

Approximately 63 percent of DirigoChoice members were either uninsured or underinsured prior to enrolling.<sup>4</sup> In addition, 40 percent were uninsured.

There were approximately 49,000 working uninsured (and their dependents) in businesses of fewer than 50 at the time the program was implemented.<sup>5</sup> DirigoChoice’s enrollment of approximately 5,500 uninsured employers, employees, and dependents represents a take-up rate of about 11 percent of that pool of uninsured small business workers. An additional 4,400 of DirigoChoice enrollees were underinsured at the time of enrollment or had Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, indicating a risk of future uninsured status.

**DirigoChoice Program Costs**

Overall, the claims experience of the DirigoChoice program has not been dissimilar to Maine’s small group market. In 2005, the first year of operation, premiums were built around an assumption of an 80 percent loss ratio.<sup>6</sup> Across total enrollment in this year, the DirigoChoice loss ratio was 79.1 percent. The loss ratio for small group enrollees was 64 percent (substantially better than the private market norm in

<sup>4</sup> The Dirigo Choice Program defines “underinsured” as having household income of less than 200 percent of the federal poverty level *and* having a health insurance deductible and copayments that can amount to more than 5 percent of household income.

<sup>5</sup> Maine Governor’s Office of Health Policy and Finance calculation, based on Current Population Survey data for 2003 and 2004, and Medical Expenditure Panel Survey data, Insurance Panel, for 2004.

<sup>6</sup> The loss ratio refers to the proportion of premium collected that is used to pay for enrollees’ medical costs. An 80 percent loss ratio indicates that 80 percent of premium is used for medical expenses and that 20 percent is retained by the insurer for administrative costs and profit. In the first two years of DirigoChoice program operations, because the likely claims experience of enrollees was unknown, the Dirigo Agency negotiated an Experience Modification Provision with the insurer, where moneys were prospectively escrowed to cover excess claims costs if claims exceeded an 80 percent loss ratio, but returned to the agency if claims remained at or below an 80 percent loss ratio.

Maine). For sole proprietors the ratio was 72.7 percent, and for individuals, the ratio was 101.3 percent (indicating the insurer paid out more for this group than was collected in premiums).<sup>7</sup>

Overall, Maine has seen deterioration in the risk distribution of the individual insurance market. DirigoChoice — probably because of its comprehensive benefit coverage in relation to products otherwise available in the nongroup market — appears to have experienced adverse selection among nongroup enrollees above and beyond that of Maine’s individual market.

The per capita spending of public subsidy dollars in the DirigoChoice program, in relation to employer and employee premium payments, is a function of the income distribution of enrollees (lower income participants require larger subsidies) and the ratio of individual enrollees to small group enrollees (individuals require more subsidy dollars to compensate for the unavailability of an employer contribution). Over the three years of the program, the ratio of public spending to private spending has increased because the most rapid membership growth has occurred in the most heavily discounted income group and nongroup enrollments (see [Table 2](#)).

**Table 2: DirigoChoice Cost Trends**

	2005			2006			2007		
	Dollar Amount	PMPM	% Dist.	Dollar Amount	PMPM	% Dist.	Dollar Amount	PMPM	% Dist.
Member Contributions	\$12,104,746	\$179	51%	\$23,330,519	\$188	47%	\$33,069,002	\$229	46%
Subsidy	11,493,893	170	49%	27,260,836	212	53%	39,475,326	192	54%
<b>Total</b>	<b>23,598,639</b>	<b>348</b>		<b>51,458,378</b>	<b>400</b>		<b>72,544,328</b>	<b>421</b>	
Total Member Months	67,728			128,754			172,350		

### How Has the Cost Performance of the DirigoChoice Program Been Viewed?

Because of the controversy around the savings offset payment funding mechanism for the DirigoChoice program, stakeholder groups have been publicly critical of DirigoChoice costs, suggesting that the program is an inefficient strategy for extending coverage to the uninsured. Dirigo program advocates, on the other hand, have suggested that the program has not received the credit it is due for efficient operations. They point to the fact that the medical claims costs of the DirigoChoice program are in line with the general population health cost experience in Maine and that half of program costs are privately financed by participants despite the heavy enrollment of low income people. The critics tend to emphasize the total public dollars (just under \$40 million to provide coverage for 15,000 people) as an excessive cost, while proponents point to the per member per month cost, which is lower than private coverage costs. The differences are perceptual rather than disagreements about the numbers. For example, in 2005 the aggregate coverage cost at average Maine premium rates for 15,000 employees in the small group market was around \$66.7 million<sup>8</sup> compared to the \$40 million expended on DirigoChoice enrollees. But because there is not a single payment source for these private policies, the aggregate cost is not familiar to the public.

<sup>7</sup> Dirigo Health Agency Annual Report 2005 & 2006: 31.

<sup>8</sup> Calculation based on 2005 Medical Expenditure Panel Survey data for average single premiums for businesses of 10 or fewer workers in Maine.

### ***How Has the DirigoChoice Enrollment Performance Been Viewed?***

The DirigoChoice take up rate for the first three years has been in the upper range of experience when compared to similar state initiatives. However, the DirigoChoice program was presented to the legislature as the linchpin in an effort to attain universal insurance coverage in Maine. An enrollment of 30,000 in the first year was suggested as a goal to policymakers. By the standards of public expectations, the take up rate of the DirigoChoice program has been seen as a disappointment.

In addition, the decision to allow currently insured individuals to enroll generated controversy. While some policymakers felt that offering comprehensive coverage to the underinsured was a priority in addition to covering the uninsured, some stakeholders felt that extending public subsidy dollars to already insured persons was an inappropriate use of limited resources.

### **DirigoChoice Plan Mid-Course Corrections**

The early experience of the DirigoChoice program led program administrators and policymakers to make a number of modifications to the program design, administrative mechanisms, and funding strategies. These changes are detailed below:

#### ***Dropping the DirigoChoice Medicaid Component***

In its initial design, the DirigoChoice program had anticipated enrolling employees of participating small businesses who were Medicaid eligible. The design of the program contemplated that the state's Medicaid Program would pay these employees' share of the premium (a 100 percent subsidy tier in the program) and that Medicaid would "wrap-around" the DirigoChoice benefit plan for these individuals, covering the cost of deductibles and copayments and providing coverage for Medicaid benefits not available through the DirigoChoice program. Maine's Bureau of Medical Services, which administers the state's MaineCare program (Medicaid) negotiated a Medicaid managed care contract with the DirigoChoice insurance carrier to accommodate a seamless relationship between the DirigoChoice program and dually eligible DirigoChoice/MaineCare enrollees.

In funding the Medicaid component of the DirigoChoice program, the Dirigo Agency expected to transfer funds drawn from pooled revenues to the Bureau of Medical Services to use as the state match for Medicaid program expenditures on behalf of DirigoChoice enrollees – making DirigoChoice enrollment a particularly cost effective method of providing Medicaid coverage.

Based on surveys of the household incomes of uninsured workers in Maine, planning models for the DirigoChoice program anticipated a substantial enrollment of these dually eligible workers, designated Group A by the program. The actual experience of the program was that less than 4 percent of DirigoChoice enrollees applied for and were deemed eligible for Medicaid coverage. The low enrollment in Group A seems to have resulted from three unanticipated factors. First, many individuals and families, while having incomes in a Medicaid eligible range, had assets that rendered them noneligible. Second, many DirigoChoice enrollees who may have been Medicaid eligible were unwilling to apply or complete the eligibility determination process due to concerns for privacy or stigma associated with Medicaid participation. Finally, employers with Medicaid eligible workers may have encouraged these employees to apply directly to MaineCare in order to avoid paying the employer share of the DirigoChoice premium.

The success of the Group A strategy was ultimately precluded by the refusal of the federal Center for Medicare and Medicaid Services (CMS), after long negotiations, to approve an amendment to Maine's state plan that would have allowed the use of Dirigo Agency fund transfers as a source of state match. Based on legal and structural barriers, as well as enrollment experience, Group A was eliminated as a component of the DirigoChoice program in 2008. An appeal of the CMS ruling by the State of Maine is pending in court.

### *Program Financing*

The mechanism for funding the DirigoChoice program, the savings offset payment (SOP), proved politically controversial, cumbersome, and insufficient to sustain program growth. The contingent nature of the SOP had two major drawbacks. First, it made financial forecasting difficult for insurers and self-funded employers, since they did not have a sufficient lead time before the final determination of the level of the assessment to correctly adjust their budgets. (Equally important, it made forecasting and program management difficult for the Dirigo Agency, which had no way of knowing what the program budget would be in each succeeding calendar year.) In addition, the funding formula proved sufficiently vague that it became a source of endless litigation. Expectations and assumptions by payers were very different from the administration and its representatives. Employers expected savings to be measured in terms of actual reductions in their claims or premium expenditures so that their costs, following the assessment, would be flat from one year to the next. The administration and the Dirigo board considered a reduction in the trend line of health care spending as savings in relation to what would have been spent in the absence of the cost savings measures put in place by the Dirigo reforms. Millions of dollars were spent annually by both payers and the administration on economic, actuarial, and legal consultants to make a case demonstrating savings or the lack thereof. Hearings before the superintendent of insurance were adversarial, with legal representation on both sides. The superintendent's rulings were contested in court on both procedural and substantive grounds and appealed up to the state's highest court (where the administration prevailed).

In addition to generating litigation, the complexity of the methodologies used to measure savings created substantial difficulties for the Dirigo board and the superintendent, who were charged with making decisions about the extent of demonstrated system savings. The dollar amounts recognized and authorized by these bodies declined over the first three years of the program, as the controversy surrounding the payments increased. By the fourth year, the amount approved for the SOP was insufficient to maintain program growth and further enrollment of subsidized individuals was frozen.

### *Revised Funding Mechanism*

Within the Maine legislature, both strong advocates of the DirigoChoice program and program critics agreed that the SOP needed to be revisited. In 2008, the legislature repealed the savings offset assessment and replaced it with a fixed assessment of 1.8 percent on paid claims for all health insurers, third party administrators, and stop loss reinsurance for health policies. This assessment is estimated to generate approximately \$33 million per year. In addition, the law increased taxes on beer and wine, soft drinks, and the sugar syrup used to make soft drinks, and dedicated these new revenues to the Dirigo Reform programs. An additional \$5 million was allocated from Maine's tobacco settlement fund.<sup>9</sup> This new, multisource funding mechanism is sufficient to allow the program to increase enrollment.

---

<sup>9</sup> Maine already allocated all tobacco settlement dollars to health improvement activities. The \$5 million for the Dirigo program was a transfer of funds from other health improvement activities to the Dirigo program activities.

However, in an effort largely financed by the industries affected by the new tax, a referendum in the fall election of 2008 will attempt to repeal the new taxes through a “people’s veto.” This referendum has placed a hold on the implementation of the new taxes and required the DirigoChoice program to rely on the existing savings offset payment mechanism in the interim. As a consequence, enrollment in the program remains frozen until the referendum issue is resolved.

### **III. Dirigo Reform Cost Containment Measures**

The Dirigo Reform law enacted a number of new regulatory constraints, established voluntary benchmarks for providers, initiated actions designed to assist consumers in selecting cost-effective providers, and established a statewide public health and health system planning process.

#### **Regulatory Constraints**

The Dirigo Act strengthened Maine’s Certificate of Need (CON) law to extend its reach to nonhospital providers and sites of care and to establish an annual aggregate dollar cap on new capital projects requiring CON review. The effect of the cap is to make the CON review a competitive process, where proposed projects compete for the limited allocations of allowable new capital expenditures and are evaluated against each other and prioritized in terms of the health system needs of the state. Maine’s Department of Human Services has established a review procedure with two review cycles per year, one for large capital projects and one for small capital projects.

The law also established new regulatory constraints on insurers in the small group market. Insurers in the small group market are now held to a minimum loss ratio of 78 percent, calculated as a three year, rolling average. Premiums collected in excess of the 22 percent allowed to be retained for administrative costs and profits must be returned to policy holders in the form of rebates. Additional requirements imposed by the law on the insurance industry include annual reporting to the Bureau of Insurance (and hence, to the public domain) of total small group enrollment, premium collected, claims paid out, loss ratios, administrative costs, and profit margins.

#### **Voluntary Benchmarks and Improvements in Transparency**

The Dirigo Act also established several benchmarks for hospital cost performance – standards that were negotiated with the hospital industry. Compliance with the standards is voluntary but the benchmarks provide a means of publicly evaluating each hospital’s performance against norms agreed to by the industry. The standards include a limit of 3.5 percent growth in average cost per case mix adjusted discharge per year and a limit of 3 percent in total operating margin per year.

Hospitals and physician practices also are required to post lists of their prices for their ten most common procedures or health care services. The lists must be posted in areas where there is ready access by the public, such as waiting rooms or patient registration areas.

#### **Health Planning**

The Dirigo Health Reform Act established an Advisory Council on Health System Development with responsibilities to:

- Collect and coordinate data on health systems development in the state;
- Synthesize relevant research;
- Advise the process of developing a biennial State Health Plan based on informed assessment of state resources and population need;



- Conduct public hearings on the state plan and capital investment fund each biennium; and
- Report annually on factors contributing to rising health care costs in Maine and make recommendations to the legislature on methods for reducing costs or reducing the rate of increase in costs.

The State Health Plan, among other things, provides the information and establishes the priorities on which the capital investment fund (allocated through the Certificate of Need review process) is sized and on which CON awards are granted.

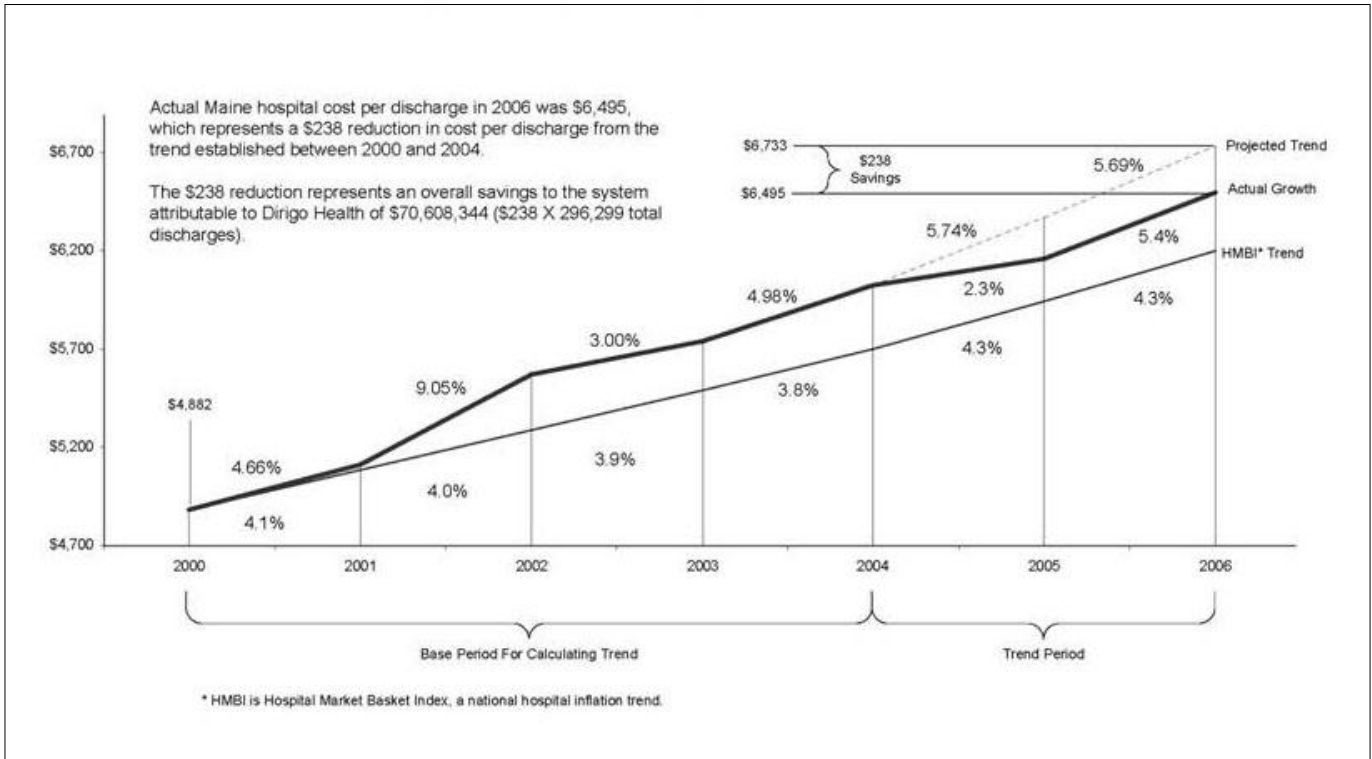
The advisory council is made up of nineteen members, five of whom are nominated by the legislature, and all of whom are appointed by the governor with approval by the joint standing committee of the legislature with jurisdiction over health and human services. The council members are selected to represent constituencies specified in the Dirigo Act, including two individuals with expertise in the health care delivery system; one expert each in long-term care, mental health care, public health financing, private health care financing, health care quality improvement, and public health; and two consumer representatives. The Department of Human Services, Bureau of Health, also has a seat on the council.

### **Experience With Cost Containment Measures, to Date**

There is early and tentative evidence that the combination of cost containment measures and restrictions on insurer administrative costs and profits may have had some moderating influence on subscriber costs in the small group market. Premiums in the small group market in Maine increased, on average, 26 percent per year in the three years prior to the enactment of the Dirigo Reform law and have increased, on average, 10.25 percent a year in the four years since enactment. In addition, the average loss ratios across the small group market in Maine in the two years prior to enactment were 72 and 74 percent, respectively, while in the first two years post enactment, the averages were 77 and 81 percent. In addition, the minimum loss ratio requirements have resulted in at least one instance of premium rebates to small group employers.

It is too soon to tell whether the moderating trends in the small group market are simply a result of the usual insurance pricing cycle, a temporary chilling effect from the focus of legislative attention on the problems of the small group market, or a long-term trend resulting from the state reforms. However, reductions in the rate of increase hospital costs in Maine point to a good faith effort by Maine hospitals to meet the benchmarks established by the Dirigo Reform Act and may be contributing to a reduction in cost pressures driving premium increases. In the year following the enactment of the Dirigo Reform, average hospital costs were projected to increase 5.7 percent based on the experience of the prior four years and national hospital trends. Instead, Maine hospital costs in this year increased by 2.3 percent (see [Figure 2](#)).

**Figure 2. Savings from Hospital Voluntary Cost Containment Measures**



#### IV. Lessons From the DirigoChoice Experience

Several states have designed programs to expand access to medically indigent people with financing models that assume that savings captured from averted bad debt and charity care can be used to help finance the new program costs (e.g., use of hospital charity care pools and provider taxes for access initiatives). However, Maine’s DirigoChoice program is the first that has attempted to link access program funds to *measured* savings and to make funding contingent on the demonstration of such savings. The Dirigo Health Reform offers valuable lessons to states considering responses to the health care crisis. It demonstrates some successes, illustrates a number of administrative and political challenges, and reiterates that sustained funding is the greatest challenge facing states striving for the goal of universal coverage. The following may be the most important findings, to date, from the implementation of the DirigoChoice plan:

- The overall rate of health care spending makes financing new initiatives extremely difficult.** Not only do high costs increase the state investment necessary to provide health coverage for the uninsured, but the stress from high health care costs led to significant resistance in Maine to the establishment of any funding source that would result either directly or indirectly in an increased cost to the business community. Tying program funding to demonstrated savings was a mechanism to try to ensure that new state dollars did not stimulate more inflation in the health economy, but also was politically necessary to attain support from key stakeholders.
- Changing the rate of growth in health care spending is extremely difficult and measuring the change is even more challenging.** Savings from reductions in bad debt and charity care are real, but are not a dollar for dollar offset against expenditures of newly insured individuals in state programs. Additional savings from state

planning efforts, tightened certificate of need (CON) controls, and enhanced public health will be realized over the course of many years, but do not provide immediate cost reductions. Even immediately realized and substantial cost reductions, such as hospital compliance with cost saving benchmarks turned out to be difficult to measure and required an assessment of actual spending against expected (and unmeasurable) spending in the absence of state reforms.

- **Voluntary programs will not achieve universal coverage, even with deep subsidies; and expanding coverage through the small group market has lower uptake rates than individual coverage initiatives.**

While pent up demand for health coverage was substantial in Maine, many eligible persons and businesses have chosen not to enroll, to date. Some reluctance may derive from uncertainty about the DirigoChoice program's future. Additionally, it may be that the payment of even modest monthly premiums for many low income individuals and families is difficult when budgets are tight and health care needs are not pressing. In addition, the employer based system of insurance is impractical and inefficient for many very small businesses. High employee turnover and alternative sources of coverage for some workers can lead to minimal take up in some of these businesses. In addition, neither employers nor their employees can afford the full premium cost for part-time employees.

Further, enrollment of small groups requires cooperation from the employer as well as the individual enrollees. Many small employers in Maine not already providing health benefits expressed reluctance to cover the employer share of the premium. Major disappointment was expressed that the subsidy was targeted to enrollees and not to the employers' contributions.

The administration proposed legislation in 2008 to establish an insurance mandate for individuals with universal employer obligations to contribute to coverage costs – similar to recent reforms in Massachusetts and Vermont. This proposed legislation gained very little traction in the legislature.

- **It is difficult to maintain consensus and bipartisan support during program implementation. Aggressively countering political attacks can be important to maintaining public support.**

The DirigoChoice Act was passed with bipartisan support in a political environment where public support for policy action on health care costs and access was high. The level of public investment needed for a major access initiative, however, immediately puts a program like the DirigoChoice initiative in competition with other state spending priorities. In addition, unrealistic expectations with regard to the rate of change in health care costs and the number of uninsured can quickly erode public enthusiasm. The Dirigo Agency was limited in its ability to communicate to the public its successes with incremental steps and to correct misinformation because of an insufficient budget for marketing and public education.

- **There are irresolvable tensions inherent in state access initiatives that try to fill the gap between private insurance and Medicaid.**

As health care costs have continued to rise faster than wages or the cost of living index, the affordability of private coverage has moved out of the reach of larger and larger segments of the public. As clearly evidenced by the history of the Medicaid program, even if political consensus is reached on a clearly demarcated line between the private market and those entitled to public subsidies, the line has to be frequently redrawn or new "gap" groups emerge. Currently, there is no consensus on how much individuals at different income levels should contribute to their own coverage and who should be entitled to coverage discounts made available through public resources. Publicly sponsored programs like DirigoChoice that open enrollment to higher income businesses and individuals put themselves in direct competition with the private insurance industry. However, if they do not extend eligibility to these individuals and businesses, they

preclude enrollment of small businesses with low income and uninsured workers, where the employer and firm management have incomes above the income eligibility threshold.

- **Complex programs are difficult to administer and to market.**

The DirigoChoice premium subsidy structure is administratively complex. Private insurers' administrative and billing systems are not designed to accommodate variable pricing based on household income or to match funding streams from two sources (public and private) for premium payments. This complexity limits the state in the number of potential contract partners and could impede the process of bringing the program to scale. In addition, it makes marketing the program to small businesses more difficult because of the need to explain the premium structure and the additional paperwork necessary to process subsidy applications.

- **The biggest challenge in the maintenance of a health access initiative is the rate of increase in health care spending.**

State budgets are countercyclical, with the greatest demand for public services occurring during economic downturns when revenues are at their lowest. Under the best of circumstances, finding the resources and maintaining the political will for costly health programs is difficult. Because tax payers — corporate and private — currently feel the strain of health care costs in maintaining their own coverage, support for programs targeted to the uninsured is even harder to maintain. The ultimate sustainability of access initiatives may ride on two factors: successful cost containment measures that provide relief to employers and taxpayers on *their* health care costs, and a new commitment at the federal level to support states and help compensate for differences in state capacity to raise revenues.