

Dirigo Health Reform Act: *Addressing Health Care Costs, Quality, and Access in Maine*

*Developed by NASHP for the
Maine Governor's Office of Health
Policy and Finance*

*Jill Rosenthal
Cynthia Pernice*

JUNE 2004

*Supported by The Commonwealth Fund
and The Robert Wood Johnson Foundation's
State Coverage Initiatives Program, housed
at AcademyHealth*



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June 21, 2004

To: Interested Parties
From: Trish Riley
Director, Governor's Office of Health Policy and Finance
Re: Dirigo Health Reform Issue Brief

Enclosed, please find a copy of *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine*. The Maine Governor's Office of Health Policy and Finance (GOHPF) has partnered with the National Academy for State Health Policy (NASHP) to develop and disseminate issue briefs on the implementation of the Dirigo Health Reform Act.

Dirigo Health was enacted in June of 2003 with 2/3rds support in each body of the Maine Legislature. Health reform was a campaign promise and priority of Governor John Baldacci. On day one of his administration in early January of 2003, he created the Governor's Office of Health Policy and Finance to direct his reform initiative. We undertook an open and collaborative process to develop Dirigo Health and after it was proposed we entered into extensive negotiations with legislators and stakeholders to reach broad agreement over the reform measures. This transparent process was key to creating a comprehensive package of reforms and achieving significant bipartisan support and consensus.

Maine faces many challenges in its health care system: approximately 14% of Maine people lack basic health coverage; we are 11th nationally in health care spending per capita, yet we are 40th in median household income; small businesses saw premiums rise 58% between 1996 and 2001; our hospital utilization rates are higher than the rest of New England; we have higher rates of chronic illness and disease than other New England states; and we have virtual monopolies in our insurance and provider markets. Maine's health care system has largely become unsustainable and our high costs are a significant drag on the economy. Dirigo Health is our solution to these obstacles.

Dirigo's overarching goal is to create a sustainable health care system in Maine. It includes strong measures to control the growth of health care costs, ensure the highest possible quality of care, and achieve universal access to coverage by 2009. This brief discusses these issues in much more detail. We hope it is informative and useful for those interested in learning more about Dirigo Health.

We would like to express our thanks to The Commonwealth Fund and The Robert Wood Johnson Foundation's State Coverage Initiatives program, housed at AcademyHealth, for support of this brief. Without their generous support, this brief and other activities being conducted to further the Dirigo Health Reform Act would not be possible.

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FOREWORD

In an effort to keep states abreast of Maine's experience in health policy reform, the Maine Governor's Office of Health Policy and Finance (GOHPF) is partnering with the National Academy for State Health Policy (NASHP) to develop and disseminate issue briefs on the implementation of the Dirigo Health Reform Act.

NASHP wishes to thank The Commonwealth Fund and The Robert Wood Johnson Foundation's State Coverage Initiative, housed at AcademyHealth, for their support of this project.

NASHP would also like to thank the Maine Governor's Office of Health Policy and Finance for providing up-to-date information on Dirigo Health and for reviewing the issue brief for accuracy: Peter Kraut, Special Assistant; Trish Riley, Director; Ellen Schneiter, Deputy Director; and Adam Thompson, Legislative and Constituent Liaison.

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WHAT IS THE DIRIGO HEALTH REFORM ACT?

The Dirigo Health Reform Act was developed by the Maine Governor's Office of Health Policy and Finance with significant input from health care policy experts and the Health Action Team (see Appendix A), a group of key stakeholders appointed by Governor John Baldacci. The Reform Act, Public Law 469, was enacted with bipartisan support and a two-thirds majority in each chamber of the Maine Legislature. Governor Baldacci signed the bill into law on June 18, 2003.

The purpose of the Reform Act is to make quality, affordable health care available to every Maine citizen within five years and to initiate new processes for containing costs and improving health care quality. A major premise behind the law is that successful health care reform must address cost, quality, and access simultaneously and with equal vigor. The law is built on the assumption that health reform cannot be done in a piecemeal fashion. If attention is paid only to access, costs will increase. If lowering the cost of care is the primary concern, access will be limited. And if quality is the sole focus, people will remain uninsured and costs will remain high. As a result, the Dirigo Health Reform Act addresses all three concerns through the following initiatives:

Costs: Delivering Lower Health Care Costs

Dirigo Health Reform engages Maine's hospitals, doctors, patient advocates, businesses and insurance companies in a focused effort to control rising health care costs. Cost containment strategies include hospital planning, public price disclosure, simplification of administrative functions and reductions of paperwork, enhanced public purchasing, oversight of insurance costs, reduction in cost shifting, and voluntary limits on the growth of insurance premiums and health care costs. A State Health Plan will set statewide goals for health care access and cost containment and will establish a budget directing health care expenditures statewide. The Act is built upon the premise that covering Maine's uninsured will significantly reduce bad debt and charity care costs.

Quality: Improving Quality of Care Statewide

The Act creates the Maine Quality Forum to promote quality of care initiatives and educate providers and consumers about best medical practices and other quality of care indicators. The Forum will collect and disseminate research, adopt quality and performance measures to compare provider performance, issue quality reports, promote evidence-based medicine and best practices, conduct technology assessment reviews to guide the diffusion of new technologies, conduct consumer education campaigns, and make recommendations to the state health plan and Certificate of Need (CON) program.

Access: Filling the Affordability Gap

The Act creates the Dirigo Health Plan, a voluntary market-based program, designed to help small businesses, the self-employed, and individuals afford health coverage. The Dirigo Health Plan will be offered by a private insurance company or will be self-administered. Workers and individuals who meet income guidelines will receive financial assistance to participate in the program.

HOW IS THE DIRIGO HEALTH REFORM ACT ADMINISTERED?

Governor Baldacci issued an executive order in January 2003 establishing the Office of Health Policy and Finance. The office was charged with bringing the human and physical resources dispersed throughout state government into a strategic, critical alliance to develop a comprehensive health policy and a plan to provide affordable, quality health care for all Maine residents. This office is now charged with coordinating implementation of The Dirigo Health Reform Act (henceforth referred to as the Reform Act) across all state agencies.

Because the Reform Act addresses the state's system of health care, its administration is multi-faceted. Many agencies of State government have responsibility for administering parts of the Reform Act. The Bureau of Insurance, the Department of Human Services, and the newly created Dirigo Health Agency share implementation responsibilities with the Governor's Office of Health Policy and Finance.

The Dirigo Health Agency is an independent agency. Its board of directors includes five individuals serving staggered terms, appointed by the Governor and approved by the Maine State Senate. Three additional members from state government, all *ex-officio*, also serve on the board. (See Appendix A for a list of members.)

The Dirigo Health Agency is responsible for the Dirigo Health Plan, which will provide health insurance coverage to small businesses, self-employed persons, and individual consumers. The agency is charged with determining enrollment costs and eligibility, conducting enrollment, arranging health coverage through either a private insurance carrier or MaineCare (the state's Medicaid program), providing discounts, and serving as a model "health and wellness" plan. Additionally, the Maine Quality Forum is an entity of the Dirigo Health Agency and is responsible for monitoring and providing information on quality of care and for conducting disease management and health promotion programs. Although it will partner with a private carrier to administer the Dirigo Health Plan, the Dirigo Health Agency will maintain authority over the design of health care benefits and define allowable administrative costs.

The board of directors of the Dirigo Health Agency appointed an executive director in January 2004.¹ The executive director is responsible for establishing the business plan and implementing the sales and marketing of the Dirigo Health Plan. He is responsible for hiring needed staff in the Dirigo Agency and launching the Maine Quality Forum. The Governor's Office of Health Policy and Finance retains overall responsibility for the Dirigo Health Reform Act and serves as a liaison to the new Dirigo Health Agency.

¹ Thomas Dunne, MBA, is formerly a partner at Accenture and a small business owner.

Boards and Commissions

A number of state boards and commissions are charged with directing and advising the cost, quality, and access initiatives that comprise the Dirigo Health Reform Act. Table 1 provides information on these entities and their key duties. Member are listed in Appendix A.

Table 1 Boards/commissions and their key duties

Board/Commission	Key Duties
Dirigo Health Board of Directors	To establish and administer Dirigo Health, hire an executive director, collect savings offset payments, develop benefits and subsidies, and establish and operate the Maine Quality Forum.
Maine Quality Forum Advisory Council	To guide research and dissemination, quality performance measures, data coordination, public reporting of data, consumer education, and technology assessment. This group is also charged with convening the Provider Advisory Group.
Commission to Study Maine's Hospitals	Conduct a comprehensive analysis of hospital costs, roles, reimbursement, capital needs, and opportunities to make policy recommendations.
Advisory Council on Health Systems Development	To guide the Governor's Office of Health Policy and Finance in establishing the state health plan, capital investment fund, and global budget and in conducting hearings and synthesizing data and research.
Public Purchasers Steering Committee	To establish and coordinate a collaborative purchasing program and to assure cost effective, high quality health care for individuals whose coverage is paid by state and local tax dollars.
Task Force on Veterans' Health Services	To analyze and assess health services to veterans and make recommendations to more effectively organize those services

A Dirigo Health Reform Act organizational chart is included in Appendix B.

HOW DOES THE DIRIGO HEALTH REFORM ACT ADDRESS COST CONCERNS?

Maine median household income ranks 40th in the United States,² yet Maine ranks 11th in the nation for health care spending per capita.³ Dirigo Health is instituting a number of measures designed to control the rising rate of health care costs in Maine and ensure the dollars are well spent.

State Health Plan

A biennial State Health Plan will assess needed and available resources, set statewide goals for health care access and cost containment, and establish a budget directing health care expenditures statewide. The Advisory Council on Health Systems Development, an independent 11-member group comprised of representatives of health care facilities, health care and public health professionals, health care researchers, and consumers, will guide the development of the state plan (see Appendix A for a list of members). The plan will include specific strategies to address the major cost drivers in the health care system and major threats to public health and safety. It will include both medical care and public health goals. The plan will guide state decisions in awarding Certificates of Need (CON); it will also guide the Maine Health and Higher Education Facilities Authority in its health care lending.

Dirigo Health includes changes to the CON program that are intended to make the process more effective and acceptable as a cost control and health system development tool. Before implementation of Dirigo Health, CON covered only hospitals. It will be revised to also include ambulatory surgery centers and doctors' offices, with the requirement for review predicated on function and cost as opposed to site of care. A Capital Investment Fund will be created as part of the CON process in order to establish a statewide budget for capital expenditures and to ensure a wise and appropriate allocation of resources. Approved expenditures must not exceed the limitations of the fund. Applications to the fund will be reviewed once or twice a year. The program reviews investments in new technologies costing more than \$1.2 million and capital expenditures over \$2.4 million (indexed to the Consumer Price Index (CPI) Medical Index). A one-year CON moratorium began in May 2003 to inform the Capital Investment Fund planning.

2 U.S. Census Bureau, Current Population Survey, 2001, 2002, and 2003 Annual Social and Economic Supplements as reported at www.census.gov/hhes/income/income02/statemhi.html

3 Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Per Capita Personal Health Care Expenditures by Type of Service, Region, and State of Residence, Calendar Year 1998, <http://www.cms.hhs.gov/statistics/nhe/state-estimates-residence/phc-percap-1998.asp>

Hospital Planning

The Commission to Study Maine's Hospitals, an independent nine-member commission (see Appendix A) is charged with conducting a comprehensive analysis of Maine's hospitals by examining hospital finances, structures, roles, reimbursement, capital, technology, staffing needs, and other pertinent areas of study. The Commission will present a report to the Legislature in November 2004, including proposed legislative action.

Public Price Disclosure

One of the premises upon which the Reform Act is built is that consumers need access to information about prices and the value of health care services in order to select services based on price and quality. By encouraging greater transparency in the health care marketplace, the Reform Act hopes to foster better informed consumer behavior. As a result, the Reform Act requires hospitals and providers to disclose average charges for the 15 in-patient and 20 out-patient services most commonly performed at hospitals, in physician offices, and elsewhere. Providers must provide this list if requested by patients. The in-patient information is currently available on the website of the Governor's Office of Health Policy and Finance. (See Appendix C.) The out-patient information was not yet available at the time of this publication.

Simplification of Administrative Functions and Reduction of Paperwork

In order to reduce the administrative burden that providers encounter, The Reform Act proposes mandating by 2005 the use of electronic claims submission, data exchange, referral submission/approval, and eligibility verification. The Dirigo Health Agency will explore the creation of a revolving loan fund to assist providers in the purchase of computer technology to meet this goal.

Enhanced Public Purchasing

Since public funds account for a significant portion of health care spending, public purchasers have the potential to demand higher quality and more cost-effective services by coordinating their purchasing activities. Total expenditures in Maine by the six reporting public entities⁴ are in excess of \$2 billion, covering services for nearly 40 percent of the state's total population and representing 40 percent of the state's total health care expenditures. The Public Purchasers Steering Committee was established by executive order to coordinate a collaborative purchasing

⁴ Maine School Management Association, Maine Education Association Benefits Trust, University of Maine System, Maine Municipal Employees Health Trust, MaineCare, and City of Portland.

program and to assure the cost effective, highest quality health care for individuals covered by state and local tax dollars. (See Appendix A for a list of members.)

Oversight of Insurance Costs

Currently in Maine only individual coverage is subject to rate review by the Bureau of Insurance. The Reform Act expands rate review to cover small group products. Carriers will also be required to file an annual report of certain performance measures, including administrative costs and underwriting gain, calculated and presented in the same manner so that they can be reviewed comparatively. Carriers issuing coverage to large groups will be required to file an actuarial certification with all rate filings. All rate filing information submitted to the Bureau of Insurance will become public.

Reduction in Cost Shifting

Currently, Maine spends over \$275 million a year in bad debt and charity care, free care to uninsured and underinsured people who require health. Those costs are now passed on as higher rates from providers and as higher premiums. Dirigo Health proposes to recapture a portion of bad debt and charity care costs and reallocate them to cover the uninsured. By providing health coverage up front, Dirigo Health program designers anticipate that individuals who are currently uninsured will access regular preventive care and will no longer need to delay care until health issues reach a more acute stage and require more costly care in a hospital setting. Hospitals, providers, employers, and consumers could all realize savings as a result of a reduction in bad debt and charity care expenses. Under the Reform Act, some of the costs of bad debt and charity care will be recovered through an assessment on insurers' revenue. This savings offset payment (SOP) will be levied only if savings in the health care system can be documented. The funds from the SOP will be reinvested into the Dirigo Health Plan to fund the discounts on monthly payments, deductibles and out-of-pocket maximum costs.

Voluntary Limits on Growth of Insurance Premiums and Health Care Costs

Dirigo Health requests that hospitals and other providers voluntarily limit their cost growth to 3 percent and their operating margins to 3.5 percent. Insurers are also asked to limit their operating margin to 3.5 percent. The Council on Health System Development (see Appendix A) will assess these voluntary efforts at the end of the first year to determine their effectiveness. If the voluntary effort is judged to be failing, the Governor may propose additional steps to control costs.

Current Status as of Early June 2004

- A draft of an annual state health plan is posted to the GOHPF website.
- A one-year CON moratorium began in May 2003 to inform Capital Investment Fund planning. It has since expired. The draft annual state health plan includes recommendations for CON.
- A rule to establish the Capital Investment Fund is in draft form. A public hearing will be held on the rule in July.
- Commissions and committees are operational.
- Information on statewide average in-patient hospital charges for the 15 most common diagnoses is available on the GOHPF website.
- Most hospitals and some insurance companies have agreed to voluntary caps on cost growth.

HOW DOES THE DIRIGO HEALTH REFORM ACT ADDRESS THE QUALITY OF HEALTH CARE?

Maine Quality Forum

The Reform Act establishes the Maine Quality Forum, a quality watchdog group that will provide the public with more information about the costs and quality of health care in Maine. The Forum will collect and disseminate research, adopt quality and performance measures to compare provider performance, issue quality reports, promote evidence-based medicine and best practices, conduct technology assessment reviews to guide the diffusion of new technologies, conduct consumer education campaigns, and make recommendations to the state health plan and CON program. The Forum is an entity of the Dirigo Health Agency and will be funded in part by the savings offset payment. The Forum will create a consumer friendly website to make available information on costs, utilization, outcomes, and other quality indicators.

More Effective Use of Data

Maine's health care data collection is fragmented. The state operates several data repositories in addition to those maintained by private organizations, including employer groups, health insurers, providers, and others. Appropriate and effective data sharing that maintains confidentiality and protections from disclosure would help provide a more comprehensive understanding of Maine's health care system than is presently available. Examples of such possible data sharing include: adding MaineCare patient level data to the state database for private payer data, obtaining data on Maine residents who receive care under federal health programs, and accessing clinical data sets in addition to administrative data. A comprehensive data set will be valuable in formulating a needs-based state health plan, making CON decisions, and developing information relative to quality improvement for the public. The Dirigo Health Agency will work with agencies that maintain data sets to attempt to achieve improved collaboration.

Current Status as of Early June 2004

The Maine Quality Forum Advisory Council is operational. Appointed by the Governor, it includes 17 members representing providers, consumers, employers, and private and public health plans. (See Appendix A.) A director was hired in March 2004.⁵

⁵ Dennis Shubert, MD, of Bangor, Maine

HOW DOES THE DIRIGO HEALTH REFORM ACT ADDRESS ACCESS TO HEALTH CARE?

The first phase of the access initiative – the Dirigo Health Plan – focuses on providing coverage for individuals, families, small business employees, and the self-employed. In the second phase, employees in large businesses may participate. The following discussion focuses on the first phase.

How is the Dirigo Health Plan financed?

The Dirigo Health Plan is projected to cost approximately \$90 million in its first year and is self-funded after that. The program hopes to save \$80 million per year by eliminating un-reimbursed medical costs (bad debt and charity care cases incurred by providers).

The Dirigo Health Plan will combine a variety of revenue streams: employer contributions, individual contributions, state general revenue (in the first year only), Medicaid dollars for those individuals who are eligible, and funds obtained through the recovery of bad debt and charity care. In 2004, the state will contribute \$53 million of state general revenue funds.

The state's ability to fund subsidies to make the Dirigo Health Plan affordable will be dependent on its ability to find savings in the system. Beginning in the Plan's second year, state general revenue funds will be replaced by the savings offset payment that will be assessed on gross revenues of insurers and third-party administrators. Insurance companies will pay up to four percent of annual revenues, money they are expected to recover through a reduction of expenses attributed to uninsured charity cases. This assessment will only be levied if and when the state can document reductions in the growth of health care costs resulting from reductions in the cost of bad debt and charity care and the impact of overall cost containment initiatives contained in the new law. The SOPs will be designed so that insurers' payments offset, but do not exceed, savings. After the first year, these payments will be used to fund subsidies for those with incomes above MaineCare eligibility and below 300 percent of the FPL after the first year and to fund the Maine Quality Forum.

Eligibility

In the first year of the Dirigo Health Plan's implementation, small businesses with 50 or fewer employees, the self-employed, and individuals will be eligible to enroll in the Plan. In the second and subsequent years, the Dirigo Health Board may increase eligibility to businesses with more than 50 employees.

Enrollees with annual household incomes below 300 percent of the federal poverty level (FPL) will receive discounts on monthly premium payments, deductibles, and out-of-pocket maximum costs. For instance, a single adult with an income less than \$28,000 and a family of four with an

income below \$56,500 will receive discounts.

Enrollees in the Dirigo Health Plan who are eligible for MaineCare will have costs paid for by MaineCare. Three months after the Dirigo Health Plan begins operation, eligibility for MaineCare will be expanded from 100 percent of FPL for single adults (non-categoricals) to 125 percent, and from 150 percent FPL for parents of MaineCare eligible children to 200 percent. Children will remain eligible up to 200 percent FPL.

Employers will be required to pay a minimum of 60 percent of the employee-only enrollment costs. The discounts and MaineCare coverage detailed above will apply to the employees' remaining share of the monthly enrollment costs. Although employers must make family coverage available, they will not be required to make contributions for family members other than the employee.

The following section defines eligibility terms used by the Dirigo Health Agency, as defined in the Dirigo Health Reform Act, Public Law 469.

Eligible businesses are those that employ at least two but not more than 50 eligible employees (see below for explanation of eligible employees) where the majority of the employees are employed in the state. In addition, 75 percent of eligible employees working more than 20 hours per week must participate in the Plan (consistent with current insurance practice). Employees with creditable coverage, such as through a spouse, are not included in the 75 percent calculation. (Crowd-out provision: If an employer drops coverage to a creditable health plan, employees will have to wait 12 months before they can enroll in the Dirigo Health Plan as an individual. This rule applies also to employers if they attempt to enroll as a self-employed of one. This provision is designed to prevent employers from dropping coverage and notifying employees that they should enroll in the Dirigo Health Plan as individuals.)

Eligible employees are employees of eligible businesses who work at least 20 hours per week. This does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually, except at the discretion of the employer.

A **self-employed individual** is defined as someone who works and resides in the state and is organized as a sole proprietorship or in any other legally recognized manner in which a self-employed individual may organize.

An **eligible individual** is an unemployed individual who resides in the state or an individual employed in an eligible business that does not offer health insurance. However, individuals can not join for one year if an employer drops coverage to an employer sponsored plan.

A **dependent** is defined as a spouse; an unmarried child under 19 years of age; a child who is under 23 years of age, is a student, and is financially dependent upon a plan enrollee; a person of any age who is the child of a plan enrollee and is disabled and dependent upon the plan enrollee; or a domestic partner as defined under Maine state law.

Benefits

The Dirigo Health Plan will look like other insurance products on the market. It will cover hospital, physician and specialist visits, and prescription medications. Several features will make it unique and innovative and enhance its value. Its comprehensive set of benefits will include disease management, health promotion and wellness initiatives, and quality information. To strengthen the relationship with primary care physicians and assure access to preventive care, it will cover preventive services such as routine physicals, blood tests, Pap tests, flu shots, mammograms, and well-baby care at 100 percent, with no out-of-pocket costs. The HealthyME Rewards Program will further enhance prevention by providing a \$100 reward for enrollees who complete a health needs questionnaire and meet health improvement goals identified with their physician, such as smoking cessation, weight loss, and fitness club membership.

The Dirigo Health Plan will cover those considered to be at low risk as well as the population that a traditional high risk pool would serve; there is no separate high risk pool. As a result, the Plan's finances were calculated to anticipate the adverse selection inherent in this approach (of "uninsurables" enrolling in the Plan). The Plan will track its experience with rates of uninsured, premium costs, and trends; compare this experience to those states with high risk pools; and report its findings to the Legislature by October 1, 2007. The Legislature may consider alternative approaches to insuring high risk individuals should Dirigo's experience indicate that a different approach would be better.

Costs of participation

The Dirigo Health Plan is designed to pool small businesses, the self employed, and individuals into a large group to bargain as effectively as possible for good prices. As the plan grows, so will its capacity to bargain for competitive prices for its members.

Projected monthly costs are illustrated in Table 2. These costs do not reflect discounts on monthly costs, deductibles, and out-of-pocket maximum costs or employer contributions.

Table 2 **Projected monthly costs**

Option	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Spouse + Child(ren)
Option 1	\$282	\$507	\$592	\$846
Option 2	\$260	\$467	\$545	\$779

GOHPF website, www.maine.gov/governor/baldacci/healthpolicy/DH%20Plan%20Q&A%204-2-04.pdf

Options 1 and 2 will offer different monthly costs as well as different deductibles and out of pocket maximum costs. Individuals and the self-employed of one will only be able to enroll in Plan Option 2.

Individuals and families with annual household incomes below 300 percent FPL are eligible for discounts on these monthly payments and also on deductibles and out-of-pocket maximum costs. The discounts will be available on a sliding scale based on income. The costs shown are subject to community rating; therefore, they may fluctuate plus or minus 20 percent. The Dirigo Health Plan will consider group size, average age, industrial classification, and geographic location when determining the exact cost for enrollees. The projected costs were based on a hypothetical group of 10 with an average age of 43.

Tables 3 and 4 provide information for determining income groups, which in turn determine an enrollee's deductible amount and out-of-pocket maximum costs. Except for Column F, each column represents the upper limit for household income. All family members are included in determining the size of a family, regardless of the number enrolled. Group A represents MaineCare.

Income Group Determination Tables

Table 3 Income eligibility thresholds for employee and/or employee + spouse contracts

Size of Family	Income group by annual income					
	A	B	C	D	E	F <i>greater than:</i>
1	\$11,638	\$13,965	\$18,620	\$23,275	\$27,930	\$27,930
2	\$15,613	\$18,735	\$24,980	\$31,225	\$37,470	\$37,470
3	\$19,588	\$23,505	\$31,340	\$39,175	\$47,010	\$47,010
4	\$23,563	\$28,275	\$37,700	\$47,125	\$56,550	\$56,550
5	\$27,538	\$33,045	\$44,060	\$55,075	\$66,090	\$66,090

GOHPF website, www.maine.gov/governor/baldacci/healthpolicy/DH%20Plan%20Q&A%204-2-04.pdf

Table 4 Income eligibility thresholds for employee + child(ren) and/or family contracts

Size of Family	Income group by annual income ^a			
	A	D	E	F <i>greater than:</i>
2	\$24,980	\$31,225	\$37,470	\$37,470
3	\$31,340	\$39,175	\$47,010	\$47,010
4	\$37,700	\$47,125	\$56,550	\$56,550
5	\$44,060	\$55,075	\$66,090	\$66,090

^a Groups B and C are rolled into Group A when the MaineCare expansion occurs

GOHPF website, www.maine.gov/governor/baldacci/healthpolicy/DH%20Plan%20Q&A%204-2-04.pdf

Deductible and out-of-pocket costs for each income group are illustrated in Table 5 on the following page.

Table 5 Illustration of deductible and out-of-pocket costs for Plan Option 1

The Dirigo Health Plan Option 1	Income Group (please refer to Table 3 and 4 to determine income groups)					
	A	B	C	D	E	F
Annual Deductible Individual Family	None None	\$250 \$500	\$500 \$1000	\$750 \$1500	\$1000 \$2000	\$1250 \$2500
Coinsurance		80/20%	80/20%	80/20%	80/20%	80/20%
Out-of Pocket Maximum^a Individual Family	None None	\$800 \$1600	\$1600 \$3200	\$2400 \$4800	\$3200 \$6400	\$4000 \$8000
Lifetime Maximum	None	None	None	None	None	None
Hospital	100%	Ded/Coin	Ded/Coin	Ded/Coin	Ded/Coin	Ded/Coin
Pharmacy	\$2.50	\$10/25/40	\$10/25/40	\$10/25/40	\$10/25/40	\$10/25/40
Physician Office Visit PCP Specialist	\$3	\$15/visit \$25/visit	\$15/visit \$25/visit	\$15/visit \$25/visit	\$15/visit \$25/visit	\$15/visit \$25/visit
Preventive Care Immunizations Routine Physicals Pap Tests Blood Tests Mammograms Well Baby Care	100%	100%	100%	100%	100%	100%

^a Out-of-pocket maximums include coinsurance and deductibles, not premiums or co-pays

GOHPF website, www.maine.gov/governor/baldacci/healthpolicy/DH%20Plan%20Q&A%204-2-04.pdf

As mentioned, discounts on monthly costs will be offered on a sliding scale to enrollees with household incomes less than 300 percent FPL. Along with income guidelines, the amount of discount will vary based on the type of coverage. While MaineCare will cover 100 percent of an eligible enrollee’s cost, those above MaineCare eligibility and below 300 percent FPL will be eligible for discounts on monthly costs up to 60 percent for a single employer and 30 percent for family coverage.

Costs to Employers

Employers will be required to pay a minimum of 60 percent of the employee cost. Employers must offer family coverage, but need only pay the 60 percent minimum of the employee-only costs. Employers will be asked to pay a modest program fee to the Dirigo Health Agency (\$150-\$350 per year depending on the size of the workforce).

Scenarios demonstrating the Dirigo Health Plan

Lucy

- Lucy works for a small employer that offers Option 1
- She is married with one child and has an annual household income of \$23,000, which is below 150% FPL, making her eligible for MaineCare
- Lucy chooses to enroll her self and her child at a total cost of \$507/month
- Even though Lucy chose the family coverage, Lucy's employer only needs to cover 60% of the employee only cost of \$282; therefore, the employer covers \$169 of the monthly cost
- Lucy must cover the remainder: \$338/month
- Lucy's bi-weekly payroll deduction is approximately \$168; however, based on her income status she is eligible for the deductible and out-of-pocket schedule under Group A; therefore, Lucy's monthly costs will be reimbursed by Dirigo Health
- Dirigo Health reimburses Lucy \$168 bi-weekly to help her pay the payroll deduction

John

- John works for an employer that offers Option1
- He is single, with an annual household income of \$14,500 (Group C)
- Total monthly cost for John to enroll is \$282
- His employer will cover 60%, or \$169
- John pays \$113 per month; therefore, his bi-weekly payroll deduction is \$56
- Dirigo Health will reimburse John \$25 (a 45% discount) every two weeks or \$50 per month
- Based on John's income, his annual deductible is \$500 with a \$1,600 out-of-pocket maximum

Current Status as of Early June 2004

The Maine Office of Health Policy and Finance and the Dirigo Health Agency contracted with the Edmund S. Muskie School of Public Service at the University of Southern Maine, Mathematica Policy Research, and the actuarial firm of Watson Wyatt to construct the health coverage benefit.

The Dirigo Health Plan was developed based on employer and employee focus groups, discussions with insurers, and data analysis by state and national experts. To develop a realistic price, an actuarial firm evaluated the product and Maine's current market.

On May 7, 2004, the Dirigo Health Agency issued a Request for Proposals seeking bids from private carriers to offer the Dirigo Health Plan. A bidders conference was held on May 17 in order to provide interested insurers an opportunity to pose questions to the Dirigo Health Agency. Six carriers attended the bidders conference; one (Anthem Blue Cross and Blue Shield of Maine) submitted a bid.⁶ The RFP is available on the GOHPF website.

Should Anthem's proposal fail to meet the Plan requirements, the state will seek legislative authority to self-administer the insurance benefit. To prepare for such a possibility, work is underway to develop a proposal to allow the Dirigo Health Plan to self-administer.

In the first year of Plan operation, the Dirigo Health Agency aims to sign up 31,000 Maine residents who were previously uninsured. The majority of enrollees will be from small businesses. During the first year, enrollment of individuals and the self-employed (in groups of one) will be capped at 4,000 to be manageable and allow for a smooth start to the program. The goal is to provide affordable coverage for all of Maine's uninsured, approximately 140,000, by 2009.

⁶ Carriers that attended the bidders conference: Aetna, Anthem Blue Cross and Blue Shield of Maine, Cigna, Harvard Pilgrim, Integrated Healthcare Corporation, and United.

MORE INFORMATION ON THE DIRIGO HEALTH REFORM ACT

Public Law Chapter 469, The Dirigo Health statutory language:

<http://janus.state.me.us/legis/ros/lom/LOM121st/10Pub451-500/TableofContents.htm>

Maine Governor's Office of Health Policy and Finance: www.healthpolicy.maine.gov

Dirigo Health Agency: www.dirigohealth.maine.gov

APPENDIX A:

Dirigo Health Reform Boards, Commissions, and Health Action Team

Dirigo Health Board of Directors

Key Duties

Establish and administer Dirigo Health; hire Executive Director; collect savings offset payments; develop benefit and subsidies; and establish and operate the Maine Quality Forum.

Membership

Chair Robert McAfee, M.D., Retired and Former President American Medical Association

Dana Connors, President, Maine State Chamber of Commerce

Mary Henderson, Executive Director, Maine Equal Justice Partners

Carl Leinonen, Executive Director, Maine State Employees' Association

Charlene Rydell, Policy Advisor to Congressman Tom Allen

Ex-Officio, Trish Riley, Director, Maine Governor's Office of Health Policy and Finance

Ex-Officio, Rebecca Wyke, Commissioner, Maine Department of Administrative and Financial Services

Ex-Officio, Robert E. Murray, Jr., Commissioner, Maine Department of Professional and Financial Regulation

Maine Quality Forum Advisory Council

Key Duties

Guide research and dissemination; promote quality performance measures, data coordination and public reporting of data, consumer education, and technology assessment; convene Provider Advisory Group.

Membership

Chair, Robert McArtor, M.D., M.P.H., MaineHealth

Clifford Rosen, M.D., Maine Center for Osteoporosis Research and Education

Janice Wnek, M.D., Maine Health Management Coalition's Pathways to Excellence Project

Stephen Shannon, D.O., M.P.H., Dean and Vice President of Health Services, UNECOM

Richard Bruns, D.C., Bruns Chiropractic Clinic

Nancy Kelleher, Senior Director of Public Policy and Communications, Sweetser

Rebecca Colwell, R.N., B.S.N., M.B.A., Vice President, HomeCare and Hospice, HealthReach

Rebecca Martins, Patient Advocate, National Patient Safety Commission

Jonathan S. R. Beal, Attorney

Lisa Miller, M.P.H., Senior Program Officer, The Bingham Program

David White, President, MDI Imported Car Service, Inc.

Frank Johnson, Director, State Employee Health Insurance

Daniel Roet, Director, Human Resources Services, Bath Iron Works

Jim McGregor, Executive Vice President, Maine Municipal Association

Chip Morrison, President and CEO, Androscoggin County Chamber of Commerce

Representative of a private health insurer (Vacant)

Laureen Biczak, D.O., Medical Director, MaineCare

Commission to Study Maine's Hospitals

Key Duties

Conduct a comprehensive analysis of hospital costs, roles, reimbursement, capital needs, and opportunities to make policy recommendations.

Membership

Chair, William E. Haggett, Chairman of the Board and CEO, Naturally Potatoes

Scott Bullock, CEO, Maine General Health

John Welsh, Jr., President, FACHE, and CEO, Rumford Hospital

D. Joshua Cutler, M.D., Maine Cardiology Associates

Patricia S. Philbrook, R.N.C., N.P., Executive Director, Maine State Nurses Association

Richard Wexler, M.D., Medical Director, Medical Care Development

Joseph Ditre, Executive Director, Consumers for Affordable Health Care Foundation

Robert K. Downs, Harvard Pilgrim Health Care

Christopher St. John, Executive Director, Maine Center for Economic Policy

Advisory Council on Health Systems Development

Key Duties

Guides the Governor's Office of Health Policy and Finance in establishing the state health plan, capital investment fund, and global budget and in conducting hearings and synthesizing data and research.

Membership

Chair, Brian Rines, Ph.D., Psychologist

Vice Chair, Lani Graham, M.D., M.P.H., Physician and Public Health Specialist

Maroulla Gleaton, M.D., President, Maine Medical Association

Norman Ledwin, President, Eastern Maine Healthcare

Stephen Farnham, Executive Director, Aroostook Area Agency on Aging

Christine Hastedt, Public Policy Specialist, Maine Equal Justice Partners

Andrew Coburn, Ph.D., Muskie School of Public Policy

Bob Keller, M.D., Orthopedic Surgeon

Edward Miller, CEO, American Lung Association (Maine)

John Carr, President, Maine Council of Senior Citizens

Dora Mills, M.D., M.P.H., Director, Maine Bureau of Health

Public Purchasers' Steering Group

Key Duties

Establish and coordinate a collaborative purchasing program and assure cost effective, highest quality health care for individuals whose coverage is paid by state and local tax dollars.

Membership

Chair, Frank A. Johnson, Executive Director, Maine State Employee Health and Benefits

Susan B. Avery, Director of Insurance Programs, Maine School Management Association

Robert Gibbons, Esq., Executive Director, Maine Education Association Benefits Trust

Thomas Hopkins, Director, University of Maine System Compensation and Benefits

Richard B. Thompson, Jr., Chief Information Officer, State of Maine

James H. Lewis, Assistant Director, Bureau of Medical Services

Stephen W. Gove, Director of Health Trust Services, Maine Municipal Association

Ben Dudley, State Representative, Maine Legislature's Joint Standing Committee on Appropriations and Finance

S. Peter Mills, State Representative, Maine Legislature's Joint Standing Committee on Appropriations and Finance

Trish Riley, Director, Maine Governor's Office of Health Policy and Finance

Task Force on Veterans' Health Services

Key Duties

Analyze and assess health services to veterans and make recommendations to more effectively organize those services.

Membership

Bruce Bryant, State Senator

Roger Landry, State Representative

John Wallace, President, Maine State Council for Vietnam Veterans of America

A representative of the Maine Department of Defense, Veterans and Emergency Management

Major General Steve Nichols

Lou Dorogi, Maine Department of Human Services

Christine Gianopoulos, Maine Department of Human Services

Kris Doody-Chabre, R.N., CEO Cary Medical Center

Arthur Newkirk, M.D., Blue Hill Family Medicine

Susan Shaw, R.N., D.O., MatureCare

Larry Mutty, M.D.

Jack Sims, Director, Department of Veterans Affairs Medical and Regional Office Center at Togus

Timothy Politis, C.L.U., CEO and Executive Director, Maine Veterans' Homes

Health Action Team

Key Duties

Advise the Maine Governor's Office of Health Policy and Finance in its work to achieve real health care reform for Maine. The Health Action Team was an advisory body representing the key stakeholders in Maine's health care system, notably consumer groups, businesses, providers, and government. The group provided guidance in creating the Governor's health care reform plan: The Dirigo Health Reform Act.

Membership

Greater Portland Chambers of Commerce: Godfrey Wood

Hannaford Brothers: Peter Hayes

Maine Small Business Alliance: Jeff Sosnaud

Employee Benefits Solutions: John Benoit

Maine Association of Health Plans: Dan Fishbein

Maine Health Management Coalition: Doug Libby

Maine Hospital Association/MHA: Richard Willett

Maine Medical Association: Dr. Maroulla Gleaton

Maine Osteopathic Association: Kellie Miller

Maine Chiropractic Association: Dr. Marc Malon

Maine State Nurses Association: Patricia Philbrook

Maine Primary Care Association: Kevin Lewis

Maine State Employees Association: Carl Leinonen

Maine Education Association: Robert Walker

Consumers for Affordable Health Care: Joe Ditre

Maine Equal Justice Partners: Mary Henderson

National Alliance for the Mentally Ill, Maine: Carol Carothers

Maine People's Alliance: Tammy Groaton

Maine Municipal Association: Steve Gove

Maine Public Health Association: Megan Hannan

Maine Health Access Foundation: Charlene Rydell

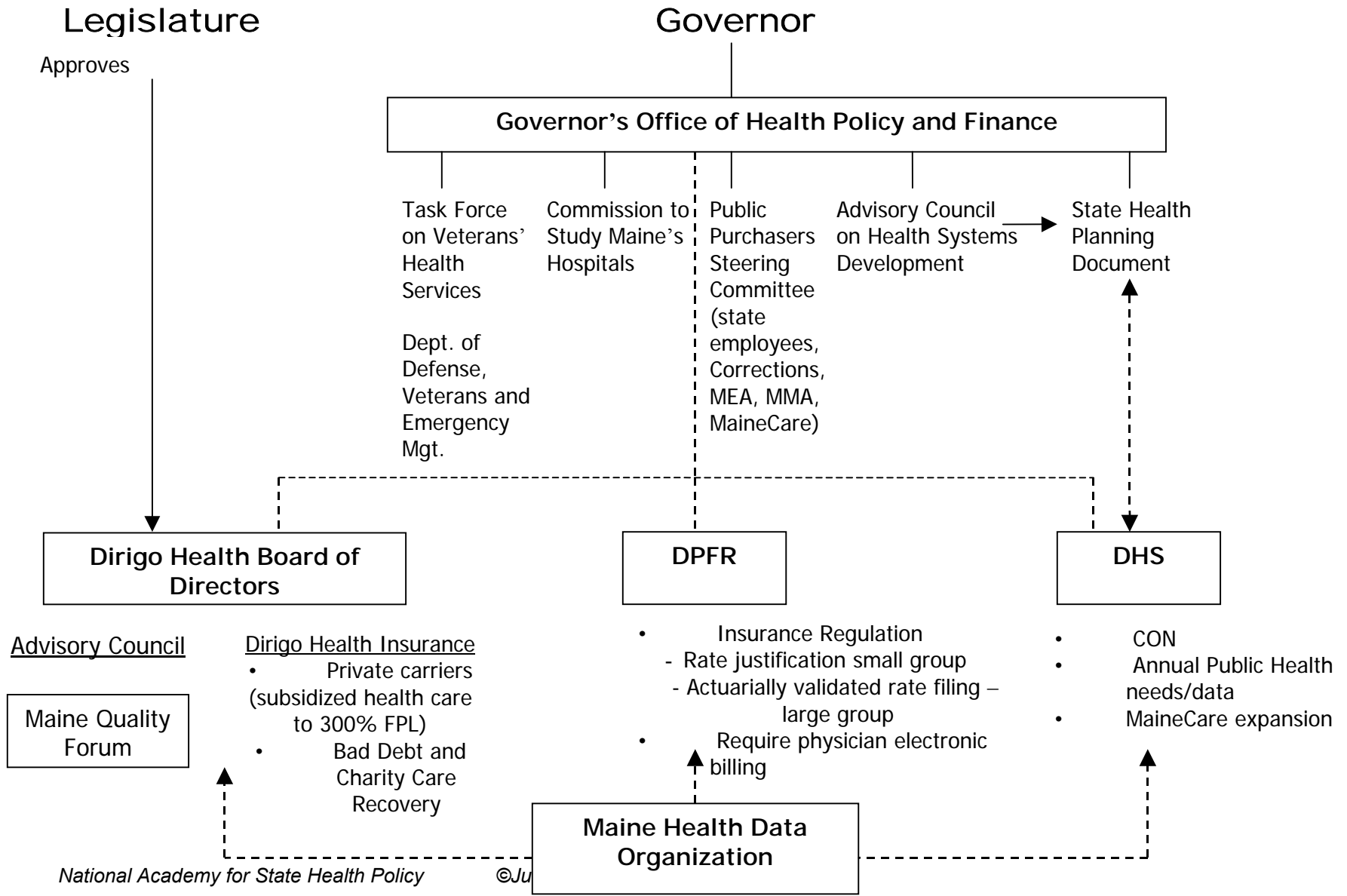
Maine Department of Professional and Financial Regulation: Commissioner Buddy Murray

Office of the Maine Attorney General: Linda Pistner

Two Legislative Republicans: Tarren Bragdon and Robert Nutting

Two Legislative Democrats: Chris O'Neil and Ann Woloson

DIRIGO HEALTH *Health Reform for Maine*



APPENDIX C

Statewide Average Inpatient Hospital Charges for 15 Most Common Diagnoses*

DRG	Description	Average Charge
Childbirth Related		
391 - Normal newborn	Hospital charges for the newborn. Newly delivered babies without significant health problems.	\$1,274
373 - Normal childbirth	Hospital charges for the mother. Normal delivery of a baby or babies without surgery.	\$3,773
371 - Cesarean section	Hospital charges for the mother. Normal delivery of a baby or babies through incisions made in the mother's abdomen.	\$7,735
390 - Neonates with other significant problems	Hospital charges for the newborn. Baby has complications such as skin disorders, low temperature, feeding problems, cyst. Complications do not require extended hospital stays or intensive care.	\$1,905
Psychoses or Drug Related		
430 - Psychoses	Major personality disorders such schizophrenia, catatonia, manic disorders, bipolar affective disorders, and paranoia.	\$13,048
523 - Alcohol or drug abuse w/o rehabilitation & complications	Drug overdose or alcohol withdrawal, w/out rehabilitation and complications.	\$4,647
Other		
127 - Heart failure & shock	Conditions related to weakening heart muscles as a result of high blood pressure, rheumatic heart disease, and congestive heart failure.	\$10,520
14 - Stroke	Stroke and related conditions, such as bleeding in the brain and sudden obstruction or blockage of blood vessels in the brain.	\$13,770
89 - Pneumonia age 17 or older with complications	Bacterial, viral, and bronchial pneumonia, pleurisy, and tuberculosis.	\$10,725
88 - COPD (Chronic Obstructive Pulmonary Disease)	Lung disease, chronic bronchitis, and emphysema.	\$9,584
143 - Chest pain	Chest pain.	\$5,428
359 - Hysterectomy	Surgical removal of the uterus through either a vaginal approach or an abdominal incision. May include a bladder repair for stress urinary incontinence. May include the biopsy and/or removal of the fallopian tubes, ovaries.	\$8,360
209 - Joint replacement and limb reattachment	Major joint replacements and revisions of lower extremities such as the hip, knee and ankle.	\$23,607

182 - Digestive disorders age 17 or older w/complications	Conditions related to the esophagus, stomach, and intestines, such as salmonella, food poisoning, infectious diarrhea, intestinal parasites, persistent vomiting, heartburn, gas, and abdominal pain.	\$8,447
296 - Nutritional & miscellaneous metabolic disorders over age 17 w/complications	Used for a wide range of conditions related to nutrition or metabolism.	\$9,082

**This list displays the average statewide charge for the 15 most commonly performed inpatient procedures in Maine hospitals statewide in 2002, summarized by Diagnosis Related Group (DRG), as reported by the Maine Health Data Organization. These procedures have standard definitions, allowing for price comparisons for each procedure across different hospitals. Charges do not include hospital-based physician charges. The most commonly performed procedures at individual hospitals may not be an identical match to the list of procedures most commonly performed statewide. Every patient is different and has unique needs, so his or her care will be tailored to meet those needs, and actual charges may differ. However, on average, charges for the most common types of services will reflect those listed above.*

Source: Dirigo Health Controlling Costs, Maine Office of Health Policy and Finance,
http://www.state.me.us/governor/baldacci/healthpolicy/reports/average_inpatient_charges.htm