Executive Summary
Backgrounder
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Command and Control: Maine's Dirigo Health Care Program

Tarren Bragdon

The Maine legislature has enacted a health policy agenda based on a massive increase in government central planning and control. Like Tennessee's ill-fated TennCare program, this ambitious regulatory agenda is also accompanied by a costly expansion of Medicaid, the federal and state program for the disabled and the indigent.

Dirigo Health is the Maine legislature's latest experiment in health care reform. Backed by Governor John Baldacci, Dirigo Health was introduced on May 13, 2003; debated for four short weeks at the end of the session; passed; and signed into law on June 18, 2003.

Each core element of Dirigo Health—Medicaid expansion, new state-designed insurance, and a new health care regulatory regime—is independent of the other two. The success or failure of one component does not jeopardize the success or continuation of another. As a political agenda, the program thus divides different constituencies, pitting them against one another and enabling the governor and his legislative allies to neutralize many groups with minor concessions while triumphing over the program's scattered opponents.

Maine's latest health care reform program is receiving widespread attention. In June 2004, the National Academy of State Health Policy (NASHP) issued a report providing an overview of the Dirigo Health reform initiative and explaining why NASHP believes that it will be effective in dealing with the cost-quality-access triangle. Advocates in the state legislature and elsewhere say that Dirigo Health offers important lessons for policymakers in other states and could *eliminate the problem of uninsurance within five years*, but Maine's latest project should serve as a warning of what *not* to do rather than as a model for other states to follow.

A Massive Program. Dirigo Health has three major elements: a massive Medicaid expansion; a state-designed, state-subsidized health insurance plan sold primarily to small employers and the self-employed; and a comprehensive and far-reaching set of new regulations and controls over the private health care and health insurance industries in Maine. The new program is characterized by government central planning, government-standardized quality, and massive public spending.

A Better Policy. Maine's situation calls for a targeted approach that would encompass a combination of ambitious insurance market reforms and serious regulatory changes to ease access and make coverage more affordable. These reforms would include:

- **Creating** a statewide insurance exchange, similar to the Federal Employees Health Benefits

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Program, in which individuals and families in small businesses can personally choose affordable private insurance;

- **Changing** the law to allow Maine citizens to purchase more affordable plans from insurers licensed in other states;
- **Eliminating** the state income tax obstacles to the purchase of affordable health savings account plans;
- **Overhauling** Medicaid to provide direct subsidies or vouchers to enable Medicaid beneficiaries to purchase private coverage if they wish to do so;
- **Opening up**, not stifling, free-market competition among providers in Maine by repealing Certificate of Need laws; and
- **Targeting** government subsidies to low-income working families who need help in purchasing the private coverage of their choice.

Conclusion. Dirigo Health is based on the premise that government officials can best control and manage the entire health care system. Predictably, it is being trumpeted nationally by those who support more government control and more taxpayer funding of health care coverage. In reality, it is proving to be a costly and ineffective expansion of bureaucracy and government control that will drive up costs and further undermine consumer choice and competition in the health care system.

There is a better way. Real and effective health care reform should be based on the core principle that personal health care decisions are best left up to individuals and their doctors, not government officials, state legislators, or well-intentioned bureaucrats. Real reform empowers the individual with the tools necessary to choose affordable, quality, and accessible health care services and health insurance coverage. It begins and ends with personal freedom.

Dirigo Health is not good for Maine and should not be copied elsewhere.

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Dirigo[1] Health is the Maine legislature's latest experiment in health care reform.[2] Presented by Governor John Baldacci, Dirigo Health was introduced on May 13, 2003; debated for four short weeks at the end of the session; passed; and signed into law on June 18, 2003.

Each core element of Dirigo Health—Medicaid expansion, new state-designed insurance, and a new health care regulatory regime—is independent of the other two. The success or failure of one component does not jeopardize the success or continuation of another. As a political agenda, the program thus divides different constituencies, pitting them against one another and enabling the governor and his legislative allies to neutralize many groups with minor concessions while triumphing over the program's scattered opponents.

Maine's latest health care reform program is receiving widespread attention. In June 2004, the National Academy of State Health Policy (NASHP) issued a report providing an overview of the Dirigo Health reform initiative and explaining why NASHP believes that it will be effective in dealing with the cost-quality-access triangle.[3] Advocates in the state legislature and elsewhere say that Dirigo Health offers important

Talking Points

- Maine needs significant health insurance and health care reforms. Health insurance premiums are high, health care providers are not competitive, and the individual insurance market—the market of last resort for those who face being uninsured—is a mess.
- Dirigo Health is based on the premise that government officials can best control and manage the entire health care system. It is characterized by government central planning, heavy regulation of the health care and health insurance industries, and massive public spending.
- Dirigo Health consists of three independent core elements: Medicaid expansion, new state-designed insurance, and a new health care regulatory regime.
- Even excluding the new Dirigo Medicaid expansion, Medicaid will consume 44 percent of all projected spending increases in the next state budget, although it currently accounts for less than 20 percent of the total general fund budget.

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A Massive Program

Dirigo Health has three major elements: a massive Medicaid expansion; a state-designed, state-subsidized health insurance plan sold primarily to small employers and the self-employed; and a comprehensive and far-reaching set of new regulations and controls over the private health care and health insurance industries in Maine. The new Maine health policy is characterized by three features:

- **Government Central Planning.** According to the NASHP, Dirigo Health attempts to control health care costs through

  > 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. [Dirigo Health] is built upon the premise that covering Maine's uninsured will significantly reduce bad debt and charity care costs.[4]

  The tacit assumption is that more bureaucracy will control costs.

- **Government-Standardized Quality.** Dirigo Health will work to improve quality through a new state body called the Maine Quality Forum, which will

  > 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.[5]

  Not only will Dirigo Health seek to control health care equipment, facility, and service investments in Maine, but the Quality Forum will attempt to ensure that patients with similar conditions receive identical treatment regardless of which doctors or medical professionals they visit.

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1. *Dirigo* is Latin for "I lead" and is Maine's state motto.
2. The Maine legislature's most recent attempted major health reform, in 1993, radically changed the health insurance environment. The legislature passed modified community rating in the small group and individual markets and guaranteed issue in the individual market. The modified community rating required that insurance premiums could not vary the premium rates due to sex, health status, claims experience, or policy duration and could only vary premiums by 20 percent due to age, occupation or industry, and geographic area. Maine is one of only four states to have both community rating and guaranteed issue in its individual market (joining New York, New Jersey, and Vermont). Since 1993, the Maine legislature has passed a variety of policy initiatives designed to reduce the price of prescription drugs and expand Medicaid and the Children's Health Insurance Program, as well as a variety of other smaller health reform initiatives.
3. Jill Rosenthal and Cynthia Pernice, "Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine," National Academy for State Health Policy, June 2004, at *www.nashp.org/Files/GNL_56_Dirigo_brief.pdf* (December 28, 2004). Trish Riley, former Executive Director of the NASHP, is currently Director of the Office of State Health Policy and Finance, the drafters and implementers of Dirigo Health.
4. *Ibid.*, p. 1.
5. *Ibid.*

- **Massive Public Spending.** The designers of Dirigo Health originally sought to expand eligibility in Maine's Medicaid program in April 2005. They also wish to create a new state-designed, privately managed insurance product marketed to individuals, small employers, and the self-employed. Individuals meeting particular income guidelines will receive premium subsidies and a richer benefit plan.

A Better Policy

Maine is a small state, with a population of 1.27 million people, and the third-oldest state in terms of its population's median age. Its health care performance is mixed. Maine's citizens are ranked as the seventh healthiest in the nation,[6] and they benefit from both high-quality hospital care[7] and reasonable hospital expenses.[8] At the same time, Maine ranks fifth nationally on public spending for health care,[9] ranks in the top five for high health insurance premiums,[10] and ties for third place for highest portion of non-elderly residents on Medicaid (20 percent).[11]

The plight of the uninsured, although less than the national average, is driving Maine's health policy. Part of the reason is that the state's 1993 insurance market reforms failed to expand coverage and apparently worsened the problem. In the decade from 1993 to 2003, Maine's individual insurance market dropped from over 90,000 covered to just over 36,000. Today, according to a recent federally financed study, 136,000 Mainers (one in eight) are without health insurance.[12] Maine has a diverse population, and almost one-quarter of its uninsured earn more than 300 percent of the federal poverty limit (FPL). Just over one-half of its uninsured are employed by a firm (as opposed to being self-employed or unemployed).

Maine's situation calls for a targeted approach that would encompass a combination of ambitious insurance market reforms and serious regulatory changes to ease access and make coverage more affordable. These would include:

- **Creating** a statewide insurance exchange, similar to the Federal Employees Health Benefits Program, in which individuals and families in small businesses can purchase affordable insurance;
- **Changing** the law to allow Maine citizens to purchase more affordable plans from firms licensed in other states;
- **Eliminating** the state income tax obstacles to the purchase of affordable health savings account plans;
- **Overhauling** Medicaid to provide direct subsidies or vouchers to enable Medicaid beneficiaries to purchase private coverage if they wish to do so;

6. Morgan Quitno Press, "2003 Healthiest State Award," at *www.morganquitno.com/hcrank03.htm* (May 3, 2005). Interestingly, Maine dropped to ninth healthiest in 2004. Morgan Quitno Press, "2004 Healthiest State," at *www.morganquitno.com/hcrank04.htm* (December 28, 2004).
7. Press release, "Maine Hospitals Among Best in Nation: Maine Ranks 3rd Highest for 2nd Time," Maine Hospital Association, January 16, 2003, at *www.themha.org/press/rank.htm* (December 28, 2004).
8. Henry J. Kaiser Family Foundation, "Maine: Health Costs & Budgets," at *www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Maine&category=Health+Costs+%26+Budgets* (December 28, 2004).
9. Henry J. Kaiser Family Foundation, "Total State Health Care Expenditures as Percent of the Gross State Product, SFY 2000," at *www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health+Costs+%26+Budgets&subcategory=State+Budgets&topic=Health+Spending+as+%25+Gross+State+Product* (December 28, 2004).
10. Alessandro Iuppa, "Maine's Health Insurance Market: A Snapshot," talk delivered to the Maine Employee Benefits Council, December 5, 2001.
11. Henry J. Kaiser Family Foundation, "State Health Facts," 2002–2003 state data, at *www.statehealthfacts.org* (December 28, 2004).
12. Erika Ziller and Elizabeth Kilbreth, Ph.D., "Health Insurance Coverage Among Maine Residents: The Results of a Household Survey 2002," University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy, May 2003, pp. 15–18, at *muskie.usm.maine.edu/Publications/hpi/HealthInsuranceCoverageMaine2003.pdf* (December 28, 2004).

- **Opening up**, not stifling, free market-competition among providers in Maine by repealing Certificate of Need (CON) laws; and
- **Targeting** government subsidies to low-income working families who need help in purchasing the private coverage of their choice.

How Dirigo Health Care Is Designed

Dirigo Health Care has three core components, which are independent of each other.

Component #1: A "Super-Sized" Medicaid Program

Like many other states, Maine has struggled in recent years with its Medicaid program. By the beginning of 2003, Maine's Medicaid program covered over 227,000 residents (or one in five Mainers). From fiscal year (FY) 1994 to FY 2003, Maine Medicaid grew at an average annual rate of 9.5 percent.[13]

Not many governors would choose such a climate to "super-size" the Medicaid program, but Governor Baldacci and his advisers saw Medicaid expansion as critical to the overall Dirigo Health initiative. Maine received almost two dollars in federal Medicaid match for each state dollar expended, and Maine officials, like officials in most other states, aggressively pursued capturing the federal Medicaid match. By any measure, the proposed Dirigo Medicaid expansion is significant. It would:

- Expand coverage to an estimated 26,000 childless adults with incomes between 100 percent and 125 percent of the FPL, and
- Expand coverage to an estimated 52,000 parents with incomes between 150 percent and 200 percent of the FPL.[14]

In theory, the 78,000 new Medicaid enrollees to become newly eligible in 2005 were not expected to add to the state's budget deficit. To be fiscally responsible, Maine officials devised a clever financing scheme that leverages federal funds from Medicaid and employers to keep the proposal cost-neutral.

Table 1 B 1878

Facts About Maine's Uninsured

About 136,000 non-elderly are uninsured.

Employment

- 28% of uninsured are self-employed.
- 52% are employed by another.
- 20% are unemployed or out of the workforce.

Income

- 16% earn less than the federal poverty limit (FPL).
- 32% earn 100–199% of FPL.
- 23% earn 200–299% of FPL.
- 23% earn over 300% of FPL.
- Income for 8% is unknown.

Age

- 17% are under age 18.
- 28% are 18–29.
- 33% are 30–44.
- 22% are over 44.

Source: Erika Ziller and Elizabeth Kilbreth, Ph.D., "Health Insurance Coverage Among Maine Residents: The Results of a Household Survey 2002," University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy, May 2003, pp. 15–18, at *muskie.usm.maine.edu/Publications/hpi/HealthInsuranceCoverageMaine2003.pdf* (December 28, 2004).

Percentages may not sum to 100 percent due to rounding.

The Dirigo Medicaid expansion would amount to a more than 30 percent enrollment increase in Medicaid. When the Medicaid expansion is fully phased in, Maine will likely have the highest Medicaid enrollment rate in the country, with up to 25 percent of those under 65 years old enrolled.[15]

The Coming Fiscal Crisis. When Governor Baldacci took office in January 2003, Maine faced a $1 billion biennial budget shortfall. Moreover,

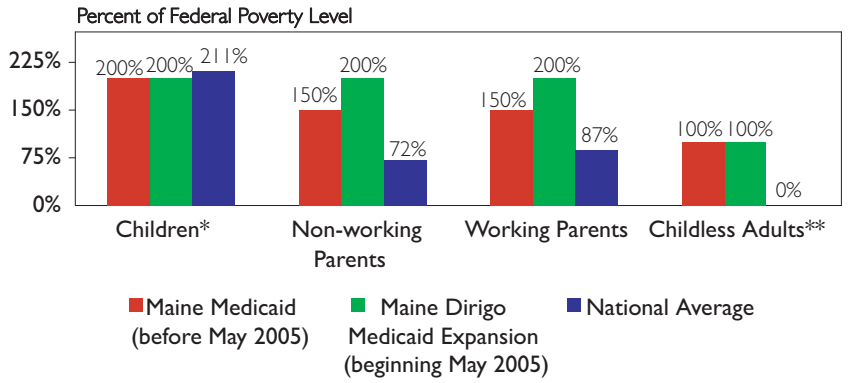
13. Maine State Legislature, Office of Fiscal and Program Review, "Medicaid/MaineCare," at *www.state.me.us/legis/ofpr/gfgap0607/General%20Fund%20medicaid-mainecare.htm* (December 28, 2004)
14. Maine State Legislature, Office of Fiscal and Program Review, Fiscal Note for LD 1611, Public Law 2001, Chapter 450, released June 11, 2003.
15. Henry J. Kaiser Family Foundation, "State Health Facts."

overall state spending was expected to grow $1 billion faster than projected revenue over the next two years. Maine should already have learned its lesson because its Medicaid program costs were significantly higher than projections and were consuming the rest of the state budget. Two years later, the story was much the same.

As the Maine legislature convened in January 2005, it faced another large shortfall of over $700 million for the projected $6.3 billion general fund biennial budget, beginning July 2005. This projected shortfall does not include any potential costs of the Dirigo Health Medicaid expansion that was set to begin on April 1, 2005.[16] Even excluding the new Dirigo Medicaid expansion, Medicaid will consume 44 percent of all projected spending increases in the next budget, even though Medicaid is currently less than 20 percent of the total general fund budget.[17]

Chart 1 B 1878

Maine Medicaid Eligibility Limits Compared to the National Average



* Includes SCHIP.
** Only five states cover childless adults.

Source: Henry J. Kaiser Family Foundation, "State Health Facts," at *StateHealthFacts.org* (December 28, 2004), and Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability (HIFA) Initiative Fact Sheet," updated November 12, 2002, at *www.cms.gov/hifa/mecarefs.pdf* (June 17, 2005).

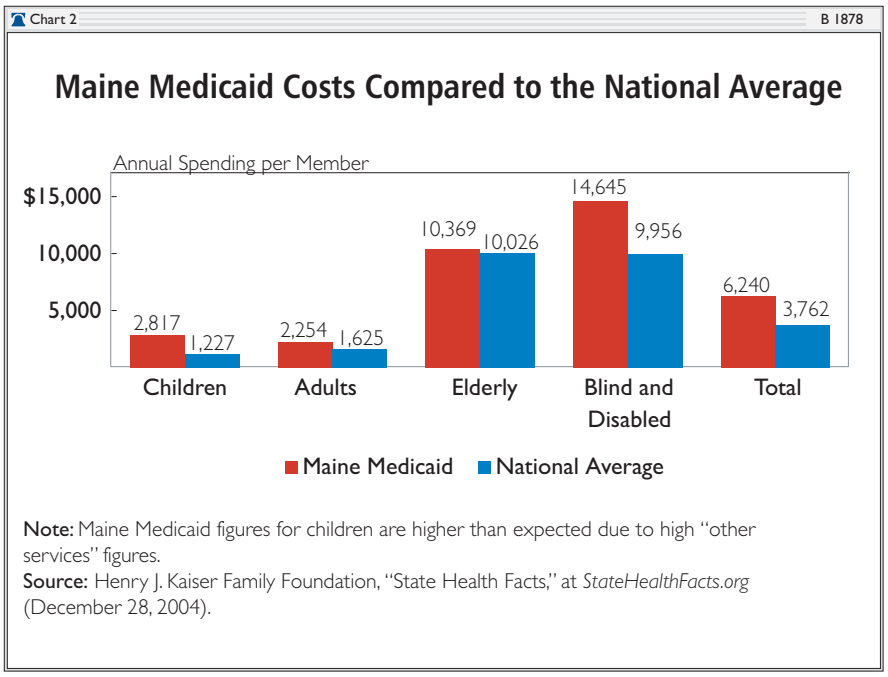
Impact of the Medicaid Explosion. In October 2002, Maine received a federal waiver to extend Medicaid coverage to "childless adults," defined as non-disabled adults without minor children.[18] The proposal was estimated to cover 15,900 adults earning up to 100 percent of the poverty limit ($9,310 per individual or $12,490 per couple per year). To fund this expansion, the legislature passed a $0.06 tax increase on cigarettes.

Less than one year after its launch, the expansion shattered the initial Maine Department of Human Services enrollment projections. By May 2003, when Governor Baldacci introduced Dirigo Health, the childless adult expansion was enrolling at three times the originally projected rate at a greater cost per enrollee and was already just 1,500 below the 15,900 total estimated number of eligible adults.[19]

The waiver expansion for childless adults capped total federal revenue available to the state at $57 million in federal FY 2003 and $66 million in federal FY 2004.[20] By November 2004, over 23,000 adults were enrolled in the Medicaid expansion—an

16. Maine State Legislature, Office of Fiscal and Program Review, "General Fund Structural Gap Estimates, 2006–2007 Biennium: General Fund Summary," at *www.state.me.us/legis/ofpr/gfgap0607/gfgap0607summary.htm* (December 28, 2004).
17. Maine State Legislature, Office of Fiscal and Program Review, "General Fund Structural Gap Estimates, 2006–2007 Biennium: General Fund Appropriations Summary," at *www.state.me.us/legis/ofpr/gfgap0607/gfgap0607approp.htm* (December 28, 2004).
18. Kaiser Commission on Medicaid and the Uninsured, "Maine Section 1115 Waiver," at *www.statecoverage.net/statereports/me12.pdf* (May 3, 2005).
19. Maine Department of Human Services and Maine Legislature, Office of Fiscal and Program Review, handout, June 2004.
20. The federal commitment as a requirement of the waiver had to be cost neutral and thus could not exceed the amount of Maine's unspent federal Medicaid disproportionate share funds.

astounding 45 percent higher than the total estimated eligible population.[21] As this Medicaid expansion now was costing more than the capped federal funds would match, the governor and the legislature instituted an enrollment cap on the childless adult Medicaid expansion at 100 percent of poverty and indefinitely postponed the expansion to 125 percent of poverty. The legislature also restructured the childless adult Medicaid program to reduce and limit covered services.[22]



Note: Maine Medicaid figures for children are higher than expected due to high "other services" figures.
Source: Henry J. Kaiser Family Foundation, "State Health Facts," at *StateHealthFacts.org* (December 28, 2004).

The Dirigo Health Medicaid expansion is even more unsustainable given that Medicaid is already consuming almost half of all new spending, Maine is already the second-highest-taxed state, and its Medicaid reimbursement rates for providers are already among the lowest in the nation. This indicates that the program has already reached its capacity.

Indeed, since Governor Baldacci took office in January 2003, the number of individuals on Medicaid has increased by almost 39,000 (17 percent) to over 266,000 by April 2005—and this increase occurred before any of the Medicaid expansion.[23] The Medicaid expansion to parents earning up to 200 percent of the FPL was delayed one month and began on May 1, 2005.

Not only has Governor Baldacci presided over the sizable growth of the Medicaid rolls as well as a significant Medicaid expansion, but state Medicaid spending also increased dramatically during his first two years in office. From FY 2003 to FY 2005 (ending on June 30, 2005), state Medicaid spending increased $140.5 million (from $543 million to $725 million)—almost 26 percent.[24]

Component #2: A State-Designed Health Insurance Plan

Of Maine's uninsured, 53 percent work for small businesses with less than 50 employees. Many of these businesses offer health insurance but may not offer an insurance plan that the uninsured employees are able or willing to join, given the total premium cost and/or the level of the employer contribution. Other small businesses do not offer any health insurance options at all.[25]

In theory, Dirigo Health attempts to provide a more affordable insurance plan through DirigoChoice, a state-designed, state-marketed insurance plan for small businesses. It is also available

21. Maine State Legislature, Office of Fiscal and Program Review, statistics provided to the author on December 30, 2004.
22. Maine Public Law 2005, Chapter 12, and Maine Public Law 2005, Chapter 457.
23. Maine State Legislature, Office of Fiscal and Program Review, statistics provided to the author on May 18, 2005.
24. Maine State Legislature, Office of Fiscal and Program Review, "Budget Overview: 122nd Legislature, 1st Regular and 1st Special Sessions," Appendix D, at *www.maine.gov/legis/ofpr/2005%20BUDGET%20OVERVIEW/Appendix%20D%20MaineCare%20Medicaid.htm* (July 27, 2005).
25. Ziller and Kilbreth, "Health Insurance Coverage Among Maine Residents," p. 19.

for purchase by individuals and the self-employed. Curiously, although they make up 47 percent of the uninsured, enrollment by individuals and the self-employed will be capped at 4,400 in the first year.

Slouching Toward Monopoly. During the spring and summer of 2004, Maine's Dirigo Health Agency, with the help of the nationally prominent William M. Mercer benefits consulting firm, designed the benefit structure and suggested premiums for DirigoChoice. Ultimately, although five insurers attended a bidders' conference, only Anthem Blue Cross and Blue Shield of Maine bid on the contract—and then only at a higher premium level than initially envisioned by the state.[26] Not surprisingly, the state awarded the contract to Anthem, which already is the dominant player in Maine's individual and small group health insurance markets.[27]

Since that award, Cigna, one of the four remaining insurers, has left the Maine individual and small group insurance market, further reducing competition and options for Maine consumers. If no insurer had bid, under the Dirigo Health law, the state could have set itself up as an insurance carrier, but such a move would have required approval from the legislature.

Deepening Complexity. The DirigoChoice program is extremely complex, with six different levels that are referred to as Categories A through F. Each category has a different employee premium share and different deductible. Each of the four different coverage options—employee only, employee and spouse, employee and child (or children), and family coverage—includes all six categories, for a total of 24 different options for employees.

To qualify to purchase DirigoChoice, a Maine small-business employer must agree to certain conditions:

- Employers must offer only DirigoChoice to employees;
- Employers must pay the same portion of the DirigoChoice premiums for all employees, with a minimum requirement of the employer paying 60 percent of the employee-only premium and 0 percent of the dependent's premium; and
- Employers would choose the DirigoChoice option (with different maximum deductibles)—Option I ($1,250 individual or $2,500 deductibles at the Category F level) or Option II ($1,750 individual or $3,500 deductibles at the Category F level).

More Red Tape. For employees, it is even more complex. The DirigoChoice plan is based on income levels, among other factors. Employees have three options:

- Apply to determine their eligibility for Medicaid and/or a premium subsidy,
- Apply to determine only their eligibility for a premium subsidy, or
- Simply pay the Category F premiums (for those earning more than 300 percent of the FPL).

To determine eligibility for Medicaid and/or a premium subsidy, an employee must provide detailed information to the Dirigo Health Agency for every member of that employee's household.[28] Obviously, some employers may be uncomfortable with participating in the eligibility determination process (including answering employees' basic questions) because of the types of information that

26. Associated Press, "Anthem Emerges as Possible Sole Bidder for Dirigo Plan," *MaineToday.com*, May 26, 2004, at *news.mainetoday.com/apwire/D82QA3AG0-146.shtml* (December 28, 2004).
27. Anthem has 95 percent of the individual Maine market and 52 percent of the small-group market. Maine Department of Professional and Financial Regulation, Bureau of Insurance, "Market Snapshot: Individual Medical," at *www.state.me.us/pfr/ins/Snapshot_individual.htm*, and Maine Department of Professional and Financial Regulation, Bureau of Insurance, "Market Snapshot: Small Group," at *www.state.me.us/pfr/ins/Snapshot_small_group.htm* (December 28, 2004).
28. Such information could include pregnancy status; income; employers and earnings (including self-employment, disability, and unemployment income); child care providers and expenses; child support obligations; current health insurance; disability or HIV status; all cashable assets (including names on account, financial institution, account numbers, and value); and all real estate assets identical to those required by Maine and federal Medicaid laws and regulations.

Table 2 B 1878

Health Care Simplification?
Navigating the 24 Different DirigoChoice Plans for Employees

2005 Family Income Eligibility

	Annual household income can be no more than:					Annual household income over
1 person family	$9,570	$14,355	$19,140	$23,925	$28,710	$28,710
2 person family	$12,830	$19,245	$25,660	$32,075	$38,490	$38,490
3 person family	$16,090	$24,135	$32,180	$40,225	$48,270	$48,270
4 person family	$20,110	$30,165	$40,220	$50,275	$60,330	$60,330
5 person family	$22,610	$33,915	$45,220	$56,525	$67,830	$67,830
6 person family	$25,870	$38,805	$51,740	$64,675	$77,610	$77,610
% of federal poverty limit	0-100%	125-150%	150-200%	200-250%	250-300%	300+%
Adults Without Minor Children*	Category A: $0/$0 deductible, currently Medicaid eligible	Category B: $250/$500 deductible	Category C: $500/$1,000 deductible	Category D: $750/$1,500 deductible	Category E: $1,000/$2,000 deductible	Category F: $1,250/$2,500 deductible
Parents*		Category A: $0/$0 deductible, currently Medicaid eligible OR Category B: $250/$500	Category A: $0/$0 deductible, May 2005 Medicaid eligible OR Category C: $500/$1,000 deductible			
Children*			Category A: $0/$0 deductible, currently Medicaid eligible OR Category C: $500/$1000 deductible			

* The first number is the individual deductible; the second is the family deductible.

Source: Information compiled by author from Dirigo Health Agency, Web site, at *www.dirigohealth.com* (May 17, 2005).

may be shared with them and their subsequent liability, whether real or perceived.

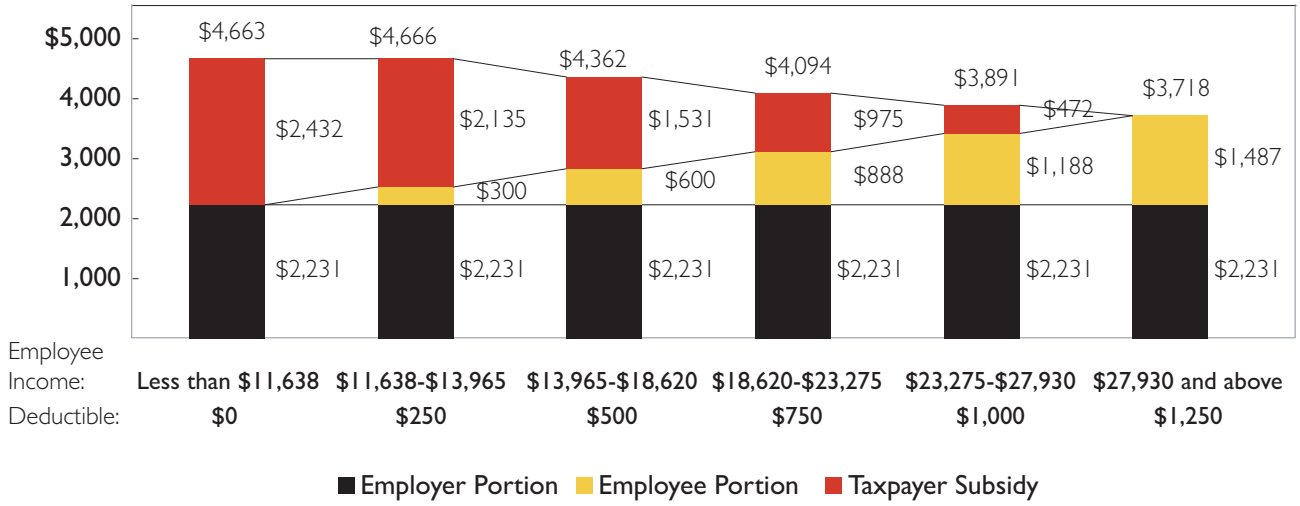
Based on his or her application, each employee is placed in one of the six categories, A to F. (See Table 2.) Category A includes employees who are Medicaid-eligible. The expansion extends Category A to include parents earning up to 200 percent of the FPL.

The required employer portion of the premium for Medicaid-eligible employees is then sent to the Maine Department of Human Services, and the state attempts to use it as seed money to help meet the federal Medicaid match.

Categories B through E include employees who qualify for a premium subsidy on a sliding scale. As noted in Charts 3 and 4, the employee's portion of the premium is also on a sliding scale, rising incrementally for every 50 percent increase in the federal poverty limit for that employee's household income. Category F includes employees earning

Chart 3 B 1878

DirigoChoice: Employer, Employee, and Premium Subsidies for Single Employees with Employee-Only Coverage



Source: Signed DirigoChoice contract between Anthem Blue Cross Blue Shield of Maine and the Dirigo Health Agency.

more than 300 percent of the FPL, who will pay the full premium without any premium subsidy.

Impact on Employees: Earn More, Pay More, and Get Less. Under DirigoChoice, the employee pays more for health insurance as household income increases. In addition, the deductible increases as an employee makes more money. The deductible increases $250 for individual coverage and $500 for family coverage for each 50 percent increase in household income relative to the federal poverty limit. This sets in motion some potentially consequential dynamics for employees, in which the cost and value of the health benefit varies based on income, household size, and marital status, among other factors.

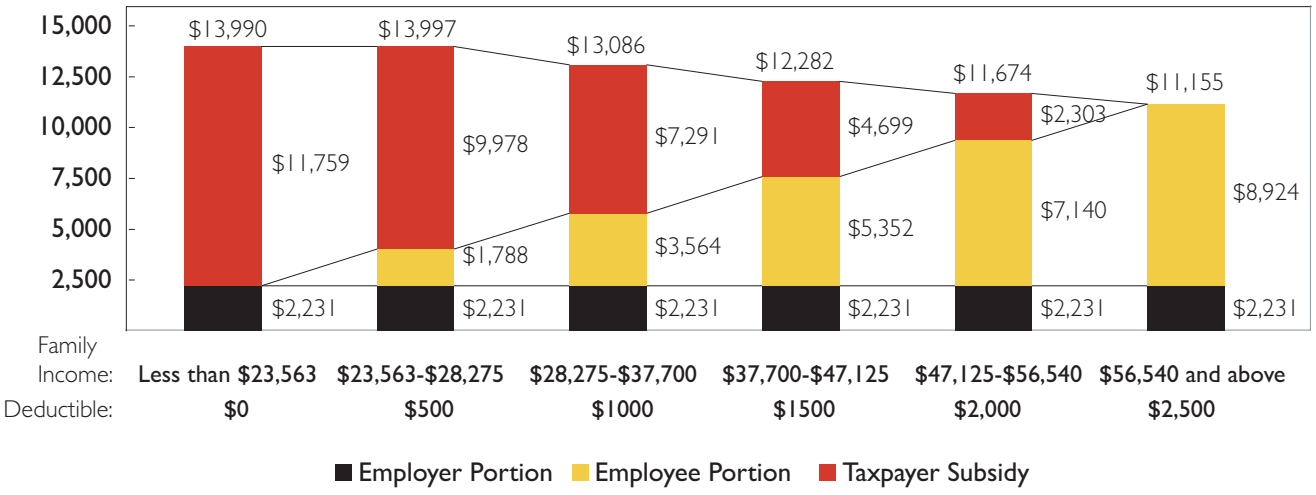
First, the more dependents the employee has, the more that employee can make and the less that employee will pay for health insurance. With most private health insurance, the family plan costs the same whether the couple has one child or several. Under DirigoChoice, a couple with one child and a household income of $40,000 will pay more for their insurance than a couple with four children and a household income of $63,000, even though private health insurance plans would typically have the same premium regardless of the number of children covered. (See Table 2.) This DirigoChoice "fertility bonus" creates a dynamic not found in private health insurance.

Second, small changes in household income will change employees' share of the premium and their deductible with a dramatic "cliff effect." Unlike Medicaid, which has one cliff between eligible employees and those who are ineligible because they are earning $1 too much, DirigoChoice has 24 different cliffs. For example, employees with family coverage earning just $50 more per year will pay thousands more for their health insurance, and their deductible will rise by $500. The same is true to a smaller extent for employees with employee-only coverage.

Third, the full premium, less the employer's portion, will be deducted from employees' paychecks. In return, each employee eligible for the premium sub-

Chart 4 B 1878

DirigoChoice: Employer, Employee, and Premium Subsidies for Employees with Employee-Only Coverage and a Family of Four



Source: Signed DirigoChoice contract between Anthem Blue Cross Blue Shield of Maine and the Dirigo Health Agency.

sidy is given an electronic funds transfer (EFT) card linked to an account into which the state deposits the subsidy on the same day that the employee is paid. The employee can then use this EFT card to make purchases. The EFT cards and accounts will be similar to those currently used for food stamps and other welfare programs. Although using a debit-style card could introduce administrative efficiency, any glitch in the premium subsidy could cause dramatic variations in the employee's net take-home pay.

Impact on Employers: "Don't Ask, Don't Tell" Health Benefits. For employers, the consequences of this tiered structure are even more complex.

- Employers will not easily know the categories to which individual employees belong and therefore cannot answer questions about problems with deductibles, premiums, subsidies, and tax implications.
- Liability for unpaid or late premiums is confusing because employers, instead of dealing directly with the insurance carriers, will send premiums to the state.
- Employers will have to explain this new system to all new hires and existing employees when they enroll in Dirigo.
- Employers will not be able to make any special arrangements with employees with unique circumstances. Under this one-size-fits-all plan, all employees must be treated the same. The small-business owner will often receive the most costly health plan with the smallest benefit if the owner's household income is over 300 percent of the FPL.
- DirigoChoice will encourage employers to minimize their share of the premium payments. For employers who pay more than the minimum, the majority of this increased benefit will accrue to the state (due to the premium subsidy arrangement), and the employee will receive only a minor reduction in net premium cost.

Dirigo Health's stated goal is to encourage employers that have not previously offered health insurance to sign up for DirigoChoice. Yet DirigoChoice creates a dizzying level of complexity for

employers and employees, and its incentives encourage employers to reduce their premium contribution to the lowest allowed level.

Abysmal Sales Record to Date. The real proof of the DirigoChoice insurance product's attractiveness is sales to date. DirigoChoice sales began on October 1, 2004, with coverage beginning on January 1, 2005. As of June 1, 2005, 7,300 persons were receiving coverage. Governor Baldacci projected that DirigoChoice would cover 31,000 persons by December 30, 2005, including 26,600 small-business employees (and their dependents) plus 4,400 sole proprietors and individuals not covered through their employers. As of June 1, 2005, total DirigoChoice sales were 61 percent below projections—seemingly the only government budget line below original projections.

When one examines the actual sales figures more closely, an interesting picture emerges. As of June 1, 2005, 4,386 individuals and self-employed persons were covered, essentially meeting the previously mentioned enrollment cap of 4,400. However, only 2,925 employees and their dependents at small businesses were receiving coverage. These sales to small business were 81 percent below the projected 16,440 who were projected to sign up by June 1.[29] The target audience for DirigoChoice—small businesses—is not buying it. Those purchasing DirigoChoice in more significant numbers—individuals and the self-employed—are choosing Dirigo not because it is an attractive option, but because Maine's individual insurance market is so expensive given its burdensome guaranteed issue and community rating mandates.

Component #3: Massive Government Control and Regulation

Dirigo Health also expands state control over the health care industry through a vast array of new regulatory controls and requirements. Presumably, Maine officials believe that increasing government involvement, approvals, controls, and oversight will lower the costs to individuals and families.

Increased Regulation of Small Group Health Insurance. Small group insurers were already required to maintain guaranteed minimum loss ratios (the minimum that must be paid out in claims for every $1 of premium) for their small group offerings and were already subject to Maine's strict community rating laws and numerous benefit mandates. As part of Dirigo Health reform, small group insurers are subject to rate review and approval and to public hearings on proposed premium increases.

Curiously, Dirigo Health is touted as making the private Maine health insurance market more competitive. As mentioned previously, since its introduction and passage, Cigna has left Maine's individual and small group insurance markets. This leaves just two major competitors, Anthem Blue Cross and Blue Shield of Maine and Aetna, and two minor players, Harvard Pilgrim Health Care and United Health Care. Each time that Maine has regulated its private health insurance industries more aggressively, it has seen a reduction in the number of carriers offering coverage, reducing competition and options for Maine consumers. Dirigo Health's increased regulations continue this trend.

Expanded CON Regulation. Maine already had one of the strictest Certificate of Need laws in the country. CON laws require health care organizations, such as clinics and hospitals, to obtain state approval before making capital investment or expanding service.

Dirigo Health expands CON regulation to include private physicians' offices. Private physicians now require state approval for new capital equipment investments of $1.2 million or more, and such investments are subject to the new Capital Investment Fund limits. Ambulatory surgical units are now also subject to CON regulation. State approval is required for $110,000 or more in capital expenditures for a new health care service and for $400,000

29. Josie Huang, "Cost Weakens Support for Dirigo Health Reforms," *Portland Press Herald*, June 12, 2005, at *news.mainetoday.com/indepth/healthcare/050612dirigo.shtml* (August 1, 2005).

or more in increased costs for a new health care service. Maine is now one of the nation's most restrictive regulatory environments for new health care capital, equipment, and service investments.[30]

The key point is that CON laws regulate *private* investment, not taxpayer-funded investment. This is the equivalent of requiring a business owner to get permission from the state to expand or improve his or her business beyond securing the typical building permits and licenses.

The Federal Trade Commission recently concluded that state CON laws have been ineffective in controlling health care costs and recommended that state officials reconsider them.[31] Based on historical experience, the new restrictions will reduce health care investment and competition and have little or no impact in controlling overall health care costs.

Capital Investment Fund. Under the new Capital Investment Fund, state officials will also set a total limit on annual private health care investment. In theory, this policy will ensure that Maine's health care remains "affordable" by limiting overall spending and investment in the private health care system. This new Capital Investment Fund, along with the more restrictive CON process, would set an annual limit of $2 million per project and a $6 million limit on total investments statewide (based on the net change in the third-year operating costs of such investments). Projects exceeding this limit would have to be spread over multiple years.

This will force a sharp reduction in health care investment. The state approved $100 million in capital health care investments in 2002, and Maine health care facilities have already submitted $200 million in approval requests during 2004. (There was a one-year moratorium on CON applications during 2003 as part of the Dirigo law.) This $200 million in capital investments is competing for the total increase in third-year operating costs of $6 million, the limit on what will be approved.[32]

Health care quality is rooted in innovation in the provision of personal care for individuals and families. The CON laws and the Capital Investment Fund undermine this by ignoring the realities and associated costs of capital improvements and technological advancements.

The Maine Quality Forum. The Maine Quality Forum is a "quality watchdog" commission of health care practitioners, consumers, and others. It is charged with

> promoting and overseeing the quality of health care in the State through the collection and dissemination of research, adoption of quality and performance measures, promotion of evidence-based medicine and practices, and the public reporting of information about costs and quality of care.[33]

The Quality Forum's first priority is to assess the feasibility and impact of an electronic medical record system that would allow closer monitoring and analysis of patient treatment data and outcomes by the state for the purpose of reducing errors in patient care.

Sharing information and suggested best practices is a laudable goal. Government and private agencies are already doing it. The danger is a government monopoly of such information for purposes of regulating doctors, hospitals, and other medical professionals, undercutting their professional independence and clinical judgment.

Having a state agency set guidelines for health care providers and their treatment of diverse patients with similar diagnoses ignores the com-

30. Thomas R. Piper, "Specialty Hospitals: Competition or Cream-Skimming?" American Health Planning Association, August 4, 2004, p. 3, at *www.ahpanet.org/Images/NASHPpiper.pdf* (May 3, 2005).

31. Federal Trade Commission and U.S. Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, p. 22, at *www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf* (December 28, 2004).

32. Governor's Office of Health Policy and Finance, "Basis Statement," July 26, 2004, p. 1, at *www.maine.gov/governor/baldacci/healthpolicy/reports/Emergency%20Basis%20Statement%20chapter%20101%20(2).pdf* (December 28, 2004). The $200 million refers to new capital investment, and the $6 million refers to third-year operating costs resulting from these investments.

33. Rosenthal and Pernice, "Dirigo Health Reform Act," p. 1.

plexities of health care treatment that applies to individuals. It also ignores the inherent sluggishness of government bureaucracy. Health care guidelines often rapidly become outdated. According to one recent analysis:

> In 2000, a group of researchers determined that 75 percent of the guidelines developed between 1990 and 1996 needed updating. In addition, they discovered that half the guidelines were outdated in 5.8 years. Of the 17 clinical practice guidelines they assessed, the entire output of a high-profile program developing practice guidelines with the assistance of the U.S. Agency for Healthcare Research and Quality (AHRQ), 13 were in need of an update. Seven needed a major update, six needed a minor update, three were judged to still be valid and no conclusion was made about the last one.[34]

Biannual State Health Plan Report. Maine officials will publish a biannual report on how health care should change or grow in different regions of the state. The proposal is to have a series of public hearings across the state to determine what communities want in their region, how much they think health care costs should grow, and what tradeoffs they are willing to make based on limited private resources. State officials will then use the feedback from these hearings to design a comprehensive State Health Plan, which will be used to help guide the approval process for the new Capital Investment Fund and the expanded Certificate of Need process.

Although central government planning is fundamental to a socialist economy, it has proven highly ineffective in market-driven economies. The notion that a variety of public hearings around the state would dictate expansions in health care equipment investment under Dirigo Health is troubling. Even if the public hearings were enlightening on the economics of health care investment, patient care is not an abstraction. The underlying premise of this process seems to be that it is somehow appropriate for one person's public testimony to dictate which new health care services are available for another individual's personal care.

Regional State Health Expenditure Targets. Initially, Governor Baldacci proposed having all 37 nonprofit Maine hospitals be subject to a global budget and limiting the operating margins of hospitals and health insurers to 3 percent annually. The political reaction to this was hostile, and the global budgets were dropped from the reform package. The 3 percent limit was modified to be a voluntary target for health care providers and health insurers.

In lieu of the global budget proposal, the fallback was a set of regional state health expenditure targets. Participants in the planning process for the State Health Plan would help to set goals for the total amount spent on health care in a particular region and the rate at which those targets could grow from year to year. State officials would devise strategies to confine growth within the preset targets.

It is unclear how this will play out in practice, improve individualized patient treatment, or affect the quality of care. However, when voluntary targets fail to realize the desired outcomes, it does provide Dirigo proponents with an opportunity to argue that new and tougher mandatory limits are necessary.

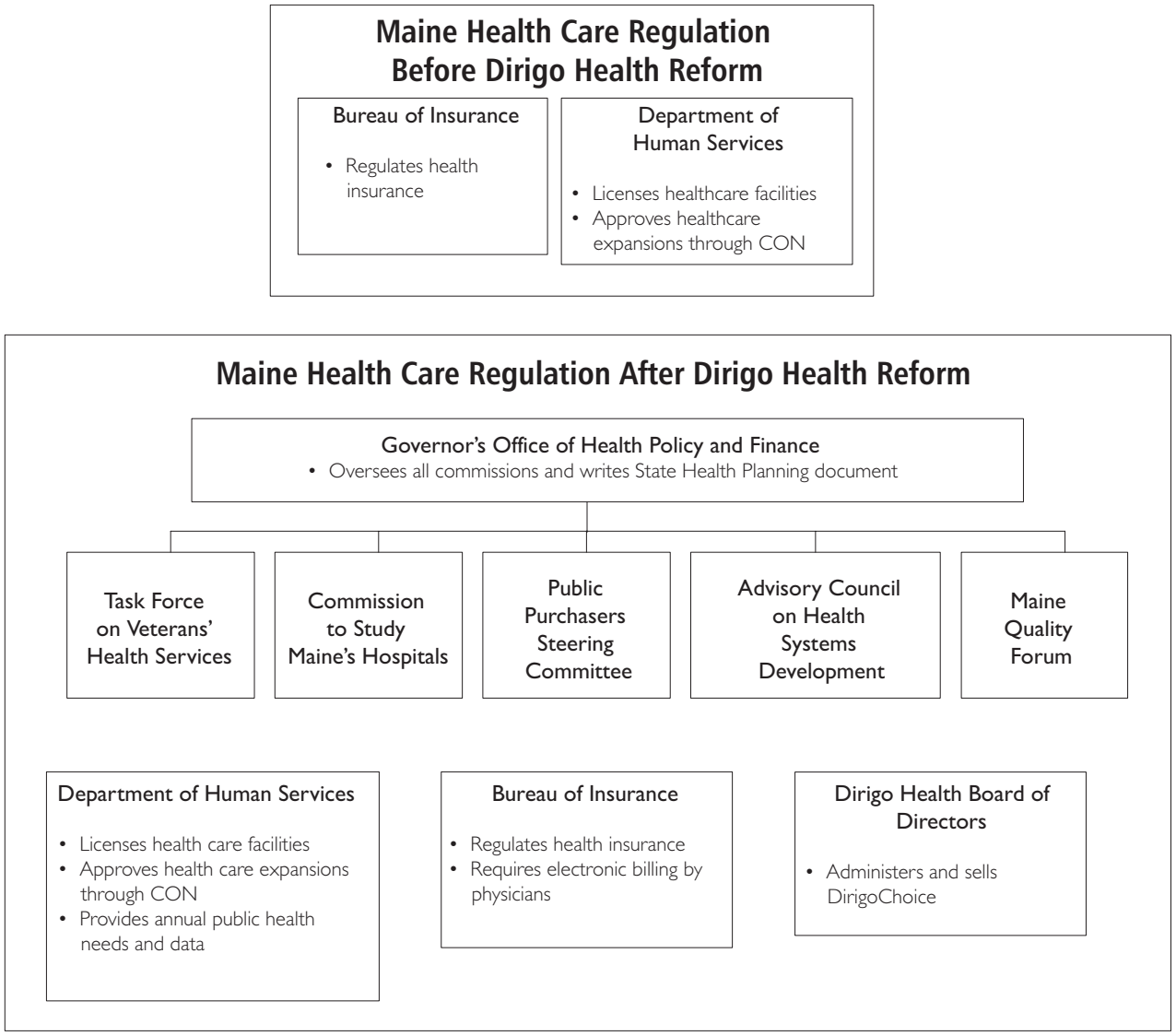
Multiple Commissions. Dirigo Health also sets up a variety of commissions and task forces to review various aspects of Maine's health care system and make recommendations on additional government controls to make these health care systems more effective. The commissions include the Dirigo Health Board of Directors, Maine Quality Forum Advisory Council, Commission to Study Maine's Hospitals, Advisory Council on Health Systems Development, Public Purchasers Steering Committee, and Task Force on Veterans' Health Services. The range and authority of each commission illustrate the scope and variety of additional Dirigo Health–sanctioned state controls and oversight.

So many commissions with overlapping authorities and competing agendas aggravate the administrative complexities that already plague health

34. Twila Brase, "How Technocrats Are Taking Over the Practice of Medicine: A Wake-Up Call to the American People," Citizen's Council on Health Care *Policy Report*, January 2005, p. 9, at *www.cchconline.org/pdfreport/index.php* (May 3, 2005).

Figure 1 B 1878

Maine's Health Care Regulatory Environment Before and After Dirigo Health



Source: Jill Rosenthal and Cynthia Pernice, "Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine," National Academy for State Health Policy, June 2004, at *www.nashp.org/Files/GNL_56_Dirigo_brief.pdf* (December 28, 2004).

care and overpromise the power and skill of agency bureaucrats and publicly appointed officials to ensure the delivery of high-quality care to patients.

These formidable regulatory controls have attracted little attention. However, even if the Medicaid expansion is modified or delayed and DirigoChoice fails, these state controls will likely remain in effect. Indeed, the Baldacci administration is adopting the most liberal interpretation of the authority granted under the Dirigo Health legislation.

How Maine Taxpayers Will Pay for Dirigo Health

Governor Baldacci said that he would provide comprehensive health care reform without raising taxes. The governor used $53 million of the federal fiscal relief provided in 2003 as part of the Bush tax cut as seed money for Dirigo. Therefore, to persuade the legislature to pass Dirigo Health, the governor needed to present the program in a way that would be "cost neutral" to Maine taxpayers. He proposed doing this by:

- Maximizing federal Medicaid funding by expanding Medicaid and leveraging premium contributions by employers from the new DirigoChoice plan to meet the state's Medicaid matching requirement, and
- Setting up an elaborate new fee system, the Savings Offset Payment (SOP), to "capture" any quantifiable reduction in bad debt and charity care realized by Maine health care providers as a result of eliminating the problem of uninsurance within five years. These SOPs would be paid by insurance carriers (ultimately health care insurance policyholders).

The Commonwealth Fund, a nationally prominent liberal think tank, provided funding to the National Academy of State Health Policy to commission Dirigo-related focus groups of business owners, insurance brokers, and employees from around Maine. They explained Dirigo's funding to the participants.

The participants' responses on the issue of financing are revealing. Specifically, small-business owners, concerned business people, and brokers all wonder about Dirigo's financing. When financing is initially explained, many of the business owners, concerned business people, and brokers have difficulty believing that the financing plan will work to pay all of Dirigo's costs. They think that if the financing plan does not work, they will be paying higher taxes to support Dirigo. Therefore, they need more details about how Dirigo will be financed and a clearer understanding of what makes this financing feasible.[35]

Medicaid Expansion Costs and Fuzzy Math. There are two scenarios under the Medicaid expansion, one with an employer contribution on behalf of the employee and one without an employer contribution.

The designers of DirigoChoice presume that, whenever possible, a small employer participating in DirigoChoice will *voluntarily* pay $2,231 (60 percent of the employee-only premium) for employees who are Medicaid-eligible. Those employees will then be put on Medicaid, and the State of Maine, through the magic of an intergovernmental transfer, will leverage the federal Medicaid match and end up making money on the deal.

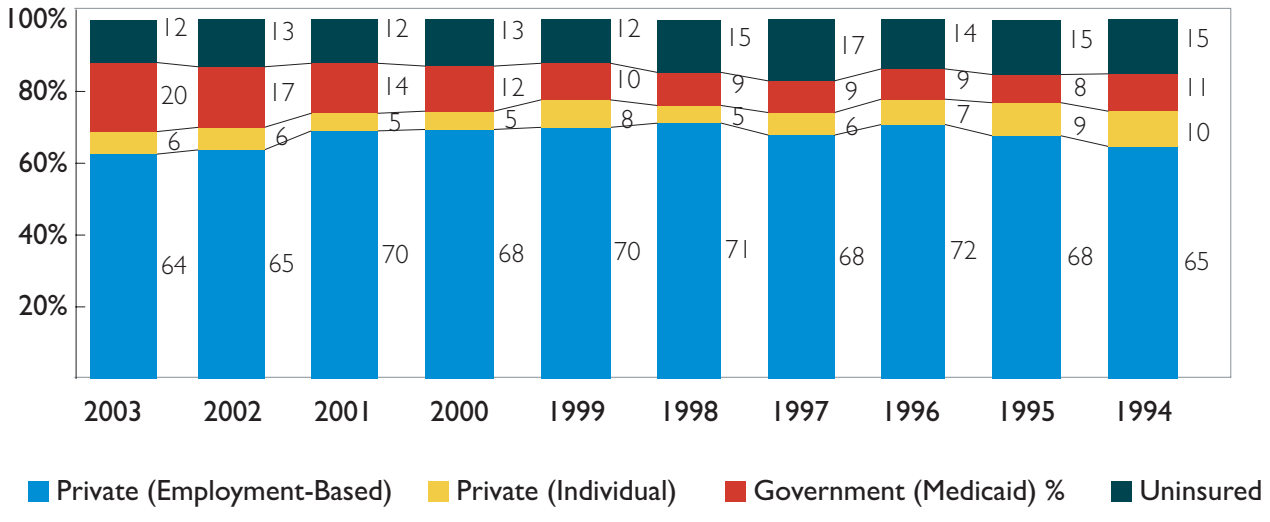
The key question is why would any employer buying DirigoChoice voluntarily send money to the state so that its Medicaid-eligible employee could go on Medicaid when that same employee is entitled to go on Medicaid anyway at no cost to the employer? Medicaid is, after all, an entitlement. An individual's eligibility is not dependent on his or her employer's actions.

Likewise, why would the federal government's treatment of the employer's premium payment be any different from the treatment of any other employer premium payment for an eligible individual participating in Medicaid premium assistance? In Medicaid premium assistance, the employer's payment is subtracted from the premium costs of the Medicaid-eligible employee, and the state and federal government share the net premium cost as well as any Medicaid wrap-around costs (those services that are available to Medicaid enrollees but not typically covered by private health care insurance, as well as the costs of any co-pays and co-insurances).

Maine officials may argue that this expansion will reduce the number of the uninsured. However, Maine's record of Medicaid expansion and reducing the uninsured population does not instill confidence. When the Maine legislature initially proposed

35. Gene LeCouteur and Michael Perry, "The Dirigo Health Plan: Report from Focus Groups with Mainers About the Dirigo Health Plan," National Academy of State Health Policy and Lake, Snell, Perry & Associates, November 2004, p. 5, at *www.cmwf.org/usr_doc/LSPA_focusgroup_report.pdf* (December 28, 2004).

Chart 5 B 1878



Source: U.S. Bureau of the Census, Housing and Household Economic Statistics Division, "Historical Health Insurance Tables," revised December 07, 2004, Table HI-6, at *www.census.gov/hhes/hlthins/historic/hihistt6.html* (December 28, 2004).

expanding Medicaid coverage to childless adults earning up to 100 percent of the FPL, they assumed that this expansion would reduce the uninsured rate by 3 percent. In fact, Maine's uninsured rate remained virtually unchanged at 12 percent. Moreover, Maine's uninsured rate has remained at 12 percent–13 percent for the past five years, even though the portion of the under-65 population on Medicaid doubled during the same time period.

The Bottom Line. Under any scenario, the costs of the Medicaid expansion are destined to plague state officials and Maine taxpayers. If left unchanged, this one aspect of Dirigo Health will bust the state budget. As already noted, even before the Medicaid expansions, Medicaid spending was busting the Maine budget.

New "Fees" for Health Insurance Premiums

By serving the uninsured, many health care providers accrue bad debt and charity care. Charity care is the cost to the provider organization of rendering free or discounted care, for which the provider did not expect payment, to persons who cannot afford to pay and are ineligible for public programs. Bad debt is the unpaid amount for services rendered for which the provider expected payment from a patient or third-party payer.

If Dirigo Health eliminates the uninsured as Dirigo proponents argue it will, Maine health care providers would no longer have to assume these costs, and these "savings" could be passed along to the state to help finance the Dirigo Health reform. Thus, in place of a direct tax on health care providers, which would break the governor's pledge of no new taxes, Dirigo Health imposes a new "fee" on health insurance premiums to recapture these "savings" through the Savings Offset Payment system.

According to Governor Baldacci's Office of Health Finance and Policy, Maine doctors, hospitals, and other medical professionals accumulated

about $275 million in charity care and bad debt in 2002. Under the governor's theory, if Maine eliminated the uninsured, health care costs would be reduced by close to $275 million.

The facts suggest otherwise. According to a major *Health Affairs* study by John Hadley and John Holahan,[36] two health policy analysts with the Urban Institute, only 49 percent of all charity care and bad debt (uncompensated care) comes from the full-year uninsured. The remainder is accrued by individuals who have private health insurance or Medicaid coverage or who are uninsured for part of a year.

Table 3 B 1878

Per Capita Health Care Spending by Insurance Status

Insurance status	Full-Year Uninsured	Privately Insured	Publicly Insured (Medicaid)
Uncompensated care	$1,033	$97	$314
Out of pocket	592	724	193
Total health care consumption	$1,705	$3,379	$3,177

Source: John Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs Web Exclusive*, February 12, 2003, at *content.healthaffairs.org/cgi/content/full/hlthaff.w3.66v1/DC1* (May 3, 2005). The 2001 figures were projected to 2005 at 8 percent growth per year.

Not all people accruing bad debt or charity care lack health insurance. At best, reducing the numbers of uninsured only reduces a portion of uncompensated care, as even the privately insured or those on Medicaid have bad debt and charity care. Interestingly, moving someone from uninsured to Medicaid clearly has much less of an impact on uncompensated care and almost doubles per capita health care spending. (See Table 3.)

For the designers of Dirigo Health to reduce the number of uninsured and reduce bad debt and charity care, all of the uninsured would have to work at the businesses that sign up for Dirigo Choice. Additionally, no businesses signing up for DirigoChoice could already provide health insurance to their employees, because the costs of shifting these employees from non-subsidized private coverage to DirigoChoice would overwhelm any "savings" from covering the uninsured. Finally, it does not matter whether an employer voluntarily pays for the employee to go on Medicaid or not, as both options involve net costs to the state.

To get the most revenue possible, the designers of Dirigo Health assumed "savings" from its impact on slowing the growth of health insurance premiums and health care costs. For example, if Maine can justify that health insurance premiums grew more slowly after Dirigo was passed than they did before it was passed, this would count as savings to be recaptured through the Savings Offset Payment. Similarly, if Maine can justify that health care costs grew more slowly after Dirigo was passed than before it was passed, these savings would also be recaptured through the SOP.[37]

Although DirigoChoice has been on the market for less than one year, the Baldacci administration is already proposing to begin this new SOP tax based on "savings" realized to date. Although the administration admits that it does not yet have an estimate of any savings to date, it is recommending an additional 3 percent tax on claims paid by insurers and third-party administrators, beginning in 2006.[38] This tax would be in addition to the 2 percent premium tax already levied on all non-HMO health insurance plans sold in Maine and would

36. John Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs Web Exclusive*, February 12, 2003, at *content.healthaffairs.org/cgi/content/full/hlthaff.w3.66v1/DC1* (May 3, 2005).
37. In Congress, when spending grows more slowly than projected, it is called a "cut" by some. In Maine, when health care and health insurance premiums grow more slowly, it will be called government-inspired savings and collected through increased taxes, called SOPs.
38. Victoria Wallach, "Tax on Private Health Insurance Plans Would Fund Dirigo," *Boothbay Register*, April 21, 2005, at *boothbayregister.maine.com/2005-04-21/health_insurance_tax.html* (August 1, 2005).

cost the average insured person over $100, and the average insured family $345, per year.[39] It is unclear how this new tax would help to make Maine health insurance more affordable.

Indeed, figures from the governor's staff show how suspect this SOP justification is. The administration claims that "$87 per month per person in bad debt and charity care is avoided by insuring the uninsured."[40] Yet the average DirigoChoice premium subsidy currently paid per person per month is $157,[41] almost twice the maximum that supposedly is "saved" each month in reduced bad debt and charity care by covering the uninsured. Additionally, this assumes that all 7,300 persons covered by DirigoChoice were uninsured.

The administration recently released results from a study to determine how many of the DirigoChoice enrollees were previously uninsured. The survey results indicate that only 22.4 percent of those enrollees were previously uninsured, that 39.1 percent switched from another Anthem insurance plan, and that the remaining enrollees switched from another insurer's plan to Anthem's DirigoChoice.[42] If these figures prove to be accurate, the marginal cost of one uninsured person receiving coverage through DirigoChoice would be $8,410 per year, with a corresponding reduction in bad debt and charity care of only $1,044.[43] It is hard to quantify savings from these outcomes.

For comparison, nationwide, 36 percent to 44 percent of health savings account plan purchasers earning less than $50,000 annually were previously uninsured. Almost two-thirds were paying less than $100 per person per month in premiums with no direct taxpayer subsidy.[44]

In effect, these SOPs are the sole financing mechanism for Dirigo if additional federal funding does not materialize. With Dirigo's fiscal foundation so shaky, the scheme could easily prove untenable, leaving Maine with expensive public programs, a Medicaid expansion, and new bureaucracies that must be funded from an already stressed state budget.

What Maine Needs: Real Health Insurance Market Reform

Maine needs significant health insurance and health care reforms. Health insurance premiums are high, health care providers are not competitive, and the individual insurance market—the market of last resort for those who face being uninsured—is a mess.

If Maine legislators really wanted to reduce the rate of uninsured citizens and make health insurance more affordable, they should repeal the poorly designed, ineffective, and costly Dirigo Program and enact real reform that would:

- **Facilitate a variety of health insurance choices for employees of small businesses.** Implementing the Maine Consumer Choice Health Plan (MCCHP), which was enacted by the legislature in 2001,[45] would set up a state-sponsored health insurance exchange offering a variety of

39. Based on a $350 monthly premium for individuals and a $1,200 monthly premium for families. The 3 percent tax is on claims paid, typically about 80 percent of the premium.

40. Wallach, "Tax on Private Health Insurance Plans Would Fund Dirigo."

41. Karynlee Harrington and Kirsten Figueroa, "Responses to 5/24/05 Questions," memo to the Joint Standing Committee on Appropriations and Financial Services, Maine State Legislature, May 25, 2005, Question 7.

42. Taryn Bowe, "DirigoChoice Member Survey: A Snapshot of the Program's Early Adopters," University of Southern Maine, Muskie School of Public Service, Institute for Health Policy, August 12, 2005, Tables 4 and 6, pp. 7–8, at *www.maine.gov/governor/baldacci/healthpolicy/Dirigo%20Survey%20PDF%208-15-05.pdf* (August 28, 2005).

43. Calculated at $157 per month in premium subsidies ($157 x 12). This assumes that 22.4 percent of enrollees in DirigoChoice were uninsured ($157 x 12 / 22.4%) and includes a bad debt and charity care reduction of $87 per month ($87 x 12).

44. Ehealthinsurance.com, "Health Savings Accounts: The First Six Months of 2005," July 27, 2005, pp. 11–12, at *image.ehealthinsurance.com/ehealthinsurance/ReportNew/072705HSA6mosReportFinal.pdf* (August 15, 2005).

45. Maine Public Law 2001, Chapter 708, at *janus.state.me.us/legis/statutes/24-a/title24-Asec4346.html* (December 28, 2004).

private health plans to participating small businesses, similar to the Federal Employees Health Benefits Program for federal employees and Members of Congress. It would provide for a state-administered insurance exchange that gives small businesses an administratively simplified way to offer their employees multiple insurance plans. Employers would provide a defined contribution health benefit, and employees could choose the plans that best meet their personal health care needs and finances. Unlike DirigoChoice, which mandates only one option for all employees, the MCCHP recognizes that employees have different needs and financial resources.

Table 4 B 1878

Insurance Status of HSA Insurance Purchasers as Reported by eHealthInsurance.com

Income Level	Percent Previously Uninsured
$0–$15,000	55.9%
$15,001–$35,000	46.1%
$35,001–$50,000	36.0%
$50,001–$75,000	30.4%
$100,000 and above	21.5%

Source: Richard Nadler and Dan Perrin, "The Center for Budget and Policy Priorities' Study on HSA Premium Tax Deduction Misses the Point," May 25, 2004, p. 6, at *www.hsainsider.com/Rebuttal.pdf* (December 28, 2004).

- **Exempt health savings account contributions from state income tax.** In June 2004, the Maine legislature voted not to conform to the federal tax code and instead to subject health savings account (HSA) contributions to Maine income taxes. The justification was that the state could not "afford" to lose $500,000 in tax revenue, which is less than 1 percent of Dirigo's $53 million budget for its first year. Maine should be encouraging HSAs, not punishing individuals who choose this insurance option with higher taxes. HSAs provide affordable coverage and are covering previously uninsured people. Considering that a single person earning more than $17,350 is subject to Maine's top income tax rate of 8.5 percent, this HSA income tax provision is particularly onerous.
- **Allow Mainers to participate in any health plan licensed in any other state.** Maine should allow any insurance plan licensed in any other state to be sold in Maine as long as it meets Maine's minimum reserve law and is sold by an insurance agent licensed in Maine and the state in which the plan is offered. Because of a variety of regulations, especially those passed in 1993, individual insurance in Maine is dramatically more expensive than comparable plans in other states. This is because Maine's individual insurance market does not have a high-risk pool. (See Table 5.)
- **Open up competition in the health care industry by repealing the Certificate of Need laws.** Maine had one of the most stringent CON laws even before Dirigo, and it does not work. Many states have repealed their CON laws. Maine should do the same.
- **Provide Medicaid-eligible citizens with vouchers to allow them to purchase private health insurance coverage if they so desire.** A Medicaid card is useless if a doctor does not accept it. Maine should seek a federal waiver to allow Medicaid-eligible individuals to take the value of their Medicaid benefit and use it to purchase private health plans that best meet their needs and circumstances. This will ensure better access for Medicaid enrollees and reduce cost shifting by providers that is caused by Medicaid's historic underpayment for health care services.

Conclusion

Dirigo Health is Maine's much-heralded, but extremely complicated and little understood, health program. It has three core elements: a massive Medicaid expansion, a state-marketed private insurance plan for small businesses, and an array of new state controls over the Maine health care industry.

Dirigo Health is based on the premise that government officials can best control and manage the

entire health care system. Predictably, it is being trumpeted nationally by those who support more government control and more taxpayer funding of health care and coverage. In reality, it is proving to be a costly and ineffective expansion of bureaucracy and government control that will drive costs up and further undermine consumer choice and competition in the health care system.

There is a better way. Real and effective health care reform should be based on the core principle that personal health care decisions are best left up to individuals and their doctors, not government officials, state legislators, or well-intentioned bureaucrats. Real reform empowers the individual with the tools necessary to choose affordable, quality, and accessible health care services and health insurance coverage. It begins and ends with personal freedom.

Table 5 B 1878

Anthem Individual Insurance Premiums and Corresponding Hospital Costs by State

State	Monthly Premium for a Male in the State Capital, by Age				Adjusted Hospital Expenses per Inpatient Day
	25 years	35 years	45 years	50 years	
Maine	$397	$397	$496	$496	$1,169
Kentucky	$64	$74	$124	$160	$1,029
New Hampshire	$101	$126	$231	$277	$1,218
Connecticut	$149	$196	$277	$354	$1,406
Colorado	$85	$110	$157	$182	$1,363
Annual Difference Between Maine and Kentucky	**$3,990**	**$3,877**	**$4468**	**$4028**	
% savings	**84%**	**81%**	**75%**	**68%**	

Note: Premiums are from the most comparable policies: Maine: HealthChoice Standard, $1,500 deductible, 20% coinsurance, $1,000 out-of-pocket (OOP) maximum; Kentucky: Blue Access, $1,000 deductible, 20% coinsurance, no OOP maximum; New Hampshire: Blue Direct Preferred, $1,500 deductible, 20% coinsurance, $3,000 OOP maximum; Connecticut: Blue Care Plus Direct, $1,500 deductible, 0% coinsurance, $2,000 limit Rx; and Colorado: Blue Direct Preferred, $2,000 deductible, 20% coinsurance, $1,000 OOP maximum.

Sources: Premium quotes are from Anthem Insurance Companies, Web site, at *Anthem.com* (July 1, 2004). Hospital expense figures are from American Hospital Association, AHA Annual Survey Database for Fiscal Year 2003, at *www.ahaonlinestore.com /ProductDisplay.asp?ProductID=637&cartID=173831* (July 1, 2004).

Dirigo Health is not good for Maine and should not be copied elsewhere.

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