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THE MARGARET CHASE SMITH ESSAY

Lessons from Health Reform

by Trish Riley

As full implementation of the Affordable Care Act (ACA) unfolds, it's hard not to reflect upon Maine's experiences with health reform. Certainly Maine's Dirigo Health reform is a microcosm in this sea of change, but a full decade after its enactment the similarities are striking. Both reforms created subsidized, private health insurance, negotiated by an independent entity; both expanded Medicaid and included strategies to improve quality and lower cost; and both met with strong, well-organized conservative opposition.

States have long experimented with health reform, and in 2003 Maine led the next wave, enacting Dirigo Health Reform. A campaign promise in John Baldacci's race for governor, it became law his first year in office, after considerable work and compromise that won strong bipartisan support but only by changing the underpinnings of the program.

Always controversial, Dirigo survived numerous assaults. Governor Paul LePage campaigned to end the program, but instead the program continued and accepted new enrollees, albeit with reduced funding. And, just as Baldacci's bipartisan advisory group recommended, Dirigo will sunset on December 31, 2013, as enrollees transition to the ACA's health exchange.

A quick review of Dirigo's accomplishments:

- Covered 40,498 people and 994 businesses with affordable commercial insurance and annually funded MaineCare coverage for about 6,500 low-income parents.¹
- Established an independent agency, like Massachusetts and the ACA

that followed, that negotiated with insurers and bargained on behalf of members for more affordable and quality products.²

- Brought new competition to the market—the nonprofit Harvard Pilgrim Health Plan routinely ranked best health plan by the National Committee for Quality Assurance, became the Dirigo insurance carrier.
 - Responded to the market, establishing a voucher program, helping low-wage, part-time workers buy their companies' insurance and programs for displaced workers and those with pre-existing conditions. Unlike Massachusetts or the ACA, Dirigo subsidized workers in small businesses, not just individuals and families.
 - Provided financial incentives for members to select a primary care physician and make appointments for wellness visits—a precursor to the “medical home” supported through the ACA today.
 - Covered preventive services with no co-pays required, a provision now part of the ACA.
 - Bucked national trends by reducing the number of uninsured in Maine, despite the deepest recession since the Great Depression, when employer-sponsored health insurance was waning. In 2003, America's Health Rankings listed Maine 18th among the states lacking health insurance; in 2011, Maine was sixth best in the country.
- Linked access to health coverage with efforts to limit costs and spur quality. Dirigo established voluntary targets that limited hospital costs to a three percent growth rate; created a state health plan to guide decisions about the health system and to limit how much new technology, equipment and buildings Mainers needed and could afford; and launched the Maine Quality Forum, advocating for high-quality health care and helping consumers make informed healthcare choices. The ACA establishes a new Patient Centered Outcomes Research Center to improve quality of care nationally. Dirigo also limited how much insurers could spend on marketing, profit and other administrative expenses, a provision now included in the ACA

Despite these accomplishments, Dirigo remained controversial. Why? First, the reform established public subsidies for private coverage, anathema to those seeking purely market-based solutions. Second, Dirigo's initial funding strategy, including a plan to use significant federal Medicaid funds, was not fully implemented. Insurance companies were expected to trim their costs, negotiate better rates with providers and reduce overall cost growth so that a fee assessed on insurers could be absorbed by cost savings and not passed on to premium payers.

Today, the Institute of Medicine reports that the U.S. wastes \$750 billion annually in avoidable health care spending. In 2003 the public and policymakers were not convinced that the system was capable

of cost reductions and the insurance industry enjoyed strong support among key policymakers from both parties. As a result, the industry succeeded in allowing the fee to be passed on to premium payers. The Chamber of Commerce raised concerns about the cost of the pass through and, with insurers, challenged the assessment up to Maine's Supreme Court where it was upheld. But, just as with the ACA, a favorable court decision does not end controversy.

Each year the Dirigo Health Agency was required to document and prove savings in the health care system before collecting the assessment. That process was costly and contentious; each legislative session saw bills to alter or repeal the program. Even bills correcting problems were amended to add language to weaken Dirigo. The 2008 legislature enacted new funding for Dirigo, a beverage tax, but conservative organizations launched a successful "no new taxes" citizen referendum campaign that rolled back the funding.

Like the ACA, Maine built its coverage initiative on a Medicaid foundation. Although the original plan to use federal Medicaid dollars was revised, Dirigo did support the expansion of Medicaid to cover parents of Medicaid-eligible children, using program revenue to match federal dollars. And like the ACA, Dirigo included reforms intended to reduce costs. For example, Dirigo proposed a global budget to hold hospitals to fixed rates of growth in exchange for more authority over how to best deliver care. Rather than the fee-for-service system that rewards procedures, this proposal would pay for good outcomes. Hospitals argued, correctly, that they could not be held to a global budget unless it included physicians and other key players who directly influenced health care costs. The global budget was replaced with voluntary targets and a new law allowed hospitals to work together, free from antitrust constraints, to develop systems of care,

laying a framework for the Accountable Care Organization—integrated systems of care, supported by the ACA.

The Dirigo reforms were not all successful, but the controversy, like that surrounding the ACA, created a challenging environment. A strong tea-party-like group declared Dirigo a failure before it had a chance to prove its mettle. Much of the criticism focused on Dirigo's enrollment rates, even though the compromises that won bipartisan support resulted in less funding to meet the original enrollment targets. However, the program failed to recalibrate and project new enrollment goals, allowing critics to claim the program overpromised. But the program continued, thanks to a strong board and staff, political leadership and support from enrollees.

Several years after Dirigo launched, Massachusetts created a similar plan, providing subsidies and linking eligible individuals to private coverage or Medicaid. Why was Massachusetts able to pull off their reform—much of which mirrored Maine's—without the controversy Maine experienced? First, Massachusetts had enacted a law decades earlier that required employers to either provide health insurance or pay a fine. Although repealed before implementation, it undoubtedly provided lessons for the new proposal. Second, the Massachusetts plan did not include cost-containment proposals as Maine did and it won important business and provider support.³ A significant, longstanding federal payment to supplement Massachusetts' hospitals was ending. Without it, the state's hospitals would experience a budget hole of \$385 million—a loss that would shift costs to the private sector. Massachusetts needed to retain those dollars and proposed to do so by reinvesting them to subsidize health coverage. The state requested and received a waiver from federal rules that allowed those funds to be used to fuel the reform and save hospitals and business from big losses.

So what are the lessons of Dirigo Health?

Separate the facts from the rhetoric:

For Dirigo, the compromises that changed and reduced funding were obscured by rhetorical attacks. Little attention was given to Maine's benefit design, its highly successful system of enrollment and eligibility for subsidies or its still unique ability to provide those subsidies to employees of small businesses. Similarly, few early reports about the ACA discuss successful state exchanges—in October half of the ten states reporting enrollment were exceeding federal enrollment targets.⁴ Nor do reports make clear that the federal government had a much bigger job than originally intended. Historically states seek flexibility and control to run federal programs. In the case of the ACA, having so many states cede authority to the federal government to run the exchange placed a far greater demand on the federal apparatus.

Controversy and complexity can be the enemy of political will and challenge effective implementation:

Elected officials listen to the drumbeat of criticism and, balancing numerous demands before them, grow quickly frustrated with implementation challenges. That leads to calls for oversight and change. Attending to those calls requires precious time of administrators trying to run the program and fuels public perception about problems without providing balance about what may be going right. The oversight role is a critical check and balance; keeping elected officials engaged is essential but not always easy. In Maine, some legislators who railed against the program and regularly voted against it, in practice used the program and accepted its subsidies to insure their small businesses. In the Congress, many of the same members who criticized the ACA and repeatedly tried to repeal it now raise sanctimonious voices decrying the web

site delays that keep their constituents from getting coverage

Keep going and stay flexible:

Ideological fights will continue, but the focus needs to be on the program and the facts. Is the web site improving? If not, are workarounds in place? Is it increasing coverage? Is it affordable? A program as significant as the ACA is bound to have implementation problems; Medicare and Medicaid did, as did the rollout of Medicare's drug benefit. Program implementers need to be flexible to respond to problems, and Congressional leaders need to allow the time for that to occur.

Expect the criticism to continue:

The rollout of the ACA has been challenging. The high call and web volume facing the new federal exchange may not be a good baseline against which to measure enrollment, but expect to hear the naysayers declare the program a failure because it enrolled far fewer than those who visited the web site. Of course, when the national exchange opened, it wasn't just interested customers who visited. The press, researchers, students, and possibly people eager to crash the system, logged in to the site.

Medicaid matters:

Some Dirigo funds provided the state dollars needed to generate federal matching funds. Because of the federal contribution, Medicaid was a cost-effective way to serve the lowest-income enrollees. The Supreme Court ruled that states could not be required to expand Medicaid under the ACA, but without that program—and its shared federal and state financing—the ACA cannot reach its goals

Keep your eyes on the prize:

The U.S. spends twice what other developed nations do for health care, yet we leave millions of citizens without coverage and get no better health outcomes. The

ACA is landmark legislation designed to redress those problems. To do so requires significant change across the health care system and for all of us. And change is not easy.

Maine's Dirigo reform reflects the challenge of change and the value of moving forward. The controversy died down, and the program operated smoothly, demonstrating how a subsidy program for private health insurance can be run. While many in Maine think the program ended, it quietly and effectively brought health coverage to nearly 1,000 Maine businesses and at least 47,000 individuals. The ACA deserves the opportunity to reach its goals of making more people eligible for subsidized health care, supporting innovation in how care is delivered and paid for, investing in public health and prevention, and beginning a national conversation about how best to achieve a high-performing, affordable health care system for our nation. 🐟

ENDNOTES

1. Dirigo Health Agency, Oct. 2013.
2. However, the Dirigo Health Agency, poised to become the state's exchange, will be phased out as the state elected to have the federal government take on that work in Maine.
3. However, in 2012 Massachusetts enacted legislation that will limit the overall growth in health care costs to growth in the state's economy.
4. "The Mixed State of Health Care Exchanges," New York Times (October 27, 2013). The table also includes the District of Columbia, which was not meeting enrollment targets, and other states not yet reporting enrollment.



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