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Not printed with State funds

Foreword

Dirigo Health: Health Reform for Maine is a narrative summary to supplement Governor Baldacci's health reform legislation. It is not intended to be a technical document but rather summarizes the considerable work over the last three months by stakeholders, economists, lawyers, actuaries, and other experts who have worked with the Governor's Office of Health Policy and Finance to frame this proposal.

This document is the result of significant input from a variety of sources. Most notably, the 27-member Health Action Team (HAT) was instrumental in providing guidance to create this proposal. The members of the Health Action Team represented business, providers, consumers, and government. Their work was further enhanced by six subcommittees with an expanded membership to broaden the reach of participation in the deliberations that helped form the plan. The membership of the Health Action Team and its committees is included in an appendix to this report.

We are grateful for the hours of work and deliberation and the insights provided by team members and by the subcommittees. As a result of HAT input, several proposals were considered and rejected as we developed this approach. However, the HAT was an advisory, not a consensus, body. Therefore, while portions of the legislative proposal are based on the extraordinary advice we received from members, we recognize that all our proposals will not be supported by all HAT members and wish to make clear that this is a proposal by the Governor. It does not necessarily represent the views of the entire HAT.

We wish to acknowledge the assistance of many others in addition to the HAT and its subcommittees. It would not have been possible to conduct the research and develop the plan this quickly were it not for a federal grant from the Health Resources and Services Administration (HRSA) and a grant from the Maine Health Access Foundation (MeHAF). The latter provided funding to the National Academy for State Health Policy (NASHP) to support our work with early research and logistical support for the HAT for which we are indebted.

The HRSA grant, administered through the University of Southern Maine's Muskie School, provided additional research and analysis. With these resources, the Governor's Office of Health Policy and Finance was able to supplement its work with part-time staff support from Charlene Rydell, on leave from Congressman's Tom Allen's staff, and from the Muskie School's Beth Kilbreth, Gino Nalli, Maureen Booth, and Erika Ziller. With support from The Commonwealth Fund of New York City, Jeanne Lambrew, Associate Professor of Health Policy, George Washington University, provided invaluable guidance. Deborah Chollet from Mathematica Policy Research and Watson Wyatt, an actuarial firm, provided significant economic and actuarial analysis of various models proposed. Karen Pollitz, Director of the Georgetown University Public Policy Institute (GPPI), and Cindy Mann from GPPI, provided consultation as did Andrew Schneider of Medicaid Policy, LLC. Finally, we are grateful to the Maine Department of Administrative and Financial Services for the time of Lars Rydell who devoted long hours to help draft the bill. The Maine Department of Human Services' Bureau of Medical Services and Bureau of Health, the Department of Professional and Financial Regulation's

Bureau of Insurance and the Office of the Attorney General provided valuable technical support and guidance. In addition, many informal groups were convened to brainstorm ideas and guide our deliberations.

The plan is rooted in the needs of Maine's citizens and businesses. We received letters, telephone inquiries, requests, and emails from concerned citizens that both identified problems in health care cost, quality, and access, and proposed specific solutions for us to pursue here. We are grateful for the many, many citizens who provided guidance and insights for us.

Most importantly, the Maine State Legislature has long been active in health reform and we have benefited greatly from their deliberations and proposals. Likewise, many groups and organizations across Maine have developed proposals for health reform. We are grateful for all the previous work that has enabled us to quickly present such a comprehensive plan.

Dirigo Health proposes a health reform plan for Maine that addresses cost, quality, and access concerns and meets the Governor's commitment to provide affordable, quality health care to every man, woman, and child in Maine. We present it here for your review.

Summary
DIRIGO HEALTH – *Health Reform for Maine*

Strategies to Address Health Care Access

1. Create Dirigo Health
   Dirigo Health will offer, through private insurance carriers, Dirigo Health Insurance (DHI), comprehensive, affordable health coverage to workers in small businesses who work 15 hours a week or more, self-employed persons, individuals without access to employer coverage, and their dependents. Employers participating in Dirigo Health would benefit from lower rates due to pooling of employer, employee, state and federal funding sources. To participate, employers must pay at least 60% of combined individuals/dependent premium costs. Dirigo Health will ensure that private plans delivering DHI meet high standards for quality and limit expenditures on administrative costs.

2. Provide Subsidies to Eligible Maine Residents
   MaineCare will be extended to parents with income up to 200% of poverty and childless adults with income up to 125% of poverty; this expansion does not require any federal waivers. MaineCare enrollees whose employers participate in Dirigo Health will have the option of getting coverage through their employer's plan with a MaineCare wrap-around or enrolling directly in MaineCare. Workers ineligible for MaineCare will receive assistance in purchasing DHI coverage on a sliding scale based on ability to pay if their income is below 300% of the Federal Poverty Level ($26,940 a year for an individual, $45,780 for a family of 3). Similar workers in large, fully insured businesses will be eligible to have a portion of their premium subsidized. Uninsured residents with incomes over 300% of poverty may purchase at cost the coverage available through Dirigo Health.

3. Pool Resources to Finance Dirigo Health
   Assistance for Maine residents up to 300% of poverty will be financed by pooling individuals and small businesses, by pooling contributions from employers, individuals, state and Federal funds and by recovering and redirecting 60% of the funds currently spent on bad debt and charity care. By pooling these resources, access can be achieved without new state appropriations.

Strategies to Address Health Care Costs

4. Develop State Health Plan to Connect Resource Allocations with Public Health Goals
   This plan will set explicit, measurable goals to address quality, cost and access to health care and will establish a budget to assist in resource allocation. A CON Capital Investment Fund will guide expenditures on new capital investment. The Governor's Office of Health Policy and Finance will be responsible for creating the plan with guidance from an 11 member Council on State Health System Development.

5. Strengthen Certificate of Need to Better Control Costs
   A moratorium will be placed on CON for one year, while the State Health Plan and Capitol Investment Fund is developed. Exceptions can be made for emergency needs. The CON

program will be revised to cover functions and expenditures regardless of site of care; respond to clear goals and criteria established in the Plan and will operate on a budget allocated during 2 competitive review cycles. Ad hoc expert panels and formal review by the Bureau of Insurance and Bureau of Health to assess implications on insurance costs and health goals will be provided.

6. Plan for Hospitals for Maine's Future - Voluntary Hospital - Physician Cooperation
   The State will work with the Maine Hospital Association, the Maine Medical Association and the Maine Osteopathic Association from June 1, 2003 – March 2004 to develop a plan to address primary and acute care needs in Maine. Plans will be developed to assure the best constellation of hospital and related services for the future, to strengthen rural health and identify specialty centers for primary care and prevention, as well as specialty acute care services. This plan will be driven by a hospital services budget to reallocate resources to better serve Maine. Statutory language will be enacted to allow cooperative planning without violation of anti-trust laws. The work will inform the State Health Plan and CON Capital Investment Fund.

7. Disclose Health Care Pricing to the Public
   To provide greater transparency and accountability on the part of providers and insurers and to better inform consumer choices, we will require disclosure of average charges and payments accepted for certain commonly performed services at hospitals, physician's offices and other providers such as health centers. This information will be required to be posted and available at each provider site will be published on the Maine Quality Forum website.

8. Simplify Administrative Functions and Reduce Paperwork
   By late fall 2003, HIPAA requires use of standardized billing forms and codes and each insurer will implement systems to accept electronic claims from providers. We propose mandating that all providers use electronic claims submission, data exchange, referral submissions/approval and eligibility verification by 2005. The State will seek funding to facilitate this requirement by making available grants and loans for providers.

9. Enhanced Public Purchasing
   The Governor will create by Executive Order a Public Purchaser's Steering Group to coordinate public entities and improve their capacity to purchase cost effective, high quality health services.

10. Strengthen Oversight of Insurance Costs
    Insurance regulations will be revised to require rate approval in the small group market and to increase accountability in the large group market by requiring insurers to file an actuarial certification, stating that rates were developed in accordance with all relevant state requirements. In addition, standard reporting definitions will be established and required to make annual reports comparable and understandable to the public.

11. Reduce Cost Shifting
If insurance coverage is extended to the uninsured, a significant reduction in bad debt and charity care will result. Those costs are now shifted to private payers. As such, bad debt represents a substantial hidden tax on health insurance costs and premiums; in fact, 16% of total premium costs today are attributable to bad debt and charity care costs. We will recoup some of the estimated costs of bad debt and charity care through assessments on insurance premiums to provide access to uninsured individuals and families.

MaineCare reimburses providers at lower than market rates. Savings accruing to MaineCare through enactment of this reform proposal will be available for future rate increases for providers, with a focus on paying providers based on performance goals.

12. Voluntary Limits to Control the Growth of Insurance Premiums and Health Care Costs
Building on a proposal from a collaborative in Southern Maine, the *Health Care Challenge*, we will ask all providers to hold price increases and operating margins to no more than 3% and insurers to limit underwriting gains to 3% through 2004. Utilization will be closely tracked as well and a report made at year end to determine the effectiveness of voluntary controls. The Governor's Office of Health Policy and Finance will be authorized to develop rate setting, global budgets and other mechanisms if voluntary measures are deemed ineffective.

Strategies to Address Health Care Quality

13. Establish the Maine Quality Forum
The Forum will be an independent, quality watchdog and resource center with its own advisory board. It will promote rapid deployment of evidence-based medicine and best practices; measure, compare and report on health care performance; conduct consumer education and conduct technology assessments to guide the diffusion of new resources. The Forum will be financed, in part, through the recovery of bad debt and charity care expenses.

14. Promote More Effective Use of Data
The Governor's proposal calls for greater integration of state data into the Maine Health Data Organization's database to cultivate a valuable resource for health planning, oversight and quality improvement. The MHDO database will be complemented by private sector databases managed by the Maine Health Data Partnership. The enhanced data set will support the design of the State Health Plan, administration of the CON Program, efforts of the Maine Quality Forum, assessment of the voluntary cost containment initiative, and will be a resource for policymakers, planners, researchers and the public.

The MHDO will use the data to prepare publications comparing Maine's health system performance against an array of measures. This information will be made available in an accessible fashion to the public to assist them in making comparisons between providers relative to cost and quality.

15. Protect the Fund for Healthy Maine

The Governor will propose a Constitutional amendment to protect for perpetuity the Fund for Healthy Maine and its public health expenditures. In seeking this Constitutional amendment, Maine would become the first state to so protect funds available from the tobacco settlements and assure their on-going availability for public health, prevention and access initiatives.

Dirigo Health Insurance
Proposed Implementation Phase-in

2003

May

- A temporary moratorium on Certificate of Need will run from May 2003 until May 2004.

- Governor Baldacci will introduce legislation in May 2003 proposing to amend the Constitution of Maine to preserve The Fund for Healthy Maine and to assure its funds are used to fund only explicit health related purposes.

June

- Public Purchasers Steering Group will be established by the Governor by Executive Order on June 1 and shall make a formal activities report to the Governor and Legislature each January 31.

September

- In September 2003 State government will launch a cross-agency initiative through the Cabinet Council on Health designed to improve the health of state employees and MaineCare beneficiaries.

October

- Council on Health System Development – Members will be appointed by the Governor and approved by the Legislature's Joint Standing Committee with jurisdiction over Health and Human Services no later than October 1, 2003.

- The Governor will make appointments to the Dirigo Health Board by October 1, 2003.

- New insurance regulation would take effect on the effective date of the statute.

2004

January

- The Maine Quality Forum will be established, and the Advisory Council will be appointed by the Governor with approval from the Joint Standing Committee with jurisdiction over health and human services no later than January 1, 2004.

- All providers will be asked to hold price increases and operating margins to no more than 3% beginning on January 1, 2004 and continuing through the end of 2004. All insurers will be asked to hold underwriting gains to 3% or less through the same period.

- DHS shall promulgate technical rules to implement revisions of CON approval procedures no later than January 31, 2004.

March

- The Maine Hospital Association, Maine Medical Association, and Maine Osteopathic Association will be asked to develop the Plan for Hospitals for Maine's Future by March 2004.

- Hospitals, physicians' offices, and other providers will be required to disclose and post at their sites the average charges and payments for certain commonly performed services by March 2004.

- State Health Expenditure Report – by March 1, 2004, public purchasers are required to present to the Council on Health System Development a consolidated state health expenditure report outlining all funds expended in 2003 for hospital inpatient and outpatient care, physician services, prescription drugs, long-term care, mental health, other services and administration by agency. The Council on Health System Development is authorized to collect what other data it needs to include private sector spending in the State Health Expenditure Report.

- Bad Debt and Charity Care Recovery Fund – on March 31, 2004, insurers begin to pay quarterly assessments on their total premium revenue.

May

- The State Health Plan shall be issued by the Governor's Office of Health Policy and Finance by May 2004.

- The MQF website will be functional by May 1, 2004.

- The Certificate of Need Capital Investment Fund will be initially established, and the first limit (cap on new CON approved expenditures) set by May 2004.

July

- MaineCare expansions and the Dirigo Health Insurance sliding scale health insurance subsidy program will begin in July 2004.

2005

July

- Simplifying Administrative Functions – use of electronic claims submission, data exchange, referral submission/approval and eligibility verification shall be mandated by July 1, 2005.

NEED FOR REFORM

Overview

Maine's healthcare system has much to herald. The UnitedHealth Foundation ranks us the 10th healthiest state[1], citing a low violent crime rate, low infant mortality, few infectious disease cases, low premature death rate and high rate of prenatal care. Rates of uninsured children declined 50% from 1995-1999.[2] Our hospitals enjoy high ranking in quality assessments. But alarming statistics about health status, access and costs undermine these successes. Far more of our citizens report not seeing a doctor due to costs, and our rates of preventable illnesses exceed national averages.[3]

Problems to Address

Cost

The growing cost of health care here and in the nation has riveted public attention. In Maine, health insurance premiums for comprehensive coverage for small businesses rose 58% between 1996 and 2001.[4] Many of Maine's largest employers are seeing similar increases in benefits costs. Bath Iron Works, for example, had increases over a 3 year period totaling 52%.[5] The University of Maine System had a 47% increase in 2002, at the end of a three year contract.[6]

In the individual and small group insurance markets there is limited competition which likely affects pricing. 87% of covered lives in the individual market are insured by one company.[7] In

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[1] United Health Foundation, *America's Health: United Health Foundation State Health Rankings 2002*.
[2] KIDS COUNT, *Maine Kids Count 2003 Data Book,* Augusta, ME: Maine Children's Alliance, pp. 3-4.
[3] AARP, *Reforming the Health Care System: State Profiles 2001*.
[4] Maine Health Access foundation, *A Primer on Health Care Coverage in Maine*, Augusta, ME: Maine Health Access Foundation, p. 12.
[5] Personal communications with Beth Kilbreth and Bath Iron Works.
[6] Personal communications with Beth Kilbreth and the University of Maine System.
[7] Mathematica Policy Research, Inc. analysis based on data from Maine's Bureau of Insurance.

the small group market, as of January 1, 2002, Anthem held 49% of covered lives and Aetna 30% while no other carrier held a double digit market share.[8]

Insurers' capacity to negotiate better pricing is also affected by lack of competition in the healthcare marketplace. In fact, Maine's health care delivery system has changed significantly in recent years with the movement to consolidated physician practices and hospitals and hospital controlled ancillary services and physician groups. For example, of Maine's 39 hospitals, 31 are part of or affiliated with, 4 large hospital systems that operate in southern, central, eastern and northern Maine. Such monopolistic or oligarchic insurance and hospital markets diminish the capacity of purchasers to negotiate lower prices.

Key cost drivers include the rapidly rising cost of prescription drugs, hospital costs and utilization. Nationally, health care spending grew 10% in 2001, led by spending on hospitals (inpatient and outpatient) reflecting increased hospital payments and use. Hospital costs accounted for ½ the total cost growth overall. Prescription drug spending growth declined, overtaken by hospital outpatient services as the fastest growth in total spending in 2001.[9]

Although Maine is the poorest of the New England states, its spending on health care ranks among the highest in New England and the nation. From 1991 to 1998, Maine led the nation in the growth of personal health care spending per capita.[10] Maine's average household income is 11 percent below the national average and a full 25 percent below the incomes in Massachusetts and New Hampshire.[11] Yet Maine now ranks 11th in the country on per capita spending.[12] Our hospital utilization rates are higher than the rest of New England, perhaps because we have the most beds/1,000 citizens in New England, and only Massachusetts exceeds our rate of admissions/1,000.[13] Maine has the highest number of inpatient hospital days/1,000 in New England, the most surgeries/1,000 and a significantly higher number of emergency room

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[8] Personal communication with Richard Diamond, Maine Bureau of Insurance, 3/7/03.
[9] *Health Affairs Web Exclusive,* Bradley C. Strunk, Paul B. Ginsburg, and Jon R. Gabel, "Tracking Health Care Costs", 9/26/2001. http://www.healthaffairs.org/WebExclusives/Strunk_Web_Excl_92601.htm.
[10] Health Care Costs, Health Affairs, July/August 2002.
[11] 2000 Census data.
[12] Kaiser State Health Reports based on 1999 data.
[13] *Hospital Statistics 2003.* Health Forum LLC, Affiliate of American Hospital Association. 2003

visits/1,000.[14] Only one other New England state exceeds our use of outpatient visits and surgeries. National research has shown that the supply of hospital beds is the factor that most strongly predicts hospitalization rates for medical conditions.[15] Maine's admission rate was 30 percent higher than New Hampshire's and 35 percent higher than Vermont's, for example, in 1999. In 2000, Maine's rate of emergency room use was 43 percent higher than the national average and substantially higher than either New Hampshire or Vermont. Some of the high utilization is driven, in part, by our high rates of preventable disease. More Mainers smoke, more have and are at risk for heart disease and stroke and we have more diabetes than all other New England states.[16] And, while our cancer rates are not the highest, more people die of cancer here than in the rest of New England.[17]

Aging is another factor that may contribute to the high utilization rates in Maine. Maine exceeds the median age of New England slightly (40.1 ME versus 38.5 New England, although Maine and Rhode Island have the same percentage of their citizens aged 65 and over.[18]) The Maine Health Information Center notes that the average age of admissions to hospitals rose from 53.1 in 1995 to 55.4 in 2001, a 4.5% increase.[19] However, aging contributes relatively little to the overall cost increases. In fact, when adjusted for case mix and wage variation, Maine's inpatient cost per discharge is significantly higher than both the US average and the Northeast.[20] The average charge for a hospital stay has increased 38% over 6 years.[21]

As in other rural states, Maine's hospitals cite an underpayment by Medicare which they report pays 88% of charges.[22] Medicare was the payer for 45% of admissions in 1995 and 48% in

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[14] *Hospital Statistics 2003.* Health Forum LLC, Affiliate of American Hospital Association. 2003
[15] Wennberg, et al. *The Dartmouth Atlas of Health Care in the United States*, American Hospital Publishing, Inc., 1998.
[16] Kaiser Family Foundation, *State Health Facts Online*, http://www.statehealthfacts.kff.org; and, National Center for Chronic Disease Prevention and Health Promotion, *Behavioral Risk Factor Surveillance System*, Center for Disease Control. http://www.cdc.org
[17] American Cancer Society, *Cancer Facts and Figures 2003*. http://www.cancer.org
[18] U.S. Census Bureau
[19] Maine Health Information Center, *Maine Health Care Data Today*, March/April 2003. Vol. 1, Issue 3.
[20] Almanac of Hospital Financial and Operating Indicators, 2002
[21] MHIC, March/April 2003.
[22] Information from the Maine Hospital Association based on '99-'00 cost reports. MHA believes the current ratio may be closer to 84% of charges.

2001.[23] Hospitals similarly report Medicaid paying 80% of hospital charges. Shortfalls in payments by the public programs plus hospital bad debt and charity care incurred by the uninsured and underinsured are shifted to private payers through mark-ups on the rates paid by those payers. However, hospitals negotiate many different discounts with different payers so payments vary by payer and it is difficult to quantify both the short-fall and the extent to which it is recouped through cost shifts. Maine's hospitals overall are the most profitable in New England and have higher total margins than the U.S. and higher median operating margins, total margins, and profits per adjusted discharge than the Northeast.[24] The median growth of capital expenditures (eg. new buildings and equipment) in hospitals is significantly higher here than in the rest of the country and the Northeast.

The Maine Hospital Association conducted a member survey comparing data from 2001 to 2002. These data show declines in operating margins and total margins declining from 3.4 to 2.2%. 32% of hospitals report negative operating margins. However, this is un-audited data, intended to provide a more up to date snapshot of hospital finances.[25]

The increases in Maine's health care costs are also driven by substantial changes in patterns of utilization over the past decade. While the high rate of hospital admissions has dropped, the intensity of care needed by hospital patients has increased and so has the average length of stay. For example the number of admissions per 1,000 enrollees for several of the largest group plans in Maine dropped 15 percent between 1995 and 2002, while the average length of stay increased 4 percent. The average case mix weight increased by 19 percent in this same time period. Thus, much of the aggregate increases in hospital spending cited earlier is driven by increases in intensity of care as well as a radical increase in the use of hospital outpatient services. Another major change in this time period was an increase in the use and cost of prescription drugs. The MaineCare Program, for example, saw increases in drug costs per person rise over 100 percent between 1995 and 2002.[26]

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[23] MHIC, March/April 2003
[24] Almanac of Hospital Financial and Operating Indicators, 2002 and Muskie School Health Policy Institute analyses of Medicare Cost Report data from 2000.
[25] Personal communication with Steven Michaud, MHA, 4/15/03
[26] All statistics above derived from analyses conducted by the Maine Health Information Center of Maine Health Management Coalition claims data and by the Muskie School of MaineCare claims data.

Maine ranks 1st in New England in the number of uninsured citizens. The uninsured tend to be more costly to the health care system because they are likely to receive less preventive care and are diagnosed at more advanced disease stages. Heath insurance would reduce mortality rates for the uninsured and could improve their annual earnings by 10-30%.[27] The uninsured are more likely than the insured to be hospitalized for preventable conditions like pneumonia and uncontrolled diabetes. Death rates for uninsured women with breast cancer are significantly higher than for insured women.[28] In 2001 Maine's hospitals reported an estimated $122M in bad debt and $68M in charity care costs that are shifted to other premium payers.[29]

Maine's health care system is an economic driver in Maine, accounting for 1 in 8 jobs, yet rising health care costs have a negative impact on the economy as well. Health care is not an export business – goods and services are generally provided here and paid here. As prices rise and other businesses need to pay them, the cost of doing business in Maine grows.

Finally, inefficiencies in the health care delivery system, variation in quality of provider treatments and practices and medical errors account for significant cost increases in the health care system and compromise patient care and quality of life.[30] Complications of surgical and medical care, some of which are attributable to medical errors, are increasing in Maine[31] and account for higher hospital costs due to repeat diagnostic tests and procedures.[32] New technologies enhance diagnosis and treatment but their availability also drives costs. Maine, for example, has more Magnetic Resonance Imaging machines (MRIs) than the country of Canada.[33]

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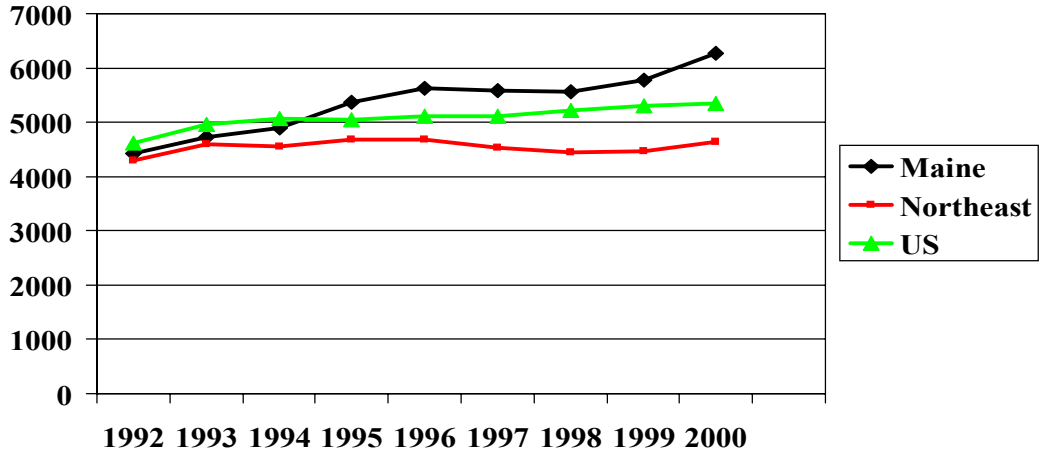
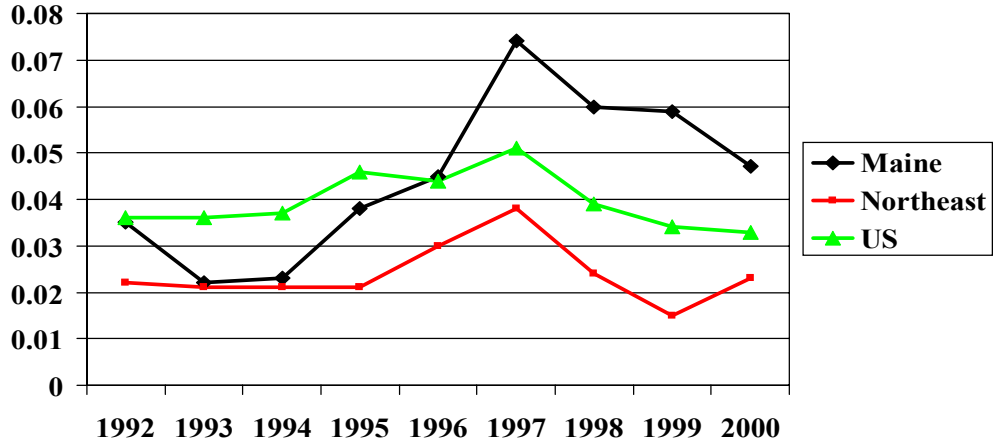
[27] Jack Hadley, Sicker and Poorer: The Consequences of Being Uninsured, the Urban Institute, Washington, D.C., May 2002.
[28] Kaiser Family foundation, "Uninsured and Their Access to Health Care", Jan. 2003 Fact Sheet 1420-oy
[29] Maine Health Data Organization, 2/10/02
[30] Institute of Medicine, Crossing the Quality Chasm: A New health system for the 21st Century, 2001
[31] Maine Health Data Organization, unpublished data.
[32] IOM, *To Err is Human*, pp. 22-23.
[33] U. Reinhardt, P. Hussey, and G. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999", *Health Affairs* (May/June 2002).

Median Inpatient Cost Per Discharge
Maine Hospitals
Adjusted for Case Mix and Wage Index



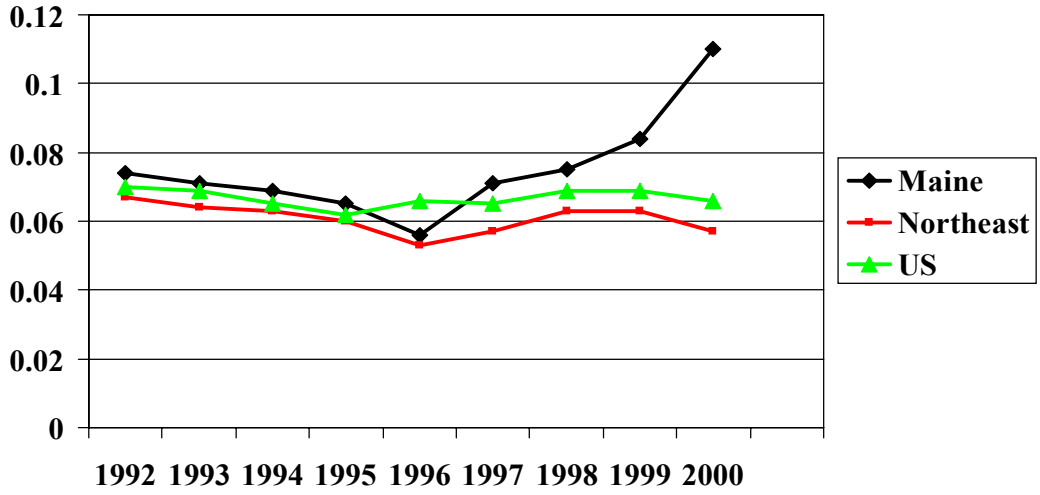
Source: Almanac of Hospital Financial & Operating Indicators CHIPS, 2002, 1997. From Nancy Kane, Harvard University, presentation to Portland Chamber of Commerce, 3/5/03.

Profitability of Maine Hospitals
Median Total Margin



Source: Almanac of Hospital Financial & Operating Indicators CHIPS, 2002, 1997. From Nancy Kane, Harvard University, presentation to Portland Chamber of Commerce, 3/5/03.

Median Growth in Capital Expenditures of Maine Hospitals



Source: Almanac of Hospital Financial & Operating Indicators, CHIPS, 2002, 1997. From Nancy Kane, Harvard University, presentation to Portland Chamber of Commerce, 3/5/03.

Access

Lack of access to care is more than a cost driver, of course, and causes significant problems for those uninsured. Over 1 in 6 Mainers under 65 lacked coverage for at least part of last year; on any given date, 1 in 8 is uninsured. 80% of the uninsured work – of those who do work 73% work in small businesses or are self employed. 52% of the uninsured are below 200% FPL or $30,500/year. for a family of three.[34] The combination of financial barriers and the mal-distribution of primary care resources in the huge rural areas of Maine result in significant barriers to appropriate care. In Maine, over 11 percent of the population reports not visiting a physician in 2000 because of cost. The population underserved by primary care doctors, in 2001, was 7.5 percent – more than double the rate of Vermont, and 72 percent higher than the rate in New Hampshire.[35] These barriers to primary care no doubt contribute to the higher emergency room use rate seen in Maine (42 percent higher than Vermont and 26 percent higher than New Hampshire)[36] and the higher rates of hospital use, as noted earlier. As noted above, the uninsured create costs to the health care system that are shifted to those who pay for health care.

Quality

Maine, however, enjoys high quality of care as evidenced by a study that shows Maine hospitals rank third highest in the nation (following New Hampshire and Vermont) based on performance on 22 quality indicators for care of Medicare beneficiaries (indicators measured delivery of services that evidence shows to be effective in preventing breast cancer, diabetes, myocardial infraction, heart failure, pneumonia, and stroke).[37] Maine also performed above the national average in avoiding hospital admissions for conditions such as uncontrolled diabetes, diabetes complications, diabetes–related lower extremity amputations, adult and pediatric asthma, congestive heart and pediatric gastroenteritis.[38]

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[34] Data from HRSA Maine State Planning grant household survey, 2002, as reported by the Muskie School Institute for Health Policy.
[35] AARP Public Policy Institute. *State Profiles 2001.*
[36] Kaiser Foundation State Health Profiles website.
[37] Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2002", *JAMA*, January 15, 2003-Vol. 289, No. 3
[38] AHRQ, *Healthcare Cost and Utilization Project, Prevention Quality Indicators, State Level Adjusted Rates, Year 2000* (unpublished)

Maine's hospital surgical mortality is at or below national norms; however, a large number of Maine hospitals perform specific procedures on a small number of patients per year which could lead to variability in the quality of inpatient care across facilities.[39]

As documented by the IOM, high volume of a service contributes to higher quality yet in Maine services are diffused and often low volume. That IOM study synthesized considerable research and concluded:

> The lag between discovery and more efficacious forms of treatment and their incorporation into routine patient care is unnecessarily long, in the range of 15-20 years. Even the adherence of clinical practice is highly uneven.

This finding suggests the need for better clinical decision support and system reforms and incentives that identify and reward quality and pay for performance. Consumers and purchasers must have valid and timely information to assess and access quality care.[40]

To balance the strengths and opportunities for health care in Maine against the considerable cost, quality and access problems the system faces is the challenge facing Governor Baldacci's health reform initiative. Careful attention has been given to balance cost, quality and access to identify any unintended consequences and build proposals that avoid cost shifting and negative impacts on the economy and business climate. Indeed, in making coverage more affordable and accessible and by focusing on system reforms and quality we hope to stabilize the health care system and its costs in ways that help businesses, small and large, and all Maine citizens.

This plan recognizes that real and sustainable reform cannot be accomplished in a piecemeal fashion. Increasing access alone increases costs; decreasing cost growth alone can hurt quality. We have therefore developed an integrated, incremental approach. No one piece of this plan works in isolation but rather as a part of a comprehensive proposal to increase access, improve quality and reduce the rate of increase in health care costs.

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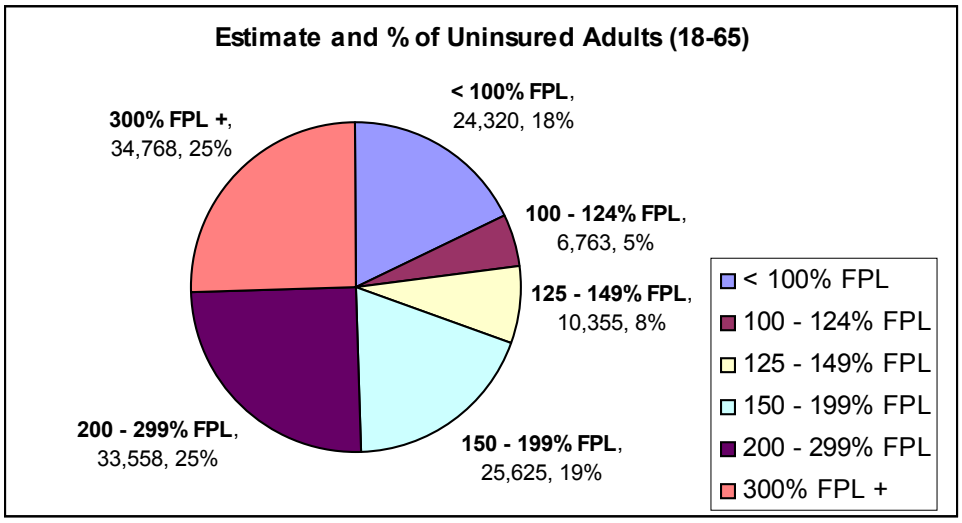
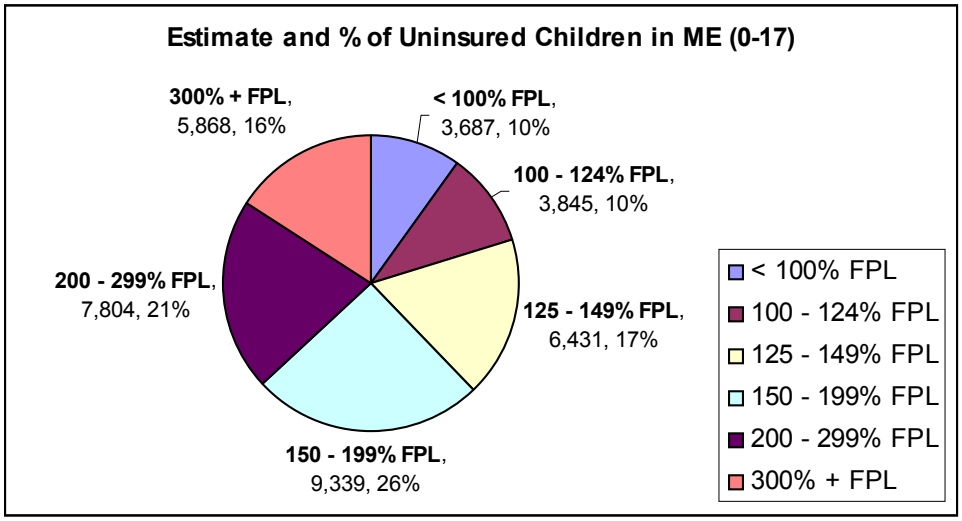
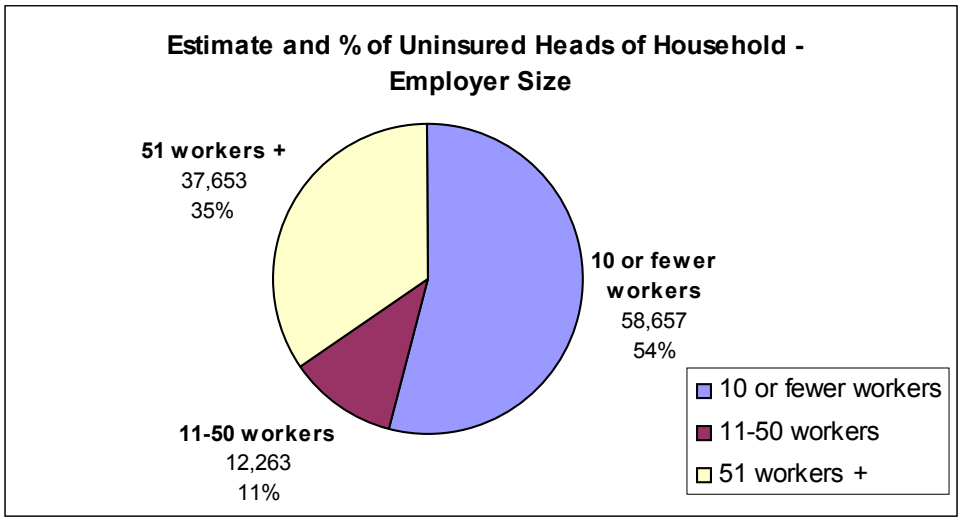
[39] Presentation by Harvard University Professor Nancy Kane to Greater Portland Chamber of Commerce, *Eggs and Issues*, 3/5/03.
[40] QC, p. 106

Who Are Maine's Uninsured?





Where do the uninsured work?



Source: USM, Muskie School of Public Service, 2003. Based on household survey conducted in 2002, funded by USDHHS/HRSA.

A. ACCESS TO COVERAGE –DIRIGO HEALTH AND DIRIGO HEALTH INSURANCE

In an effort to expand access to affordable health care coverage to Maine residents, we are proposing the development of Dirigo Health (DH). This organization will be established as an instrumentality of the State, structurally akin to the Maine Turnpike Authority or FAME. It will have its own eight-member Board of Directors; five voting members who will be appointed by the Governor and approved by the Legislature and 3 ex officio non-voting members: Commissioner of the Department of Professional and Financial Regulation or designee; Director of the Governor's Office of Health Policy and Finance or its successor; and, Commissioner of the Department of Administrative and Financial Services or designee. The five voting members of the Board must have knowledge and experience in one or more of the following areas: health care purchasing; health insurance; Medicaid; health policy and law; state management and budget; or, health care financing. Voting members may not be a representative or employee of an insurance carrier or health care provider or affiliated with a health or health related organization regulated by the State. The Governor will make appointments in October 2003.

DH will also have an Executive Director who serves at the pleasure of the Board, and a staff to carry out organizational functions. DH will be charged with a number of responsibilities, each of which is outlined below.

Dirigo Health Insurance – Overview

In terms of access to affordable coverage, Dirigo Health Insurance (DHI) is the key aspect of the reform plan. DHI is designed to arrange for a comprehensive, affordable subsidized package of insurance benefits to be made available to Maine's small business community as well as to individuals without access to job-based coverage – those sectors which are experiencing the greatest difficulty in accessing affordable, comprehensive coverage. It will also provide premium assistance to certain individuals employed in large businesses who are unable to afford their employer-sponsored plan. DHI will function using a pooling strategy, combining a variety of revenue streams: employer contributions, individual contributions, federal matching funds and funds obtained through the recovery of bad debt and charity care. This pooling will help

stabilize rates and provide more affordable access to private health insurance and those who join DH.

Importantly, DHI will subsidize premiums to low income residents of Maine, whose income is above eligibility for MaineCare (Medicaid) benefits but below 300% of poverty. In addition, MaineCare will contract with private insurers who are participating in DH to make that coverage available through DH private carriers. MaineCare will also be expanded, covering parents of currently eligible children to 200% of poverty and childless adults to 125% poverty; these expansions do not require any new federal waivers. The plan will also provide premium assistance to eligible individuals employed in certain large businesses who are unable to afford their employer sponsored plan. DHI will be closely coordinated with MaineCare; taking advantage of every opportunity to maximize federal funding.

Dirigo Health will issue an RFP for one or more private insurance carriers to partner with it in the provision of this product. Eligible insurers will be licensed to do business in the small group and individual markets in Maine. The successful bidder(s) will be required to provide the specified Dirigo Health Insurance benefit package to all enrollees, while limiting administrative costs and underwriting gain. This program will be marketed under the Dirigo Health name. Participating insurers will not be precluded from marketing alternative products in the small group and individual markets. Also, in order to satisfy any relevant non-discriminatory laws that would otherwise preclude DH's ability to limit enrollment of subsidies, insurance partners will be required to offer a non-subsidized "version" of DHI.

Who will determine the benefits to be covered?

DHI will develop the specifications for the plan benefit package. A model benefit package is summarized at the conclusion of this report. This model was used to calculate the costs and likely premiums for DHI.

DH will also specify criteria for member services, grievance procedures and so on, to be provided by the contractor(s). The aim will be to provide DHI enrollees with the highest quality member services as well as access to high quality care.

What benefits will be available under DHI?

The benefit package offered by DHI will be comprehensive and updated as needed, and will include coverage for primary and preventive services, as well as hospital care and prescription drugs. All state mandated benefits will be covered as well, including mental health parity. The product will satisfy all of the requirements of Maine's insurance code. There will be copayments and deductibles, intended to encourage thoughtful utilization on the part of enrollees.

At the discretion of the Board and the contracting insurer, Dirigo Health Insurance may include the offering of benefit riders, providing access to coverage for special services not covered under the routine benefit (e.g. dental care and eyeglasses).

Pre-existing exclusions or waiting periods will not be applied, with the following exception: persons moving to DHI from catastrophic coverage will be subject to the deductible specified under their former coverage for a period of six months, in accordance with currently existing insurance rules. This provision will protect against severe adverse selection.

Disease management will be an integral part of the plan. This is not intended to convey the image of tightly managed care. Instead, DH will encourage plans to employ outreach techniques to reach members who are at risk for disease, complications or high medical care costs, engaging them in participating in their own care at an early stage, before an adverse event is realized. This effort will encourage shared, informed decision making by patients, a strategy heavily dependent upon patient education and correlated with much improved satisfaction and outcomes of care. Disease management services will be provided either through the insurance contractor in accordance with protocols specified by DH or through a subcontract with a disease management company.

Dirigo enrollees may access the care of specialists and other covered providers without attaining prior authorization from a primary care physician. However, higher copayments will be required for those services.

Who can join Dirigo Health Insurance?

Maine businesses with 50 or fewer employees – including the self-employed – may voluntarily join Dirigo Health and enroll in DHI. These businesses may already provide insurance coverage to their employees or they may have declined to do so in the past; in either event, the business is eligible to enroll in DHI.

Employers wishing to join DHI must meet certain minimum criteria. First, just as is the case with other commercial products, a small business must bring *at least* 75% of its eligible employees into the plan. This means that all employees who work more than 15 hours and who do not have other creditable coverage (for example, coverage through a spouse, MaineCare, Cub Care, etc.) must agree to join the plan.

Second, employers must pay a specified portion of the entire premium cost, be it for a single individual or a couple, an adult with child(ren) or a family – whatever is applicable; for purposes of modeling we have set that payment level at 60%. Anecdotally, we understand that the average small business is currently paying about 60% of the combined premium; therefore, on average, this requirement should not prove a hardship to small business.

The exception to this requirement relates to premiums for part time workers. Part time employees who work at least 15 hours each week are eligible to participate in DH.[41] However, the employer is only required to pay a pro rated portion of the premium. For example, if an employee works only 20 hours per week, the employer would be required to contribute a minimum of 30% of the total premium (one-half of 60% of total premium).

Third, employers choosing to impose a waiting period for new employees (also known as an exclusion period) for health benefits must agree to limit that period to no longer than three months.

Individuals will also be eligible to purchase Dirigo Health Insurance. Similarly, persons eligible for a subsidy working fewer than 15 hours in <u>any size</u> business – big or small – will be eligible to

[41] Part time workers who work less than 15 hours per week are eligible to enroll in DHI as individuals.

join the plan. Importantly, though, DH will prohibit individuals who had employer sponsored health insurance within the twelve month period prior to their application to Dirigo Health, from enrolling in DHI. The exception to this rule will be individuals who lost employer sponsored coverage due to loss of employment or switching employers. This "crowd out" provision is meant to provide disincentives to employers to cease provision of health plan sponsorship.

Finally, individuals working more than 15 hours a week in large businesses who are not MaineCare eligible but whose household incomes fall below 300% of poverty will be eligible for premium assistance through Dirigo Health Insurance. For non-MaineCare eligible lower income workers, DHI will provide the individual's employer with a payment to be used to offset the employee's share of the premium cost, should the employee choose to enroll in his/her employer's plan. Premium assistance is not available to support buy-ins to self-funded (ERISA) health plans.

How Will People Join DHI?

Small businesses (with 50 or fewer employees) will shop for insurance, just as they do now. They can either use a broker or can approach an insurer directly. With Dirigo Health Insurance, they will simply have another choice to consider. They will be able to purchase DHI through an agent or directly from DH; if they choose to use a broker, the participating insurer will pay the broker's fee. If Dirigo Health ends up contracting with more than one insurer, the business will have to choose which subcontractor to enroll with; marketing materials related to the various participating carriers will be provided by the carriers themselves, although distributed through Dirigo.[42]

Importantly, DHI will serve as one more option for coverage in the individual and small group markets. Other options will continue to be available to those who wish to purchase them. However, Dirigo subsidies will not be available through other products – *only for plans under contract with Dirigo Health*.

[42] This Chinese wall between the businesses interested in Dirigo and the participating carriers remains intact; we would like to avoid opportunities for carriers to select against Dirigo by enrolling favorable groups into non-Dirigo products.

DH will be responsible for the actual enrollment process, regardless of whether an account comes in through a broker or directly to DH. Employees will complete an enrollment form, just as they do now for existing health insurance coverage. This form will include a section related to eligibility for premium assistance; employees who wish to apply for assistance will also be asked to complete that portion of the form as well. Such applications will be automatically screened for potential MaineCare eligibility.

DH will be responsible for the enrollment process, regardless of whether or not enrollees seek or receive subsidies. MaineCare eligibility screens will be conducted by MaineCare eligibility workers outstationed with Dirigo Health[43] using the criteria for eligibility specified by the MaineCare program. These workers will identify the level of poverty for each applying household. Those applicants eligible for MaineCare will have the option of getting health insurance directly from Dirigo Health Insurance or through MaineCare.

Individuals and their families enrolled in both DHI and MaineCare will receive MaineCare covered benefits through the private plan, including nominal cost sharing. MaineCare will provide wrap-around coverage for any additional MaineCare benefits not covered in the DHI plan.

Applicants who are above MaineCare eligibility but below 300% poverty will pay reduced premiums. DH will make up the difference between the employer and employee contributions and the cost of premium in paying insurance companies for DHI enrollment.

Subsidy levels will be re-determined annually. Subsidized enrollees and employers will be responsible for notifying DH of any changes in employment or wage level. In any case, eligibility for MaineCare and Dirigo Health Insurance subsidies will be reviewed on an annual basis.

[43] Funding for these workers will be provided by Medicaid, taking advantage of a 50/50 administrative match with federal dollars. Every resident of Maine is entitled to an eligibility review.

Once the enrollment process is completed and subsidy determinations are made, DH will prepare a "statement" for the employer, detailing the premium costs for the group, the premium contribution that the employer will be responsible for and the premium contribution for which the employee will be responsible. This statement will resemble the monthly premium billing that Dirigo will generate to the enrolled business. Similarly, those enrollees requesting a screening for MaineCare or subsidy eligibility will be notified by DH, in writing, of the determination made relative to their request.

DH will also forward the completed enrollment materials to the selected participating insurer, which will add the new enrollees to its electronic files and issue the membership cards to the business. DH will forward the full premium amount, including the employer and employee contributions and state subsidy dollars to the participating insurer. In this manner, all DHI enrollees, regardless of the number of businesses and individuals participating, will get the advantages that large groups receive from insurers in reduced administrative costs related to marketing, enrollment and premium collection.

As long as the business continues to forward the monthly payments in a timely manner, the group will remain enrolled in Dirigo Health Insurance.

What will the cost of coverage be?

The cost of the benefit package developed as part of the reform proposal has been determined by an actuarial firm serving as a consultant to the Governor's Office. The rate is very competitive and becomes even more attractive when subsidies are factored in.

The final rate will be subject to review by Maine's Bureau of Insurance.

How will the funding work?

The funding strategy used by DH is essentially a pooling mechanism designed to combine employer contributions with individual contributions and federal dollars, along with monies recovered from the health care system through a recovery of charity care and bad debt.

As noted above, employers will contribute toward the cost of coverage. When an employer makes a contribution on behalf of an employee who turns out to be eligible for MaineCare, that contribution will be transferred to MaineCare to offset the costs to MaineCare for that coverage.

In addition, DH will recapture some of the reduced bad debt and charity care write offs for Maine providers that result from reducing the number of uninsured Mainers. Currently, we estimate that a conservative estimate of the level of bad debt and charity care costs across all providers that is available for "recovery" is $164 million (see discussion in Cost Shifting section). To sustain their practices and facilities, providers often shift the cost of care for those who cannot or will not pay to those who do pay. Those costs are therefore reflected in the premiums paid by insured Mainers and employers who sponsor insurance benefits. By providing coverage to un- and underinsured persons, Dirigo Health will help to reduce the burden of non-reimbursed costs on both providers and payers.

In the earliest years of the program, however, these costs will still be reflected in premium rates. We intend to recover part of these costs by requiring insurers to contribute a recovery amount – expressed as a percentage of premium revenue – to the general fund. Those monies will, in turn, be used to subsidize comprehensive coverage for low-income DHI enrollees and to stabilize coverage in the pool. We appreciate the fact that there will be a lag between the point at which the recovery strategy is implemented and when providers will realize reductions in their uncompensated care burdens. We will strive to minimize the impact of that lag on insurers and providers.

According to our analysis, these policies will generate adequate monies to provide subsidized coverage to Mainers participating in DHI with income up to 300% of the federal poverty guidelines. In 2003, a family of three with a household income of less than $45,780 would be eligible for subsidized coverage, as would a single individual with an income under $26,940.

Subsidies will be provided on a sliding scale based on ability to pay. Although the final decision on subsidy levels will be determined by the DH Board of Directors, lower income eligible individuals and families will receive no more than an 80% subsidy of their premium costs while

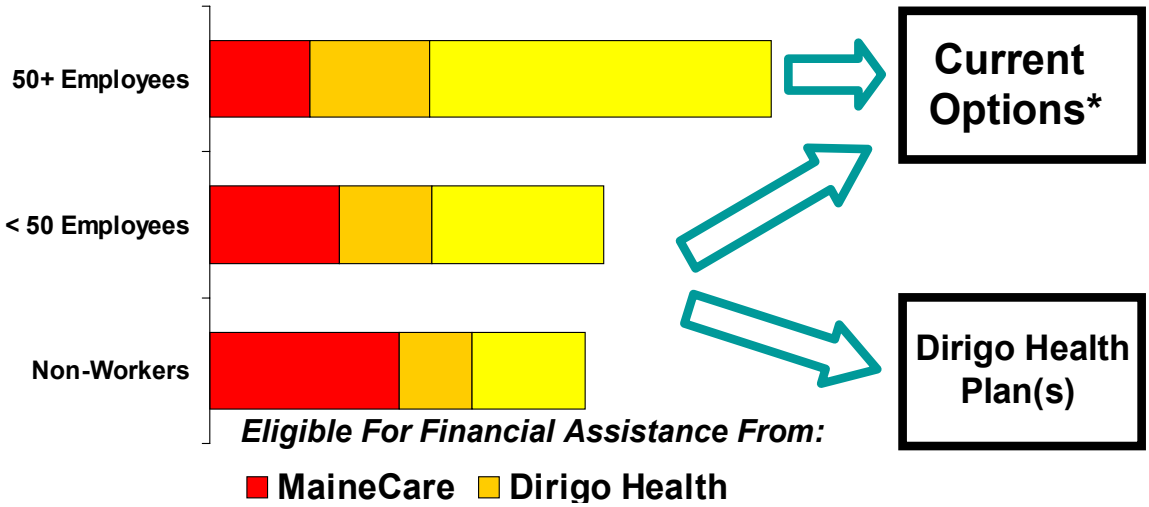
higher income eligible will receive no less than a 20% premium subsidy. The MaineCare expansions and the sliding scale subsidy program will begin in July, 2004.

Will this plan shift costs to large business?

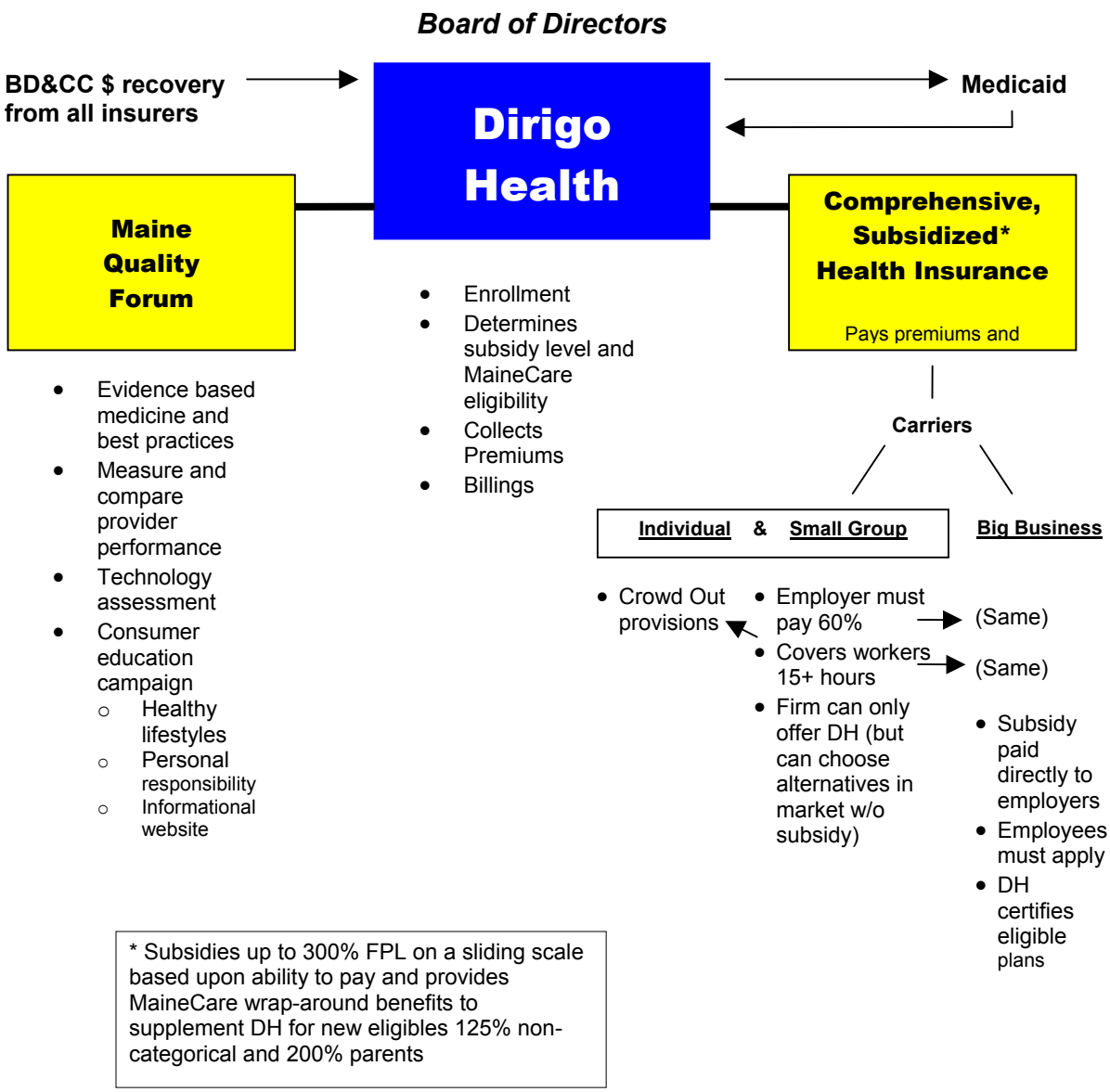
No, this plan is actually expected to shift cost *away* from large businesses, which are currently bearing the burden of subsidizing care provided to low income uninsured and underinsured Mainers. By making comprehensive coverage available to such persons, DH will serve to bring down the uncompensated care load on premium payers. Additionally, the State will be implementing a variety of cost controls, generating savings that will accrue to large businesses and other premium payers. Finally, a determined focus on quality will ensure that all Mainers receive the highest quality care available, a strategy which, in and of itself, assists in ensuring appropriateness of costs.

In addition, employees of large businesses, except those that self insure, will be eligible for subsidies to help pay premium costs of employer sponsored coverage.

All Mainers Would Have Access To Affordable Coverage



* The plan builds on current options: self-insurance, private insurance, and Medicaid
Source: USM analysis of HRSA Survey of Maine Residents, 2002

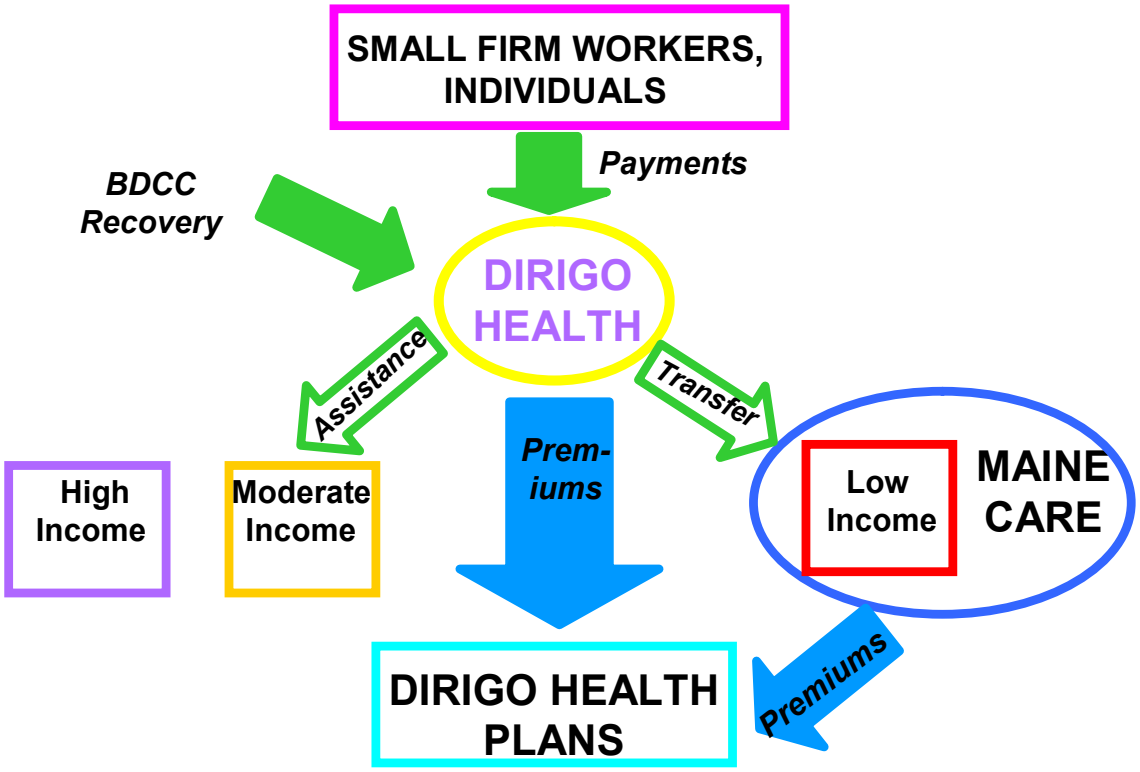

Board of Directors
BD&CC $ recovery from all insurers
Dirigo Health
Medicaid
Maine Quality Forum
Comprehensive, Subsidized* Health Insurance
Pays premiums and
Evidence based medicine and best practices
Measure and compare provider performance
Technology assessment
Consumer education campaign
Healthy lifestyles
Personal responsibility
Informational website
Enrollment
Determines subsidy level and MaineCare eligibility
Collects Premiums
Billings
Carriers
Individual & Small Group
Big Business
Crowd Out provisions
Employer must pay 60%
(Same)
Covers workers 15+ hours
(Same)
Firm can only offer DH (but can choose alternatives in market w/o subsidy)
Subsidy paid directly to employers
Employees must apply
DH certifies eligible plans
* Subsidies up to 300% FPL on a sliding scale based upon ability to pay and provides MaineCare wrap-around benefits to supplement DH for new eligibles 125% non-categorical and 200% parents

Dirigo Health Plan Benefit Design[44]

Income-level subject to cost-sharing (No cost-sharing below income level)	200% FPL
Out-of-Pocket Maximums	
• Individual	$1250
• Family	$2500
Deductibles	To be estimated to achieve target premium (approximately $250/$500)
Lifetime maximum	none
Hospital inpatient	$50 per day; $300 max per admission
Hospital outpatient/diagnostic, X-ray, Lab	20% coinsurance
Primary care provider visits	$10 co-payment
Specialty provider visits	$20 co-payment
Emergency department	$50 co-payment, waived if admitted
Mental health/substance abuse benefits	Parity
Prescription drugs[45]	
Copay-generic	$10
Copay-brand/preferred	$20
Copay-brand/nonpreferred	$35
Skilled nursing	$25 co-payment per day; $150 max per admission
Home health care	$10 co-payment
Durable medical equipment	20% coinsurance
Misc. included benefits (not subject to cost-sharing)	Preventive/wellness care, nutritional counseling, smoking cessation, wellness education, cardiac rehab, routine vision.
Excluded benefits	Dental, cosmetic, infertility/sex change, routine foot care, custodial care, eyeglasses/lenses, vision correction surgery (LASIK).

[44] Relative to the Benefit Design 3A accepted by the Health Security Board (December 2002), this benefit design adds a deductible for all participants subject to cost sharing, and omits dental benefits and coverage for eyeglasses.
[45] May adopt closed formulary to control cost.

How Dirigo Health Works



B. STATE HEALTH PLAN

Background

Although Maine spends over $5 billion each year in healthcare and has significant public health needs to address, the state has no mechanism to plan the health care system. A formal, comprehensive state health plan has not been developed for many years in Maine. No vehicle exists to plan for the orderly and economic development of health facilities and resources in the state.

Proposal

The Governor's Office of Health Policy and Finance (GOHPF) will issue a State Health Plan biannually to establish and address health care cost, quality, and access goals for the Maine. Specifically, the Plan will support a healthy citizenry by ensuring access to affordable, sustainable health care, maintaining a rational, affordable system of preventive health and health care services and facilities and stimulating an adequate, qualified workforce to operate the system at the highest quality standards.

The Plan will set forth specific goals and strategies to achieve them, establish priorities annually among the goals and develop specific benchmarks and indicators to measure and report on progress toward meeting goals. The work conducted by the Maine Health Performance Council and the new Maine Quality Forum (see Section K) will inform the Plan. An annual report to the public will assess progress toward meeting goals and provide any needed updates to the Plan.

Approach

<u>Council on Health System Development</u>

Planning has little utility unless it is broadly reflective of state and local needs and expectations and unless it explicitly relates to and directs resource allocation.

There shall be established the Council on Health System Development, staffed by the GOHPF. This independent council of 11 members will be responsible for guiding the development of the State Health Plan. Members of the Council will be appointed by the Governor and approved by the Legislature's joint standing committee with jurisdiction over health and human services no later than October 1, 2003.

Board members must be experienced in health care and be recognized leaders of considerable experience and credibility who share a commitment to a public and private collaboration in state health improvement planning and who transcend special interests of any one stakeholder group in health care. Membership must represent the geographic, ethnic, and gender diversity of the state. Members must include:

- 2 experts in health care delivery
- 1 expert in long-term care
- 1 expert in mental health
- 1 expert in public health care financing
- 1 expert in private health care financing
- 1 expert in health care quality
- 1 expert in public health
- 2 consumer representatives
- 1 representative from Healthy Maine Partnerships
- GOHPF sits ex-officio and non-voting on the Council and staffs its work.

Members will serve five-year terms, and those terms will be staggered to maximize political neutrality. Prior to appointing members, the Governor shall solicit nominees from the public.

In establishing the Plan, the Council will first synthesize current research and studies available in Maine and collect and coordinate existing data. The Maine Health Data Organization, Maine Health Information Center, and DHS Bureau of Health and Bureau of Medical Services or their successors shall be resources to inform the Council; additional staff support shall be provided by the Bureau of Health and other agencies of State government as necessary and appropriate. At

least one public hearing will be held prior to the Council's adoption of the biannual Plan or annual updates.

The Plan will include specific strategies to address the major cost drivers in the health care system and the major threats to public health and safety. The Plan presented by May, 2004 will include specific strategies to reduce Maine's high rates of lung disease, diabetes, cancer, and heart disease and to address health workforce shortages such as the lack of adequate dental health providers. The Plan must include both medical care and public health goals. The State's Bureau of Health (or its successor), in consultation with the Maine Center for Public Health, Healthy Maine Partnership Coalitions and the Maine Public Health Association, shall forward to the Council each year data documenting key public health needs by region of the state, informing the development of the Plan.

Designed as a plan to provide rationality and coordination to a diffused health system statewide, the Plan will explicitly identify levers to stimulate change such as purchasing strategies, consumer information, pay for performance, state licensing and regulations. It will guide decisions made by the State in awarding Certificates of Need and by the Maine Health and Higher Education Facilities Authority in its health care lending. No Certificate of Need or public financing that increases health care costs will be approved unless it sufficiently meets goals and budgets explicitly outlined in the State Health Plan.

To assist the Council in developing a responsive plan capable of assisting purchasers and providers to make resource decisions that improve the public's health and build an affordable, quality health care system, the Council will create, each year beginning in 2004, a state health expenditure budget report. That expenditure report will be the vehicle to establish priorities within the Plan. However, the Plan must explicitly show how public health needs will be met.

State Health Expenditure Report and CON Investment Fund

In 2004 public purchasers are required to present to the Council a consolidated state health expenditure report outlining all funds expended in 2003 for hospital inpatient and outpatient care, physician services, prescription drugs, long-term care, mental health, other services and

administration by agency. Private purchasers through the Maine Health Management Coalition and other groups will be encouraged to develop a similar document. The Council is authorized to collect what other data it needs to include private sector spending for the Council's consideration in the report by 2004. The Council will use this report in conjunction with needs specified in the State Health Plan, input from the Maine Quality Forum, and research and consultation regarding trend factors to project future costs, to set a limit for resources allocated annually under the Certificate of Need Program. This CON Capital Investment Fund will initially be established by May 2004.

C. Certificate of Need

Background

In 1978, the Maine Legislature enacted the state's Certificate of Need law, finding it in the public's interest to minimize unnecessary construction and/or modification of health care facilities and the duplication of services and to exercise control over the cost of and access to health care. Over time, though, the effectiveness of Maine's program has eroded. It is generally viewed as unsuccessful at controlling capital investment; it hasn't prevented the proliferation of services and hasn't promoted the orderly dissemination of new technology. For these reasons, we are proposing a strengthening of the CON program.

Currently, the requirement for a Certificate of Need[46] applies to "health care facilities" wishing to undertake any one of the following activities:

- A transfer of ownership or acquisition by lease or other comparable arrangement or acquisition of control of a facility;
- Acquisitions of major medical equipment with costs equal to or greater than $1.2 million;
- Capital expenditures equal to or greater than $2.4 million (with the exception of capital expenditures to replace facilities or equipment lost as a result of natural disaster, accident or failure);
- The implementation of a new health service; or
- Changes in bed complement that exceed 10%.

Health care facilities are defined as hospitals, psychiatric hospitals, kidney disease treatment centers/freestanding hemodialysis facilities, rehabilitation facilities, ambulatory surgical centers, freestanding radiology centers, independent cardiac catheterization labs, cancer treatment centers and nursing facilities. The definition specifically excludes private physician and dental offices, whether group or individual practices.

[46] We are focusing on Certificate of Need for acute care services as opposed to long term care services. We are not proposing any changes to the regulations for LTC/CON.

The dichotomy between application of the CON requirement to facilities rather than provider offices has been the focus of debate over time. Hospitals tend to view this disparate application as discriminatory, making it more difficult for hospitals to quickly respond to changing market demands, due to what is sometimes viewed as the cumbersome nature of the CON review process. In contrast, physicians argue that they lack the financial capacity to develop appropriate CON applications, which may require substantial investment of development funds.

These arguments aside, we view the uneven application of the law troubling. As more and more services have migrated from the inpatient to outpatient settings and, now, off the hospital campus entirely, the development of very sophisticated and costly services in freestanding and office based settings is more common. This type of development is currently outside the purview of the CON statute, leaving a significant gap in our ability to carefully consider and direct the rational development of Maine's health care system, as well as our ability to assess the impact on system costs these investments represent.

Proposal

The goal of this reform is to make CON a more effective and credible process to promote the rational development of Maine's health care system and to assure access to necessary services for all Mainers and to promote the orderly and economic development of health facilities and resources in the State.

We therefore propose to alter the Certificate of Need Program to make it a more useful tool for cost control and health system development; the recommendations of the Health Action Team's Subcommittee on Cost Containment, Planning and Regulation have guided us in formulating this proposal. Importantly, the CON program will be strengthened by the adoption of several guiding principles – listed below – forming the foundation for the review of each proposed project:

- Projects must be consistent with the State's health plan;

- Projects must ensure the realization of high quality outcomes and must not negatively impact the quality of care delivered by existing service providers; and
- Projects must not result in inappropriate increases in service utilization, as deemed appropriate by the principles of evidence based medicine.

Approach

Four significant reforms are proposed for the CON process:

- The applicability of a requirement for CON review will henceforth be determined upon the capital and operating cost of the project, the need for the proposed functions and activities, rather than the site of care;
- CON criteria will be clearly defined in the State Health Plan;
- CON will be governed by a budget, allocated during two competitive review cycles each year;
- The competency of review will be enhanced by expert panels, and by reviews from the Bureau of Insurance and Bureau of Health.

The requirement for CON review and approval will be predicated on function and cost, as opposed to site of care. That is, the requirement for review will be triggered by the parameters (e.g. investment thresholds) mentioned above, regardless of whether the project is proposed by a hospital, a consortium of physician practices or a single practitioner's office. This change will serve to "level the playing field" and to ensure that all significant investments are carefully considered.

As part of our overall strategy to introduce cost constraints and rationality to Maine's delivery system, we are recommending the development of a comprehensive State Health Plan described in the preceding section of this report. This Plan will serve as a roadmap for changes in the health care system needed to meet the pressing needs of the state's population. At the present time, the most urgent health care needs relate to the prevalence of cardiovascular disease, chronic

lung disease, diabetes and cancer. Investment in our delivery system needs to address those diseases explicitly.

We must be cognizant of the impact new projects will have on the ability of people to access and afford health care services and the long term sustainability of the system. To that end, we are recommending the development and implementation of the Maine Capital Investment Fund; a "cap" on new CON approved expenditures. The level of this fund will be set on a biannual basis, subject to annual review and adjustment. Approved expenditures must fall within the limitations of the Fund, regardless of the type of provider making application for approval, thus limiting the growth in capital expenditures over time. The level of the Fund will be determined by the Governor's Office of Health Policy and Finance with the Council on State Health System Development. The Investment Fund will be established based upon review of the State Health Expenditure Report and the Hospitals for Maine's Future report (described later in this document). The first Capital Investment Fund limit will be set by May 2004. Exceptions to the Fund limit will be made available in specific circumstances such as reconstruction required as the result of a natural disaster.

Reliance on the Fund as a cost limiting strategy will necessitate the institution of competitive review cycles. Without such cycles, some applicants might be unfairly positioned relative to likelihood of approval simply due to timing of the submission of the application. In order to avoid that problem, we will establish two annual review cycles, one for very large projects and another for smaller projects. Applicants will be required to submit by the deadline for the appropriate review cycle and will "compete" for the funds allocated for that cycle by the GOHPF and Council.

The final decision on applications will remain with the Commissioner. However, staff recommendations will be strengthened by the guidance provided by the explicit criteria/principles for approval of any project, technology assessments conducted by the Maine Quality Forum, by input from the Bureau of Health and Bureau of Insurance and by input and suggestions from *ad hoc* expert panels. While the Commissioner is explicitly allowed to consult with experts on new technologies and needs (22 MRSA c.103-A §338), this capacity will be

extended to the DHS staff charged with carrying out the actual review of applications. The Department cannot reasonably be expected to maintain in-house the special expertise required to review many applications. The ability to convene expert panels of consultants on an as needed basis will serve to expand the staff's access to necessary expertise and to enhance the review process. In addition, affected parties will retain the right to intervene in an application process, as well as the right to request a hearing if they are able to argue they are adversely affected by a decision to approve or disapprove any given project.

There will be a cost associated with the use of expert consultants, which will be reflected in the fiscal note to the omnibus reform bill.

Currently, the Commissioner does not receive the benefit from informed input and comment by other State officials involved in oversight of Maine's health care delivery system. In the future, these officials will provide comment as appropriate on CON applications: the Director of the Bureau of Health, the Superintendent of Insurance and the Maine Quality Forum. The Director of the Bureau of Health is responsible for assessing Maine's health care needs and will contribute to the development of a new, comprehensive health plan for Maine (*see* discussion regarding this plan elsewhere in this document). Therefore, the Director's input regarding pending proposals will provide the Commissioner with needed insight into how the needs of the people of the State of Maine might be served (or not) by approval of the project. The Superintendent is responsible for oversight of Maine's health insurance market. Approved projects involving a recoupment of investment through service delivery charges will likely have an impact on premium levels paid by Maine rate payers. Some projects will result in increased costs of care; others may actually generate decreases in such costs. The degree to which approved projects will impact premium prices by increasing costs of health care holds important implications for affordability and the sustainability of this coverage. As such, it is important that the Commissioner fully understand this aspect of a project's impact, before deciding on approval.

As part of its charge, the Maine Quality Forum will assess the cost and benefits of new technologies, information that will be valuable to the Commissioner in making final approval

decisions. MQF will also advise the Department on current best practices and the recommendations inherent in evidence based medical protocols.

The current provisions for requests for hearings and reconsideration will stand. Appeals of the Commissioner's decisions will still be made directly to the courts.

DHS shall promulgate technical rules to implement these revisions no later than January 31, 2004. Because it will take some time to put the proposed reforms into place and because the issue of health care cost has reached what some might characterize as crisis proportions, we believe it is highly advisable to place a temporary moratorium on Certificate of Need. This moratorium, which would be put into effect by emergency rulemaking and which will run for one year, would provide time for redesign of the process, an evaluation of the prioritized needs and resources of the state and the development of a State Health Plan. It would seem unwise to move ahead with project review and approval until those vital mechanisms are in place. The moratorium would not apply to those projects actively under review nor to those described in Letters of Intent on file at the time the emergency rule is signed. Nor will it apply to emergency projects that are required to preserve health and safety, or which are needed to maintain accreditation.

D. Hospitals for Maine's Future - Voluntary Hospital/Physician Cooperation

Background

Hospital spending represents 34% of Maine's annual health care expenditures, a figure in excess of $1.7 billion and, by far, the largest single category of our health care dollar expense. Hospital spending also represents the fastest growing category of health care expenditures, outstripping recent growth in expenditures on prescription drugs. At the same time, hospitals report concerns about the sustainability of all 39 of our hospitals. An important part of any successful plan to create a sustainable, affordable health system in Maine will be its attention to hospital costs and access to appropriate care statewide.

Of course, Mainers want and deserve access to high quality hospital services. However, the general public perception and concern over the high cost of medical care and coverage suggests that we may be unwilling or unable to sustain the level of growth in investment in our health care system that we have made over the past several years, including investment in hospital facilities and care. Currently, our hospital system develops and evolves in the absence of any deliberate planning context and often on the basis of competitive advantage, as opposed to an objective assessment of local health care needs or convenience.

The result of this type of fragmented process is a "medical arms race" between facilities, each striving to provide the latest technology to their local communities; without regard to the broader impact such action exercises on Maine's health care costs, generally. If planning occurred within a rational context, with a focus on the appropriate dissemination of technology throughout the state relative to need and quality standards, Maine's hospital system would likely look different than it does today. Investment in high cost technologies such as cardiac surgical programs and cardiac catheterization - services that have been documented to generate utilization - might be more regionalized and fewer in number. It is true that, if this were the case, some patients and their families would have to travel further to access this highly specialized care. By the same token, it is true that by seeking care at established specialty centers performing high numbers of procedures and demonstrating high quality care, patients are more likely to experience a

favorable outcome of risk-laden services. And Maine should encourage innovation in health care delivery and the creation of centers specializing in primary care and prevention, rural health and/or telemedicine as well as more specialized care, for example.

A rational planning process requires open discussions between hospitals and physicians across the state regarding what the most favorable allocation of resources might be. This type of discussion, however, is precluded by state and federal antitrust law, which prohibits discussions between providers regarding price or allocation of services. While amending state antitrust statutes to allow such discussions is a relatively straightforward exercise, federal law remains problematic. Discussions with Maine's Attorney General have provided us with guidance regarding how a cooperative planning structure might be designed and implemented to satisfy federal requirements. Details of this planning process will be determined after hospitals and providers and their antitrust counsel have been given an opportunity for input.

Proposal

We are proposing a planning process, aimed at engaging hospitals and physicians in the difficult task of allocating hospital investment in Maine to achieve the greatest efficiencies and highest quality care possible, without sacrificing critical access to care, especially in our state's most rural areas. This process must stress an allocation of highly specialized services that emphasizes quality and efficiency, and the preservation of local access that builds and strengthens capacity for primary and preventive care services. Incentives should be proposed that would facilitate change.

The overriding goal of such an effort is to ensure the creation of the best possible constellation of hospital and related services for the future health care system, strengthening our rural health care systems and more efficiently and effectively allocating our scarce resources.

Approach

- Maine hospitals and physicians will be charged with the task of allocating annual expenditures for hospital services. This involves the development of a statewide hospital "budget" of approximately $1.7 billion (1999 dollars), trended forward from 1999 to state fiscal year 2005 by the Consumer Price Index.

- Legislation will be enacted to allow hospitals and physicians to jointly discuss and plan the allocation of resources. Such discussion will necessarily involve which hospitals will provide what services, and will have a special focus on the preservation of access to critical services in rural communities. Consideration will also be given to the impact that new technology and substantial changes in population demographics may have on future budgetary needs. Similarly, the budget levels must reflect anticipated changes in case mix adjusted volume of services.

- The planning process will be subject to active state oversight, a prerequisite for such a planning process under federal law. The Governor's Office of Health Policy and Finance (or its successor, if any, as established through a reorganization of state health care agencies) will convene a planning group of hospitals and physicians charged with responsibility of developing and implementing this budgeting process. The group will be staffed by the GOHPF, and the GOHPF Director or her designee will sit as a member of the group. The group will make recommendations to the Governor and will inform the work of the Council on Health System Development, responsible for developing the State Health Plan, and provide the basis for changes to Maine's Certificate of Need Program.

Importantly, this initiative is a voluntary one. It is anticipated that the hospital and physician communities will take on an on-going responsibility for this effort, establishing annual and multi-year resource allocation plans with the State. If the provider community is unable or unwilling to take on this challenge, the task of resource allocation will necessarily be carried out by the State.

E. DISCLOSURE AND HEALTH CARE PRICING

Background

In order to play an active and effective role in any market, consumers must have access to information regarding prices and value. In the health care marketplace, however, such information is difficult to come by. For example, it is not easy for a consumer to obtain information regarding the comparative cost of a specific procedure from providers delivering that service. This information would help the patient "shop around" for price and quality.

Compounding this problem, insurers individually negotiate discounts with providers that might vary by service. Because most patients are covered by an insurance plan, it becomes virtually impossible for them to exercise any meaningful responsibility in terms of comparing providers' prices and outcomes to arrive at an informed choice regarding where to receive services.

Proposal

In order to introduce greater transparency and accountability on the part of providers and insurers, and to stimulate more informed consumer behaviors, we propose requiring disclosure of average charges and payments accepted for commonly performed services at hospitals, physician offices and other providers such as health centers. In the case of hospitals, this will include those types of discharges listed in 24-A MRSA §4306-B, as well as the daily rate for room and board (other than ICU/CCU/SCU/NICU) and the base rate for an emergency department visit. It will also include the twenty-five most common outpatient services provided statewide. In the case of physicians, this will include but is not necessarily limited to routine office visits, new patient visits and extended office visits.

Approach

Posting of average charge and accepted payments lists will be required. Any text included in these notices must be written at a sixth-grade reading level, to ensure it is understandable to the

majority of the public. It must also be published in any of the predominant languages spoken in the provider's locale.

This information will also be posted on the Maine Quality Forum's public website.

F. SIMPLIFYING ADMINISTRATIVE FUNCTIONS – REDUCING PAPERWORK

Background

One component of health insurance is the administrative expense incurred by carriers in marketing, enrolling, billing/premium collection and providing member services to enrolled businesses and individuals. Administrative expense also includes, but is not necessarily limited to, the adjudication of claims, payments to providers, processing of referral requests and eligibility verification.

In the case of small businesses and individuals, marketing, enrollment and billing costs are high on a per unit basis; the economies of scale realized by working with large employers are not available in these market sectors. This is one reason the premium expenses for small groups and individuals are higher than those for larger businesses. The structure of Dirigo Health (described in Section A) addresses these issues and is designed to insulate participating insurers from most of these costs.

Proposal

Claims submission, referral approvals, eligibility verification and other types of administrative services that are associated with similar costs across groups of all sizes, can be addressed more globally. It is our recommendation that Maine take full advantage of the efficiencies that technology can provide.

Approach

Specifically, we propose mandating the use of electronic claims submission, data exchange, referral submission/approval and eligibility verification by 2005. The State shall seek ways to establish loans and grants to facilitate implementation of this requirement. HIPAA requirements will be in full effect by late fall 2003. This means that each insurer will have implemented systems to accept electronic claims from providers. Moreover, standard codes will be in place

and local codes will no longer be used. These changes will reduce the administrative burdens borne by providers.

However, not all providers will have the capacity to submit claims, query eligibility files and so on, using a computerized system. The purchase of necessary hardware and software and training may serve as barriers to the adoption of this technology. We recognize that some providers will never choose to join the electronic age, no matter what incentives are provided to them. There are others, though, who would do so given the appropriate assistance or incentives. At least some of the health plans operating in Maine provide a degree of financial (or in kind) assistance to providers wishing to establish electronic data transfer systems. This can involve the provision of hardware and software required to electronically exchange information and data with the particular carrier involved. Some payers have established Internet-based systems for the exchange of certain information, which can be accessed and used without charge.

Providers need additional assistance to make the investment in more global software that will facilitate electronic interchange of data with all relevant insurers. We estimate the cost of such an investment at $2000. We recommend carriers continue to invest in the dissemination of this technology and, to the greatest extent possible, expand this investment. To encourage a continuation of this type of effort, we will request funding for a revolving loan account to be matched by private funds and used for the purpose of assisting providers' purchase of computer technology. From information provided to us by industry representatives, there is a marked differential in the cost to the payer of processing paper claims, referral requests and so on as opposed to electronic claims, referral requests, etc. This savings will obviously allow payers to reduce their administrative costs, thereby allowing their products to be more competitively priced.

From the providers' perspective, use of electronic systems for communicating with payers can reduce billing errors and will result in a quicker turn around time for payment remittance. Because providers will also realize a benefit from the use of such systems, it seems reasonable that they share in the cost of implementing them.

Maine should work with insurers and engage in a bidding process for software companies to develop a standardized, global software product for statewide use, in an effort to provide reasonably priced access to an effective technology for all providers in the state. The Governor's Office of Health Policy and Finance will take the lead in pursuing this initiative.

G. ENHANCED PUBLIC PURCHASING

Background

Public funds, administered by state and local programs, account for a significant portion of health care spending. The State employee plan, the University of Maine System at the State level and the Maine Municipal Association, Maine Educational Association and others at the local level spend public funds to buy health care. While recognizing the individual populations served by public entities and the sometimes unique needs of these populations, it is nonetheless compelling to investigate, organize and implement coordination and collaboration strategies between public entities in Maine that serve to arrange and purchase cost effective, value based and quality health services on behalf of their employees, the dependents of these employees, retirees and others.

By acting in coordination to demand quality and efficiency, these purchasers can have a positive impact on the delivery of health care and on the overall culture of Maine's health care system. Some coordination is already underway and leaders in that effort joined forces as the Health Action Team's Subcommittee on Public Purchasing. They guided our recommendations to strengthen collaboration and enhance public purchasing.

This plan will increase coordination and collaboration among public entities in Maine to organize and implement strategies that arrange and purchase cost effective, value based and quality health services on behalf of their employees, the dependents of these employees, retirees and others.

Approach

The Governor will create by Executive Order the Public Purchasers' Steering Group. The Steering Group will be located within the Governor's Office of Health Policy and Finance or another agency as directed by the Governor.

Scope

Areas of priority for the Public Purchasers' Steering Group (hereafter, Steering Group) are expected to include, but not be limited to:

- Identifying, establishing and implementing appropriate joint purchasing strategies that may include pharmacy services, mental health and substance abuse services, centers of excellence, dental benefits, disease management services, and/or comprehensive health benefit plans.
- Developing and implementing a common wellness strategy. Elements of this strategy may include: utilizing and expanding activities presently underway among individual purchasing units, identifying and partnering with existing community based resources, and developing innovative approaches to reach populations who are often overlooked.
- Adopting a common set of valid and reliable quality metrics for purposes of communicating to beneficiaries and providers.
- Establishing a standard policy for differential payment strategies to validly and reliably identify quality providers and requiring all carriers contracting with public entities to implement such strategies.
- Establishing standard procedures and protocols for utilization and medical management of benefits and requiring all carriers contracting with public entities to implement these procedures.
- Investigating the feasibility and appropriateness of a coordinated competitive bidding for primary insurers or contracts with integrated delivery systems.

The Steering Group is expected and directed to actively collaborate with other private and public purchasing organizations and quality organizations in furtherance of the purpose as well as specific tasks.

Priority Timeframe

The following initiatives represent the initial, first year priorities for the Steering Group to consider:

- Determine the feasibility of a group purchasing pharmacy program for common and indicated price, formulary, rebates, utilization management and disease management arrangements.
- Develop a common health education and wellness promotion program for public employees.
- Adopt a common set of valid and reliable quality metrics and define a plan for initiating a communication/education strategy around these metrics and a performance based payment structure for public employees.

Structure

There will be seven permanent members of the Steering Group who represent:

- Maine Educational Association
- Maine Medicaid program (MaineCare)
- Maine Municipal Association
- Maine School Management
- Maine State Employees
- Office of Health Policy and Finance
- University of Maine System

In addition, the Governor shall appoint two additional individuals representing other public employee sectors that are not represented by the permanent members. These representatives shall be randomly appointed to one or two calendar year terms. Upon expiration of these initial terms, replacement representatives will be selected to serve a two year term. Non permanent members may serve only three consecutive terms.

Each January, members of the Steering Group shall select a Chairperson and Secretary. The Chairperson shall be responsible for convening the meetings, preparing the agenda and chairing the meetings. The Chairperson shall also be the official representative of the Steering Group to external organizations The Secretary shall be responsible for recording and reporting the deliberations of the Steering Group. The Secretary shall be also responsible for preparing the annual report, subject to review and approval, by majority, of its content by the Steering Group.

The Steering Group shall meet not less than bi monthly at a location agreed upon by the Steering Group. Five members of the Steering Group shall constitute a quorum and all decisions of the Steering Group shall be by simple majority.

Accountability

The Steering Group shall, each January 31st, make a formal report to the Governor and Legislature as to its activities with regard to the stated objectives in the proceeding calendar year as well as objectives and work plans for the current year of activity.

Resources

The Steering Group has the authority to identify appropriate staff and consultant resources to assistant in its work efforts. The Steering Group is also authorized to seek appropriate funding to support its activities, through either an assessment of the organizations represented on the Steering Group or external sources.

H. STRENGTHEN OVERSIGHT OF INSURANCE COSTS

Proposal

In working to establish affordable and sustainable health care coverage alternatives, we have identified several changes that might be made to improve Maine's health insurance regulatory system. The purpose of the system is to ensure the viability of the state's private insurance market; but that must be balanced with the impact that the cost of coverage has on individual enrollees, employers and the health care system, generally. We recommend that a series of reforms be applied to our system of insurance oversight to ensure a greater degree of consumer focus.

Approach

Presently, only individual coverage is subject to rate review by the Bureau of Insurance. Rates for small and large group coverage are "filed" then used, without review by the Bureau. Because the preponderance of problems associated with health insurance occur in the individual and small group markets, we suggest rate review be extended to include small group products. This change will increase the accountability of the small group market to the public and subject those products to greater scrutiny.

We also recommend that carriers issuing coverage to large groups be required to file an actuarial certification with all rate filings. Such a certification will provide an attestation by a certified actuary that the rates filed are true and correct and developed in concert with all relevant state rating rules.

At the same time, we believe it is necessary to adopt certain standard definitions of measures to be reported to the Bureau of Insurance each reporting period. It is particularly important that a standard definition and approach to calculating "profit" or underwriting gain be established. The forms insurers use to make annual reports to the Bureau are not particularly helpful to the average consumer trying to evaluate profit margins or administrative costs and compare them

across insurers. Therefore, the Bureau should be directed to develop and promulgate a rule, requiring an annual report by each carrier doing business in Maine (right now, these reports are made by managed care organizations only) to report certain performance measures. Each of these measures – which are to include administrative costs and underwriting gain – must be calculated and presented in the same manner, so as to facilitate a comparative review across carriers.

We propose introducing a greater degree of transparency to insurance rating by declaring all rate filing information submitted to the Bureau of Insurance as public documents. At the current time, only documentation relative to individual premiums is available for public review.

The implementation of Dirigo Health (described in Section A) will necessitate certain technical changes to Maine's Insurance Code. An exemption from the licensure requirements otherwise applicable to private purchasing alliances must be created for Dirigo Health. As a public instrumentality, Dirigo Health does not fit neatly into the definition of such an alliance, although it will have certain similar functions. A specific exemption from licensure will help clarify Dirigo's status.

I. REDUCE COST SHIFTING

Proposal

If insurance coverage is extended to uninsured persons in Maine, a significant reduction in bad debt and charity care (BD&CC) costs can be expected. Presently, these costs are largely borne by private payers. As such, bad debt and charity care represent a substantial indirect, hidden tax on health insurance premiums and costs to fully and self-insured health plans in the state as well as to those persons paying out of pocket for their own care. This proposal will recover a portion of those costs and reallocate them to cover the uninsured directly.

Approach

For hospitals, bad debt and charity care (BD&CC) costs are reported to be an estimated $190,000,000 in 2001.[47] Based on a trend of 8 percent, this amount is increased to $205 million for 2002. Presuming that hospital BD&CC represents 75 percent of all health care bad debt and charity (when physician as well as other professional and institutional providers are included), a total of nearly $275 million is estimated.[48] [49] Significantly, these amounts are annual expenses incurred by individuals without health insurance and without the ability to pay for their own care. These individuals often delay seeking care until their health problems reach a critical point, necessitating the provision of acute and costly care, often in the hospital setting. Providing care at this late stage is inefficient and contributes to suboptimal outcomes. If care is sought earlier and on a regular basis, many crisis situations can be averted, generating reductions in bad debt and charity care expense. These reductions would represent annual savings to hospitals and other providers and, in turn, to those who pay for services either directly or through premiums.

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[47] Maine Health Data Organization. 2/10/03

[48] Memo from Gino Nalli, USM Muskie School, 4/20/03, who states that the factor is conservative. The Year 2000 Blue Ribbon Commission on Health Care estimated that hospital bad debt and charity represent 64% of the total for 1999.

[49] These estimates do not include discounts in provider payment levels that are imposed by third party payers such as Medicare, Medicaid and private insurance plans. These latter discounts are considered contractual allowances, independent of bad debt and charity costs which are written off by providers.

It is expected that actual savings that can be reasonably estimated will be less than the potential amounts noted above due to the following factors:

- Providers are likely to have reported bad debt and expenses based on charge amounts. Charges rarely reflect expected payment levels; they are almost always higher.
- Some continued bad debt and charity care costs will be incurred by copayment, deductible and other cost sharing provisions as well as costs associated with non covered services.
- For a variety of reasons, it is unlikely that all uninsured persons will enroll in any new health coverage plan.

This proposal seeks to recover bad debt and charity care funds from the "back end" of care and reinvest them in the front end of coverage to provide health insurance for the uninsured. However, given the factors listed above we will not recover all bad debt and charity care, rather, we anticipate a recovery rate of 60%. If "universal" coverage is provided to all eligible persons, this rate represents $164 million in savings. As described in further detail in the Access proposal (see Section A) in this document, we recommend recovering some portion of bad debt and charity care costs through an assessment on all health premiums, including reinsurance, paid in Maine. These monies will be invested in the subsidization of health insurance premiums for low income persons through the State's new health coverage plan. This essentially rationally reallocates BDCC funding to purchase coverage for primary and preventive care as well as hospital care, providing an avenue of access to less costly, more appropriate services.

This proposal recognizes that MaineCare (Medicaid) reimburses providers at less than market rates. We anticipate that the State Health Plan will reduce health care cost growth. Should such savings be realized, funds will be available in the future for provider reimbursement increases and to support initiatives to reimburse providers based on their success in meeting performance goals. We commit to increasing Medicaid reimbursement rates to become more competitive in the marketplace as cost savings make that expenditure possible.

J. VOLUNTARY LIMITS TO CONTROL THE GROWTH OF INSURANCE AND HEALTH CARE COSTS

Proposal

A coalition of organizations including Maine Health, its members and affiliates, large businesses including Bath Iron Works and Hannaford, organized labor (MSEA, SEIU) and public employees (Maine Municipal Trust), among others, have endorsed the Health Care Challenge. The Challenge is billed as a first step toward addressing the complex problems of Maine's health care system, with a common goal of coverage and care for all. Its sponsors believe that working cooperatively, we can solve Maine's health care crisis.

The Challenge issues roles for each of the "players" in the health care system: providers, government (both state and federal), insurers, employers and individuals. We find ourselves in agreement with many of the charges to stakeholders included in the Challenge and feel it important not only to endorse them, but to advocate for their extension.

The Challenge lays out specific goals for State government. These include:

- increasing MaineCare (Medicaid) reimbursement levels;
- the development of a state health plan that incorporates specific goals for access, quality and affordability of care;
- a restructuring of the Certificate of Need Program;
- the preservation of the Fund for a Healthy Maine;
- encouragement of innovation in insurance product design and pricing; and
- pursuit of federal support for purchasing arrangements that facilitate small businesses and individuals to purchase insurance coverage.

The Governor's health reform proposal encompasses many of these "assignments." Key provisions are discussed elsewhere in this paper, but some deserve special highlight here. The

proposal includes a reinventing of the health planning process, predicating it on Maine's most pressing public health needs and balanced against a voluntary statewide expenditure limit.

As described in Section C, the Certificate of Need Program will be guided and strengthened by the new State Health Plan, ensuring that priority is given to those projects that address the needs and goals of that plan. In addition, CON will be revised to apply to all providers; projects will be subject to review on the basis of the size of investment and need, regardless of whether they are proposed by a hospital, a free standing facility or a physician group. Annual investment will be limited by a cap on new investment, calibrated to track changes in Mainers' ability to take on new costs.

The creation of Dirigo Health Insurance will inject a measure of competition into the small group and individual markets that does not now exist, with the introduction of a subsidized insurance product. Employers and individuals would still be able to select from a variety of products offered in the marketplace, although only DHI will provide subsidies. Such competition may, in and of itself, encourage similar innovation. Moreover, Dirigo Health Insurance provides an affordable coverage alternative for small businesses and individuals – without requiring any waivers of Federal regulation.

The Governor's reform plan also includes strategies to encourage Mainers to adopt healthy lifestyles and to become better informed consumers of health care. It will provide consumers with tools needed to ensure the accountability of all stakeholders regarding systems improvement and performance.

This proposal contemplates increases in MaineCare reimbursement for physicians and other providers once savings accrue from these reforms. However, the current budget environment does not allow for immediate increases now. Despite the severe budget constraints, the Administration has been able to maintain current eligibility for MaineCare benefits, adhering to the goal of coverage and care for all. The Governor is clearly committed to preserving the Fund for Healthy Maine, as evidenced in the most recent budgeting process.

Approach

Over the course of the coming year, the State will work with our Congressional delegation and through other avenues to encourage more equitable reimbursement by Medicare, as well as the expansion of educational opportunities and the creation of more effective incentives for rural practice.

Insofar as the State is demonstrating a commitment to the principles of the Health Care Challenge, we would advocate that the other stakeholders continue to do the same for the immediate future. We propose extending the Challenge to *all* providers, health care organizations, insurers, employers and individuals in the state – not just the organizations currently participating in this innovative initiative. We are calling for all providers to hold price increases and operating margins to no more than 3% through the end of 2004, and for all insurers to hold underwriting gain to 3% or less for the same time period.

The correlation between cost constraints and utilization levels are well documented and understood. When unit costs are capped, utilization tends to increase to maximize revenues. This phenomenon could hurt an insurer who is holding premium costs constant or a provider who is being paid on the basis of a capitation rate. When total expenditures are capped, there is concern about the impact "natural" increases in utilization and severity of illness may have on the revenues of providers and insurers. The introduction of Dirigo Health Insurance to the small group and individual markets is expected to result in increases in utilization when the program goes into effect next summer. We understand and appreciate the pressure this will exercise on a health care system that is working diligently to keep price increases to a minimum. However, the provision of coverage to many individuals who were formerly uninsured should assist providers in holding down unit costs by providing a broader population over which fixed costs may be distributed.

As is contemplated in the Challenge, we firmly believe in holding all parties accountable for their actions, and urge all parties to continue to do so over time. For our part, we intend to monitor the performance of stakeholders over the next year, with regard to their compliance with

the Challenge. We will be especially interested in the willingness of providers and insurers to hold down the cost of their services and products. This will be accomplished in a number of ways:

- increased transparency relative to the "construction" of insurance premiums (standardized reporting regarding medical claims costs, administrative costs and underwriting gain for all insurers and all lines of health insurance business);
- the implementation of rate review for small group health insurance products and the requirement of actuarial certification for large group health insurance products;
- the requirement of posting of average charges and average payment accepted for commonly performed services at hospitals and physician offices;
- monitoring of purchaser/employer behavior relative to the continued provision of insurance coverage;
- stringent review of data submitted to the Maine Health Data Organization to track changes in utilization and expenditures, with special attention paid to the level of bad debt and charity care provided; and
- stringent review of MaineCare and Cub Care expenditures and utilization trends to identify significant changes on a geographic and/or provider specific basis.

This is a voluntary effort which we believe can work if all stakeholders carry their fair share of responsibility. Over the next eighteen months, the reforms contemplated in this proposal will be implemented, providing some measure of control and added rationality to Maine's health care system. Until that time, we will rely on the good intentions of providers and insurers, to hold the line on cost increases.

The Council on Health System Development, in conjunction with the Governor's Office of Health Policy and Finance, will coordinate the monitoring effort. In consultation with insurers and providers a report will be issued at year end to track the experience with voluntary price and utilization controls. If after one year the voluntary effort is failing, the development of more aggressive cost containment measures will be triggered. The Governor would be empowered to

set in motion plans to establish a rate-setting system, mandate global budgeting or take other measures to control cost growth.

K. Maine Quality Forum

Background

Quality of care is receiving ever-increasing levels of attention. Americans had always believed that our health care system provided the finest quality care in the world, and it likely has. Still, there is a great deal of room left for improvement, as documented in recent years by the National Institute of Medicine. The IOM has published a series of books that lay out the problems associated with sub-optimal medical practice and poor patient outcomes, making the case that such issues may be more widespread than most of us thought. As the IOM has suggested, we need to take a critical look at how we are practicing, delivering and receiving health care in order to identify opportunities to improve the operation of the system, improve the quality of care provided and realize improved patient outcomes.

Approach

The Maine Quality Forum will be established within Dirigo Health. The Forum will serve as a "quality watch dog" and will provide an independent forum to coordinating data and quality initiatives to improve the quality of health care in Maine. It will be governed by the Board of Directors of Dirigo Health, with advice from an Advisory Council appointed by the Governor and approved by the Legislature. The Forum shall be funded in part through the recovery of bad debt and charity care premium assessments and is empowered to seek and receive grants and contracts to advance its work.

The Maine Quality Forum will have four primary functions:

1. Collect and disseminate research regarding evidence-based medicine and patient safety to promote rapid deployment of best practices.
2. Adopt a robust set of measures to compare provider performance, working collaboratively with other organizations to collect health care data, analyze performance, and disseminate

comparative performance information in formats useable to consumers, providers, purchasers, and policy makers.

3. Conduct consumer education campaigns to help health care consumers make more informed decisions and engage in healthy lifestyles.
4. Conduct technology assessment reviews to guide the diffusion of new technologies in Maine and to make recommendations to the State Health Plan and Certificate of Need Program.

The Maine Quality Forum will conduct its work in an open, transparent manner and make an annual report to the public and annual recommendations for inclusion in the State Health Plan.

MQF will develop and maintain a public website that will make information on costs, utilization and outcomes available in a format accessible to all consumers. The website will include information on improving personal health status and maintaining healthy lifestyles. It will also provide users with links to other sites which have been certified by the MQF as reliable sources of health information.

The Advisory Council overseeing the work of the Maine Quality Forum will be appointed by the Governor with approval from the Legislature. Membership shall include:

- Providers - 2 physicians (1 M.D.; 1 D.O.); a hospital; a nurse; and, a mental health provider;
- Consumers - 1 employee who receives health care through a commercially insured product; 1 representing organized labor; 1 representative of advocacy groups; 1 representative of the uninsured or Medicaid;
- Employers - 1 representative from the State of Maine Employee Plan; 1 large private employer with over 1,000 full-time equivalent employees; 1 medium employer with 50-1,000 full-time equivalent employees; 1 small business;
- Other - 1 health plan and 1 representative from MaineCare.

Prior to making appointments to the Council, the Governor will seek nominations from the Maine Medical Association, the Maine Osteopathic Association, the Maine Hospital Association, the Maine Nurses Association, the Maine Health Purchasing Collaborative, the

Maine Health Management Coalition, organized labor, Consumers for Affordable Health Care, the AARP, the Maine Peoples' Alliance, Maine Equal Justice, the Maine State Chamber of Commerce, Maine Businesses for Social Responsibility, the National Federation of Independent Businesses, the Maine Association of Health Plans, and others as appropriate.

Dirigo Health will provide staff to the Maine Quality Forum as needed. Additional staff can be funded through grants and contracts. In addition, the Forum, through Dirigo Health, is authorized to contract with the Maine Health Information Center, the Maine Health Data Organization, and other entities to assist its needed responsibilities.

L. HEALTH SYSTEM DATA

Proposal

Data play a vital role in any informed effort to understand and improve the health care system. Ideally, cost and quality data from all service providers would be integrated with outcomes data and population based demographic and utilization data to provide a comprehensive view of the system. While Maine's health care data collection is relatively good, the effort is still fragmented.

The State operates several data repositories, ranging from the Maine Health Data Organization to the Cancer Registry and Vital Statistics to occupational injury and illness. The MaineCare program has a wealth of data – historical and current – related to recipients of Medicaid services. The State Employee Health Program has utilization and cost data related to one of the largest employee groups in the state.

Private organizations also collect and maintain data. The Maine Health Information Center manages data bases for a wide range of clients, including EMS and the Maine Workers' Compensation System. It also manages the claims database belonging to the Maine Health Management Coalition, a group comprising Maine's largest employers. Each insurer – health, workers' compensation, auto, etc. – has its own database. Providers also maintain data (although frequently not in electronic form) that relate to health and health outcomes for individual patients.

The objective of the Governor's plan is to ensure that the data resources needed to develop a comprehensive and broad-based understanding of our health care system are available in a usable and sustainable and coordinated format. Such a resource will prove invaluable as we work to develop informed and effective strategies for both improving health care in Maine and evaluating the impact those strategies have.

Approach

Several issues stand in the way of our maximizing the value of this Maine's data resources. The data are maintained in separate databases, each formatted in its own unique manner, and often unable to be collated with other compatible data. This phenomenon occurs not only between public and private databases but among the State's own databases as well. The State must lead the way in enhancing the value of the data by developing strategies to effectively share data across programs and Departments as appropriate. Clearly, all necessary protections must be taken to maintain the confidentiality of individuals; that requirement can be satisfied when stakeholders work together to address that challenge.

As a first example of such collaboration, the MaineCare Program will be directed to work diligently with the Maine Health Data Organization (MHDO) to add its patient level data to the private payer data already being collected and maintained by the Data Organization. HIPAA regulations may exercise severe limitations on the sharing of MaineCare data, even with another state agency. The Governor's office will work with DHS and counsel to resolve any outstanding issues in order to effectuate timely data sharing in a manner that meets HIPAA requirements.

Similarly, current law requires both AMHI and BMHI to submit data to the Maine Health Data Organization. However, compliance with this requirement has been sporadic, at best. Although such compliance might stretch the resources of BDS, inclusion of patient-level discharge data in the public database would enhance its usefulness.

Historically, the Bureau of Health has been reluctant to release certain data related to cancer and chronic illness at the level of detail suitable for specific analysis with other health-related data sets. This reluctance is undoubtedly due, in part, to concerns regarding confidentiality. While we recognize the absolute importance of guarding confidences, we are convinced there are ways to protect individuals while sharing data. This effort will require the dedicated attention of Bureau and MHDO staff, but we firmly believe it can be accomplished and, when implemented, will

provide valuable information that can be used to help explain utilization trends and assist in formulating a comprehensive needs-based State Health Plan.

The addition of Medicare, Champus and federal employees' health insurance data to the MHDO database would provide Maine with an extraordinarily comprehensive and valuable resource. It would facilitate comparisons between public and private sectors with regard to charges and prices for services provided, utilization patterns and variations in patterns of care. To date, these programs have been unwilling to share data with the MHDO. The Governor's Office will work in conjunction with the MHDO with CMS and Northeast Health (the federal quality improvement organization – which used to be known as the peer review organization – serving Maine) to secure their participation.

The Togus Veterans Administration Hospital does not submit data to MHDO either. As a federal facility, it is not governed by the laws of the State of Maine. However, the hospital serves a great many Maine residents from across the state. If we are to have a database that is truly inclusive of all Maine residents, the Togus data would have to be obtained, albeit on a voluntary basis. Again, the Governor's office pledges to work with the MHDO to attempt to secure the participation of Togus in this effort.

While administrative data are useful, they do have limitations when trying to evaluate the quality of care by examining outcomes. Outcomes assessment requires the collection of certain clinical data, which are only available at the provider level. As mentioned elsewhere in this paper, it would be ideal if each health services provider were to have access to electronic systems both for billing and other administrative functions, but also for maintenance of clinical data sets. As provider offices increasingly adopt electronic systems, collection of such data will be facilitated. Providers can be encouraged to share these data (blinded to protect confidentiality) as part of research and quality improvement efforts.

The Maine Health Data Organization and the Maine Health Information Center – a private, nonprofit data management organization – are partners in a new, public/private partnership called the Maine Health Data Partnership. This entity manages a merged dataset of both public

and private data. By enhancing the public data set to be as broadly based as possible, we will vastly improve the quality and predictive power of the data managed by the Partnership. This will undoubtedly prove to be a unique and extremely valuable resource for policymakers, researchers, providers, insurers and the public, alike.

Uses of Data

The new, more comprehensive database will be used for many purposes. These activities include, but are not limited to the following:

- Design of the State Health Plan – this task, described in greater detail elsewhere in this paper – will be built on a foundation of data related to demographics, need, utilization, costs and outcomes.
- The Maine Certificate of Need Program will rely on data from this database in order to understand resource use, need and the potential impact new projects might have on existing programs.
- The Maine Quality Forum will use these data to fuel its examination of patterns of service use and delivery, costs and outcomes of care to develop and disseminate information relative to quality improvement. It will also use the data to formulate recommendations for the state health system development plan and for initiatives to improve personal health.
- The public may use the information available through this database to gain a greater understanding of the cost of services, the outcomes of certain types of care and the health care resources available to them in this state. Importantly, the data will help inform a public website, to be maintained by the Maine Quality Forum, which will assist consumers in identifying ways to improve their own health status.
- Policymakers will use the data to inform their examination of problems facing the health care system and the development of solutions to those problems. The data will be used by the MHDO to publish at least a subset of those indicators called for in the report of the Maine Health Care Performance Council, measuring the performance of Maine's health care system.
- These data will be integral to the State's efforts to monitor compliance with the voluntary price caps called for elsewhere in this proposal. They will also be used in the

development of a global budget and any future health system regulatory reforms that might be considered in the future.

M. Public Health and Disease Prevention

Proposal

The Health Reform Proposal's focus on cost, quality, and access will be balanced with a strong commitment to supporting activities that prevent disease, promote good health, and healthy behaviors.

In addition to an annual public health report and State Health Plan, proposals to build public health infrastructure will be included in the Governor's reorganization plan for the Departments of Human Services (DHS) and Behavioral and Developmental Services (BDS).

The State government will launch in 2003 a cross-agency initiative through the Cabinet Council on Health, designed to improve the health of state employees and MaineCare beneficiaries. The first initiatives will target reduction in the rate of diabetes and associated complications among these two large beneficiary groups of State financed health care.

Governor Baldacci is eager to see Maine's tobacco funds protected and used as strategically and effectively as possible. To assure a balance between health finance and affordability with access to health and effective disease prevention, the Governor will take action to protect The Fund for Healthy Maine and assure its resources are used for health in perpetuity.

Approach

Specifically, the Governor will introduce legislation proposing to amend the Constitution of the State of Maine to preserve The Fund for Healthy Maine and assure its funds are used to fund only explicit health related purposes. Beginning each year in 2004, in order to achieve the state health prevention and access goals, the Governor shall propose and the Legislature shall allocate or reserve for future allocations, all such revenues and all interest earned or other investment income on balances in the fund, only to the following health related purposes:

A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State;
B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age;
C. Child care for children up to 15 years of age, including after-school care;
D. Health coverage for children and adults, maximizing to the extent possible federal matching funds;
E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds;
F. Dental and oral health care to low-income persons who lack adequate dental coverage;
G. Substance abuse prevention and treatment;
H. Comprehensive school health programs, including school-based health centers; and,
I. Other disease prevention and health promotion activities included in the State Health Plan.

This proposal will be introduced as a separate, companion bill to the overall health reform since it requires a two-thirds vote of the Legislature.

Appendix A

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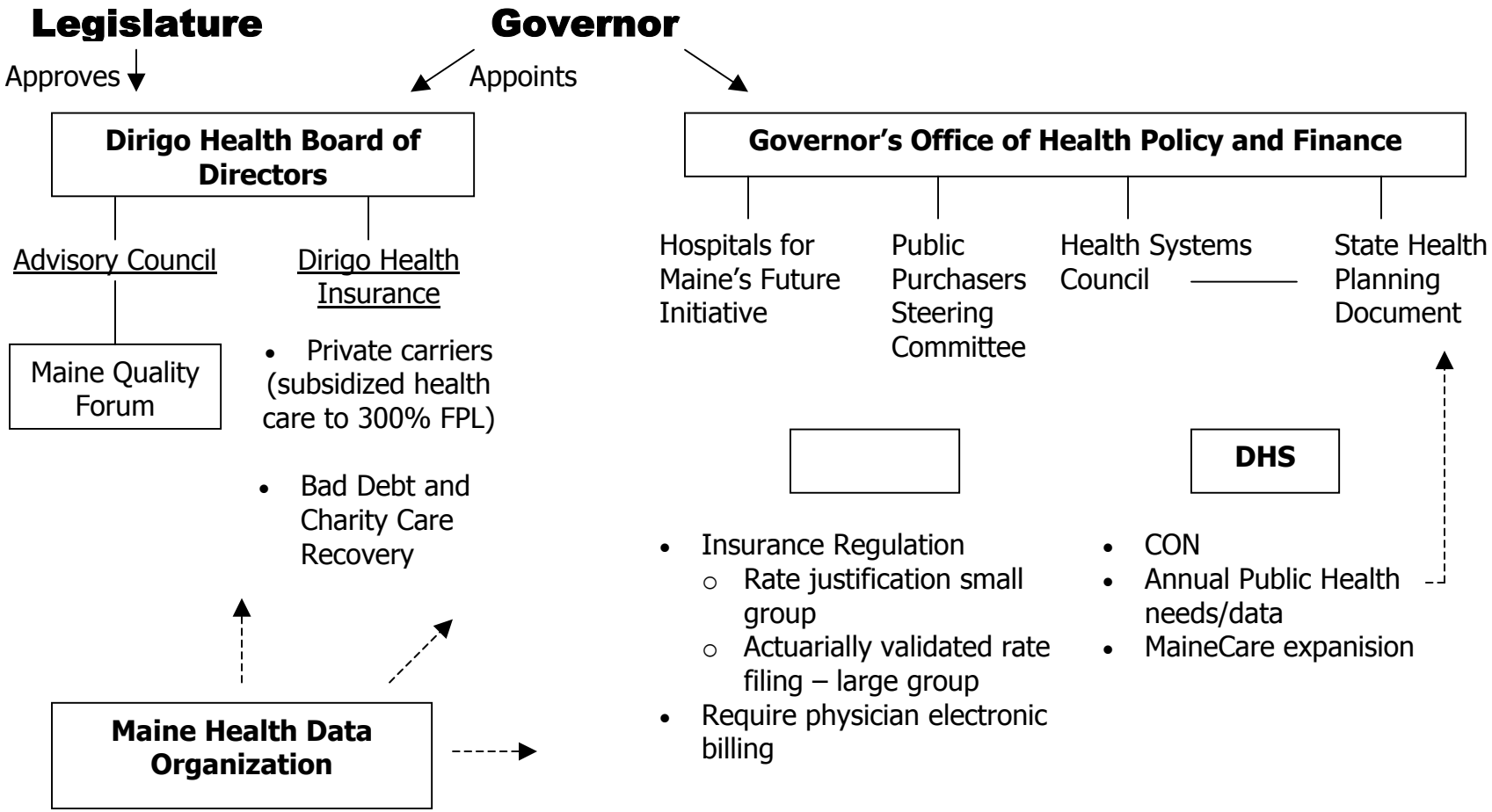
OVERVIEW

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