MAINE HEALTH ACCESS FOUNDATION

ISSUE BRIEF

MARCH 2007

Health Reform in Maine, Massachusetts, and Vermont: An examination of state strategies to improve access to affordable, quality care

Key Findings

Maine has demonstrated leadership and a sustained commitment to comprehensive health reform, including the implementation of its Dirigo health reform in 2003. This reform has been informed by innovative thinking within the state and in the national arena. The purpose of this report is to inform that on-going discussion by providing an overview and comparison of Maine's reforms with those enacted in Massachusetts and Vermont in 2006. This examination of the reforms in these states reveals six key findings. (It is important to note that Massachusetts and Vermont are still implementing their reforms and some of the details of the efforts may change and, indeed are changing, as the states translate their plans into working programs.)

1. **Maine was the first state to simultaneously enact and implement a comprehensive health reform dedicated to increasing access to affordable, comprehensive coverage, improving quality, and containing costs for all state residents.** The reforms in Massachusetts and Vermont also seek to address all three components of the system for all residents. Maine emphasizes all three goals equally; Massachusetts's reform was primarily directed to attaining their coverage goal; and Vermont expresses four goals for its reform: increase access; simplify administration; decrease cost shift; and improve quality.

2. **Maine, Massachusetts, and Vermont are not seeking to replace the current system but rather to improve it.** There is much evidence of this incremental approach.

   a. All three states see employer coverage as a critical element in maintaining and expanding access to coverage and paying for coverage. Both Massachusetts and Vermont will require employers who do not provide coverage to pay an assessment or penalty.

   b. All three states created a new state-sponsored coverage option (e.g., DirigoChoice) that offers comprehensive coverage. But the details of the coverage are different in terms of covered benefits, premiums, cost-sharing and in other ways. For example, Vermont defined a new type of product for the uninsured (Catamount Health) that it is asking carriers to offer. Maine and

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The National Academy for State Health Policy (NASHP) is grateful to the Maine Health Access Foundation for its support in producing this report and for its ongoing commitment to health care reform in Maine. We are especially appreciative of the insights and guidance offered by Wendy Wolf, President and Leslie Goode, Director of Public Policy and Communication at the Foundation.

The authors' thanks also go to all those in Maine, Massachusetts, and Vermont who developed these reforms. Their energy, creativity, and persistence in continually working to improve the health care system in their states are admirable. Particular thanks go to those who reviewed a draft of this report. They are: Susan W. Besio of Vermont's Agency of Administration; Russell Frank and Betsy Forrest of Vermont's Agency of Human Services; Amy Lischko, formerly of Massachusetts's Division of Health Care Finance and Policy; John McDonough of Health Care for All in Massachusetts; and Trish Riley of the Maine Governor's Office of Health Policy and Finance. Finally, it is important to note that the views presented here are those of the authors. Any errors or omissions are ours.

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Key Findings (continued)

Massachusetts both created a new agency to administer their coverage programs. Further, Massachusetts's new authority (the Connector) will aggregate employer contributions for employees with multiple employers, enable small businesses to offer employees a choice of health plans, and enable participants to pay for the coverage with pre-tax dollars.

c. All three states expanded their existing Medicaid and/or SCHIP programs as part of their health care reforms and found innovative ways to use Medicaid financing to help cover the cost of their state-sponsored coverage.

d. All three states incorporated the insurance carriers that were already delivering coverage in their state-sponsored coverage. Vermont is asking existing carriers to voluntarily offer Catamount Health coverage through the carriers' current distribution system. Maine and Massachusetts both contract for coverage with existing carrier(s).

e. All three states made changes to the private market to make the coverage offered by existing insurers more affordable.

3. Because the reforms build on the existing health care system in each state, the nature of that system affected the changes each state could make and needed to make. For example,

a. Prior to the health reform, residents in Massachusetts had greater choice of insurers than those in Maine and Vermont. Now that Massachusetts has selected the health plans that will offer non-subsidized coverage (called Commonwealth Choice) through the Connector for those with incomes over 300 percent of the Federal Poverty Level (FPL) it is clear that the difference will continue. Maine currently contracts with one carrier to deliver DirigoChoice, Massachusetts will have seven carriers offering Commonwealth Choice, and Vermont anticipates that two will offer Catamount Health.

b. Massachusetts, unlike Maine, has a long history of contracting with HMOs to deliver services to Medicaid beneficiaries. The state was able to quickly create its new state-sponsored coverage for those with incomes of 300 percent FPL or less (called Commonwealth Care) by building on this existing system of Medicaid-contracted plans.

c. Maine addressed medical error reporting separately from the Dirigo reform, while patient safety was a major element of Vermont's reform. Similarly, Vermont had developed a state health plan before enacting its 2006 reform, while developing a plan was a significant element of Maine's reform.

4. There is a trend among these three states toward using mandates to ensure that individuals and employers fulfill their responsibilities in obtaining coverage. Maine's reform, which was enacted in 2003, relies on incentives. In 2006, however, Massachusetts and Vermont both enacted reforms that plan to make greater use of assessments and penalties, in addition to incentives. Other states, including Maine, are now considering greater use of assessments and penalties.

5. Maine, Massachusetts, and Vermont have all acknowledged that people with lower incomes require subsidies to purchase coverage. All three of these states offer (Maine and Massachusetts) or plan to offer (Vermont) subsidies to people with incomes of no more than 300 percent FPL. The exact amount of the subsidy varies based on family income and those with the lowest incomes are exempted from paying premiums and most cost-sharing.

6. Maine and Massachusetts both seek to use savings produced by providing coverage to the uninsured and underinsured to partially fund their reforms. Maine sought to recapture these savings (as well as others produced by the health reform) to partially fund its reform through the Savings Offset Payment; Massachusetts is redirecting funds that it was already capturing to provide subsidies to people for purchase of individual coverage. Maine's approach proved to be difficult to implement largely because Maine must demonstrate savings before collecting funding.

Introduction

For over 30 years state governments have experimented with a wide variety of initiatives to expand access to health care for the uninsured. These initiatives built on the many opportunities to expand coverage offered by states' roles in the health care system as:

- ***Regulator*** of the health care marketplace (insurance carriers and medical providers),
- ***Administrator*** of public programs that offer coverage (e.g., Medicaid and the State Children's Health Insurance Program or SCHIP), and
- ***Purchaser*** of health care services for state employees and retirees, Medicaid and SCHIP participants, and others, such as prison inmates.

In recent years a number of states have once again risen to the challenge of using the multiple levers available to them to reform health care. Maine was the first state in this new 'wave' to implement comprehensive health care reform.[1] In 2003 it enacted the Dirigo Health Reform Act with a goal of "universal access to quality and affordable health care for all Maine people within 5 years."[2] Dirigo seeks to address cost, quality, and access.[3] The state has since implemented the health reform and continues to work to improve it. For example, the Governor convened a Blue Ribbon committee in July 2006 to make recommendations with respect to "long-term funding and cost containment methods to continue the efforts of Dirigo Health in increasing the affordability, accessibility and quality of health care for the people of Maine."[4]

Also, since that time other states have followed Maine's lead. Most notably, in 2006, Massachusetts, and Vermont enacted and began to implement comprehensive reform packages that seek to increase access to affordable coverage.[5] The reforms in these states have many similarities to Dirigo. For example, Maine, Massachusetts, and Vermont all:

- Created new state-sponsored coverage options,[6]
- Expanded existing public coverage (Medicaid and the State Children's Health Insurance Program or SCHIP),
- Implemented various small group and individual market reforms,
- Require participating employers and employees to pay a share of premiums,
- Established subsidies to help those with incomes up to 300 percent of the Federal Poverty Level (FPL)[7] pay for coverage.

Each also has unique features. For example:

- Maine established the Maine Quality Forum to promote quality of care initiatives and educate providers and consumers,
- Massachusetts requires all individuals to have health insurance (individual mandate), and
- Vermont's reforms seek to increase patient safety and improve management of chronic conditions.

Maine has demonstrated a sustained commitment to comprehensive health reform that has been informed and shaped by innovative thinking within the state and in the national arena. The purpose of this report is to inform that on-going discussion by providing an overview and comparison of recent reforms in Maine, Massachusetts and Vermont with a special emphasis on the strategies these states used to address four specific issues: expand access to coverage, contain health care costs, help individuals to make appropriate decisions, and incorporate employer coverage into their reform. This information is provided in five sections:

- The *Overview* contains a brief summary of the reform in each state, including a description of the environment in which each reform was enacted and how each plans to fund their reform.
- *Strategies to Increase Access to Coverage* identifies the strategies each used to expand access to coverage and how each state plans to administer its new coverage options.
- *Strategies to Contain Cost* examines the strategies each state implemented to contain costs, including many strategies designed to both contain cost and improve quality. More specifically this section includes information about the formal state plans and planning

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bodies each state developed to support this aspect of their reforms, as well as descriptions of the strategies each state implemented to limit institutional cost growth and reduce the administrative burden on providers.

- *Strategies to Support Personal Responsibility* examines the strategies these states implemented to support all people's responsibility to obtain coverage, make healthy choices, and seek appropriate care.
- *Strategies to Incorporate Employer Coverage* examines the roles these states created for business in the ongoing administration of the health reforms and the responsibility to help employees obtain coverage established in each reform.

Primary Sources of Information

The authors gathered the information presented in this report from a host of sources, but primarily from websites maintained by the three states. Unless otherwise indicated, these are the sources of information:

Maine

- The official website of Dirigo Health: http://www.dirigohealth.maine.gov
- The official website of the Maine Quality Forum: http://www.mainequalityforum.gov

Massachusetts

- The official website of the Commonwealth Connector: http://www.mass.gov
- MassHealth and Health Care Reform, maintained by Massachusetts's Medicaid agency: http://www.mass.gov

Vermont

- Vermont's Health Care Reform of 2006, a website maintained by Vermont's Agency of Administration: http://hcr.vermont.gov
- Catamount Health: The 2006 Health Care Affordability Act, a website maintained by the Vermont Legislature: http://www.leg.state.vt.us/HealthCare/catamount.htm

Overview of Reforms in the Three Study States

The reforms in the three study states all called for comprehensive reform, addressing access quality, and cost. There were, however, similarities and differences among the three study states in the environment in which the reforms were developed, the specifics of the reforms, and how the states planned to pay for the reforms, including the following.

- Each state had implemented previous reforms (including expanding Medicaid coverage) and in each there was a broad consensus that reform was needed.
- During their reform efforts all three states documented the amount of money that was being spent to provide care to the uninsured and underinsured. They also showed evidence that the money was being spent inefficiently because the uninsured were less likely to obtain preventive care and more likely to delay seeking care until an illness reached an advanced stage. Therefore, increasing the number of people with coverage was a means to making the health care system more efficient.
- The health care system on which each reform was based differed—and these differences shaped the reforms. For example, before the reform residents of Massachusetts had greater choice of insurer than those of Maine and Vermont.[8] This enabled Massachusetts to offer a greater choice of insurers through its reform then Maine and Vermont are able to offer.
- All three states fund (or plan to fund) the reforms with payments from individuals and families, payments from employers, and federal and state Medicaid/SCHIP funding. Each also identified other sources of funding.

Overview of Reforms in the Three Study States (continued)

Maine

In 2002 there was a broad consensus in Maine that health reform was needed but little agreement on what specific changes were needed. In Maine's 2002 campaign for Governor, then candidate (now Governor) John Baldacci pledged to develop a comprehensive plan that would address access, cost, and quality—including providing universal access to health insurance coverage. Both of his opponents and other organizations in the state each had their own reform plan. Also the legislature had recently created the Health Security Board to study and report on the feasibility of a single payer plan for Maine.[9]

State revenues began to fall before Governor Baldacci took office and he inherited a 20 percent budget deficit—leading many to doubt that health reform would be possible. Nonetheless, upon taking office the Governor created the Office of Health Policy and Finance (GOHPF) to lead the reform effort and appointed a Health Action Team (HAT) with representatives from business, consumers, purchasers, and government to help develop the reform plan. The GOHPF and the HAT crafted a plan that after negotiations with a variety of constituencies and passage through the legislature was enacted in 2003 as the *Dirigo Health Reform Act, An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs.*

Maine's Dirigo health care reform was specifically designed to address access, cost, and quality, and is now fully implemented. Maine's state-sponsored coverage, DirigoChoice, was implemented in January 2005. On April 2, 2007, the Dirigo Health Agency reported 13,832 members were enrolled in DirigoChoice as of March 2007. Since the program's inception, 24,688 people in Maine have obtained health coverage as a result of the reform. The reform called for a wide range of other actions, including:

- Creating a State Health Plan to set statewide goals for health care cost and quality,
- Creating the Maine Quality Forum to promote quality of care initiatives and educate providers and consumers about best medical practices and other quality of care indicators,
- Revising the Certificate of Need (CON) program and adding a capital investment fund to support reform goals,
- Implementing voluntary limits on the growth of premiums and health care costs, and
- Requiring electronic claims.

Maine, like Massachusetts and Vermont, funds its reform through a combination of payments from participants and employers, as well as Medicaid funding.

- Individuals and families who choose to join DirigoChoice pay premiums and cost-sharing amounts that vary based on income.
- Employers who participate in DirigoChoice also make payments to help pay the cost of their employees' coverage.
- Maine also uses Medicaid funding to help lower-income participants purchase DirigoChoice; and expand Medicaid to cover some parents of Medicaid-eligible children.

In addition, in 2004, the state provided $53 million in general revenue funds as start-up funding but in subsequent years planned to cover program costs through the Savings Offset Payment (SOP) created by the reform. The intent of the SOP is to recapture the savings generated by all elements of the Dirigo reform (including the savings generated by reducing the number of uninsured and underinsured people) and use that savings to purchase coverage for individuals through DirigoChoice. The SOP is an assessment on insurer's premium revenues and on the revenues of other organizations that administer coverage, such as self-funded employee health plans. The legislation requires the state to document savings in the health care system through an independent review by the superintendent of insurance before levying the assessments. It is important to note that the requirement for Maine to document the savings before assessing payment created problems with program funding because insurers (and others) contested the amount of savings the program generated.

Overview of Reforms in the Three Study States (continued)

Massachusetts

Massachusetts has a long history of health reforms intended to reduce the number of uninsured. Between 1985 and 2006 Massachusetts enacted eight key statutes related to health care reform into law, including a previous attempt at ensuring universal coverage that was passed in 1988 and repealed in 1996. Also, there was a broad consensus among stakeholders (including the Governor, legislators, businesses, and consumer representatives) that health reform was needed—and consumer advocacy groups were already taking action including promoting a ballot initiative to achieve universal coverage that would have levied a substantial payroll tax on employers.[10]

The Blue Cross Blue Shield foundation in Massachusetts played a role in preparing stakeholders for reform. For several years before the reform was enacted they had periodically convened stakeholders to discuss reform as part of their *Roadmap to Coverage* initiative and had also commissioned the Urban Institute to develop policy options for increasing coverage.

Finally, Massachusetts, at the time of the reform, was in danger of losing significant funding from the federal government ($385 million) upon the expiration of the waiver under which it operated its Medicaid program. This funding was redirected as part of the health reform and with the permission of the Federal government to expand access to insurance. This potential loss of federal funding was a major driver of the health care reform and was especially critical for, in effect, setting a time limit for reaching consensus on reform. All of these factors combined to enable the enactment, with bipartisan support, of *Chapter 58 of the Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care.*

Massachusetts enacted its health reform in April 2006 with the goal of "covering 95 percent of uninsured residents by 2009."[11] The reform is still in its early phase of implementation. Like Maine's Dirigo program, this reform called for coverage expansions and subsidies. In addition, Massachusetts's reform establishes an individual mandate and creates assessments and penalties for employers with more than 10 employees who do not offer employees adequate access to coverage. As of March 2007, over 52,000 people (many of which were previously served by an uncompensated care pool) were enrolled in Commonwealth Care. Commonwealth Care is the Medicaid expansion implemented as part of the reform. Commonwealth Care provides subsidized coverage to people with incomes under 300 percent FPL who are not otherwise eligible for Medicaid and are not offered subsidized coverage through an employer.[12] Massachusetts has not yet implemented its non-subsidized program for people with incomes over 300 percent of the FPL. Unlike Dirigo, Massachusetts's reform did not include explicit goals of addressing cost and quality. The law did establish and/or fund a number of commissions tasked with developing approaches for addressing costs and quality as follows:

- Health Care Quality and Cost Council
- Racial and Ethnic Health Disparities Council;
- Funded several public health initiatives, including some meant to address asthma and diabetes; and
- Embraced computerized prescription orders by Massachusetts medical providers.

The state provided $308 million in start-up funding from state general funds to support the new initiative during its first three years of operation.[13] Massachusetts anticipates that ongoing funding for the new initiative will be through a combination of payments from participants and employers, as well as Medicaid funding.

- Individuals and families who are eligible and choose to purchase coverage through the Connector (the public authority Massachusetts created to administer their new coverage) pay premiums that vary based on income and cost-sharing. Beginning in July 2007 individuals who have access to affordable coverage but do not purchase it will pay a penalty.
- Employers who choose to purchase coverage through the Connector also make payments to help pay the cost of their employees' coverage. Beginning in 2007 employers with more than 10 employees who do not offer their employees adequate access will also pay assessments and, under some conditions, penalties.

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Overview of Reforms in the Three Study States (continued)

- Massachusetts also uses Medicaid funding to help lower-income participants purchase Commonwealth Care and employer sponsored insurance (ESI) and expand Medicaid.

A final critical source of funding is Massachusetts newly created safety net pool. Massachusetts will, over a two-year period, redirect a significant portion of the total $1.3 billion funding in its safety net pool (a combination of federal Disproportionate Share Hospital payments and Medicaid waiver funds, and state funding) to purchase coverage for individuals through Commonwealth Care. However, it is anticipated that there will remain a need for some funding to continue to flow to the safety net system to support the care of people ineligible for the subsidized coverage. The state dollars that are contributed to the safety net come from the state's existing uncompensated care pool which is funded by assessments on hospitals and insurers, among other sources. It is anticipated that the federal funding will continue to be available through the Medicaid waiver to be used to purchase coverage for those who qualify for Commonwealth Care in future years. Massachusetts policymakers believe that, over time, the state will fund more individual coverage and fewer uncompensated care costs.

Vermont

Vermont, like Massachusetts and Maine, has a long history of efforts to address the issues of access, cost and quality. Several of these were important building blocks for the state's 2006 health reform. For example,

- In 2003 the legislature had directed the Secretary of Human Services to develop a state health plan that set "forth the health goals and values for the state." The Plan assesses needed and available resources and defines actions needed to achieve goals. It also guides the development of Vermont's health resource allocation plan.
- In 2005, Vermont had negotiated a Medicaid waiver with the federal government, called the Medicaid Global Commitment to Health. This waiver provides them with financial and administrative flexibility to cover services and people in Medicaid that they would otherwise be unable to cover, manage health care by focusing on health outcomes, and explore ways to reduce the number of uninsured.
- In 2006, Vermont was already engaged in implementing its Blueprint for Health which sets forth a plan for improving the prevention and treatment of chronic conditions. By 2006, the state had already,
  - Established a community-based chronic care management program in two hospital service areas, was funding its expansion to four more areas, and was providing grants to other communities to prepare for implementing the model,
  - Provided training to help over 300 people with chronic conditions better manage their own condition,
  - Begun to work with physicians to identify a common set of evidence-based guidelines for treating chronic conditions, and
  - Contracted with two private companies to develop a web-based chronic care patient information system.[14]

In Vermont there was also broad consensus that health reform was needed. For over two years, Governor Jim Douglas's administration had engaged in extensive negotiations with legislators and other stakeholders that resulted in the signing of several Acts that, together, form the base of Vermont's 2006 Reforms: *Act 190, An Act Relating to Catamount Health; Act 191, An Act Relating to Health Care Affordability for Vermonters; Act 142, SorryWorks!; Act 153, Safe Staffing and Quality Patient Care;* and *Act 215, Appropriations Bill.* The legislature also formed the Health Care Reform Commission to oversee all aspects of the reform.

Vermont enacted its health reform in May 2006 to, "Control the rising cost of health care by better managing chronic care and making health care affordable and accessible for all." The reform is still in an early phase of implementation. Like Maine and Massachusetts this reform called for coverage expansion and subsidies. In October 2006 three insurance carriers submitted letters of intent to offer Catamount Health (the new state-sponsored coverage created by the reform). The state anticipates approving two of these carriers to begin offering the coverage in October 2007. The reform calls for a wide range of other actions, including the following:

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Overview of Reforms in the Three Study States (continued)

- Making chronic care management available to all, regardless of source of coverage,
- Requiring hospitals to report medical errors and hospital acquired infections,
- Creating a multi-payer database to provide consumers with information on price and quality, and
- Coordinating the implementation of information technology, including the development of statewide electronic health records and common claims forms and procedures.

Vermont estimates that the cost of the reforms to the state over four years will be $1.9 million in 2007, $21.6 million in 2008, $32.4 million in 2009, and $39.3 million in 2010. Vermont anticipates that these costs will be offset by payments from participants and employers, as well as Medicaid and tobacco funding.

- Individuals and families who choose to purchase Catamount Health coverage pay premiums and cost-sharing amounts that vary based on income.
- Beginning in 2007 employers who do not offer their employees health insurance or who have employees who do not have coverage will pay an assessment based on the number of uninsured employees.
- Vermont plans to use Medicaid funding to help lower-income participants purchase Catamount Health and ESI, expand Medicaid, and lower premiums for Medicaid beneficiaries who participate in the Vermont Health Access Program and children who participate in Dr. Dynasaur (the state's SCHIP program).
- Vermont plans to use a 60¢-per-pack increase in the state's cigarette tax and payments that tobacco manufacturers will make to the state beginning in 2008 to help fund their reforms.

Strategies to Increase Access to Coverage

The reforms in the three study states had a stated goal of improving access to coverage. All three of the study states depend on three strategies for increasing access to coverage: creating new state-sponsored coverage, expanding existing Medicaid/SCHIP programs, and reforming the private market (Table 1). All three states are also working to ensure that people who qualify for coverage take up that coverage.

Although all three states used the same general strategies to expand access there are some important differences among these approaches. For example, there was a great variety in the type of small group and individual market reforms in each state. For example: Massachusetts merged the two markets, Vermont will provide financial assistance to carriers in the individual market, and Maine asked insurers to voluntarily limit their operating margins. (See Table 1, next page)

TABLE 1: STRATEGIES TO INCREASE ACCESS TO COVERAGE

MAINE	MASSACHUSETTS	VERMONT
STATE-SPONSORED COVERAGE		
DIRIGOCHOICE • Comprehensive coverage for employees of employers with less than 50 employees, self employed/sole proprietors, and individuals. • Offered by Anthem BC BS of Maine under a contract with the Dirigo Health Agency. Brokers are primary distribution channel for coverage. • State will subsidize cost of coverage for participants with incomes of no more than 300% FPL. Participants who qualify for Medicaid but choose to enroll in DirigoChoice do not pay premiums nor pay most cost-sharing. • Enrollment began 1/05, as of 3/07, 13,832 people were enrolled.	**COMMONWEALTH CARE** • Subsidized, comprehensive coverage for qualified residents who have incomes of no more than 300% FPL. • Offered by four health plans currently providing coverage to Medicaid beneficiaries. • Coverage and cost varies by family income and plan. Participants with family incomes of 100% FPL or less do not pay premiums. • As of 3/07 over 52,000 people were enrolled (many transferred from existing uncompensated care pool). **COMMONWEALTH CHOICE** • Non-subsidized, comprehensive coverage for qualified residents with incomes over 300% FPL. • Coverage and cost varies by plan, within limits established by the state. • As of 2/07, seven insurers selected for participation. • Enrollment to begin 5/07 for coverage effective 7/07.	**CATAMOUNT HEALTH** • Comprehensive coverage for uninsured Vermonters. • Will be offered by at least two private insurers (if no insurer volunteers then the state will require one to offer). • Insurers and brokers expected to begin selling policies 10/07. • Participants pay premiums based on income. • Participants pay cost-sharing for services, but have no cost sharing for preventive care or chronic care. • State will subsidize cost of coverage for participants with incomes of no more than 300% FPL.
MEDICAID/SCHIP		
• Expanded Medicaid/SCHIP to cover parents (Medicaid) and children (SCHIP) from families with incomes up to 200% FPL.	• Expanded SCHIP to cover children with family incomes up to 300% FPL. • Expanded the employer partnership program to 300% of the FPL. The partnership uses Medicaid funding to subsidize qualified employer coverage for children and adults with family incomes of no more than 300% FPL who work for employers with no more than 50 employees. • CMS had informed the state that it was not going to be allowed to continue an arrangement providing funding to two hospitals that had, historically, served a disproportionate share of Medicaid beneficiaries and the uninsured. Reform redirected the funding to provide subsidies towards coverage to individuals.	• Seeking permission from CMS to expand Medicaid to cover adults up to 300% FPL who would enroll into Catamount Health or employer coverage. • Offers adults premium assistance that uses Medicaid funding to subsidize qualified employer coverage and Catamount health coverage. • Some higher-income beneficiaries required to pay premiums. • The reform provided funding to reduce the premiums paid by some Medicaid and SCHIP program participants (VHAP and Dr. Dynasaur). • The reform provided funding for outreach activities to ensure that those eligible for Medicaid/SCHIP enrolled into the programs.
SMALL AND INDIVIDUAL MARKET REFORMS		
• Increased oversight of insurers, including expanded Bureau of Insurance rate review, required annual report from insurers, and actuarial certification for large-group carriers required to file actuarial certification. • Insurers and providers asked to voluntarily limit operating margin to 3.5%. • Individuals and small groups that purchase coverage through DirigoChoice pay the same price for the same coverage (in effect merging the two markets for participants.)	• Merge individual and small group markets. • Create insurance products for young adults (19-26). • Extend dependent coverage through age 25. • More flexibility in insurance market, such as permitting deductible levels consistent with federal Health Savings Accounts (HSA) laws. • Imposes moratorium on new mandated benefit legislation until 1/08.	• Provides assistance (reinsurance) to insurers in individual market to reduce premiums by 5%. State has created the Non-Group Market Security Trust to administer this program. (Governor proposing additional funding to reduce premiums by 11%.) • Study to determine feasibility of merging the individual and small group markets. • Allows insurers to offer discounts for 'healthy lifestyles'.

Administering Agency

Maine and Massachusetts both elected to create new agencies or authorities to administer the new programs while Vermont chose to use existing agencies (Table 2). Further, Massachusetts's new authority (the Connector) is also designed to aggregate employer contributions for employees with multiple employers, increase the health plan choices available to employees of small businesses, enable individuals to retain coverage when they change jobs, and to enable employed individuals to pay premiums with before-tax income.

TABLE 2: ADMINISTERING AGENCY

MAINE	MASSACHUSETTS	VERMONT
DIRIGO HEALTH AGENCY	**COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY**	**DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION (BISHCA)**
• Independent agency governed by a Board of Directors. • Administers DirigoChoice, operates the Maine Quality Forum, and collects the Savings Offset Payment. • Employers with 50 or fewer employees, the self-employed/sole proprietors, and individuals may purchase coverage through the agency.	• Independent authority. • Offers both Commonwealth Care and Commonwealth Choice. • Non-working people, employees of large employers who do not have access to employer coverage, and employers with 50 employees or fewer can purchase coverage through Connector. • Participants can retain coverage when changing jobs. • Can aggregate employer contributions for employees with multiple employers.	• Existing state agency that regulates health insurance. • Coverage will be offered through existing channels by private insurers as part of the small group market (uninsured individuals may join). • If no insurer voluntarily develops package, BISHCA may require one of two plans doing business in the state to offer the coverage.
		REFORM COMMISSION
		• Will review for cost-effectiveness in 2009 and may move to self-insured plan.

Strategies to Contain Cost

A major thesis in these health reform efforts is that expanded coverage and improved systems can be used to help bring poorly-controlled costs into a more rational system that will limit future spending and reduce cost-shifting to the privately insured. Maine, for example, reported in 2004 that it estimated that bad debt and charity care to the uninsured and underinsured cost the state over $275 million a year, and that an expansion of health insurance to more people would reduce the burden of cost-shifting on insurance premiums. Vermont estimates that spending on chronic conditions represents 70 percent of the cost of health care in the state. The three states have undertaken various efforts to control uncompensated care, especially as it relates to hospital care, align health information systems to reduce administrative costs, and improve the transparency of health care costs and quality.

Convening Planning/Advisory Bodies

Each state has adopted a slightly different focus in regard to cost containment, but all have adopted the notion of vigorous planning and advisory groups (Table 3). Maine's efforts include limiting the rate of medical cost growth through a review of large proposed capital investments, as well as a voluntary limit on the rate of growth in provider and insurer costs and operating margins. Vermont is focusing on improving the provision and coordination of chronic disease management services. Massachusetts' Health Care Quality and Cost Council convened in August 2006. The Council has yet to produce any public documents, but it is working to develop strategies to improve quality and constrain health care costs.

TABLE 3: HEALTH CARE PLANS/PLANNING BODIES

MAINE	MASSACHUSETTS	VERMONT
• Biennial state health plan, directed by 11-member advisory council, • Assesses needed and available resources, • Sets statewide goals for health care access and cost containment, • Establishes a budget directing health care expenditures statewide. • Public Purchasers Steering Committee established to coordinate collaborative purchasing of health services by public entities.	• A 13-person health care quality and cost council, which is advised by a broad-based committee, began meeting in August 2006 to, • Establish quality improvement and cost containment goals, including reductions in racial and ethnic disparities, • Contract with an independent health care organization to analyze data across the health care continuum, • Develop performance measurement benchmarks.	• State health plan, produced in 2005 with guidance of 13-member advisory committee to the Vermont health resources allocation plan and 8-member executive committee of the Vermont Blueprint for Health. • Required under 2003 State Law, to set "forth the health goals and values for the state," • Assesses needed and available resources and defines actions needed to achieve goals, • Guides development of health resource allocation plan.[15]
		• *Blueprint for Health* prevention and chronic disease management plan seeks to standardize disease management across all payers and providers, including Catamount Health and Medicaid programs.

Limiting Institutional Cost Growth and Administrative Burdens on Providers

A major component of cost containment efforts in the three states is gaining better control over expenditures by providers, especially hospitals (Table 4). All three states' reform efforts attempt to make hospital and provider practices more transparent—focusing on capital expenditures, cost-shifting, quality, pricing, and interoperability of electronic records.

TABLE 4: STATE REFORM IMPACTS ON PROVIDER PRACTICES

MAINE	MASSACHUSETTS	VERMONT
HOSPITAL AND INSTITUTIONAL PLANNING		

• Strengthening Certificate of Need process for high-cost expenditures:
  • Major medical equipment over $1.2M,
  • Capital expenditures over $2.4M,
  • New services requiring more than $110,000 in capital expenditures,
  • New services with third year expenses over $400,000.
• Established a Capital Investment Fund to establish a statewide budget for capital expenditures. 9-member Commission to Study Maine's Hospitals issued final report in 2005 The report examined hospital finances, structures, roles, reimbursement, capital, technology, staffing needs, etc.
	• Hospital rate increases to be made contingent on hospital adherence to quality standards and achievement of performance benchmarks.	• Undertaken "cost shift review" to
		  • Expand hospital reporting of cost shift,
		  • Establish task force to examine cost shift,
		  • Establish process to create a uniform uncompensated care policy for hospitals.

IMPROVED PUBLIC DISCLOSURE BY PROVIDERS		
• Hospitals and providers required to disclose average charges for the most common 15 inpatient and 20 outpatient services, and provide this list if requested by patients. • Statewide list is available on Dirigo website; more will be available on Maine Quality Forum website.	• Health Care Quality and Cost Council will establish a consumer health information website, including comparative provider cost and quality information, average insurance payment rate by type of procedure, and patient safety and satisfaction measures.	• Multi-payer database and consumer price and quality data reporting. • Improved medical event reporting. • "Sorry Works!" attempt to replace medical malpractice suits with oral apology/explanation of how medical errors occurred.
ADMINISTRATIVE AND PAPERWORK SIMPLIFICATION		
• Requires electronic claims submission, data exchange, referral submission/approval, and eligibility verification.	• $5M appropriation for the initial implementation of computerized prescription order entry system.	• Establishment of common claims and procedures, common credentialing, HIT coordination.
LIMITS ON PROVIDER COST GROWTH		
• Requests hospitals to voluntarily limit cost growth to 3% and operating margins to 3.5%.		

Strategies to Support Personal Responsibility

The decisions we all make every day about whether to go to the doctor, what to eat, whether to exercise, and so forth, as well as decisions about whether to purchase health coverage (and which coverage to purchase) impact our health. These decisions also ultimately impact not only our own health, but the overall cost of health care. Recognizing this, the three study states have, as part of their health care reforms, sought to encourage residents to make the 'right' decisions—to obtain coverage, to seek preventive care, to choose a healthy lifestyle, and to better manage chronic conditions (e.g., diabetes, asthma, etc.).

Supporting People's Responsibility to Obtain Coverage

One of the purposes of the health care reform in all three states was to support individuals in their efforts to obtain coverage by making affordable, comprehensive coverage available to all residents. Massachusetts, believing that a voluntary program would fail to achieve its goal of universal coverage has gone beyond this. This state will soon require residents to obtain coverage or incur financial penalties (Table 5).

TABLE 5: REQUIREMENTS FOR INDIVIDUALS TO OBTAIN COVERAGE

MAINE	MASSACHUSETTS	VERMONT
REQUIREMENTS TO OBTAIN COVERAGE		

• No requirement, but seeks to make comprehensive care affordable.
• Considering implementing individual mandates for those with incomes over 400% FPL (recommended in 1/07 by Blue Ribbon Commission on Dirigo Health).
	• As of July 1, 2007 all Massachusetts residents age 18 and older must have creditable coverage. Those without coverage
	  • Lose their personal state income tax exemption—full if filing individually; half if filing jointly,
	  • Pay a penalty for each uninsured month, starting 1/08.
	• Individuals may be exempted from the requirement due to religion or if they do not have access to affordable coverage.
	• The Connector will establish affordability guidelines and an appeal process.
		• No requirement, but seeks to make comprehensive care affordable.
		• Legislation gives legislature option for individual mandate if insured rate is less than 96% in 2010.

Supporting People's Responsibility to Make Healthy Choices and Seek Appropriate Care

The cost of health care, overall and for individuals, is affected by individual choices in maintaining health and seeking care. All three states included elements in their health reforms to encourage residents to seek preventive care (Table 6). For example, all three states cover preventive services in their state-sponsored coverage—and neither Maine nor Vermont require cost-sharing for those services. These states' reform efforts also place a heavy emphasis on helping consumers make more informed decisions about health care treatments by providing them with information about cost, quality, and best practices.

Finally, these states have included strategies meant to help people with chronic conditions better manage those conditions in their health care reforms. Vermont's efforts in this area are the most extensive. This state's reforms, which build on its previous work in this area, not only feature a commitment to make their community-based model of chronic care management available to all Vermonters, but also establish payments for providers that support improved delivery of chronic care services, create incentives for residents to join the chronic care program, and provide those with chronic care needs information to help them better manage their own care.[16] (See Table 6, next page)

Strategies to Support Personal Responsibility (continued)

TABLE 6: STRATEGIES TO PROMOTE PERSONAL RESPONSIBILITY AND HEALTHY LIFESTYLES

COVERAGE

MAINE

DIRIGOCHOICE

- Covers preventive services (e.g., physicals, mammograms, and well-baby care) with no cost-sharing requirements.
- $100 incentive to participants for selecting and seeing primary care physician and completing health risk assessment.
- Includes mental health parity requirement.
- Discounted health club memberships available.

MEDICAID

- Piloting care management program for high utilizers.

OTHER COVERAGE

- Considering requiring insurers to give premium discounts for worksite wellness programs and to non-smokers (recommended in 1/07 by Blue Ribbon Commission on Dirigo Health).

MASSACHUSETTS

COMMONWEALTH CARE

- Covers preventive services.
- Covers diabetes management.
- Carriers all offer additional benefits such as smoking cessation classes and discounted health club memberships. Specifics vary by plan.

COMMONWEALTH CHOICE

- Will cover preventive services, some plans do not charge co-pays for preventive physician visits.

MEDICAID

- New smoking cessation (implemented) and wellness benefits (under development).

ALL COVERAGE

- Carriers permitted to vary insurance product rates by smoking status.

VERMONT

CATAMOUNT HEALTH

- Will cover preventive services, with no cost-sharing.
- Will have chronic care management program and no cost-sharing for chronic care services provided to people in program.

MEDICAID

- Will create chronic care management program.
- Will restructure payment to providers to improve chronic care.

OTHER COVERAGE

- Insurers in individual and group markets may offer discounts of up to 15% of premium for compliance with health promotion program.
- Plans approved for premium assistance will be required to have chronic care management program and no cost-sharing for chronic care services provided to people in program.

OTHER

MAINE

- State health plan establishes community goals to improve chronic care, including improving it through prevention.
- Develop "Contract for Better Health" to encourage individuals to make a written commitment to another party to make a change to improve their health.
- Make quality and price information broadly available through Maine Quality Forum website and other means.

MASSACHUSETTS

- Funded public health/prevention efforts on conditions such as diabetes and cancer.
- Will improve availability of cost and quality information to help consumers make informed decisions (under development).

VERMONT

- Builds on *State Health Plan and BluePrint for Health*, which were already in existence at time of 2006 reform, activities completed include
  - Grants to communities employing a comprehensive approach and promoting wellness across community and lifespan (2 implemented before 2006; 4 additional funded in 2006),
  - Over 300 people trained in self-management of chronic disease in 2006.
- Will improve availability of cost and quality information to help consumers make informed decisions.

Strategies to Incorporate Employer Coverage

Employers are a major source of coverage in the United States. Nationally, about 61 percent of non-elderly Americans had health coverage through their employer in 2005. The rate of employer coverage in the primary study states was, in 2005, 59 percent in Maine, 67 percent in Massachusetts, and 59 percent in Vermont.[17] Because employers are a major source of coverage (and payment for coverage) the three study states each designed reforms that were intended to maintain, and, ideally, expand that type of coverage.

All of the states involved employers (and employee representatives, such as workers' unions) in the design of their reforms and created roles for them in the ongoing administration of their reforms. These states also considered how to structure their state-sponsored coverage to encourage employer participation. For example, Massachusetts and Vermont are both establishing modest financial assessments and/or penalties for employers who do not offer coverage.

Creating Roles for Businesses in Ongoing Administration

Including representatives of businesses is an important method of ensuring that state health reforms help businesses and their employees' access affordable, quality coverage. All three states included business representatives on the Boards and advisory committees that guide/oversee the implementation and operation of their reforms.

- In Massachusetts the reform legislation specified that businesses would be included on the Connector's board and on the advisory committee to the Health Care Quality and Cost Council.
- Maine includes business representatives on almost all of the boards that oversee the various reform activities, including the Dirigo Health Agency Board and Maine Quality Forum Advisory Council.
- Vermont includes business representatives on many of the Task Forces and Boards connected with the health care reform, including the Blueprint Executive Committee, the Common Claims Workgroup, and the Cost Shift Task Force.

Establishing Responsibilities for Employers in Obtaining Coverage for Employees

None of the three states require employers to participate in the state-sponsored coverage. Both Massachusetts and Vermont, however, have established financial assessments and/or penalties for employers who do not offer coverage to their employees (Table 7). Massachusetts also established penalties for employers who do not provide access to pre-tax payment of premiums for their employees. This penalty is based on the amount and cost of the care the uninsured employees of such firms use and must meet a threshold of more than $50,000 of state-sponsored care. It is, however, important to consider this information in light of Massachusetts's individual mandate, which was discussed in the previous section.

TABLE 7: EMPLOYER RESPONSIBILITIES

MAINE	MASSACHUSETTS	VERMONT
• Employers with less than 50 employees, including the self-employed and sole proprietors, may join DirigoChoice. • Employers that join DirigoChoice must pay at least 60% of the premium cost for their employees. • *State Health Plan* developed as part of health care reform calls for creation of a program to recognize and promote best practices in employer wellness programs. • Considering requiring employers to offer coverage (recommended in 1/07 by Blue Ribbon Commission on Dirigo Health).	• Employers with fewer than 50 employees may obtain coverage through the Connector • Employers with more than 50 employees may obtain coverage through the Connector for their seasonal, temporary, or part-time employees. • Requires employers with more than 10 full-time employees to create "cafeteria plans" that enable employees to use pre-tax dollars to pay health insurance premiums. • Employers with more than 10 employees that fail to (1) insure at least 25% of full-time employees or (2) Offer to contribute 33% of a full-time employee's individual premium will pay the fair share penalty of $295 per employee per year. • Employers with more than 10 employees who do not offer a cafeteria plan will incur a 'free rider' penalty if an uninsured employee or dependents receive state-funded services above $50,000).	• Employers with uninsured employees pay a $91.25 quarterly assessment based on number of uninsured FTEs (with exemptions of 8 FTEs phased down to 4 FTEs by 2010).

Summary

Maine has demonstrated a sustained commitment to comprehensive health reform, including the implementation of its Dirigo health reform in 2003. The purpose of this report is to inform the on-going effort to improve health care in Maine by providing an overview and comparison of Maine's reforms with those enacted in Massachusetts and Vermont in 2006. This examination of the reforms in these three states reveals the following.

- Maine was the first state to enact and implement a comprehensive health reform dedicated to, simultaneously, increasing access to affordable, comprehensive coverage, improving quality, and containing costs for all state residents.
- Maine, Massachusetts, and Vermont are not seeking to replace the current health care system but rather to improve it. There is evidence of this incremental approach in many areas of these states' reforms. All three states, for example, see employer-based coverage as a critical element in expanding and financing access to coverage, expanded their existing Medicaid and/or SCHIP programs as part of their health care reforms, and incorporated the insurance carriers that were already delivering coverage in their new state-sponsored coverage.
- Maine's reform, which was enacted in 2003, relies mostly on incentives to ensure that all individuals and employers fulfill their responsibilities in obtaining coverage and seeking appropriate care. In 2006, however, Massachusetts and Vermont both enacted reforms that include incentives for employers and individuals—and also include the possibility of penalties for both groups.
- Maine, Massachusetts, and Vermont all subsidize the cost of coverage for people with incomes of no more than 300 percent FPL. The exact amount of the subsidy varies based on family income and those with the lowest incomes are exempted from paying premiums and most cost-sharing.
- Maine, Massachusetts, and Vermont all used the cost of providing care to the uninsured and underinsured as a justification for implementing health reforms. All three states documented the amount of money that is going to provide care to the uninsured and underinsured. They also showed evidence that the money was being spent inefficiently because the uninsured were less likely to obtain preventive care and more likely to delay seeking care until an illness reached an advanced stage. Therefore, increasing the number of people with coverage was a means to making the health care system more efficient.

Endnotes

1 Although New York enacted health care reform legislation in 2000 (referred to as Healthy New York) that reform, unlike those in Maine, Massachusetts, and Vermont is not comprehensive but focuses solely on making premiums more affordable for small employers, sole proprietors and individuals. Source: Katherine Swartz, *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (New York, NY: The Commonwealth Fund November 2001) Retrieved 22 March 2007. http://www.ins.state.ny.us/website2/hny/reports/hnystudy.pdf.

2 Dirigo Health. *Timeline and Milestones.* State of Maine. Retrieved 22 March 2007. http://www.dirigohealth.maine.gov/dhsp01c.html#passes.

3 Jill Rosenthal and Cynthia Pernice. *Dirigo Health Reform Act: Addressing Health Care Costs, Quality and Access in Maine.* (Portland, ME: NASHP 2004) Retrieved 8 March 2007. http://www.nashp.org/Files/GNL_56_Dirigo_brief.pdf.

4 Maine Governor's Office. *Executive Order No. 18 FY 06/07. An Order to Amend the Order Regarding Dirigo Health Reform.* Retrieved 8 March 2007. http://www.maine.gov/tools/whatsnew/index.php?topic=Gov+News&id=29304&v=Article-2006.

5 In 2006 other states implemented more incremental approaches, such as reforms meant to increase coverage for employees of small businesses (Arkansas, New Mexico, and Rhode Island), or cover all children (Illinois and Pennsylvania)

6 In this report, ***state-sponsored coverage*** includes state initiatives in which a state (1) offers coverage directly to residents, (2) helps employees purchase the coverage offered by employers (e.g., premium

assistance), and (3) helps contain the cost of private coverage by spreading the cost of services provided to some or all people who need expensive care among all insurers or even more broadly (e.g., high risk pools). States choose whether they will subsidize this type of coverage, how people will learn of the coverage, and how the coverage will be delivered.

7 The *Federal Register* publishes poverty guidelines that establish the federal poverty level (FPL) for Medicaid and SCHIP each year. The FPL varies by family size and residency. In 2006 a family of three living in one of the 48 contiguous states with an income of $16,600/year was considered to have an income of 100% of the federal poverty level. *Federal Register*: January 24, 2006 (Vol. 71, No. 15) Page 3848-3849. Retrieved 8 March 2007. http://aspe.hhs.gov/poverty/06fedreg.htm.

8 In 2005 there were eight HMOs operating in Massachusetts compared to three in Maine and two in Vermont Source: The Henry J. Kaiser Family Foundation, www.statehealthfacts.org. Number of HMOs, July 2005. Retrieved 12 March 2007. http://www.statehealthfacts.org.

9 The information in this section was drawn from two sources: (1) Jill Rosenthal and Cynthia Pernice. *Dirigo Health Reform Act: Addressing Health Care Costs, Quality and Access in Maine.* (Portland, ME: NASHP, 2004) Retrieved 8 March 2007. http://www.nashp.org/Files/GNL_56_Dirigo_brief.pdf. (2) Trish Riley. *Dirigo Health: Maine's Health Reform Law; A Speech before the National Academy for State Health Policy's 16th Annual State Health Policy Conference*, August 3, 2003. Retrieved 8 March 2007.

10 Most of this information was drawn from two sources (1) John McDonough. *The Politics of Creating and Sustaining Comprehensive Health Coverage Initiatives*, Webcast presentation, February 5, 2007. Retrieved 8 March 2007. http://www.nashp.org/Files/Presentation_packet_2-5-07.pdf. (2) *Community Catalyst. Massachusetts Health Reform: What it does; How it was done; Challenges ahead.* (Boston, MA: April 2006). Retrieved 2 April 2007. http://www.communitycatalyst.org/resource.php?base_id=1023

11 Helman, Boston Globe, 4/4, referenced in KaiserNetwork.org Daily Reports April 5, 2006. Retrieved 8 March 2007. http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=36435.

12 In addition, one reviewer reported that about 60,000 more people have joined MassHealth (the part of the state's Medicaid program that existed before the reform) since the reform's enactment. Source: John McDonough, Personal communication to Neva Kaye, March 26, 2007.

13 Kaiser Commission on Medicaid and the Uninsured. Massachusetts Health Care Reform Plan, Fact Sheet. (Kaiser Family Foundation, April 2006). Retrieved 2 April 2007. http://www.kff.org/uninsured/upload/7494.pdf

14 Much of the information in this section was drawn from the following two sources, in addition to those identified in the "Primary Sources" section: (1) Vermont Department of Health. *Vermont State Health Plan: A Model for Lifelong Prevention and Care.* (2005). Retrieved 2 April 2007. http://healthvermont.gov/pubs/health_plan05.aspx. (2) Vermont Department of Health. *Vermont Blueprint for Health*, 2007 *Legislative Update.* January 2007. Retrieved 2 April 2007. http://healthvermont.gov/admin/legislature/documents/VTBlueprint2007.pdf.

15 Vermont Department of Health. *Vermont State Health Plan: A Model for Lifelong Prevention and Care.* (2005). Retrieved 2 April 2007. http://healthvermont.gov/pubs/health_plan05.aspx.

16 Vermont Department of Health. *Vermont Blueprint for Health, 2007 Legislative Update.* January 2007. Retrieved 2 April 2007. http://healthvermont.gov/admin/legislature/documents/VTBlueprint2007.pdf.

17 Kaiser StateHealthFacts.org. Health Insurance Coverage of Nonelderly 0-64, states (2004-2005), U.S. (2005). Retrieved 8 March 2007. http://statehealthfacts.org.