Can it Work? Three New England states have made bold reforms in how we provide health care in America. What can we learn from their lead?

Health reform swept the nation’s capitals in 2007 with at least 28 states considering new laws or discussing proposals to change the system—some inching toward the goal of universal coverage and others taking a giant step. Leading the way for this somewhat uncharted course are three New England states: Maine, Massachusetts and Vermont.

Maine led the most recent wave of health reform in 2003. The goal of Maine’s Dirigo Health is to contain costs and improve the quality of care, aiming for universal coverage by 2009. Taking its name from the Latin state motto that means “I lead,” Dirigo is a statewide plan for improving and changing the health care system. It requires public disclosure of prices for medical services, simplification of administrative functions, reductions in paperwork, and voluntary limits on the growth of health insurance premiums and health care costs. The state also established the Maine Quality Forum to promote better quality of care and DirigoChoice to offer affordable, partly subsidized health insurance to small businesses and those without employer-sponsored insurance.

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On April 12, 2006, Massachusetts enacted legislation aiming for near-universal health insurance coverage. The law distributed responsibility for coverage among individual state residents, who are required to purchase health insurance; the government, which offers new subsidies to ensure affordability; and employers, who pay an assessment for uninsured employees. “Health care reform could not be achieved unless we adhered to the principle established in our Massachusetts Constitution of shared responsibility,” House Speaker Salvatore F. DiMasi says.
“Our commitment to this principle ensured the passage of our health reform bill.”

The Massachusetts law also creates the Commonwealth Health Insurance Connector, which, among other things, assists small businesses and individuals in navigating the insurance marketplace.

One month later, Vermont adopted health reform legislation designed to make affordable health insurance more available, improve the quality of health care and control costs. Two key components of this reform are subsidized health insurance for low-income Vermonters and a statewide effort to improve health care by managing chronic diseases. Employers in Vermont will also be assessed for certain uninsured employees.

With health care reform still high on almost every state’s legislative agenda, what have we learned from these three states?

COVERING THE UNINSURED

The foundation of coverage in Maine, Massachusetts and Vermont is an expanded Medicaid and SCHIP program. Each state covers the poorest of the uninsured with these publicly funded programs—beyond levels that are covered in many other states. For people above the eligibility levels, the states created health insurance programs that are publicly subsidized on a sliding scale based on income.

The centerpiece of the Maine reform is DirigoChoice, an insurance plan for businesses with 50 or fewer employees, self-employed and individuals. The state projected initial enrollment for this program to be around 30,000 with an overall goal of universal coverage by 2009. To date, the plan has enrolled about half that amount, many of whom were already insured. Although enrollment numbers are lower than the state planners hoped, the DirigoChoice insurance plan has grown faster than any in Maine’s history, according to Representative Ann Perry, co-chair of the Health and Human Services Committee.

Maine found that financing health reform can be the Achilles’ heel. Maine has struggled with the primary financing mechanism for Dirigo—a “savings offset payment (SOP)” program. The Dirigo board of directors determines the aggregate measurable cost savings in the health care system, which is then filed with the superintendent of insurance, who makes the final determination. Under this system, health insurers and self-funded plans pay a claims assessment that changes each year depending upon this agreed upon savings. The system has been challenged in court and upheld, but the real problem has been in the determined amount of savings, which has been less than projected.

“This year the Bureau of Insurance has determined that Dirigo saved the system around $40 million, which translates into a tax of 1.74 percent that is paid on all health insurance claims in the state,” says Senator Peter Mills. That is far less than the Dirigo board of directors was hoping for—they filed for about $70 million—and not enough money to cover all residents eligible for the program. Because of this, enrollment in DirigoChoice has been capped. “The SOP system is withering away, which threatens the survival of this program,” Mills says.

DirigoChoice, which has voluntary enrollment, combines individuals and small groups in the same risk pool. It became clear as enrollment began that there would be a substantial demand among individuals for the new insurance product. A few more than 77 percent of the enrollees are individuals and sole proprietors, which makes them higher risk and costlier to cover. Because everyone is in the same risk pool, the small-employer groups help to cross-subsidize the high-cost individuals making their insurance premiums higher than expected.

“Small businesses can get insurance on the private market that is less expensive and doesn’t come with the requirements imposed by Dirigo,” says Mills. In DirigoChoice, small employers are required to pay 60 percent of their employee’s premium and the coverage is very comprehensive. “The lack of employer participation hurts the bottom line,” adds Mills, since funding projections were based on models that estimated more payments from small employers.

“One needs incentives or mandates to make the pool big enough to achieve economies of scale and also include high- and low-risk individuals,” says Debra Lipson, senior researcher at Mathematica Policy Research. Which is
The Problem of the Uninsured

There are 46.6 million uninsured people in the United States—an increase of 1.3 million people since 2004, according to the Census Bureau. That amounts to about one in every six Americans. Most have incomes below 200 percent of poverty, but they are likely to be employed or have an employed family member. At least half are racial or ethnic minorities.

Why the increase? The rise can be largely attributed to the decline in employer-sponsored coverage because of the rising cost of health plans. Although health care cost increases have leveled in the past three years, the growth rate still outpaces that of inflation and wages, making health insurance premiums unaffordable for many.

“In Massachusetts, many factors contributed to the need for our reform, but the skyrocketing health insurance costs that are prohibitively expensive for our families was the biggest driver,” says Representative Salvatore DiMasi, speaker of the House. The uninsured were costing the state about $1 billion each year, he says.

In 2007, most states considering health reform included covering the uninsured as a top priority. Some use public programs, like Medicaid and the State Children’s Health Insurance Program (SCHIP), while others focus on private market reforms. Most use a combination of both.

exactly what Massachusetts did in 2006.

MANDATING HEALTH INSURANCE COVERAGE

Taking lessons from Maine, the Massachusetts reforms include a first-in-the-nation requirement that all individuals aged 18 years and older obtain health insurance, if it is affordable to them as determined by an annual schedule of affordability. A penalty will be imposed for not having insurance by the end of this month—those remaining uninsured will lose their personal income tax exemption, which amounts to approximately $219. For the 2008 tax year and beyond, the penalty is scheduled to increase to half of the premium of the least expensive plan afford-
able to the individual.

Because research and experience show that a voluntary insurance system will not yield full participation; the mandate was considered critical to reaching universal coverage.

“We knew that we could not make reform work without asking individuals to take some responsibility for making sure they have health insurance,” says Representative Patricia Walrath, House chair of the Joint Committee on Health Care Financing, who was a leader in developing the legislation.

To help ensure the success of mandatory health insurance, Massachusetts made other reforms. For example, the non- and small-group markets were merged, which, according to a special commission created to study the impact, is expected to reduce current individual rates by 15 percent and increase small-group rates by only 1 percent to 1.5 percent.

After Massachusetts passed its reform law, Maine soon began talking about reforming its plan. Enter the Maine Blue Ribbon Commission on Reforming Dirigo, created in May 2006. One of the many items discussed by the commission was making insurance more affordable. Recommendations from the commission include a health insurance mandate for people with incomes greater than 400 percent of the federal poverty guidelines.

Taking a slower, more cautious approach, Vermont chose not to mandate coverage unless goals aren’t met by 2010. The state created comprehensive and affordable health insurance for uninsured people with the cost dependent on the household income. “If we haven’t reached a 96 percent coverage rate by 2010, the state will consider an individual mandate,” says Susan Besio, director of Health Care Reform Implementation in Vermont. Currently, 89.5 percent of Vermonters are covered.

THE MASSACHUSETTS CONNECTOR

Another first from Massachusetts is the creation of the Commonwealth Health Insurance Connector Authority, charged with developing regulations to determine the annual affordability schedule and what will qualify as health insurance coverage. “We run a couple of insurance programs,” says Jon Kingsdale, director of the Commonwealth Health Insurance Connector Authority. “One is subsidized for the low-income uninsured at or below 300 percent of the federal poverty level. And the other is a group of more than 40 products that are private, unsubsidized health insurance, particularly for uninsured individuals who are going to be buying out of their own pocket.”

A big piece of what the “connector” does is organize and create a one-stop shopping center for health insurance. It began enrolling individuals who make up to 300 percent of the federal poverty level in October 2006. After 11 months, there were about 115,400 enrolled, 92,000 of whom pay no premiums at all. Further, uncompensated care spending had decreased by 9 percent, and is trending downward. Enrollment in the nonsubsidized plans began in May 2007, and continues to exceed projections.

Massachusetts has learned that many people with nontraditional work have a very hard time getting insurance. The connector is improving the “portability” of health insurance to help people with part-time jobs, many different jobs or seasonal jobs get coverage. It allows people to combine contributions from various employers to pay for coverage as well as continue with coverage when seasonal work is over.

“If the state’s health care system is reformed so that health insurance attaches to individuals and not to jobs—like the connector system—a significant portion of the uninsured will be able to get and keep coverage without the need for additional public subsidies,” says Ed Haislmaier of the Heritage Foundation. “That means that the state’s efforts to target the remaining uninsured can be more focused on people who need the subsidy to get coverage.”

Many states are studying the connector idea to see if they can learn from Massachusetts’s experience. Washington passed legislation this year. The Washington Health Insurance Partnership will initially target small employers with low-income workers. The state will provide premium subsidies, based on a sliding scale, for employees who earn less than 200 percent of the federal poverty level.
EMPLOYER REQUIREMENTS

The “shared responsibility” of the Massachusetts reforms includes employers. To satisfy the business community, a provision that would have required a payroll assessment on employers was modified, in a conference committee compromise, into a flat, per-worker, annual assessment. All employers with 11 or more employees who fail to make a “fair and reasonable” contribution to the health insurance premiums of their workers are required to pay a “fair-share contribution” of $295 per year for each worker. Employers are also required to offer a Section 125 “cafeteria plan” to avoid a so-called “free rider surcharge,” on any workers and their dependents who receive care through the state’s Health Safety Net Trust Fund.

While Massachusetts has a relatively high rate of employer-sponsored insurance, this fair share contribution and other new policies attempt to level the playing field between the majority of employers who offer coverage to their workers and those who do not. Collections started recently. The effects of these new policies during a time when the state is enjoying record high levels of employers offering health insurance will be monitored closely. So far, there’s been no ERISA challenge, but the federal Employee Retirement Income Security Act of 1974, raises potential problems. The act preempts state laws that “relate to” employer-sponsored benefit plans. For example, the Maryland Fair Share legislation which required employers to pay an assessment based on a percentage of payroll if they did not offer certain health insurance to their employees was overturned on the basis that it violated ERISA.

Vermont also included an assessment on employers to help finance the new subsidized insurance program. “Our employer assessment amounts to one dollar per day for each uninsured employee,” says Besio. “Businesses have been trying hard to cover their employees—they were at the table when this assessment was crafted.”

Maine does not assess employers but the Blue Ribbon Commission recommends that the governor consider the concept.

IMPROVING QUALITY

Most states working on health reform are including measures to improve the quality of health care. Compared with Australia, Canada, Germany, New Zealand and the United Kingdom, the U.S. health care system ranks last or next-to-last on five dimensions of a

Vienna's Blueprint for Health

Driven by the rising costs and high death rates associated with chronic diseases, a public-private partnership called the Vermont Blueprint for Health Chronic Care initiative was launched in 2003. Its goal is to standardize chronic disease management in Medicaid, state employee benefit programs, state-approved employer sponsored insurance plans, and the Catamount Health plans. This is a new approach to managing chronic care that focuses on:

◆ Supporting public policies that promote healthy lifestyles and effective health care.
◆ Establishing community activities that encourage healthier lifestyles.
◆ Encouraging personal responsibility by making self-management tools easily available.
◆ Improving health care information technology.

Health reform in 2006 broadened and strengthened the 3-year-old initiative by creating implementation timetables and requiring annual status reports to the General Assembly. The program is now in six communities across the state with a goal of taking it statewide by 2011.

For more information, go to: http://healthvermont.gov/blueprint.aspx
—Melissa Hansen

States Expanding Health Coverage

As the number of uninsured Americans continue to grow, more than half the states are seriously considering or have improved some form of universal coverage of adults

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<th>State</th>
<th>Comprehensive access laws in effect</th>
<th>Task forces or commissions actively considering future action</th>
<th>Substantial steps taken by legislature or executive branch this year</th>
<th>No substantive proposals currently being considered*</th>
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*Includes 10 states in which universal coverage bills were introduced but made little headway, as well as states that are acting on health-care reform other than comprehensive insurance.

For a 50-state map on insurance coverage for children, go to State Legislatures Online at www.ncsl.org/magazine.

high performance health system: quality, access, efficiency, equity and healthy lives, according to a Commonwealth Fund report.

In conjunction with the Dirigo reforms, Maine created the Quality Forum to advocate high quality health care. The forum, according to its director, Joshua Cutler, helps citizens make informed choices by publishing medical information on a public web page. It also conducts research to ensure that all health care meets certain quality standards and convenes health providers to discuss quality goals and standards.

“As a nurse practitioner,” says Maine’s Representative Perry, “I can see firsthand how the forum has encouraged hospitals to review the care that patients are receiving and make needed changes.”

Vermont’s reform aims to help prevent and manage chronic diseases through a public-private partnership that includes all commercial and public payers, providers, state leaders, and the business community. Called the Blueprint for Health, the goal is to provide better support for primary care providers though coordinated payment reform; care coordination resources at the community level; promote wellness; and improve health information technology through support for electronic health records in primary care settings and medical information sharing across all care settings statewide. Vermont also is trying to increase the number of physicians practicing in rural and hard-to-serve areas through enhanced loan forgiveness and loan repayment programs.

“We are trying to change the way we deliver health care by reforming the payment system to encourage more appropriate care for chronic diseases, prevention and wellness,” says Besio, director of Vermont’s Health Care Reform Implementation. She adds that “50 percent of Vermonters have one or more chronic conditions and only half of those get the right care at the right time.”

And there is some evidence that it may be working. “For the 400 people enrolled in our healthy living workshops, there has been a 60 percent reduction in emergency room use,” Besio claims.

Massachusetts’s health reform is moving in that direction, too. The Massachusetts Health Care Quality and Cost Council promotes safe, effective, timely, efficient, equitable and patient-centered care. The council has regulatory authority to make resources available to health care consumers and hold providers accountable. Controlling costs and improving quality must accompany any expansion of coverage.

“We consider the work of the council to be critical to the success of health care reform,” says Senator Richard T. Moore, one of the major architects of the Massachusetts law. “Unless we can contain costs while maintaining quality care, access to coverage will be unsustainable.”

All three states have found the road to health reform to be long and winding with many unexpected bumps and turns. “Dirigo passed with support from both sides, but it has been a partisan battle ever since,” says Perry of the struggles in Maine to maintain political support for the new programs. “Don’t lose sight of the big picture and the ultimate goal,” she warns. “There is a strong temptation to fix one problem in our dysfunctional system with smaller more incremental reforms that may cause a reaction in another part of the system that we didn’t plan for and certainly didn’t want.”