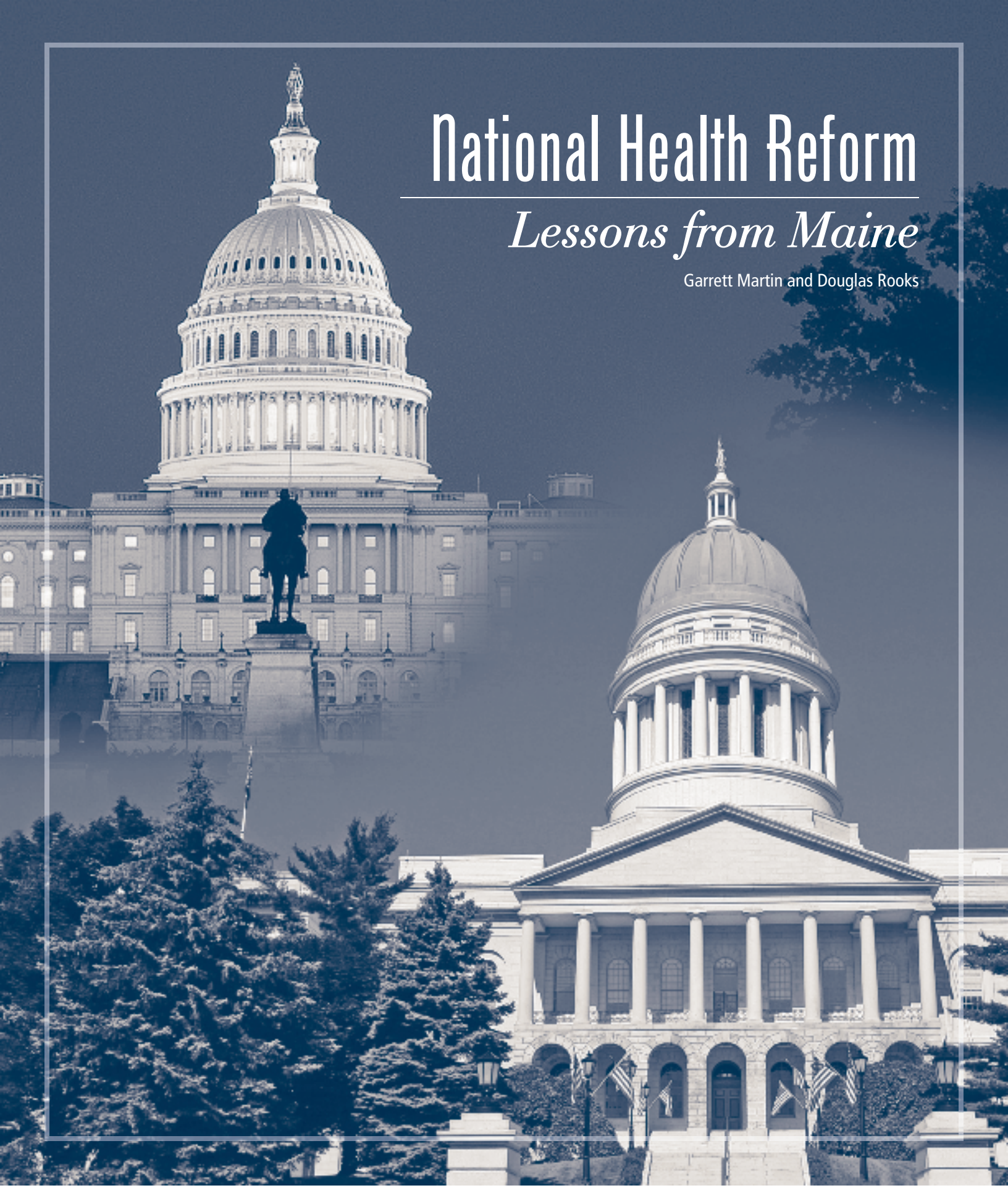

National Health Reform

Lessons from Maine

Garrett Martin and Douglas Rooks

MECEP
IDEAS FOR SHARED PROSPERITY
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Preface and Acknowledgements

All too often discourse about policy issues breaks down along ideological lines. As a result, sound bites and simplistic messages seem to carry the day rather than a comprehensive and open assessment of the issues, alternatives, and outcomes. While it would be easier to live in a world of simple solutions and unanimous consent, differing viewpoints are inevitable. Policy analysts believe that quality research and analysis can and should play an important role in informing political decisions. To the greatest degree possible, such analysis should be evidence-based rather than driven by ideology or theory alone. It should also recognize the political, economic, and human context in which decisions are made.

From the beginning, Dirigo Health Reform has been a victim of ideologically driven battles. As a result, it has been cast in such a negative light that few are able to acknowledge its successes and the lessons it offers health reformers at a state and national level. Dirigo does not offer a definitive rebuttal of the public option as some might suggest, nor does it make clear how best to rein in health care spending. Dirigo does offer important insights for health reformers willing to set aside ideological blinders and make an honest assessment of the costs and challenges associated with providing access to affordable, quality health care for all. This paper is a resource to those efforts.

A review such as this would not be possible without significant contributions from a wide range of people. Trish Riley, from the Governor's Office of Health Policy and Finance; Sara Gagne-Holmes, from Maine Equal Justice; Karynlee Harrington and Josh Cutler, from the Dirigo Health Agency; Gordon Smith, from the Maine Medical Association; Mia Poliquin Pross, Doug Clopp, and Lisa Webber, from Consumers for Affordable Health Care; Frank Johnson of the State Employee Health Commission; and Senator Peter Mills offered substantive feedback.

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Any errors or omissions are the sole responsibility of the authors. For the sake of full disclosure, Garrett Martin acknowledges having been an enrollee in the DirigoChoice program in 2005.

Executive Summary

In 2003, Maine enacted one of the most significant health reform plans of any state. This plan was quickly acclaimed as a national model for health reform and included several key elements intended to expand access to health care, limit costs, and improve overall health care quality. While implementation of this plan, commonly referred to as Dirigo, encountered significant challenges, it achieved tangible results and offers valuable lessons for state and federal policymakers alike. In particular:

- **States can't go it alone.** Meaningful reform requires significant upfront investment which states can't shoulder alone. While Maine benefits from federal matching funds for Medicaid programs, Dirigo's success has been hindered by the lack of reliable funding.

- **Don't let opposition forces water down reforms.** Dirigo health reforms have played a role in controlling costs and improving quality though not at the scale or pace that its designers had hoped. Cost savings take time to realize and are easily undermined by inadequate support and unanticipated implementation challenges. Comprehensive reform is neither simple nor easily explained. This provides ample opportunity for the opposition – in Dirigo's case anti-tax and anti-government groups – to chip away at reforms diminishing both their scope and impact.

- **The public option works.** Increased public involvement in providing coverage choices serves an important function particularly in the face of consolidation in the private insurance market. DirigoChoice, the publicly supported insurance product, has had a limited, and what appears to be a positive, impact on the private insurance market. Both previously insured individuals and those without insurance have benefited from the availability of this quasi-public option, though not at the levels initially projected for the program. The shortcomings associated with DirigoChoice can be attributed to persistent funding issues and to problems associated with the role private insurance companies played in implementing the program.

- **Payment reform is a must.** The current health care system is one that focuses on sick care rather than preventive care. Changing this picture requires a fundamental shift in the way health care is paid for. At present, there are few payment incentives that encourage or reward improved quality of care and a focus on prevention. Instead the bulk of incentives point in the direction of increasing the number of high-dollar, high-volume services provided. Overcoming these structural flaws requires more than good intentions. It requires better information and a restructuring of the payment system. Dirigo health reforms have made some progress in this area by bringing greater transparency to Maine's health system and shining a light on the greatest inefficiencies within the system.

- **Recognize and support early adopters.** Some states have made significant investments in health reform and should not be adversely impacted by national reforms. Maine expanded Medicaid eligibility and coverage beyond what is being considered in national reforms. This has allowed more people to obtain coverage and access to needed services. It also has reduced bad debt and charity care. States like Maine should be rewarded with continued federal support rather than penalized with expanded maintenance of effort requirements or reduced funding. Similarly, Maine has enacted important consumer protections such as guaranteed issue and community rating that are not in place in other states. These should provide a floor rather than a ceiling for national reform.

Comprehensive health reform at the federal level is a critical opportunity that should not be squandered. While much has been written about Massachusetts health reforms and their potential to inform federal reform, Maine's efforts have received relatively little mention. This paper seeks to provide a better balance by providing an overview of Dirigo, its successes and shortcomings, and lessons for state and federal policymakers.

Introduction

National health reform has taken center stage in Washington. At issue is the future physical and financial health of individuals and communities throughout the country. As policymakers attempt to strike a balance between public and private interests, the question of whether or not individuals will be allowed to voluntarily buy into a public insurance plan has become a hot-button issue.

Proponents and detractors alike offer a myriad of scenarios in making the case for or against a public option. Few are able to provide concrete evidence to demonstrate the validity of their claims. Whether or not the final proposal contains a public option is immaterial if the reform package is inadequately funded, does not cover more people more affordably, and fails to change spending patterns and extract real cost savings.

In 2003, Maine enacted one of the most significant health reform plans of any state. This plan was quickly acclaimed as a national model for health reform and included several key elements intended to expand access to health care, limit costs, and improve overall health care quality. While implementation of this plan, commonly referred to as Dirigo, has encountered significant challenges, it offers valuable lessons for state and federal policymakers alike.

Maine's experience with Dirigo speaks to the importance of federal support for state level reform efforts, the difficulties associated with accomplishing cost savings and quality improvements, and, perhaps most germane to current federal reform efforts, the impact of a public option on overall reform and on the private insurance market. While much has been written about Massachusetts health reforms and their potential to inform federal efforts, Maine's efforts have received relatively little mention. This paper seeks to provide a better balance by providing an overview of Dirigo, its successes and shortcomings, and lessons for policymakers.

Maine Takes the Lead in Pursuit of Comprehensive Health Reform

On June 18, 2003, Governor John Baldacci signed the Dirigo Health Reform Act into law, at the time perhaps the nation's most ambitious health reform plan at any level. After nearly a decade of relatively little action at the federal and state level, Dirigo marked the beginning of a wave of innovation in health policy.

In its initial conception the main objectives of Dirigo were to: 1) reduce health care costs; 2) expand health insurance coverage; 3) improve public health; and 4) improve the delivery and quality of services.[1] These objectives would be pursued through three strategies.

- Expand eligibility for MaineCare, the state's Medicaid program, to cover more low-income individuals and families.
- Create DirigoChoice, Maine's version of a public option, to provide affordable insurance to small businesses and individuals based on a sliding scale for those earning up to 300% of the Federal Poverty Level.
- Introduce a series of reforms aimed at curbing the rate of growth in health care spending, promoting public health, and improving the delivery and quality of care.

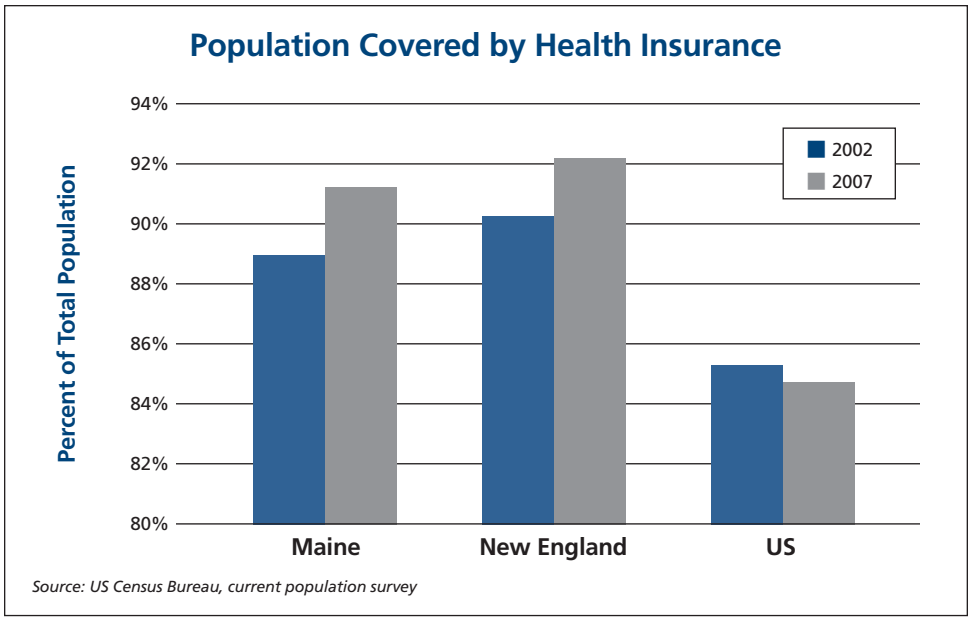
Tangible Results of Health Reform in Maine

Six years into Dirigo, several reforms have delivered tangible results.[2] Others have only recently begun to demonstrate their potential. Specific accomplishments include:

1. Reducing Maine's rate of uninsurance by 20% from 2002 to 2007.[3]
2. Documenting $160 million in savings as a result of various reforms.[4]
4. Slowing the growth of insurance premiums more than any other state in New England.[5]
5. Developing and analyzing new data systems to identify at least $400 million in potential costs savings.[6]
6. Implementing new initiatives, some with support from private funders, to improve the quality and cost-effectiveness of delivering services.
7. Creating a roadmap for future action as depicted by a state health plan that is produced biennially with input from key stakeholders.[7]

"Sufficient post-Dirigo experience has now developed to identify a significant change in cost growth trends pre- and post-Dirigo."

Eric Cioppa, Acting Superintendent of Insurance (September 17, 2007)[7a]



Source: US Census Bureau, current population survey

1. Reduced the ranks of the uninsured

Coverage expansions related to Dirigo significantly increased the number of Maine people with health insurance.[8] In 2002, Maine had the lowest levels of insurance coverage among New England states and ranked 16th among all states. From 2002 to 2007 the trend among New England states and nationally was a decline in the percentage of people covered by some form of health insurance.[9] By 2007, Maine had the second highest rate of coverage (91.2%) among New England states and ranked 4th nationally behind Massachusetts (94.6%), Hawaii (92.5%), and Minnesota (91.7%).[10] As a result 25,000 Mainers who lacked health insurance before 2003 gained coverage through Medicaid expansions and the availability of affordable insurance through DirigoChoice.

2. Contained costs in measurable ways

Each year, the Dirigo Board holds hearings to determine savings associated with Dirigo reforms. The Superintendent of Insurance reviews the Board's findings, requests additional information as needed, and makes a final determination as to the actual level of savings realized. The final amount becomes the basis for a payment from insurance companies to the Dirigo Health Agency also known as the Savings Offset Payment. Over the last four years, the Bureau of Insurance has recognized $160 million in savings which have been paid to the Dirigo Health Agency. Based on the filings by the Bureau, $113 million (71%) of these savings are the result of a voluntary annual cap on cost increases by hospitals.[11] Twenty three million dollars (14%) are attributed to reductions in cost-shifting resulting from increased funding to hospitals and other providers,

> *"There is ample evidence that the voluntary effort to limit increases in hospital spending and operating margins that began four years ago is one aspect of the Dirigo reforms that is working exactly as Governor Baldacci and those of you who supported the original legislation anticipated."*
>
> Elizabeth Mitchell, Senior Director of Public Policy, MaineHealth (April 7, 2008)[11a]

and $21 million (13%) are attributed to reductions in bad debt and charity care as a result of increased insurance coverage for previously uninsured or underinsured individuals.

3. Put the brakes on double digit premium increases

The federal Medical Expenditure Panel survey shows that between 2001 and 2003, before Dirigo, Maine's insurance premiums grew by 13.2% a year, higher than the New England average of 10.1%. After Dirigo was enacted, from 2004 to 2006, premiums in Maine rose 6.4%, half the previous rate, while premiums in New England grew by 8.1%.[12] This change is tied in part to an agreement by insurance companies to voluntarily limit profits to 3% for the first year after Dirigo's passage.[13] These voluntary limits were not renewed and private insurance premiums and associated profits have returned to alarming levels even while hospitals continue to abide by a voluntary cap on annual cost increases. Recently, Anthem Blue Cross, Maine's largest insurer, proposed increases in regulated individual policies averaging 18%.

4. Used information to identify future savings and quality improvements

A key issue for reformers and consumers alike is the lack of clear and consistent information on prices and quality of care. Dirigo reforms called for posting the prices and information on quality of care for specific services by hospitals and doctors offices and standardizing reports of financial information by insurance companies and hospitals. Specifically, the Maine Health Data Organization (MHDO) develops and manages claims data. The Maine Quality Forum (MQF) was created within the Dirigo Health Agency for the purpose of collecting and analyzing data on how medicine is practiced around the state. The MQF also helped provide start up funds to launch Health Info Net which has received national attention for its efforts to develop a statewide health information system. Although some of the information available through these entities has been slow to come and needs to be more publicly accessible, its value cannot be overstated. Since 2007, several studies have been produced using data from MHDO and MQF.[14] These studies paint a much clearer picture of health care cost drivers in Maine and identify specific opportunities to achieve greater savings and improved quality. This includes identification of $284 million in potentially avoidable inpatient services[15] and approximately $115 million in avoidable emergency department services.[16] The Advisory Council on Health Systems Development has begun to use this information to inform its efforts in the development of a new state health plan.

5. Promoted improvements in service delivery

In addition to its role collecting and analyzing data, the MQF is also charged with providing information on best practices and working with providers to improve performance, reduce costs, and improve quality. In this capacity, MQF has facilitated several important initiatives and pilot projects to improve coordination and delivery of care for patients. These include the development of the Maine Critical Access Hospital Safety Collaborative and the Patient-Centered Medical Home Pilot. MQF has also secured additional federal and philanthropic funds to support other initiatives in the state. The MQF deserves much credit for pursuing all its work on a very limited budget and with a staff, at present, of two.

6. Created a mechanism for future planning and prevention

Dirigo requires the Governor – with advice from a citizen and stakeholder council known as the Advisory Council on Health System Development (ACHSD) – to issue a state health plan every two years. The goals of the plan are to improve overall health in Maine and bring down costs by focusing on disease prevention, chronic illness, and delivery of services particularly in rural areas. The plan provides a roadmap for future action. The first plan was released in 2006 and led to the creation of a Public Health Work Group charged with building a public health system for Maine. The second plan, released in 2008, provided the directive that resulted in the reports on cost drivers in Maine and emergency department use discussed above. These activities highlighted a key role assigned to the ACHSD by the Legislature in 2007: reporting on cost drivers and making recommendations to slow the rate of growth of health care spending in Maine.

Impediments to Greater Success

At the time the Governor signed the original Dirigo Health Reform bill, all signs were positive. The legislation had significant bipartisan support, passing the House 95-46 and the Senate 25-8. However, several legislative compromises that helped secure Dirigo's passage all but assured that the reforms would fall short of initial expectations. In particular, the decision to annually calculate the fee that would be paid by insurers as a result of cost savings, rather than assess a flat 4% fee as called for in the original bill, left the reforms on unstable financial footing. The elimination of global budgets for hospitals guaranteed the continuation of the existing fee for service payment model effectively undermining the potential for greater cost containment and quality improvements. Public support for the reform package was eroded by persistent attacks against the program long before it had a chance to deliver meaningful results.[17]

Insufficient Funding Makes It Difficult to Realize Dirigo's Full Potential

As initially conceived, Dirigo would be funded primarily through a 4% assessment on gross revenues of health insurance. The argument for the assessment on insurers was that their rates already reflected costs that Dirigo would eliminate from the system. These costs are associated with inefficient delivery of care, overutilization of services, bad debt, and charity care. Reducing these expenses would result in increased savings which would translate into additional profits for insurance companies.

Rather than allow insurance companies to hold onto profits that resulted from the savings associated with Dirigo, the administration maintained that they should be recouped as public revenue through the 4% assessment and used to pay for the reforms. Insurance companies balked at what they called a 4% tax with no proof that any savings would materialize. Effectively, they said, "Prove it."

Confident in the reform package's ability to deliver real savings, the bill's sponsors agreed to replace the flat assessment with a variable assessment that would be calculated annually and based on "actual" savings as approved by the Superintendent of Insurance. This arrangement came to be known as the Savings Offset Payment and set the stage for costly annual battles between representatives of the Dirigo Health Agency and insurance companies reminiscent of the classic playground shouting match – "Our plan saved this much money", "Did not", "Did too" and so on.

Beyond the annual expense and frustration associated with negotiating the Savings Offset Payment, the real impact of this concession was that it undermined both the amount and predictability of funding for Dirigo. This created a domino effect that guaranteed that the reform would never deliver on its initial promise. Since DirigoChoice lacked the necessary funding to support continued coverage expansions, a portion of the anticipated savings associated with reductions in bad debt and charity care for those without insurance would not be achieved. This translated into a reduction in the Savings Offset Payment and resulted in further decreases in funding for the reforms. Thus a cyclical contraction, rather than expansion, of Dirigo was all but assured.

Recognizing the need to secure more reliable funding, the Governor's office worked with legislators to implement a flat assessment of 1.8% and pass a dedicated beverage tax in 2008. However, a successful referendum campaign funded with $4 million contributed by the national beverage industry – twice the amount spent by the winning candidate in the previous gubernatorial election – overturned this law. Dirigo was left in much the same place as it was before, not totally broken but not able to fund the repairs needed to get back on track.

During the most recent legislative session, the administration finally succeeded in scrapping the Savings Offset Payment and replaced it with a 2.14% surcharge on paid claims. This assessment is projected to raise $42 million a year, enough to maintain existing participation levels in DirigoChoice. Effectively this represents a stopgap until federal reform efforts conclude and a new legislature convenes. It does not, however, negate the adverse effects of insufficient funding from the previous six years.

The Savings Offset Payment muddied the waters and created a missed opportunity for all Maine people. The lesson is clear: if you want to achieve far reaching health reform, you must find a reliable way to fund it.

HOW WE GOT HERE:
The Implications of the Fee for Service Model on Health Spending[17a]

Most health care providers in the U.S. operate on a fee for service model. As patients (also known as consumers) this means that we pay, either directly or through our insurance companies, for each service we receive. One shot – check! One physical exam – check! Two aspirin – check!

At face value this makes a lot of sense. Pay for what you get, nothing more, nothing less. Unfortunately, where health care is concerned this payment model has several flaws that contribute to the escalation of health spending with little improvement in quality.

For starters, very few health care consumers, particularly those with insurance, decide what services to purchase based on cost. We tend to trust the advice of our doctors and rely on them to determine which tests, treatments, and medications make the most sense. Even if we choose to be more cost conscious, it is very difficult to figure out how much things cost. This is particularly true when the same service provided by the same facility is billed at several different rates depending on whether or not you have insurance and who your insurance company is. Finally folks living in rural areas may have limited options to begin with. Assuming they could get the relevant price information, the notion of finding a lower priced provider within a reasonable distance is even more farfetched.

Of course, any remaining conception that we as health care consumers are price sensitive quickly flies out the window when we are faced with an emergency or life-threatening illness. Our main objective is to get better, regardless of the costs.

Ironically, the one place where cost does seem to influence our behavior as health care consumers, particularly those who lack insurance, is in the decision to forgo routine or preventive services. It is precisely these types of services that could improve long-term health outcomes and reduce overall health spending.

For hospitals and health care providers, the reality of an effective delivery system under the fee for service model is even more elusive. Increasingly, hospitals are being run like for profit companies. From a financial perspective, the objective is to minimize costs and maximize revenues. Under a fee for service system there are several ways to do this that run counter to the notion of improving patient outcomes and minimizing health care spending.

The first way to increase revenues is to increase the volume of services provided. The more tests run, the more people treated, the more cash flow generated. The second way is to offer more specialized and increasingly high tech (and higher cost) services. For example, cardiac and orthopedic surgery are more lucrative than basic preventive care. This dynamic contributes to an increasing shortage of primary care physicians as more and more medical students gravitate toward specialization. What happens if we achieve universal coverage and there aren't enough primary care physicians available to meet the demand for basic preventive care?

While it is important for patients that they get the services they need, health care is a little like television. The more televisions there are in a house, the more likely it is that someone is watching one. Similarly, the more health care services that are available, the more likely it is that someone is using them. For consumers and providers alike, more is not necessarily better. Indeed, the best hospital may be one that is focused on putting itself out of business based on the preventive services and quality of care it provides.

Beyond the perverse incentives at play under a fee for service model, the administrative burden of tracking each expense adds significant costs to the system and little, if any, value to the overall quality of care. Picture the nurse who has to spend time logging in all the items – gauze pads (4), syringes (1), aspirin (2), etc. – used for various procedures conducted throughout his shift or members of the accounting or billing departments working diligently in their cubicles to generate bills and collect payments. These functions combined with insurance paperwork account for 20% of spending on hospital services.[17b]

The final reason the fee for service model doesn't result in the delivery of the best quality services at the lowest possible price is the role that insurance companies play in negotiating prices with providers. This effectively shields consumers from the true cost of care. At best, insurers use their bargaining power to drive down costs and lower rates for their customers. At worst, they are complicit with hospitals in resisting any reform that might undercut the ability of each to reap huge profits at great expense to consumers and society in general.

The United States is one of the only countries in the industrialized world that still relies on the fee for service model to pay for health care. Consider where it has gotten us. We spend nearly twice as much per capita on health care as other countries and continue to lag behind in terms of health outcomes and life expectancy.

Key Measures Aimed at Reducing Health Spending Are Removed from the Final Bill

A core tenet of Dirigo was that the cost savings associated with the reforms would reduce overall health spending and enable more individuals to obtain affordable insurance. In order to rein in spending, the original bill included several measures intended to provide hospitals with incentives to begin operating more efficiently and effectively. First, Dirigo established a global budget intended to set limits on hospital spending. Second, Dirigo proposed a mechanism for better coordination and planning by hospitals aimed at eliminating redundancies and overuse in the current delivery system. Maine maintains 39 acute care hospitals while New Hampshire, with a comparable population, has nine. Finally, Dirigo sought to regulate investment in new technologies and facilities by hospitals. The trade-off for these concessions would be greater protections for hospitals from anti-trust charges.

In the end, hospitals balked at these provisions. Only one of the three measures – regulating technology and other capital investment – made its way into the final version of the bill. While hospitals did agree to voluntarily limit profits and spending per patient, this does little to change the underlying incentive structure of the current system where more is better. Unfortunately, with regard to health care, more is not necessarily better and, without question, results in increased costs.

Once again the tough choices that could result in substantial long-term savings were put off for another day. Similar to Maine's current discussion of school consolidation, the issue of how to cut costs while delivering a high level of service at a local or individual level reflects a deep conflict between our public and private selves. On the one hand, we want to have our own school or hospital capable of providing all the services we need when we need it. On the other hand, we don't want to pay for a level of service that results in increased taxes or increased insurance costs. This is particularly true if we perceive that others are benefiting more than we are from this arrangement. It's as though we're all in the same boat – individually we've all got our own oar and are rowing in our own direction, but collectively we're still going where ever the current takes us.

Absent substantial payment reform that alters the incentives for how health care is delivered, it remains all too easy for insurers and health care providers to go about business as usual. This may continue to work for some, particularly those who profit from the current system, but the long term adverse impact on Maine's economic and physical health is inescapable.

A Public Option in Private Hands is No Public Option

A featured element of the Dirigo reforms was the development of a publicly subsidized insurance plan that would give small businesses and individuals more affordable coverage options. This plan, dubbed DirigoChoice, held great promise but never gained the traction it needed to flourish.[18] Long before funding constraints scuttled any possible expansion of DirigoChoice, early implementation challenges put the program at a distinct disadvantage.

The original vision for DirigoChoice was that the state would charter a new nonprofit insurance company to implement the program. This plan was dropped for several reasons including concerns over federal regulations, insufficient funds to capitalize a new firm, and a limited number of potential customers which would make it hard to generate adequate revenue in the short term.

The next best option would be a public/private partnership with a non-profit insurance company. However, consolidation in Maine's insurance market meant that the only large non-profit insurer based in Maine, Blue Cross-Blue Shield, had been converted to a for-profit subsidiary of Anthem several years earlier. In addition, two Massachusetts non-profits that sold policies in Maine in the 1990s had also departed, leaving the state without a substantial non-profit insurer. Such consolidation within the health insurance market was typical in other states, particularly rural ones.[19]

Absent a non-profit partner or the ability to charter a new entity, implementation of DirigoChoice would be managed by a for-profit partner through a competitive bidding process. The only bidder for the original contract was Anthem Blue Cross, a company that controlled over 70% of the insurance market in Maine and had no obvious motive for selling subsidized policies. In effect, why would Anthem sell you a cheaper product that better meets your needs, when the company can get you to buy a more expensive one? Doing so would undermine profits and place downward pressure on the prices of other products. It is a little like trying to buy an airline ticket before the growth of low-cost carriers and the ability to compare prices online. The airline companies were perfectly happy to sell

The DirigoChoice Enrollment Labyrinth

When it was first introduced, signing up for DirigoChoice was no small feat. If you wanted to take advantage of this exciting new insurance product, you might call the Dirigo Health Agency to find out where to apply. From there you would be directed to Anthem to obtain a quote. Depending on whether you called Anthem or went on their website, you may or may not be able to navigate the system to the DirigoChoice product. Assuming you did, you likely were offered several competing Anthem products along the way.

Once you managed to find your way to the DirigoChoice product, you would be given a quote based on the full cost of coverage. If you were planning to pay full price then you were all set. But if you were eligible for the subsidized product based on income, you were in for another round of calls and paperwork.[20a]

It turns out Anthem was not responsible for calculating the subsidy (or for helping you understand how the subsidy would impact the ultimate cost of being covered by DirigoChoice). Instead, you would have to make another round of phone calls to the Dirigo Health Agency and file additional paperwork to determine the level of subsidy that you qualified for.

Once the subsidy was calculated, you would still be expected to pay the full cost of the plan as quoted by Anthem. After the fact, the Dirigo Health Agency would place a credit on your "account" which you could access with an electronic benefits card provided by the state. The enrollment process for small businesses was much the same with each employee responsible for submitting his or her own information directly to the Dirigo Health Agency for the purposes of calculating the subsidy.

While Dirigo means "I Lead," the question for many caught in this enrollment process might be "Where?" Assuming you navigated the process without getting sidetracked or discouraged, the DirigoChoice product initially turned out to be a good one at a reasonably affordable price. Although the enrollment process has improved in recent years, new enrollments have been limited and affordability has suffered due to the inability of the program's supporters to secure sufficient funding.

you a higher priced ticket even though a less expensive one was almost always available if you knew how to find it.

In the case of DirigoChoice, anecdotal evidence suggests that Anthem did very little to promote the product and actively promoted other products in its place.[20] The DirigoChoice enrollment process was further convoluted by the subsidy calculation and reimbursement procedure at the state level. These issues, combined with persistent attacks on Dirigo by opponents of the program and the annual wrangling associated with the Savings Offset Payment, undermined public support for the Dirigo reforms in general and DirigoChoice in particular. The lack of support combined with the funding constraints associated with the Savings Offset Payment assured that DirigoChoice would never achieve the lofty enrollment projections cited by proponents of the program.

Persistent Negative Publicity Erodes Support for Reforms

Expanded eligibility for MaineCare, the state's Medicaid program, was the foundation for increasing health insurance coverage for low-income individuals and families under Dirigo. Maine sought to expand coverage to childless adults with incomes between 100 and 125% of the Federal Poverty Level (FPL), approximately $9,310 to $11,638 per individual in 2004. Dirigo also called for expanding coverage to parents with incomes between 150 and 200% of the FPL, approximately $18,850 and $23,563 for a family of four. Due to budget constraints the program expansion for childless adults was capped at 100% of the FPL. The program to enroll parents went forward as planned.

Anti-tax and anti-government constituencies railed against this plan claiming that it was financially unsustainable. They argued that Maine was facing a budget shortfall and could ill-afford to generate the revenues needed to support these measures. They were also quick to point out that Maine would have one of the highest Medicaid enrollment rates in the country and grossly overstated the number of people who would benefit from this plan.[21] Some suggested that it was unfair to ask taxpayers to pay for some people's care and that expansion of these programs would erode the initiative and sense of self-reliance that characterized Maine people.

These arguments tapped a vein of contempt and antipathy toward public programs that anti-tax and anti-government groups had cultivated for years. Lost in the conversation was any sense of the public good and the notion that public investment in health care could save money and result in better physical and financial health for Maine and its people.[22] For example, individuals who lack insurance or are underinsured tend to forgo preventive services and early intervention. When they do access health services it tends to be in the least cost-effective manner. Because they are likely unable to pay for the care they receive, uninsured and underinsured individuals contribute to increases in bad debt and charity care. In order to cover the costs of such care, providers pass them through the system resulting in increased insurance premiums and cost shifting to private payers. This creates a vicious cycle where increasing costs lead to reductions in affordable coverage and vice versa. Thus, as a society we are going to pay the price for an out of control and increasingly unaffordable health care system one way or another – a fact that is conveniently ignored by anti-tax groups.

Beyond these concerns, several other issues related to MaineCare threatened to erode public and provider support for health reform. The Baldacci administration inherited a $22 million contract to install a new computer system for Medicaid billing and payments that malfunctioned in 2005. This problem became a poster child for government mismanagement and provided another opportunity for opponents to rail against the costs of expanding MaineCare eligibility.

Hospitals had their own concerns when it came to expanding coverage through MaineCare. While Maine pays higher Medicaid reimbursement rates to hospitals than many other states, hospitals and other providers still claim to lose money when they treat Medicaid patients. As a result hospitals continue to shift costs incurred from Medicaid patients to other payers and many private practitioners have stopped accepting Medicaid patients altogether.

Further complicating the issue was a preexisting backlog of Medicaid payments to hospitals that was exacerbated by expanded MaineCare enrollments associated with Dirigo. After four years of effort, payments to hospitals for these bills were made possible by Maine's share of federal stimulus spending.

These problems quickly detracted from the overall reform effort. They reinforced the challenges associated with managing many moving parts and the complications associated with tying into existing programs, particularly when federal officials proved unwilling to issue the necessary waivers to allow for a more seamless integration of MaineCare into the overall reform package. Still, reimbursement issues aside, Medicaid has proven effective in both Maine and Massachusetts as a cornerstone for improving coverage, particularly to low-income individuals, and helping to reduce bad debt and charity care.

Dirigo's Future in Maine

With a new administration in Washington and a new one in Augusta in less than two years, Dirigo's future remains uncertain. Has Dirigo served its purpose as a reform experiment? Should it be retooled or abandoned altogether? In particular, what is the future of DirigoChoice, the Dirigo Health Agency, and the Maine Quality Forum?

The next administration would be well served not to throw out the proverbial baby with the bath water. DirigoChoice has provided an affordable insurance alternative to some and has served as a bridge for those who are dropped from MaineCare once they have exceeded income limits. While DirigoChoice's ultimate success has been compromised by funding constraints, new federal support may make it easier to finance and possibly expand the program in the future.

The Dirigo Health Agency has played an important role in planning and administering new initiatives and is well-positioned to insure that Maine maximizes opportunities provided by federal reforms. Regardless of what happens at the federal level, the agency in concert with the Governor's Office of Health Policy and Finance and the Advisory Council on Health Systems Development would continue to add value by serving as a State Planning Office for health care, pursuing new policy objectives outside the Department of Health and Human Services. In addition, the agency is battle-tested, efficient, and competent at many tasks.

Other reforms, particularly those associated with the MQF and MHDO, are only now beginning to take root and demonstrate their potential. These should be expanded to take on other projects that directly improve patient care and identify further cost savings, using general fund dollars if necessary. Beyond these activities, both entities should play a greater role in increasing transparency and public understanding of health care quality and costs.

To summarize, the next administration should:

- Maintain the state's commitment to MaineCare as a cornerstone of expanded coverage and continue to work with providers to address reimbursement issues.
- Use anticipated new federal programs to refinance and possibly expand DirigoChoice.
- Focus on cost-containment measures and extracting cost savings identified through work conducted on behalf of the Maine Quality Forum and the Advisory Council on Health Systems Development
- Retain and expand the Governor's Office of Health Policy and Finance and the Dirigo Health Agency's role in coordinating, planning, and administering new initiatives, both federal and state.
- Increase the scope and funding of the Advisory Council on Health Systems Development and the Maine Quality Forum.
- Emphasize initiatives that provide greater transparency and public understanding in support of payment reform and quality improvements.

In pursuing these activities, the administration must continue to coordinate with key stakeholders including consumers, providers, insurers, businesses, and other government agencies – whose cooperation is necessary for achieving lasting change.

Reform efforts often follow a predictable pattern – initial promise, followed by contention and increased complexity, followed in some cases by outright failure and dissolution. Dirigo displays a different pattern – limited success with some objectives, but promising and valuable work in others. Retooled and recast, it could be given new life by a new administration, and do valuable work in coordination with federal programs in the years ahead.

PAYING FOR REFORM: Cutting Costs and Securing the Necessary Public Investment

Dirigo accomplished significant cost savings to health care purchasers and extended coverage to a larger number of Maine people than would have been covered without it. The plan, however, failed to reach its originally ambitious goals for cost savings or the number of people to be covered, in part, due to insufficient funding.

Pending plans for federal health reform to cover the great majority of American people have been estimated to cost in the vicinity of $1 trillion over the next ten years. As with Dirigo, accomplishing this important goal will require both serious cost savings in current health expenditures and substantial new federal revenues.

Proposals for cost savings have included strengthened authority to a board of health experts to annually determine Medicare reimbursement levels for doctors and hospitals, developing new payment systems that pay providers for improving health outcomes not simply for numbers of visits or procedures, and the development of a "public plan" option for small business and individuals to compete with private insurance plans.

Proposals for new revenues have included a higher income tax on people with household incomes over $350,000, limiting itemized deductions for very high income households, and a payroll tax on employers who do not provide health insurance.

As with Dirigo, a variety of interest groups are aligned against these reform proposals. However, the cost of inaction is clear. With national health spending at $2.4 trillion in 2008 and, absent significant reform, projected at $4.4 trillion by 2018, we can no longer afford to put off the cost of reform to another day. Securing the necessary cost savings and public investments to pay for reform now will help create an environment in which all Americans can prosper in the future.

Lessons for National Health Reform

Dirigo continues to be an ambitious program of reform. Maine's experience with Dirigo sheds light on important lessons for federal policymakers to consider as they pursue comprehensive health reform. Specifically,

- **States can't go it alone.** Meaningful reform requires significant upfront investment which states can't shoulder alone. While Maine benefits from federal matching funds for Medicaid programs, Dirigo's success has been hindered by the lack of reliable funding.
- **Don't let opposition forces water down reforms.** Dirigo health reforms have played a role in controlling costs and improving quality though not at the scale or pace that its designers had hoped. Cost savings take time to realize and are easily undermined by inadequate support and unanticipated implementation challenges. Comprehensive reform is neither simple nor easily explained. This provides ample opportunity for the opposition – in Dirigo's case anti-tax and anti-government groups – to chip away at reforms diminishing both their scope and impact.
- **The public option works.** Increased public involvement in providing coverage choices serves an important function particularly in the face of consolidation in the private insurance market. DirigoChoice, the publicly supported insurance product, has had a limited, and what appears to be a positive, impact on the private insurance market. Both previously insured individuals and those without insurance have benefited from the availability of this quasi-public option, though not at the levels initially projected for the program. The shortcomings associated with DirigoChoice can be attributed to persistent funding issues and to problems associated with the role private insurance companies played in implementing the program.
- **Payment reform is a must.** The current health care system is one that focuses on sick care rather than preventive care. Changing this picture requires a fundamental shift in the way health care is paid for. At present, there are few payment incentives that encourage or reward improved quality of care and a focus on prevention. Instead the bulk of incentives point in the direction of increasing the number of high-dollar, high-volume services provided. Overcoming these structural flaws requires more than good intentions. It requires better information and a restructuring of the payment system. Dirigo health reforms have

DEFINING AFFORDABILITY: A Key Element to Reform

For many low and middle income families, paying for health care has become increasingly difficult. Insurance premiums have increased but cover fewer expenses. Wages have remained virtually stagnant while food costs and other household expenses have continued to rise. As evidence of this financial squeeze, 62% of bankruptcy filings in 2007 were partly the result of medical expenses and included individuals who had health insurance.[22a] Against this backdrop policymakers must develop a plan that not only improves coverage but also increases affordability.

The federal poverty level (FPL) provides the most common metric used in determining affordability. Many advocates maintain that families and individuals with incomes under 200% of the FPL ($44,100 for families and $21,660 for individuals) should be exempt from all out of pocket health care costs while families and individuals with incomes between 200% and 400% FPL should be required to make modest contributions toward their coverage. The question for policymakers is what percent of a family's income can be reasonably expected to go toward health care? Nationally, policymakers consider housing costs that consume more than 33% of a family's income to be unaffordable. No comparable standard exists for health care.

Beyond defining affordability, Maine's experience with Dirigo highlights the importance of adopting a standard that is easy to administer and easy for the average consumer to understand. Such a standard should recognize all out of pocket costs including premiums, deductibles, coinsurance, and copayments that an individual may incur. In addition, affordability should be assured on a sliding scale relative to income. Massachusetts reform efforts demonstrate that an individual mandate is meaningless without affordable coverage options. Preserving affordable options requires continued public support and greater cost containment.

made some progress in this area by bringing greater transparency to Maine's health system and shining a light on the greatest inefficiencies within the system.

- **Recognize and support early adopters.** Some states have made significant investments in health reform and should not be adversely impacted by national reforms. Maine expanded Medicaid eligibility and coverage beyond what is being considered in national reforms. This has allowed more people to obtain coverage and access to needed services. It also has reduced bad debt and charity care. States like Maine should be rewarded with continued federal support rather than penalized with expanded maintenance of effort requirements or reduced funding. Similarly, Maine has enacted important consumer protections such as guaranteed issue and community rating that are not in place in other states. These should provide a floor rather than a ceiling for national reform.

Provide Adequate Support to States

Maine's efforts to fund Dirigo highlight two important points. First, cost cutting must go hand in hand with coverage expansions. To be comprehensive and affordable such coverage expansions require significant upfront investment. Second, states have limited capacity to raise the funds needed to support such activities on a consistent basis. This relates in part to the federal role in determining tax policy and to increased financial demands being placed on state and local governments as a result of the devolution of federal programs over the last 25 years. Absent these issues, many states, particularly rural

and economically distressed ones, lack the economies of scale or the financing capacity to sustain comprehensive reform. Federal reforms need to account for these challenges and pursue financing mechanisms that provide the necessary downpayment to accomplish reform at all levels.

Keep the Reform Agenda on Track

At every turn special interests and implementation challenges have the potential to undermine both the comprehensiveness and long-term impact of reforms. From the beginning it is important that policymakers set realistic and measurable results. Dirigo ran into early difficulty because it failed to live up to the expectations created by the administration and lost public support because few people understood the many integral parts to Dirigo.[23]

Because the cost savings took time to realize and DirigoChoice benefited a limited constituency of individuals and small businesses, political and public support for reforms proved increasingly difficult to maintain. What support existed was muted by coverage of the difficulties associated with the Savings Offset Payment and the persistent drumbeat of anti-government, anti-tax rhetoric.

The lessons for reformers are twofold. First, keeping comprehensive reform on track from start to finish requires an ability to appreciate the unintended consequences of concessions during the legislative process and to anticipate implementation hurdles along the path to reform. From their respective experiences both Maine and Massachusetts can offer insights into these issues but a certain amount of learning by doing is inevitable. Second, the case for greater public investment in our shared prosperity must be reinforced at every turn. Whether or not we like to admit it, federal tax policy (and that of many states too) has been crafted to meet the interests of a few, precluding critical public investments

that would create an environment in which all Americans can prosper. We can ill-afford to continue in this fashion or we will all suffer the consequences. That said, people and businesses must begin to appreciate the benefits of these investments in their own lives before they will lend their support. For this reason, it is important to define and manage expectations about what comprehensive and affordable coverage will look like and who will benefit.

Make the Case for a Public Option

Maine's experience with DirigoChoice proves that a public option can work. Faced with private insurance consolidation and skyrocketing premiums, Maine was able to secure better and more affordable coverage on both the public and private insurance markets through reforms that included a quasi public option. In the two years before Maine implemented major health reform in 2003, insurance premiums in the state grew by 13.2% a year, higher than the New England average of 10.1%. In the two years after, Maine premiums rose 6.4%, half the previous rate, while New England saw growth of 8.1%.

DirigoChoice also served as a bridge between Medicaid and other insurance alternatives. While we may never know the benefits of a fully funded and effectively implemented state level public option, Maine's experience with DirigoChoice suggests that a public option should be part of initial reforms. However, such an option must have reliable funding and a large enough risk pool to be sustainable over time. It must also possess sufficient purchasing power to impact the broader market.

Change How We Pay for Health Care

The best hospital may be one that is focused on putting itself out of business as a result of the preventive services and quality of care it provides. Unfortunately, our current payment system doesn't reward this type of approach to practicing medicine. While Maine has begun to experiment with new payment models intended to result in more patient friendly, higher quality and lower cost care, more widespread adoption is many years away. Even with these efforts, better information is needed to identify inefficiencies and develop new payment approaches. Massachusetts has similarly recognized the need for payment reform and recently considered global budgets, much like those proposed in the original Dirigo Health Reforms, as a means to achieving the cost savings needed to sustain more affordable coverage options. Without such options, the individual mandate can't be sustained over time as more and more people opt out for lack of affordable insurance.

Do No Harm to States that Have Made Health Care a Priority

States like Maine and Massachusetts have invested significant time and resources into comprehensive health reform. While these efforts should leave these states better positioned to take advantage of federal reforms, it is important that they are not penalized for their role as early adopters of comprehensive reform. For example, these states will likely exceed federal minimums on Medicaid eligibility and have chosen to invest limited public resources in support of enrollment expansions over the last several years. Maintenance of effort requirements and similar calls for states to shoulder more of the financial burden associated with expanded enrollment should be carefully evaluated to ensure a level playing field. Similarly, states like Maine with strong consumer protections such as community rating and guaranteed issue should not be undermined by less stringent federal protections.

Conclusion

Like many states, Maine felt the pinch of spiraling health care costs in 2003. Unwilling to wait for federal reform, Maine took action and enacted the Dirigo Health Reforms. Dirigo was the most comprehensive state level health reform and was designed to create savings in the skyrocketing costs of health care and reinvest those savings to support health coverage and quality improvements for all Maine people. Dirigo has had both successes and shortcomings that merit further exploration by any new administration in the state. In addition, federal policymakers would be well-served to incorporate the lessons of Dirigo in current efforts to enact national health reform.

The relevance of a public option, the need for more substantial payment reform, and the importance of acknowledging existing state level innovation and assisting states in fully funding reforms are all issues that have clear antecedents in the Dirigo experience. Comprehensive health reform is a critical opportunity that should not be squandered. Having been forewarned of the challenges to reform at the state level, we must choose a better path at the national level. Dirigo can help point the way.

About the Authors

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About the Maine Center for Economic Policy

The mission of the Maine Center for Economic Policy is to advance public policy solutions to help Maine people prosper in a strong, fair, and sustainable economy. MECEP is an independent, nonpartisan research organization and one of thirty state groups funded through the State Fiscal Analysis Initiative. The SFAI is funded by the Ford, Charles Stewart Mott, Annie E. Casey, Stoneman Family, Public Welfare, and Kellogg Foundations, and the Open Society Institute. A portion of MECEP's health policy work is funded by grants from the Robert Wood Johnson Foundation and the Maine Health Access Foundation.

Endnotes

1 For a recent overview of Dirigo and its components see: Governor's Office of Health Policy and Finance. (2009) "Dirigo Health Reform – An Overview and Progress Report," prepared for the Maine Development Foundation's Policy Leaders Academy Health Care Forum, Issues Brief 2009. (http://www.mdf.org/publications/Dirigo-Health-Reform---An-Overview-and-Progress-Report/141/). An earlier overview is provided in: Rosenthal, J. and Pernice, C. (2004, June) Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine. National Academy for State Health Policy. (http://www.nashp.org/Files/GNL_56_Dirigo_brief.pdf).

2 Additional assessments and lessons learned related to Dirigo can be found in the following: Lipson, D.J., Verdier, J.M., and Quincy, L. (2007, December) Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms, The Commonwealth Fund. (http://www.mathematica-mpr.com/publications/pdfs/Dirigofinalrpt.pdf); Frink, D. M., Esq. and Linge, G. M., Esq. (2006) Maine's Dirigo Health Reform Act – Is it Working? FORC Quarterly Journal of Insurance Law and Regulation, vol. XV, Edition VII. (http://www.curtisthaxter.com/pub.php?id=11); Woolhander, S., Day, B., and Himmelstein, D. (2008) State Health Reform Flatlines. Baywood Publishing Co., Inc. International Journal of Health Services, Volume 38, Number 3, Pages 585-592.

3 U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. Table HIA-4. Health Insurance Coverage Status and Type of Coverage by State All People: 1999 to 2007 retreived on July 1, 2009 at: http://www.census.gov/hhes/www/hlthins/historic/hihistt4.xls.

4 Based on review of Dirigo Decision and Order of the Superintendent for 2005-2008, Bureau of Insurance. Docket numbs: INS-05-700 (http://www.maine.gov/pfr/insurance/dirigo/ins05700Dirigo.htm), INS-06-900 (http://www.maine.gov/pfr/insurance/dirigo/pdf/INS-06-900_Decision_and_Order.pdf), INS-07-900 (http://www.maine.gov/pfr/insurance/dirigo/2007/Dirigo_Decision_and_Order_091707.htm), INS-08-900 (http://www.maine.gov/pfr/insurance/dirigo/2008/ins-08-900_Dirigo_Part_I_Decision_092308.htm)

5 DirigoHealth. Health Care Cost Drivers in Maine. p.21.

6 A summary of these can be found in: DirigoHealth (2009, April) Health Care Cost Drivers in Maine: Report and Recommendations. Report to the Legislature from the Advisory Council on Health Systems Development. (http://www.maine.gov/tools/whatsnew/attach.php?id=70889&an=1). Individual reports include: Health Dialog (2009, April) All-Payer Analysis of Variation in Healthcare in Maine. Conducted on behalf of Dirigo Health Agency's Maine Quality Forum and The Advisory Council on Health Systems Development (http://www.maine.gov/tools/whatsnew/attach.php?id=72161&an=1). Kilbreth, B., Gray, C., Chitashvili, T. and Finison, K. (2009, February) Analysis of 2006 Maine Emergency Department Use. A study conducted on behalf of the Emergency Department Use Work Group of the Maine Advisory Council on Health Systems Development (http://www.maine.gov/tools/whatsnew/attach.php?id=68564&an=1). ACHSD Public Purchasers Steering Group (2009, January) 2008 Report to the Governor (http://www.maine.gov/tools/whatsnew/attach.php?id=68755&an=1).

7 See Governor's Office of Health Policy and Finance with Advisory Council on Health Systems Development (2008, April) Maine's 2008-2009 State Health Plan. (http://www.maine.gov/tools/whatsnew/attach.php?id=54721&an=1)

7a INS-07-900 (http://www.maine.gov/pfr/insurance/dirigo/2007/Dirigo_Decision_and_Order_091707.htm).

8 In addition to Dirigo related coverage expansions, Maine received a federal waiver in 2002 to enroll "childless adults" in MaineCare, the state's Medicaid program. This proposal was expected to cover an additional 15,900 adults earning up to 100 percent of the federal poverty level ($9,130 for individuals or $12,490 per couple).

9 The overall increase in the percentage of people covered by health insurance in New England from 2002 to 2007 is driven by coverage improvements in Massachusetts and Maine. Rhode Island, New Hampshire, and Vermont experienced declines in coverage for the same period and Connecticut saw a slight increase.

10 See U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

11 Hospitals agreed to voluntarily limit their profits to 3% and growth in spending per patient to 3.5%. These limits were renewed for another 3 years. Despite these caps, the greatest driver in health care costs since Dirigo's inception have been increases in medical expenses.

11a Mitchell, Elizabeth. "A Booster Shot, and More, for Health Care" Portland Press Herald, April 7, 2008 Maine Voices section (http://pressherald.mainetoday.com/story.php?id=179700&ac=PHedi).

12 DirigoHealth. Health Care Cost Drivers in Maine. p.21.

13 A more complete analysis of the impact on premium growth would include more detailed comparisons of changes in deductibles as this is a means by which insurers could shift more costs to members while holding down premiums. That said, Trish Riley with the Governor's Office of Health Policy and Finance confirmed in correspondence with the author via email on July 17, 2009 that insurers compliance with the voluntary profit limits had an impact on premium growth.

14 See footnote 5 above.

15 DirigoHealth. Health Care Cost Drivers in Maine. p.10.

16 Ibid. p. 15.

17 From the beginning, the Maine Heritage Policy Center barraged the media and the public with criticisms of Dirigo. An article that captures such sentiments and impatience appeared four months after enrollment for DirigoChoice began in MaineBiz. See Smith, T. (2005, April 18) "Up for debate: While some tout the success of DirigoChoice, others say it should be scrapped altogether" MaineBiz. (http://www.mainebiz.biz/news11894.html?Type=search)

17a For an excellent overview of issues related to the fee for service model and the perverse incentives in the current health care system see Gawande, A. (2009, June 1). "The Cost Conundrum: What a Texas town can teach us about health care." The New Yorker (http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande).

17b Kahn, J.G., Kronick, R., Kreger, M., and Gans, D.N. (2005) The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals. Health Affairs, 24, no. 6, p 1629-1639 (http://content.healthaffairs.org/cgi/content/full/24/6/1629).

18 Not only was DirigoChoice touted for its affordability, but also for the plan's comprehensive nature that included a focus on prevention, provided mental health parity, and eliminated preexisting conditions as a reason for denial of coverage.

19 Health Care for America Now. (2009, May) Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses. (http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isltl.pdf).

20 Anthem created and actively promoted a new product targeting small business that competed directly with DirigoChoice. Thus, even on the margins, the availability of a quasi-public option appeared to improve rather than supplant the private insurance market in Maine.

20a While this arrangement made sense from the standpoint of employers who did not want the burden of paying differential rates for different employees and employees who wanted protection from employers knowing their family income, it added a layer of complexity to the enrollment process that took time to resolve.

21 Opponents of Medicaid expansion claimed that this plan would cover 78,000 people. See Bragdon, T. (2005, September 16) Command and Control: Maine's Dirigo Health Care Program. The Heritage Foundation, No. 1878. (http://www.heritage.org/Research/HealthCare/upload/82925_1.pdf). At present, approximately 26,000 people have benefited from the expansions as implemented.

22 Kavilanz, P.B. (2009, March 5) "Underinsured Americans: Cost to you" CNNMoney.com (http://money.cnn.com/2009/03/05/news/economy/healthcare_underinsured/index.htm)

22a Himmelstein, D, Warren, E., Thorne, D. and Woolhander, S. (2009, June 4) "Medical bankruptcy in the United States, 2007: Results of a national study," American Journal of Medicine (online).

23 In addition, the administration lost legislative leadership when a special committee created to deal with Dirigo Health Reforms was disbanded and term limits reduced the ranks of legislators conversant in the many components of Dirigo.

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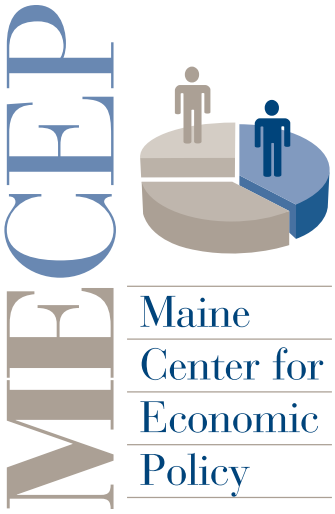

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