EDITORIAL

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Universal health coverage: Maine braves a new world

The Physicians' Working Group for Single-Payer National Health Insurance recommended, in the August 13 issue of *JAMA*, that we move quickly to a system of both universal health coverage and a single-payer national health insurance plan.[1]

The Group argued that single-payer national health insurance is the only affordable option for universal health coverage. It believes that by eliminating the hundreds of private insurance plans and for-profit providers, an estimated $200 billion in administrative costs could be saved. These funds could then be used to finance health coverage for all 41 million uninsured Americans. If our current pluralistic health system were used to provide coverage to the uninsured, the Group predicts, the costs would require major tax increases. The Group proposes that health care for all Americans be provided by a Medicare-style health program.

Medicare-style plan too radical?

The proposal is important because it was published in our most widely circulated medical journal and endorsed by over 8,000 doctors—including the 2 previous surgeons general. However, many business and health industry leaders reacted with the opinion that this plan is probably too radical and would be unacceptable in the current political environment. They prefer that efforts focus on a pluralistic approach to covering the uninsured.

Maine's experiment in universal health care

In June 2003, Maine embarked on an innovative plan to provide universal health coverage using a pluralistic system of insurers and providers. The aim of the plan—called "Dirigo," which means "I lead (I direct)" in Latin, and is also the state motto—is to provide health insurance to all residents by coordinating the efforts of providers, insurers and payers.

All individuals (including the self-employed) and small businesses will be offered a low-cost package through the state's private insurance carriers. The state will expand its MaineCare Medicaid program to include more low-income adults and children. Federal grants and matching funds for Medicaid, and subscriber and business payments will supplement the program's costs.

To control costs (see our October 2003 editorial, "Exploding health-care costs threaten other vital needs"), the expenses of the entire system will be voluntarily capped to grow by no more than approximately 3.5% the first year. All major health investments (equipment and buildings) will be regulated by a state board.

Advantages. The Dirigo plan offers these benefits:

- One critical and obvious factor is that it was politically feasible to start Dirigo, since both houses of the Maine legislature and the executive branch supported the enabling leg-

islation. Many business leaders supported the plan because in the previous year, health insurance premiums had increased up to 40%, and these executives wanted to experiment with a different approach to cost containment. In fact, in some surveys, business leaders noted that they worried more about health-care costs than they did about state and federal taxes.

- In addition, state leaders noted that health care in Maine is not an "export business." The care is provided in Maine and paid for by Maine citizens. As health-care costs rise, fewer financial resources remain to invest in new business development that could result in exports and more jobs.
- For many citizens of Maine, the universal health insurance system increased their sense of security. Further, it made them feel as if they were doing "the right thing" by ensuring that their uninsured fellow citizens had access to preventive and other health-care services.
- Paradoxically, prior to Dirigo, Maine had both the highest per capita health-care expenditures and the highest number of uninsured persons of any New England state. One small incentive for health providers was that Dirigo eliminated the burden of "free care," which should also reduce cost shifting from insured to uninsured patients.
- The plan offers the hope of reducing administrative paperwork by streamlining the electronic billing systems.
- A key feature of Dirigo is the initiation of a statewide system for assessing and auditing patient outcomes, which is likely to improve the quality of care.

Formidable barriers to success. These factors could stand in the way:

- Many business leaders and health-care providers believe Dirigo will create a huge bureaucracy. They also fear it will cause an increase in health-care premiums to cover the uninsured. Hospital administrators noted that, given the plan's built-in escalations, holding cost increases to 3.5% is probably an unrealistic goal without layoffs, elimination of services, and the development of an informal system of queuing or rationing of services. For example, 1 hospital expects liability premiums to increase 50%; pharmacy costs, 10%; and labor costs, 5% in the next fiscal year.

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- Fundamentally, it is the rate at which health-care costs rise that is likely to undermine the Dirigo plan's effectiveness. Hidden beneath these cost escalations is consumer demand for sophisticated procedures (such as hip replacements) and medications.
- Some doctors are predicting that this controlled growth of expenditures will reduce physician reimbursement. Apparently some specialists are already planning to leave Maine. Just as companies relocate to states with favorable business climates, physicians may choose to practice in states that offer environments favorable for supporting a 30-year career.

Maine Governor John E. Baldacci has made it clear that his goal is to provide "quality health care for everyone at a price we can afford." We should closely follow the impact of his state's experiment on health care. The positive features of Dirigo may be portable to other states, and negative aspects may be modifiable to maximize the benefits and minimize the risks of this approach to universal health care. ■

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REFERENCE

1. Physicians' Working Group for Single-Payer National Health Insurance. Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. *JAMA.* 2003;290:798-805.