

Commentaries on the Maine Health Care Reform Commission

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The final report of the Maine Health Care Reform Commission (MHCRC) was submitted to Governor King in November, 1995. Given the complexity of what we call the healthcare system as well as the moving targets of federal and state incentives for reform, the report accomplished a great deal in a short period of time.

Commission members were "mandated to offer a single payer universal coverage bill, a multiple payer universal coverage bill, and a bill to achieve reform through incremental changes to the existing system, emphasizing cost containment, managed care, and improved access. The commission was also mandated to cost out its recommendations" (Executive Summary, MHCRC Report).

Reactions to the MHCRC report were invited from individuals who represent constituencies which often have an influential role in healthcare. Five commentaries address pros and cons of particular elements of the commission's report: the first is by David Wihry, an economist at the University of Maine; the second comes from Peter Millard, Clifford Rosen, and Susan Thomas, practicing physicians in Maine; Representative Richard Campbell (r) comments on the development, process, and outcomes of the commission; Elizabeth O. Shorr, Blue Cross and Blue Shield, provides a third-party payer perspective; and Dale Gordon and Kim Boothby-Ballantyne offer a nursing perspective. Adjunct to these commentaries, Senator Dale McCormick comments on the work of the Maine Health Professions Regulation Project and links the efforts of this task force to that of the commission's recommendation to adopt an incremental reform plan in Maine.

Healthcare Reform Proves Difficult at State Level

Elizabeth O. Shorr

As healthcare moved to the top of the national agenda, many special interest groups advocated for changes in our healthcare system: universal access, comprehensive benefit packages, and insurance industry reforms. However, once the serious debate began, it was obvious that there is a huge gap between the goal of universal coverage and the nation's ability to pay for it. Based on the draft recommendation of the Maine Health Care Reform Commission, that same debate has taken place and the same conclusions have been reached here in Maine. Throughout the commission's exhaustive process of meetings, public hearings, and consultant reports, opinions and facts were offered by a broad cross-section of Maine citizens. Although the conclusion that universal coverage is not feasible at this time was clearly disappointing to the commissioners, several important points could serve as the basis of consensus on healthcare in Maine.

Universal Coverage Not Possible Without Economic Disadvantage

The commission leads its report by stating that "...one conclusion has become inescapable: the attempt to establish universal healthcare through the resources of the state alone, cannot be accomplished without putting Maine at a significant economic disadvantage vis-a-vis other states." Outside evidence indicates that the commission's conclusion is correct. Maine is currently fighting to attract and keep companies that will offer residents stable, well-paid jobs. We are competing not just against other New England states, but against states across the country where the cost of doing business is often less. We need to maintain every possible competitive advantage. It is no accident that the only state that has successfully mandated universal coverage is Hawaii, whose isolated state economy gives companies limited options for relocating.

We also believe that significant change in Employee Retirement Income Scrutiny Act regulations which exempt self-insured businesses from state insurance mandates, is extremely unlikely to occur. Exempting this significantly large segment of companies from contributing to the healthcare equation makes it more difficult to attain universal coverage because these companies are generally the largest and most financially successful. Compounding the problem is the trend toward legislating mandated healthcare benefits. Because self-insured companies are exempt from these state mandates, the mandates simply act as an incentive for more companies to self-insure to control employee benefit costs.

Public Health

Blue Cross has been involved with the public and private sector in improving public health in Maine since 1938 through specific promotion of public health initiatives. Two examples are the company's support of the Maine Medical Assessment Foundation in developing their study of pediatric asthma, and with the Maine Diabetes Control project to develop baseline data on diabetes. In addition, Blue Cross recently made an annual commitment of \$175,000 to the Maine Immunization Program toward the cost of childhood vaccinations. These initiatives have reinforced our belief in the need for public/private cooperation in the health arena.

The commission has recommended that the state fund a survey to estimate resource needs and to evaluate Maine's performance in each of the fourteen "core function" areas of public health. We would recommend that the state consider building on the efforts already made in developing Healthy Maine 2000, spearheaded by the Department of Human Services under Dr. Lani Graham. This plan documents the health needs of Maine residents and provides clear public health goals. Should any new program be initiated as a result, we agree that a cost/benefit analysis should be required.

The Role of Medical Data

From a public health standpoint, medical data are critically important to track progress toward reaching objectives and to identify potential problem areas. Much of these data are already being collected by the Maine Health Care Finance Commission, as well as by insurers and providers throughout the state. Clearly, this is also an area where public/private sector cooperation is essential, and there is already a strong history of cooperation starting with the 1976 founding of

the Maine Health Information Center by representatives of Blue Cross and Blue Shield of Maine, Unionmutual, Maine Medical Association, Medical Care Development, the Bingham Program, the Maine Department of Human Services, Emergency Medical Services, Inc., Health Insurance Association of America, and the Maine Hospital Association.

Much has also been accomplished in Maine in terms of moving towards the electronic transmission of data. Health information networks have been developed to provide a communications infrastructure for the inter-networkings of physicians, hospitals, payers, clinics, laboratories, home health agencies, employers and other healthcare entities. This simplifies administration for healthcare providers, an important issue in a regulated environment such as healthcare. Blue Cross maintains the largest health information network in Maine, and is currently involved in the creation of three integrated health information networks, two with hospitals and one statewide.

The commission's call for comprehensive health data systems is a positive one, and much of the data infrastructure is already in place. However, care needs to be taken to resist the temptation to "reinvent the wheel," as this will simply generate more healthcare costs. Another concern is the cost to physicians and thus to the healthcare consumer inherent in mandating extensive data reporting, especially those in rural private practices. This should be carefully evaluated in terms of the real value of the data collected. We believe the data should be collected and organized to the state's public health objectives. In fact, it is logical that the responsibility for data collection and manipulation should be an integral part of the state's public health responsibility.

Quality Assurance

The commission expressed concern that pressures to contain healthcare costs will negatively affect the quality of healthcare. They cite the annual report of the Physician Payment Review Commission, which indicated "a clear need to develop a quality assurance system that will provide external monitoring of health plans in addition to internal quality assessment methods." We think that the growth of managed care in Maine will do more than anything else to measure the quality of healthcare available through these plans and to make that information available to the public.

As the commission noted, the National Commission for Quality Assurance has uniform standards to evaluate Health Maintenance Organizations (HMOs), and Maine employers are beginning to recognize the value of these measurements. Requirements of the national commission affect quality improvement, physician credentialing, preventive health services, utilization management, member rights and responsibilities, and medical records. All major HMO players in Maine have completed or are undergoing evaluation by this national commission.

In addition, many healthcare companies in Maine have already initiated quality assurance programs targeting specific diseases. Blue Cross currently has eight clinical quality improvement projects underway, designed to improve the management of asthma, diabetes, allergies, and follow-up care of patients hospitalized for major affective disorder, as well as to improve access to preventive healthcare in the areas of coronary heart disease, breast cancer, cervical cancer and

first trimester prenatal care. In particular, asthma and diabetes are two chronic diseases that can be effectively managed at home, and new patient education programs have been shown to be highly effective in improving both quality of life and cost of care for these patients. These efforts are typical of requirements for accreditation by the National Commission on Quality Assurance.

While only about 15 percent of Maine residents receive their healthcare via a managed care plan, in more mature managed care markets both high quality and patient satisfaction are documented.

- According to the Health Care Financing Administration, elderly members of HMOs with cancer were more likely to be diagnosed at an early stage than their peers with traditional coverage because HMOs covered routine cancer screenings and annual physicals.
- Women in HMOs are more likely to obtain mammograms, Pap smears, and clinical breast exams than women in traditional programs, according to the Center for Disease Control and Prevention.
- A 12-year experiment by the RAND Corporation showed that members of HMOs had up to 40 percent fewer hospital admissions and saved up to 28 percent on healthcare costs without lowering their health status.
- A just-published joint study by Peter D. Hart Research Associates, Luntz Research Companies, The Mellman Group, Public Opinion Strategies, and American Viewpoint indicated that "Americans in managed care are satisfied with their healthcare coverage. Over-whelmingly, the weight of evidence indicates that those enrolled in managed care plans are as satisfied with their healthcare arrangement as are other Americans. What resistance there is to managed care comes not from managed care enrollees, but from those who do not have first- hand experience with this system. Indeed, the longer enrollees remain in a managed care plan the greater their degree of satisfaction."

Basic Benefit Plan

Blue Cross and Blue Shield of Maine has long been an advocate of the development of a basic benefit plan. This would have been a positive achievement on the national level, giving consumers an understandable yardstick to compare price and service of competing health plans. However, the standard benefit plan as defined by the commission is "more comprehensive than is currently available to the consumer." The price tag attached to the universal coverage option gives some indication as to why these "more comprehensive" plans are generally unavailable in the open market.

Our market experience indicates that the Maine employer and consumer need healthcare plans that ensure good healthcare, but do not necessarily cover the entire spectrum of healthcare options. Because consumers are driven by affordability as well as quality, they favor plans that use proven cost management tools. Individual case management, both in a preventive sense for chronic diseases and in a coordinating role for catastrophic illnesses, is a good example of cost management that enhances quality care.

The marketplace currently offers a range of plans so people can choose what is most important and affordable. Because consumer demand for preventive care is on the rise, more and more

plans are including it. This, along with the strong physician-patient relationship and the low out-of-pocket costs, contributes to the growing popularity of managed care.

Alliances

As proposed by the commission, the objective of an alliance would be to increase access, stimulate use of managed care, and conserve costs through administrative efficiencies and purchasing power. The principle of an alliance is that consumers and smaller businesses, who by themselves have limited purchasing clout, will gain leverage by buying through an alliance. However, because the proposed alliance is voluntary, only those groups who cannot negotiate a good deal outside the alliance will purchase inside it. This prediction has already come true in Florida and California, two states where voluntary alliances have existed for several years. In Florida, the alliances have attracted less than four percent of eligible businesses because it is possible to get less costly coverage outside the alliance. Despite strict regulations in California, the alliances seem to attract the least healthy consumers, driving alliance prices to unacceptable levels.

A second objective is to conserve healthcare costs. However, since the alliance would be voluntary, many businesses including large self-insured businesses would continue to purchase outside the alliance. In order to serve them, insurers and managed care companies would essentially be forced to operate in the same full-service mode as they do today. Since most if not all carriers are now staffed to provide quality assurance, marketing, reporting, grievance, and administrative functions, this would result in duplications that would actually add to healthcare spending.

A similar duplication issue is reflected in the proposal that the alliance would handle enrollment. For every day enrollment data are delayed in getting to the insurer or managed care company--the entity responsible for paying claims--the risk of paying ineligible claims increases. This would also add complications in terms of accurate and timely customer service, another area for which the insurer is responsible.

In our opinion, many carriers will be reluctant to offer a product within an alliance where control over marketing and rate is limited. If true, this will result in less competition and higher prices. More incentives do exist for carriers to stay out of the alliance, because the commission has recommended that risk rates must be the same for a product whether it is offered inside or outside the alliance. This represents a major disadvantage if the pools inside the alliance tend to be higher risk than the pools outside the alliance. A carrier would set an adequate rate based on the risk generated by businesses inside the alliance, then find that the same rate would be too high--and thus uncompetitive--outside the alliance.

Finally, the commission has not provided any clear documentation as to whether cost savings generated by the alliance would be sufficient to offset the expense of maintaining an oversight committee, and complying with the reporting requirements. Overall, it appears that the alliance will duplicate administrative costs, distance carriers from their customers, and make it more difficult to effectively manage risk. In summary, the commission has not made a clear case as to

how a healthcare alliance in Maine would operate differently than existing alliances in Florida and California, where they are widely believed to have had no impact on access or affordability.

Summary

Clearly, the solutions to the dilemma of how to provide quality healthcare to all Maine citizens are not simple or easy. Maine has succeeded in passing a law mandating the availability of healthcare coverage to individuals and small businesses. This was landmark legislation at the state level. There is hope as well as many challenges in the proposal to extend managed care to Medicaid recipients. This could bring some consistency of care, along with additional preventive care, to a population that has tended to access medical care in the most expensive, crisis-driven manner. The growth of managed care in the private sector, along with increased acceptance of National Committee for Quality Assurance standards, will contribute to controlling the rise of healthcare costs while maintaining measurable quality. The public's increasing awareness that healthcare dollars must be used as wisely as possible will influence the discussion of these complex questions surrounding the cost of healthcare benefits in Maine.



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