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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.

Playing With a Stacked Deck: Why was a Single Payer Plan Dealt Such Bad Cards

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Approximately 145,000 Mainers are currently without health insurance and a far greater number have inadequate coverage. The proportion of working Mainers receiving health insurance from their employers is continuing to drop and those with coverage are facing steadily increasing out-of-pocket costs. Although healthcare spending in 1991 totaled slightly less in Maine than the U.S per capita average of \$2,868, the average Maine family is spending almost 50 percent more than in Canada (\$1,915), or in Germany (\$1,659). In fact, Americans are spending far more for their healthcare than people in any other industrialized country, in spite of the fact that a substantial and growing proportion of the U.S. population is without coverage (Drew, 1993). Furthermore, spending is increasing faster in the U.S. than in any other country--an average of 10.5 percent annually from 1980 to 1991 (Levit et al., 1993)--and medical inflation has not been influenced

by 20 years of federal cost-control strategies, or by the rapid expansion of managed care in the past decade (Iglehart, 1994; Redelmeier and Fuchs, 1993). In 1993, healthcare spending consumed 14.4 percent of the gross domestic product (GDP) and cost over \$900 billion.

The MHCRC Draft Report

The creation of The Maine Health Care Reform Commission (MHCRC) in 1994 is the legislature's most recent effort to grapple with the enormous inequalities and inefficiencies of healthcare financing in Maine. The MHCRC was charged with drafting three alternative bills (universal-coverage single payer, a managed care plan, and a plan for incremental reform of the current insurance-based system) and, after an extensive process involving public input and external analysis, the commission released its draft report in June, 1995.

The three members of the commission should be commended for making the best of the few resources they were granted by the legislature and for creating an open forum, in which opposing groups were given the opportunity to participate in the process. The commission accepted public comment on the draft report until mid-September, with a final report due by the end of 1995. Not having seen the final report, this commentary will focus on the draft report of June, 1995.

The MHCRC draft report came to some surprising conclusions about relative benefits and costs of health reform strategies in Maine, conclusions which contradict previous findings. The draft report concluded that it will be impossible to institute universal coverage in Maine in the near future, that a single payer system would be extremely damaging to the Maine economy, and that the only viable alternative is to slightly expand coverage for low-income individuals. The draft report concluded that a single payer system would reduce Maine's gross state product by 4.8 percent by the year 2002 (versus a 1.1 percent reduction under a managed care plan) and that many businesses would leave Maine if a single payer system were instituted.

The remainder of this commentary focuses on the assumptions of the draft report, how those assumptions resulted in biased conclusions, and why a single payer plan is a viable option for Maine.

Assumption #1. The increased utilization that will result from a single payer system will bankrupt the system.

The MHCRC draft report (p.60) concluded that a single payer system would increase overall spending (premiums plus out-of-pocket expenses) in Maine from a 1996 baseline of approximately \$2.1 billion under the current system to \$3.2 billion in 1997, an increase of 48 percent in a single year. This large increase would presumably result from increased utilization because of pent-up demand for services; the increase projected under a managed care system would be smaller because substantial out-of-pocket expenditures would discourage increased utilization.

The commission's spending estimates under a single payer system are markedly different from the estimates recently produced by other governmental and private agencies (figure 1, see pdf format). Previous studies have assumed increased utilization under a single payer system, but the

increased spending from pent-up demand has been largely counterbalanced by savings in administrative costs. For example, in 1993 the Congressional Budget Office estimated that adoption of a universal coverage single payer system would result in a five percent increase in national healthcare spending (Congressional Budget Office, 1993); the U.S. General Accounting Office estimated that spending would decrease by 0.4 percent (U.S. General Accounting Office, 1992); and the accounting firm of Lewin/ICF estimated that spending would increase by 4.3 percent (Sheils, Young, and Rubin, 1992). In an effort similar to Maine's, Minnesota estimated that changing to a universal access single payer system would increase overall spending by 0.4 percent (Minnesota Office of the Legislative Auditor, 1995). A recent Health Affairs study estimated that universal coverage under the current healthcare financing and delivery system would increase overall health spending by two percent (Long and Marquis, 1994). How does one reconcile the commission's estimated 48 percent increase in spending under a universal coverage single-payer system with estimates ranging from a small decline to a five percent increase by other groups? Clearly, the commission's assumption that administrative costs would be four percent under a single payer system varies substantially from the known administrative costs of the Medicare program (2.1 percent) and of the Canadian single payer system (0.9 percent) (Letsch, 1993; Woolhandler and Himmelstein, 1991). The commission's estimates of increased utilization must also be markedly higher than those of other groups to explain the nearly 10-fold difference in predicted spending compared to the next-highest Congressional Budget Office projections.

In the commission's draft report, the projected spending increases from universal coverage under a managed care model are more modest. However, the failure to include subsidies for small businesses and low-income individuals in the managed care model (although all costs are contained in the single payer model) is a serious omission by the commission and may explain some of the differences in first-year spending projections between the managed care and single payer models.

Assumption #2. Costs will increase more rapidly under a single payer system than under managed care or the current system.

In addition to the high projected costs of initiating universal coverage, the commission predicted that overall spending would increase rapidly under a single payer system. From an annual cost of \$3.2 billion in 1997, the draft report projected annual spending of over \$5 billion by 2006. Under the managed care plan, spending would fall in the second year (from \$2.5 billion to \$2.2 billion), would not exceed \$2.5 billion until 2002, and would only exceed \$3.2 billion (the start-up estimate for a single payer system) in 2006. The projections for the "incremental reform" approach are similar to those for managed care (MHCRC Draft Report, table 6B, p. 60).

The rapid cost increases projected under the single payer plan are at variance with Canada's experience (Detsky, 1993) and about what is known of spending controls in global budgets. Global budgets are used by such disparate organizations as the Veterans Administration healthcare system and staff model health maintenance organizations like Kaiser Permanente, and are the best way to control healthcare spending (White, 1993). The attractiveness of a single payer system is that spending increases are planned through global budgeting and can be set at the level appropriate to economic growth. The goal of managed care companies, on the other

hand, is profit maximization and reductions in spending will only occur to the extent that this goal is advanced.

Assumption #3. Copayments are necessary to reduce utilization and therefore to control costs.

In light of the MHCRC's guiding principles, it is ironic that the commission embraced copayments (out-of-pocket payments by the consumer at the time medical care is given) as a means of limiting utilization of healthcare services and saving money. The draft report states:

The coverage of healthcare should reflect differences in people's healthcare needs, not differences based on factors such as geography or income. Ability to pay should not advantage certain subpopulations with regard to access to fundamental medical services. The poor should not face lower quality services or restricted access. Such limitations result in limited opportunities, can lead to pain and suffering and even loss of life. They can also lead to increases in total costs of health and welfare programs (MHCRC Draft Report, p. 14).

In contrast to these principles, copayments are discriminatory against low-income families and probably have only modest short-term effects on spending. The Rand Health Insurance Experiment showed that copayments caused people to delay or forgo healthcare and had modest overall effects on spending, but had adverse effects on health outcomes particularly among the poor and the sick (Brook et al., 1983; Manning et al., 1987). Once an individual consults a physician the intensity of that care is largely determined by the physician and not by the consumer. Thus, while physician visits for both needed and unnecessary care may be somewhat reduced by copayments, the overall effect on spending is limited (Rasell, 1995).

In addition, copayments reduce the use of preventive services. A recent study among Medicare recipients showed that only 14 percent of women who had copayments for mammography actually had the test performed, whereas 45 percent of those with employer-sponsored supplemental insurance (i.e., no copayments) appropriately underwent mammography (Blustein, 1995).

Copayments in the United States are already the highest in the world. Ironically, while the burden of copayments has increased markedly in the U.S. over the past decade, overall costs have increased more rapidly than in any other country. All other developed, industrialized countries have fewer copayments and higher rates of healthcare utilization than the U.S., but all spend markedly less on medical care (Rasell, 1995).

Assumption #4. Competition helps to reduce costs and promotes quality.

The MHCRC draft report assumed that competition will reduce costs and promote healthcare quality. It also assumed that overhead administrative costs (and profits) under a managed care plan would total 11 percent of premiums and that costs would increase by only five percent per year (MHCRC Technical Appendices, chapter IV, p. 30). Unfortunately, these assumptions do not appear to be based on current data. Premiums for managed care plans are generally slightly lower than for traditional health insurance, because managed care plans do not pay premium

taxes and because they have succeeded in "skimming" the youngest and healthiest enrollees. However, premiums for managed care plans have increased at the same rate as those for traditional insurance plans in recent years (Gabel, 1992). The General Accounting Office concluded that "although many employers believe that, in principle, managed care plans save money, little empirical evidence exists on the cost savings of managed care" (U.S. General Accounting Office, 1993). In California, one-third of the population is covered by managed care, but costs are 19 percent above the national average and rising more rapidly than in states where traditional fee-for-service policies are more common. Massachusetts and Minnesota, which have the second and third highest managed care penetration, have had similar cost experiences (Himmelstein and Woolhandler, 1993).

Managed care plans are often successful at reducing hospitalization and length of hospital stays, but the extra layer of administration (many physicians are now well-acquainted with the local "utilization review" team) has largely offset savings from reduced hospitalizations. Recently, the New York Times (1995) reported on the administrative costs and profits of large managed care companies (figure 2). Overhead amounted to 15-27 percent of premiums, a figure substantially higher than the 11 percent assumed in the draft report. The five largest managed care plans in California have administrative costs and profits which amount to more than 20 percent of total insurance premiums (California Medical Association, 1994). These figures contrast markedly with the administrative overhead of the Medicare program (2.1 percent) and the Canadian system (0.9 percent) (Letsch, 1993; Woolhandler and Himmelstein, 1991). The frustrating experience of Maine's 35,000 state workers and retirees with managed care is illustrative. The 1993 move from traditional fee-for-service to managed care for state employees was designed to save money. Instead, biweekly premiums for a worker with a family have increased from \$58 in 1993 (under the insurance-based system) to \$77 currently, and are projected to rise by another 15 percent next year (Bangor Daily News, September 8, 1995).

In what might be called the "Walmart-ization" of healthcare, the proliferation of out-of-state managed care firms will assure that most profits and administrative jobs for managed care go to large companies outside of Maine. Thus, while Mainers would be paying for a huge administrative apparatus, few of those jobs would remain in Maine. The record of deception by managed care companies participating in the Medicare program (Kertesz, 1995) suggests that a new state bureaucracy would be needed to police managed care companies, assuring that at least some new jobs would be created in Augusta!

Conclusions

The financial projections in the MHCRC's draft report are markedly out of line with the projections made by other mainstream researchers and bring into question many of the basic assumptions which went into the commission's models. Pessimistic conclusions that universal healthcare access is untenable in Maine in the near future should be seriously questioned by critical readers.

Other researchers have found that a single payer system may be a viable alternative to the current system, and interested readers may wish to request a copy of Minnesota's report at the address listed in the reference section of this paper. The major savings from a single payer system come

from reduced overhead and administrative costs. Much of the \$250 billion that the U.S. spends annually is not directly related to delivery of health services; it is paid to insurance and managed care companies as reimbursement for advertising, billing, administering claims, "utilization review," and profits. A sizable proportion of healthcare expenditures in Maine is consumed by administrative costs, estimated at \$400-600 million annually (Woolhandler and Himmelstein, 1991). A single payer system could save sufficient amounts to nearly pay for universal coverage in the first year, and global budgeting through a single payer mechanism is our best chance to control healthcare spending in the future.



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