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The Challenge of Preserving and Expanding Affordable Health Care in Maine

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The Challenge of Preserving and Expanding Affordable Health Care in Maine

by Wendy J. Wolf

Maine's health care system is in crisis. The state's health care expenditures represent the third highest percentage of Gross Domestic Product in the nation; state health care spending is projected to top $11 billion per year, or $8,291 per person per year, over the next seven years; businesses in Maine pay 12-23% more for coverage than the national and New England state averages; and, the state's uninsured and vulnerable populations continue to grow. Clearly, we are headed down the wrong road. In this article, Wendy Wolf charts the rising cost of health care in Maine and the implications of these costs for all Mainers. In turn, she looks at each of the drivers of cost and calls for a comprehensive approach to solving our crisis. Only when all of the players agree to work together and, more importantly, to make changes will we be able to change directions. Wolf argues it's high time we choose a different road.

Maine's health care system is ailing—and the prognosis for its continued health is unclear. Health insurance premiums are rising, employers and individuals are opting for coverage with higher and higher deductibles, and the downturn in the economy has left a growing number of Mainers unemployed and uninsured.

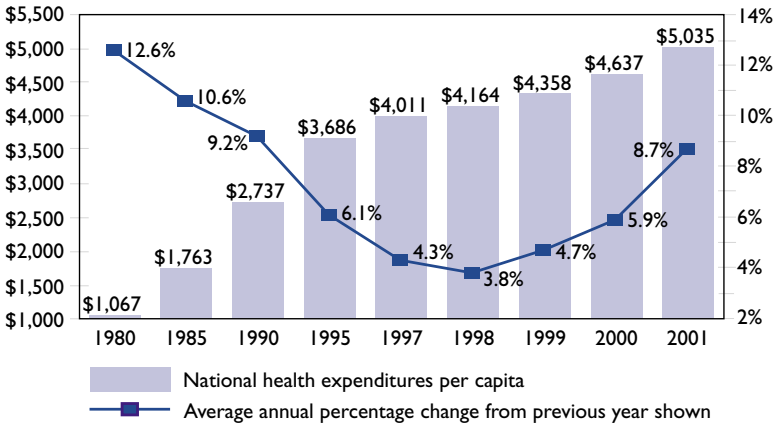
This change in health care cost and coverage follows a decade of economic posterity and lower cost. From 1991 to 2001, the national growth of health care spending averaged 6.5%. In fact, from 1980 to 1998, the average annual percentage change in health care costs was actually declining from year to year. This trend ended in 1999 when the cost of coverage and care started rising again at an accelerating pace (Figure 1). In 2001, health care costs grew 8.7%, accounting for $1.4 trillion in national spending (Levit et al. 2003).

America's health care spending is growing faster than the rest of the economy. It currently accounts for 14% of the nation's Gross Domestic Product—a figure that far exceeds the 9-10% of national income other comparable industrialized nations pay. While paying less for care, these countries insure all their citizens, who enjoy longer life spans than you and I. As one health policy analyst noted, "We're paying so much more for health care, but where's the bang for the buck?"

As the economy sags and health care costs increase, there's a growing concern in Maine and across the nation about losing one's health insurance coverage and being unable to bear the increasing cost of care. A March 2003 tracking poll released by the Kaiser Commission on Medicaid and the Uninsured showed that the public's concern about the rising cost of health care services or insurance eclipsed all other issues mentioned in the survey, including "being very worried about losing money in the stock market; not being able to pay their rent or mortgage; or being the victim of a terrorist attack" (Kaiser Family Foundation Health Poll 2003).

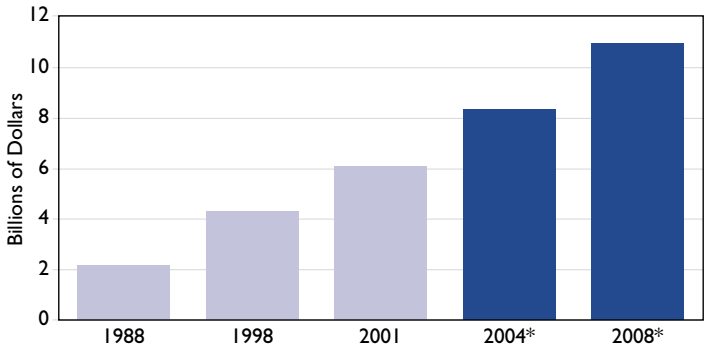
Although the rise in health care spending for Maine parallels the national trend, it's building on an existing costly system. In 1998, Maine's health care expenditures totaled more than $2 billion—the third highest percentage of any state's Gross State Product,

FIGURE 1: **National Health Care Cost Trends**



Source: Adapted from the National Center for Health Statistics, U.S. DHHS, 2002

FIGURE 2: **Maine's Health Care Cost Trends**



* Projections based on national and Maine-specific data at 13% per year from 2001-2004, and CMS projections at 5% for health care costs and 7% for Rx drugs from 2004-2008.

Source: Chollet, Mays, andAngeles 2002

exceeded only by North Dakota and West Virginia. From 1998 to 2001, overall health care spending has grown from $2 billion to over $6 billion. Over the next seven years, spending is projected to top $11 billion, at $8,291 per person (Chollet, Mays, and Angeles 2002) (See Figure 2). This projected rapid growth has prompted a growing chorus of concern about rising insurance and health care cost, particularly

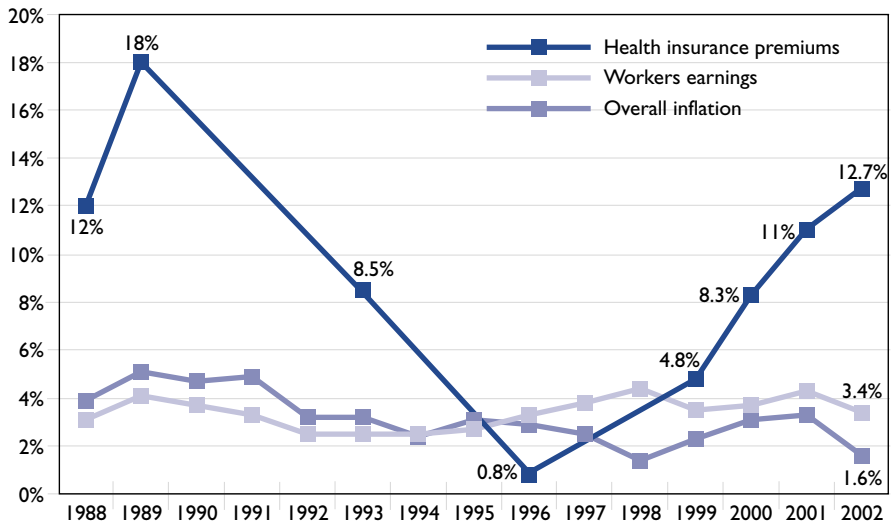
TABLE 1: **Why is Health Care So Costly in Maine?**

- Lack of universal coverage
- Inefficient, costly care for the uninsured
- Significant cost shifting
  - Inadequate government reimbursement
  - Uncompensated care for the uninsured
- An older, aging population
- Rural state with large geographic area
- Poorer health status with higher rates of chronic illness
- Advances in costly technology and new drugs
- Rising demand for services
- Inadequate information
- Changes in provider and health care systems
- Inconsistent quality
- Administrative costs
- Mandates

since there are many factors that elevate the cost of care in Maine even more so than the rest of the nation.

It's critical to understand the factors that influence coverage and cost if we're to have any success in expanding access to better health care for every Maine resident (Table 1). However, controlling the cost of care is like squeezing the proverbial inflated balloon—applying pressure on one point makes the balloon bulge in another place. We cannot focus on just changing one element in our health care system to provide a viable solution to Maine's health care crisis. Addressing rising health care costs must involve the collaborative participation of hospitals and health care systems, providers, employers, consumers, insurers and policymakers if we're to solve this complex issue.

FIGURE 3: **National Data on the Changes in the Cost of Health Insurance**



Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Source: KFF/HRET *Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996*

THE STATUS OF HEALTH CARE COVERAGE IN MAINE

Expanding health care coverage is essential to eliminate inequities in access to health care, but if Maine follows national trends, we are more likely to experience a growth in the ranks of the uninsured in the near future.

Most people across the nation and within Maine under age 65 receive their health care coverage through their employer. During the economic boom of the 1990s, providing comprehensive employer-sponsored health care coverage was a standard benefit for many companies. By 1996, annual increases in health care premiums had dipped to their lowest level in a decade, but that nadir was short lived. Health insurance premiums are once again on the rise at an unsustainable pace (Figure 3). A national survey of 3,262 public and private employers reported premium increases of 12.7% in 2002, with a projected 15% increase expected in 2003

(Kaiser Family Foundation and Health Research and Education Trust 2002).

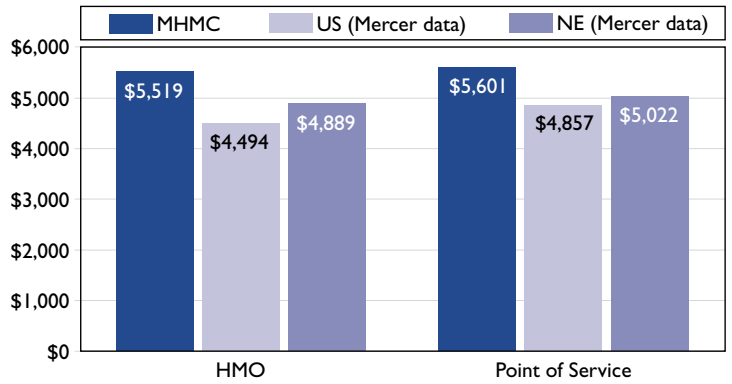
Compared to national trends, employers and individuals in Maine have faced even steeper increases in premiums over the last few years. In 2002, members of the Maine Health Management Coalition, which includes employers, hospitals, health plans, and providers, reported a 46% increase in the cost of their premiums between 1999 and 2002. They also found that the current cost of health care coverage for Maine businesses exceeds both national and the New England state averages with Maine businesses paying between 12-23% more for coverage (Figure 4).

These steep increases, particularly in the face of a slowed economy, make it a challenge for Maine employers to maintain their current level of employer-subsidized coverage. Many have had to increase employee contributions or decrease benefits. Others have dropped coverage altogether. There are no current data specific for Maine employers, but national surveys indicate that 44% of employers report they are likely to increase the amount that employees pay out of pocket for health premiums in the next year.

Across the nation, 55% of private sector establishments offer health insurance to employees, but only 49% of private businesses in Maine offer coverage. The primary reason that companies do not offer health insurance is cost. National survey data indicate that virtually all large firms (with at least 200 workers) still offer health insurance to their employees, compared to only 58% of small firms (those with three to nine workers). This discrepancy reflects the challenges small businesses face trying to offer health care coverage. Smaller companies typically pay higher premiums overall for the same benefits compared to large employers. As premiums rise, fewer small companies can afford to offer health insurance. Maine, with its high proportion of small employers, is particularly hard hit by this cost differential (Figure 5).

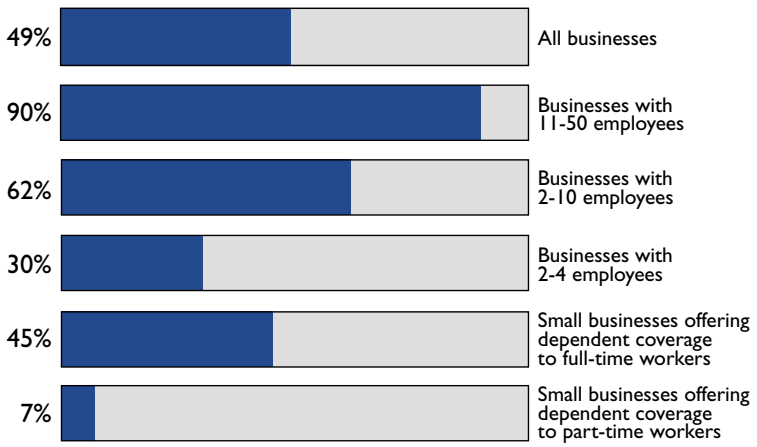
FIGURE 4: **Health Care Coverage Cost for Maine Health Management Coalition Members**

MHMC premium (employer and employee) by contract type



Source: Data from the Maine Health Information Center; comparison with Mercer national and regional averages

FIGURE 5: **Which Maine Businesses Offer Health Insurance?**

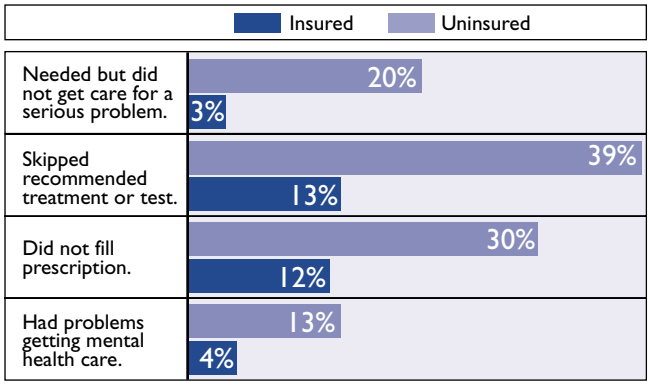


Note: Data derived from several sources. See text for full details.

HEALTH CARE COVERAGE AND THE UNINSURED

John, a 50-year-old delivery driver, felt the stress of his job getting to him. He was having more problems with indigestion and discomfort below his breastbone, but the Pepto-Bismol he routinely used didn't seem to be working as well. John thought he should see a doctor, but his employer didn't offer health insurance, and he was too strapped by car repair bills to pay for a check-up. One evening, while loading his delivery van, John suffered a heart attack. Although he survived, the hospital bills exceeded $10,000,

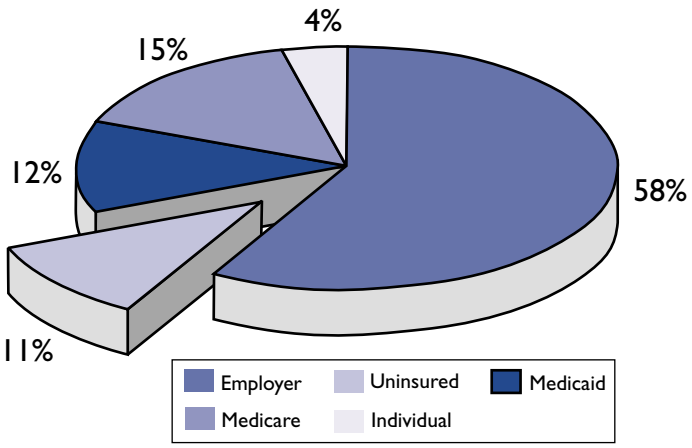
FIGURE 6: **Percent of Adults Ages 19-64 Experiencing Barriers to Care, by Insurance Status**



Source: Kaiser Commission on Medicaid and the Uninsured, *The Uninsured and Their Access to Health Care,* 2000

FIGURE 7: **Health Care Coverage in Maine**

Based on two-year rolling Census data: 2000-2001



wiping out his hard-earned savings. John doesn't know how he will now pay for his recommended rehabilitation.

There is no question that having health insurance coverage is one of the most important factors in preserving health and well-being (American College of Physicians 2000). People without health care coverage are more likely to delay visiting a doctor and are less likely to obtain preventive services. The uninsured seek care at later stages of illness, and face a higher risk of premature death compared to individuals with insurance (Figure 6).

Studies conducted within the state have shown that uninsured people in Maine face the same poor outcomes. More than half of uninsured Mainers have delayed purchasing prescription medications because they can't afford the expense. Twenty percent of Maine parents who lacked health care coverage for their children were unable to obtain care for their child's unmet health care needs (Ormond et al. 2000). People who lack insurance often wait until there is a crisis to seek care, and they do so in emergency rooms and settings were providing care is more costly, less efficient and less comprehensive.

Although the number of uninsured Americans declined between 1998 and 2000, with the faltering economy and rising unemployment, their numbers are once again on the rise. The last U.S. Census figures found 41.2 million Americans, including 8.5 million children, lacked health care coverage in 2000. In Maine, the number of uninsured reported by the census has remained relatively stable at about 11% of the population (approximately 140,000 people). Although the latest census suggests the number of people lacking health insurance in Maine is remaining stable, these data were collected over two years ago. With Maine's weakening economy and rising health insurance cost, newer state-specific surveys suggest the number of Mainers without coverage is increasing.

If coverage is so important to ensuring health and reducing costs, why don't all Mainers have health insurance? The answer to this question is complex and reflects the challenges of sustaining a system of

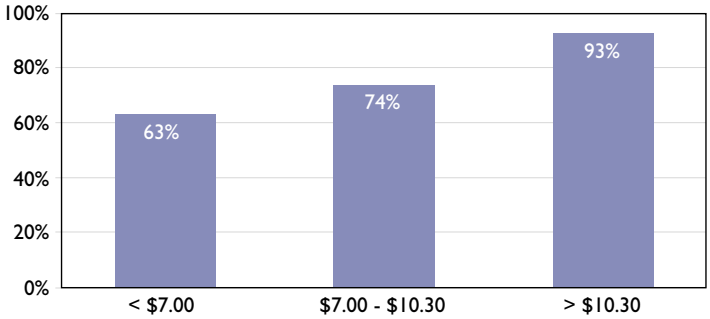
employer-based coverage that has served as the backbone of the nation's system of care since the end of the 1940s.

In Maine the majority (58%) of individuals under the age of 65 obtain their health care coverage through their employers (Figure 7). Another 4% of Mainers purchase individual coverage and the remaining 27% receive coverage through public programs, notably the federal Medicare program (15%) that provides limited health care coverage for nearly all persons age 65 and older, and Medicaid (12%).

Because employer-sponsored health care coverage is the most common mechanism providing insurance for persons under age 65, it's no surprise that the majority of the uninsured are adults between ages 21 and 64 years. However, it's important to emphasize that eight out of 10 uninsured adults are working men and women employed either full- or part-time. Half of these uninsured people live in families with incomes below 200% of the federal poverty level ($35,300 for a family of four). These hard-working people would like health insurance for themselves and their families, but coverage is either not offered by their employer or is simply too expensive to purchase.

In fact, employer-sponsored coverage is not offered equitably in the workforce. A survey of Maine businesses showed that health insurance is offered to 93% of workers earning more than $10 per hour, but it's only offered to 63% of those making less than $7 per hour (St. John, Ditre and Pohlmann 2000) (See Figure 8). Lower-wage workers are up against the wall. They are less likely to have coverage provided by their employer and they are hard-pressed to choose between necessities such as rent, food and other basics to spend scarce dollars on health insurance.

FIGURE 8: **Percent of Workers at Various Hourly Wages Working in Firms that Offer Coverage to All Full-time Workers**



Source: St. John, Ditre and Pohlmann 2000

SQUEEZING THE BALLOON I: COST-SHIFTING BY PUBLIC PROGRAMS

One major factor driving up health care costs is the effect of cost shifting from one sector of the population to the other. For example, the federal Medicare program—which provides coverage for Americans age 65 years and older, as well as people with disabling conditions, those on kidney dialysis and others—systematically underpays Maine's hospitals and providers for the direct cost of care. The federal Medicare program pays Maine providers just $0.88 on the dollar for care rendered to Medicare beneficiaries. This leaves hospitals and other health care providers short millions of dollars. In comparison to other states, Maine ranks 46th—right near the bottom—in federal Medicare reimbursement rates. Because of this under-payment, hospitals and health care providers look to other groups such as insurers, employers, and consumers to make up the lost revenue.

Another major source of cost-shifting onto the private sector is the state's MaineCare (or Medicaid) program. MaineCare, which is funded by state and federal revenues, is a government-sponsored health care program for low-income children and their parents, pregnant women, people with disabilities including low-income elderly, and very low-income adults. In 2001, nearly 191,000 Mainers received care through this program. MaineCare is a fiscal bargain for the state since the federal government contributes $2.00 for every $1.00 of state revenue spent on MaineCare beneficiaries. The state has considerable flexibility in determining eligibility, program structure and payment rates for service delivery in MaineCare, but this program also underpays the cost of care. The Maine Hospital

Association estimates that MaineCare pays only $0.80 on the dollar for care delivered to their enrollees.

By 2003 it is estimated that public sector spending, which includes Medicare, MaineCare, federal, state and local government spending for public employees and direct health care services, will finance more than 50% of all health care expenditures in the state. Yet the systematic underpayment of these programs means higher costs for others.

SQUEEZING THE BALLOON II: PROVIDING CARE TO THE UNINSURED

"A Young Woman, An Appendectomy, And a $19,000 Debt.

Dreams of a bright career in a big city lured Rebekah Nix here from the western plains of Texas two year ago. An appendectomy sent her home.

But not because she was ill. Ms. Nix, 25 years old, was fleeing the nearly $19,200 in medical bills that had piled up on her bedroom dresser. (She) couldn't fathom how two days in the hospital could cost so much, until she learned that people like her—who don't have health insurance—often are expected to pay far more for their medical care than large insurers, health-maintenance organizations, or even the U.S. government" (Lagnado 2003).

Adequate insurance is the key to getting health care. When Mainers are uninsured, they are far less likely to obtain preventive services. Doctor visits are delayed, and filling prescriptions and getting needed medication is difficult. Without health care coverage, people are three to four times more likely to report problems getting needed medical care, even for serious conditions. Many people assume our health care system provides comparable care to the uninsured, but a recent article reported that even for those involved in car accidents, the uninsured are 37% more likely to die from their injuries than those with insurance (Doyle 2002).

Medical outcomes are poorer for uninsured people. Individuals without health insurance are diagnosed at later stages of life-threatening illness, and are hospitalized more often on an emergency basis for chronic conditions that could be appropriately controlled through outpatient care. Rendering care in this manner is inefficient and far more costly than providing ongoing, routine care where providers can screen for and detect problems that might lead to a major illness before it strikes.

As previously noted, Medicare and MaineCare set payment schedules that are generally lower than the private market. Large insurance companies are often able to negotiate lower charges for health care. However, health care providers and hospitals will typically charge the full cost of care to individuals who pay directly. Although Maine law requires that hospitals offer care without charge to people with limited income, this applies to a small proportion of the uninsured. Others try to pay for their care directly out of pocket, but many of those who are uninsured cannot afford the entire cost of their care.

Last year, the Maine Hospital Association estimated that uncompensated hospital care cost its member hospitals $150 million. This shortfall is passed on to those who can pay, including health plans, employers who offer coverage, and those who purchase individual private insurance. In fact, Maine's major insurer, Anthem Blue Cross and Blue Shield, estimates that subsidizing care for the uninsured elevates premiums by 8-10% due to the effect of cost-shifting from uncompensated care.

MAINE'S HIGH COST POPULATION

Another factor driving the high cost of coverage and care is the profile of our state's population. Over the last century, life expectancies have risen dramatically, causing the median age of the U.S. population to rise. In 1990, the median age in the United States was 32.8 years, but by 2000 the median age had risen to 35.9 years. Accompanying this trend is the growth of our elderly population. Over the next 50 years the proportion of our nation's elderly will increase from 12.7% to 20.3%. This trend is even more dramatic in Maine where the proportion of older people is rising faster than the national average (Table 2). Older people generally use more health care services, driving health care costs even higher.

Maine is also a large rural state with a sparse population spread over a wide geographic area. Although

TABLE 2: **Proportion of Maine Versus U.S. Population Over Age 64 Years**

	Maine	U.S. Total
1940	6.90%	6.90%
1980	11.50%	11.30%
2000	14.40%	12.30%
2020	19.30%	

Source: U.S. Census

Maine's land mass could contain all the other remaining New England states, we still have to ensure that the 60% of Mainers living in rural areas have access to critical health care services. There are other aspects of rural life that also have a negative impact on health care coverage and cost. Folks living in rural areas are older and more likely to live in poverty, with lower median incomes than their urban counterparts. Rural workers also include a higher proportion of people who are self-employed or work for small companies where health care coverage is either not offered or too costly.

There also are fewer hospitals, health care centers and providers in rural areas, and the cost of providing care in these settings is higher overall. People in rural areas want health care services delivered promptly and close to home, but providing care in these settings is more expensive for each service rendered. For example, the small rural hospital must keep an emergency room physician available to care for a handful of patients per day. That facility also has to ensure that essential emergency equipment is on hand, that personnel are properly trained, and that salaries are paid, even though fewer patients receive care in this facility compared to a busy urban emergency room.

THE "PERFECT STORM" OF HIGH HEALTH CARE COSTS

Just as the economic slowdown is spurring the growth of the uninsured, Maine is also facing the "perfect storm" as we struggle to provide costly care for a growing number of Mainers with chronic illness. Maine has the fourth highest death rate due to chronic disease (Mills 2000). We lead the nation in three unhealthy lifestyle behaviors that increase our risk for chronic illness—tobacco use, poor nutrition and lack of physical activity. It is estimated the health care costs and lost productivity due to chronic disease cost Mainers well over $1.5 billion annually, or approximately $1,700 per adult annually (U.S. DHHS 1998).

It is critically important to do everything we can as a society—and as individuals—to diminish our risk of acquiring a chronic condition. Data provided from Anthem Blue Cross and Blue Shield shows that just 5% of their enrollees account for 55% of their health care expenditures and 1% of these individuals with severe chronic conditions account for 25% of medical costs. Controlling health care spending means identifying those individuals at risk and helping them avoid chronic illness. Since many chronic illnesses are influenced by lifestyle choices, adopting healthy behaviors and seeking appropriate preventive care can decrease this personal and societal fiscal burden.

The state also faces another health crisis that will dramatically drive up costs if left undeterred. Maine is facing a veritable epidemic in the growth of adult and childhood obesity. More than half of Maine adults are overweight, and the number of obese children in our state is growing at a rapid and unprecedented pace. Currently, it is estimated that the economic burden of obesity costs $450 per adult annually in Maine. Left untreated, today's obese children and teens will become tomorrow's chronically ill adults who will require much more costly care from our health care system. If we don't come together now to promote healthier life styles and behaviors, Mainers will be paying far more exorbitant amounts for the treatment and care of those with largely preventable diseases.

BETTER CARE, BETTER INFORMATION, AND CONTROLLING COSTS

Kathy, a 40-year-old computer technologist employed in a firm with a self-insured health care program, recently visited her doctor for a suspected sinus infection. After a careful examination, the doctor confirmed her suspicions, and prescribed a potent new antibiotic. Kathy filled the prescription, paying her $10 co-payment. The actual full cost of this new drug to her employer was $89. Kathy wasn't aware of the full cost, nor did she know there was another

equally effective older antibiotic that only cost $24. Her doctor prescribed this newer drug so Kathy would have the most up-to-date treatment. Neither Kathy nor her physician considered that the difference between these two therapies cost her employer $65—income that could have gone toward next year's salary increases or lower health care premiums.

In addition to requiring more care, the explosion of new technologies and the advent of widespread consumer information, including prescription drug advertising, is driving up the cost of care. New technology such as magnetic resonance imaging, laproscopic surgery, chemotherapy, and the development of new drugs greatly improve medical care. However, folding these new developments into routine care drives up health care costs. In April 2002, PriceWaterhouseCoopers estimated the impact that many of these factors play on increasing health care costs (Table 3). More than 20% of the increase could be attributed to the impact of drugs and advanced medical devices.

The success and visibility of medical advances also has prompted us to demand more services. Yet there is a disconcerting lack of knowledge on the part of consumers and providers regarding the actual cost of care. A recent study in the *Journal of General Internal Medicine* showed that doctors often did not know how much prescription drugs cost and how much patients pay for them. This lack of knowledge led them to unwittingly prescribe more expensive medications that push the cost of health care even higher (Korn et al. 2003).

TABLE 3: **Factors Driving Health Care Costs**

- 22% from drugs, advanced medical devices, and care
- 18% from increased provider costs
- 18% from general inflation
- 15% from increases in consumer demand

Source: National data from PriceWaterhouseCoopers 2002

On the consumer side, Drew Altman, President of the Kaiser Family Foundation, stated the problem succinctly, noting that when it comes to controlling health care cost, "[T]he enemy is us, the American people. We want more medical technology, we want it in our community and we want it now."

Part of this problem can be attributed to a lack of knowledge regarding the true cost of care. Data from the Muskie School demonstrated that nearly 75% of health care spending in 2001 was borne by someone other than the patient at the time they received services (Nalli and Coburn 2003). Yet each of us need to be more aware not only of how much health care truly costs, but how every decision we make with regard to our health and medical care affects overall health care spending. This scenario occurs over and over again with the net effect of driving up the cost of care, and consuming valuable fiscal resources. Providing better information to consumers and providers can help us all make more informed choices that will keep health care more affordable.

THOUGHTFUL CARE THROUGH IMPROVED QUALITY

After 20 years of working for a local shipping company, Stanley's knees were giving him trouble. His doctor told Stan he had arthritis, and referred him to an orthopedic surgeon for evaluation. The orthopedist recommended that Stan have arthroscopic surgery—a relatively simple procedure where a small illuminated tube is inserted into the knee joint that allows the surgeon to see inside the knee and smooth any rough joint surfaces that are causing pain. Stan had the procedure, and felt better for several weeks. However, his knee pain returned after a few months.

Medical care is driven by science and the careful study of what works and what doesn't. However, there is still much that is unknown or unproven in modern treatment and care. Many patients do not get recommended preventive services and treatment, while others get more care than they actually need. In fact, the Midwest Business Group on Health estimated that administrative inefficiency and the overuse, underuse and misuse of medical services waste 30 cents of every

dollar spent on health care. This inefficient waste of time and resources has spurred the recent trend in promoting better care through evidence-based (scientifically proven) medicine.

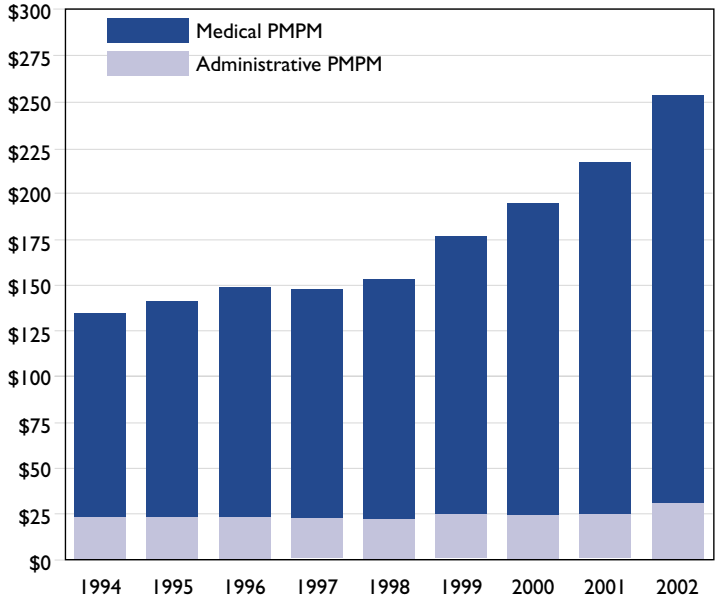
Medical care is constantly changing. It's critical to test both old and new therapies so we can retain what works, and eliminate treatments that are ineffective, or even harmful. The vignette about Stan is a good example Recently, medical researchers reported the results of a well-designed clinical trial that examined the proposed benefits of arthroscopic knee surgery for common arthritis (Moseley et al. 2002). In this elegant study, patients coming in for arthroscopic knee surgery were randomly assigned to either have the complete surgery or undergo the entire surgical procedure without the key treatment of scraping and cleaning the arthritic joint. Despite the widely accepted belief that this type of surgery improved arthritis, the investigators were unable to show any significant difference in pain symptoms or function between those who had the real surgery and those who didn't. With 650,000 such athroscopic knee surgeries performed a year at approximately $5,000 each, more than $3 billion in annual health care spending could be redirected to other, more appropriate and proven care.

Improving the quality of care also can cut health care costs in other ways. For example, providing better and more coordinated care for people with diabetes in Maine could save millions in annual health care spending. It has been estimated that if 90% of Mainers with diabetes had their illness under good control, there would be a 50% reduction in diabetes-induced kidney failure. This, in turn, decreases cost by eliminating the need for dialysis or kidney transplants. The estimated savings in Maine alone could reach $25 million annually.

We are fortunate that Maine has excellent health care facilities and providers that deliver first-rate care. In fact, for the second year running, the state's hospitals have finished third in the nation when it comes to providing Medicare patients with quality care. However, there is still much that can be done to improve quality. A recent study in the *Journal of the American Medical Association* found that many physicians are still slow in adopting standard care management practices. Providing high-quality care improves patient outcomes and helps control costs by applying medical care in a more effective manner (Casalino et al. 2003).

FIGURE 9: **Medical and Administrative Expenses of Maine's HMOs**

Per Member Per Month (PMPM)



Note: Medical and administrative expenses per member per month are the total of all medical, hospital, and administrative expenditures for the Maine domestic HMOs, as reported in their financial statements, divided by the total member months as reported in their financial statements, except that HMO Maine's financial information is based on gross amounts (exclusive of quota share reinsurance).

Source: Maine Bureau of Insurance 2002

THE ROLE OF ADMINISTRATION AND MANDATES IN COST

There has been much discussion about the potential cost savings that could be recouped from decreasing the amount of administrative expenses incurred by private health insurers. In fact, it has been estimated that in the private health care market, Americans spend close to 24 cents of every health care dollar for overhead. In Maine, private insurer's administrative costs are considerably lower, averaging 12-15%.

TABLE 4: **Everyone Has a Role to Play in Solving Our Health Care Crisis**

- *Individuals:* Adopt a commitment to health and healthier life styles. Use information resources to be a wise consumer.
- *Employers:* Work in partnership with employees to promote health, educate employees on the impact of health care choices, and improve prevention and quality to decrease cost.
- *Providers/Health Care Systems:* Practice evidence-based care and treat health care as a precious resource. Strive for better collaboration rather than competition. Include patients as decisive partners in the care process.
- *Insurers:* Keep administrative and premium costs low, with a greater focus on quality and care coordination to help trim costs.
- *Policy Analysts/Academics:* Provide the tools for real-time, data-driven decisions that have realistic policy impacts.
- *State Government:* Keep the focus on innovation but don't lose sight of the long term. Insure Maine's most vulnerable residents are cared for in a way that promotes health rather than acute intervention.
- *Federal Government:* Provide equitable payment for those served by Medicare, including enacting prescription drug coverage.

Although this figure is far below national averages, administrative costs for publicly funded health care programs are considerably lower. MaineCare, which is the state's Medicaid program, had an overall administrative cost of 4.8% in 2001. The federal Medicare program is estimated to expend even less, at 2-3% in administrative overhead. These data suggest there is the potential to lower administrative cost that could then result in some cost savings overall.

However, it's important to acknowledge that the vast majority of spending by private and public insurers goes toward the payment of direct health care costs. Data from the Maine Bureau of Insurance confirms that spending on medical claims dwarfs the proportion spent on health plan administration (Figure 9). A February 2003 Blue Cross and Blue Shield Association analysis showed that an average of 85.7% of commercial premiums went to pay medical claims, whereas 11.6% was spent on administration and 2.7% went toward profits. It's clear that while some savings may be realized by paring administrative costs and profits, the vast majority of spending will be unaltered unless we bring down costs associated with the direct delivery of care.

Although federal and state legislative mandates help to ensure equitable availability of coverage and health care services to individuals and groups, these actions also increase the cost of care. For example, a few years ago, federal lawmakers mandated that insurers and health plans provide 48-hour—as opposed to 24-hour—hospital maternity care, although there was no compelling scientific evidence that the additional day of care improved health outcomes. Mandates generally are enacted to protect consumers, but that protection comes with some additional costs.

WHERE DO WE GO FROM HERE?

Expanding and maintaining Maine's health care system is one of the most challenging problems today confronting legislators, policymakers, consumers, employers, insurers, providers, and health care systems. Our fragile patchwork system of public, private and individual coverage is ailing, and it leaves many working Mainers uncovered and vulnerable. The inequities of our current system, where health care coverage is primarily determined by one's income (or lack thereof), must be addressed so we can move toward a system that provides affordable, comprehensive, and high-quality health care for everyone in Maine.

We have a crisis in health care in Maine, but the magnitude of the problem is prompting a collaborative spirit and a real willingness for action. There is a growing chorus of voices from key stakeholders outlining their plans to improve Maine's health care system, and new alliances are forming to frame realistic solutions that have Maine on the forefront of health care reform. Maine has a new governor who has articulated a firm commitment to health care reform, and a new Office of Health Policy and Finance that promises action to expand access to care rather than generate

more reports or commissions. A new Health Action Team representing business, labor, hospitals and health care systems, providers, insurers, and consumers has been working nonstop since its appointment by the governor to bring forward achievable strategies that can expand Maine's health system through realistic "raging incrementalism." This support from Maine's leadership is critical to achieve a better and more affordable health care system. However, it doesn't negate the role that organizations and every individual must play in bringing about real and substantive change (Table 4).

Think back to 1960 to remember a time when America didn't provide a system of care for senior citizens. Now, 40 years later, it seems unimaginable that there was ever a time when our elderly were not assured they could receive necessary health care. Improving Maine's health care system is possible—and we can lead the way as long as every one of us is willing to be part of the solution.

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