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## Reaction to the MHCRC Draft Report

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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.*

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## Reaction to the MHCRC Draft Report

*David F. Wihry*

When the legislature created the Maine Health Care Reform Commission (MHCRC) in the spring of 1994, it reflected the widely held opinion that the healthcare system in Maine (as in the United States at large), while generally providing high quality services, is failing in several ways. We are putting resources into healthcare that could be used better elsewhere; we are not using healthcare resources efficiently; and we are not making health insurance available on terms that all citizens can afford.

The first two problems stem from important structural weaknesses in the healthcare sector. A huge deficit of consumer knowledge about the practice of medicine--natural in light of the complex scientific basis of modern medicine--has forced the ill to rely on the expertise and judgment of providers who have been rewarded--as are most sellers of services--for delivering more rather than less. Even if consumers had the knowledge to make informed and frugal

choices, the third-party nature of public and private insurance has removed the incentive to do so. These factors, along with costly advances in medical technology and an aging population, largely account for the rapid rise in healthcare expenditures over the second half of the twentieth century. The third problem, less-than-universal access to health insurance, is a by-product of the unequal way income and wealth are distributed in the United States. Since a wholesale restructuring of the income distribution--one that would make health insurance "affordable" for all--is unlikely, universal access has joined cost containment at the core of the healthcare reform agenda. The theoretical and empirical bases for the issues of efficiency and equitable access are well documented in the health economics and health policy literature. They have come to the forefront of the policy agenda. Efficiency (in the form of cost containment) and equitable access (in the form of guaranteed universal insurance coverage) were the key goals of the Clinton administration's ill-fated reform efforts. With the federal government's failure to make progress on either front, these issues have become the focus of healthcare reform at the state level. In Maine, these concerns have been the subject of actual and proposed reforms for more than a decade, and they were the principle goals of the MHCRC's immediate predecessor, the Legislature's Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program. When all is said and done, the MHCRC's work will be considered successful to the degree that its report helps move the state forward in the direction of greater efficiency in the use of healthcare resources and greater equity in access to healthcare services.

In turn, the extent to which the efficiency and equity goals will be furthered by the commission's efforts will depend on two considerations: the political feasibility of the options the commission presents, and their soundness as policy tools. The reflections below address each of these counts in turn.

### **The MHCRC's Approach**

In its draft report, the MHCRC responded to the legislature's mandate by describing three reform models, all based on the same benefit package, and by presenting estimates of the cost and economic impact of each. All the models address in one way or another the twin concerns of cost containment and expanded coverage for the uninsured. The commission also offered recommendations regarding public health, health information systems, quality assurance, and medical liability reform, all of which the commission sees as essential elements of any reform plan. The commissioners and their staff produced a coherent draft report on a complex topic in a very short period of time with ample opportunity for public involvement.

The report is a sound starting point for legislative action in 1996. The options outlined by the commission represent the principal generic approaches that are available to state lawmakers for trying to restrain healthcare costs and to expand access to health insurance. In the draft report, each model is presented clearly and compactly in its essential features. Estimates of the cost and economic impact of the various options are as likely to be reliable as any the commission might have been able to acquire with its limited budget.<sup>1</sup>

However, in what is perhaps a step beyond the letter of the legislature's charge, the commissioners chose to recommend and argue for only one of the three options they presented: an incremental approach that would address equitable access by extending Medicaid to include children in families with incomes up to 250 percent of the poverty line, and would address cost

containment by relying on emerging market forces-- augmented by a state-sponsored insurance purchasing cooperative.

### **Political Constraints**

Advocates of universal coverage will likely argue the commission may have overreached its mandate by advocating only one of the three options it was instructed to explore. The commission's report surely will make it more difficult for those who support reform models that ensure universal coverage to make their case. Nonetheless, while the commission may be faulted for succumbing to the temptation to express its own opinion, it should be credited for taking into account--at least implicitly--the current political and economic climate for healthcare reform. Indeed, it would make little sense to put forward a program that either lacks the political base to be enacted or, once enacted, will lack the political underpinnings to survive and function effectively. Unfortunately, in the political arena the ideal solution to a problem (in this commentator's view, the single-payer model applied nationally) is often the one least likely to prevail and endure. Recent attempts at significant healthcare reform in Washington and in Maine testify to this lesson and suggest that the status quo in healthcare will be hard to radically reform.

A case in point is President Clinton's Health Security Act. The President's initiative foundered in Congress for several reasons that suggest that basic healthcare reform will be as challenging a political goal in Maine as it has been nationally. The following parallels should be kept in mind:

- Congressional Democrats were not unified in support of the Clinton proposal. Many supported basic reform in principle but balked when faced with the opposition of powerful constituencies. The history of the Maine Health Care Finance Commission (MHCFC) reflects a similar phenomenon at the state level. Political support for the MHCFC, substantial early in its life, eroded steadily once the hospitals it regulated managed to organize an effective anti-regulatory campaign. The forces arrayed against a radical restructuring of the healthcare payment and delivery system in Maine--i.e., against either a single-payer approach or mandated universal coverage--would be formidable to the point of invincibility.
- Congressional Republicans displayed increasing conservatism on fiscal issues and increasing solidarity during the last Congress. The same forces are at play in the Maine legislature and will be a powerful obstacle to radical healthcare reform for the foreseeable future. Fiscal conservatism is the linchpin of the Republican strategy for wresting full control from the Democrats who have dominated the legislature for so long.
- To avoid further unbalancing the federal budget, Congress had constrained itself not to create new programs without estimating their cost and specifying where the needed financial resources would come from. In stark comparison to earlier major social reforms--such as Social Security and Medicare--good long-term cost estimates were available to federal lawmakers and could not be ignored in the face of demands to balance the federal budget. At the state level, budget balancing is always an issue. Operating deficits are not an option. This means that new spending must be financed either by cutting programs or raising taxes. The Maine Health Plan fell prey to the demands of a tight state budget, as did the state's earlier flirtations with subsidized catastrophic coverage and a subsidized high risk insurance pool. The kind of actuarial and economic forecasting technology that better informed Congress's deliberations on healthcare reform also made possible the cost and impact estimates that led the MHCRC

to worry about the potential adverse effect their more generous models might have on the Maine economy. The commission's estimates--however shaky in this very difficult area of analysis--will have a major conservative impact on legislative deliberations about healthcare reform in Maine.

- Short-term party politics--the perennial maneuvering for votes--often overlies more fundamental political forces that reflect the distribution of benefits and costs of government programs. From this perspective, the Clinton proposal was doomed from the start. Nationally, only a small minority of the population would have benefited from a move to universal coverage. The cost would be borne by the majority and would have been distributed across some very powerful interest groups, including physicians, hospitals, drug companies, insurers, small business, and the elderly. In contrast, the uninsured minority--those with neither public nor private insurance coverage--are among the most poorly represented in the political process. All of this is as true of Maine as it is of the nation at large.
- Perhaps recognizing this dismal political arithmetic, the Clinton administration dubbed its proposal the Health Security Act, a title that might have broadened its appeal to include that portion of the middle class whose insurance coverage is always under some threat from the business cycle and is threatened more recently by the wave of corporate downsizing. While the threat from private sector restructuring continues, augmented at the state level by the threat of business relocations elsewhere, an improved economy has taken some of the edge off of the security issue nationally and, to a lesser extent, in Maine. Further, Maine's recent health insurance reforms may have further blunted the security issue, although the impacts of these reforms have yet to be assessed.
- The Clinton bill was long (over 1300 pages) and complex. The institutional changes it proposed were abundant and novel. What was intended to be seen as a market-oriented approach had large doses of government bureaucracy built in. In all, the workability of the proposal was difficult to assess and its implications for potentially affected parties were shrouded by its complexity. Such is likely to be the case with any attempt at wholesale restructuring of the healthcare finance system. Complexity means uncertainty and uncertainty can be exploited by opponents of change. It is difficult to defend what the public does not understand. The MHCRC was wise to stick to the essential elements of the models it presents. The relative compactness and clarity of the commission's presentation will have to be preserved when legislation is written, if significant reform is not to run into opposition on grounds that proposals are not comprehensible.

In Maine the political fortunes of basic reform are further limited by two factors. Considering all of the above obstacles, basic reform is unlikely to survive the legislative process without the enthusiastic support of the governor. In Maine this necessary--though certainly not sufficient--condition, for significant change in healthcare policy appears to be absent at the moment. Secondly, Maine's economy is much more open and vulnerable to external competition than that of the U.S. at large. This means that increased tax burdens--not matched by similar changes in other states--could place the state at a competitive disadvantage in recruiting and retaining business enterprises. The commission's report makes much of this fear, which--combined with the strictures of the Employee Retirement Income Security Act--forms the basis for its rejection of universal coverage as too costly an option at this time.

Beyond these political and economic constraints, the commission was further challenged by the fact that the healthcare landscape continues its rapid evolution from a system driven by the isolated decisions of individual providers to one driven by institutional controls over physician behavior. Again the Maine Health Care Finance Commission (MHCFC) experience is instructive, since its regulatory program--Maine's rather dramatic attempt at healthcare cost containment--had to be superimposed on a rapidly changing institutional landscape, a consideration that has contributed to its recent demise. The MHCFC's ultimate weakness was that in the end the revenue limits it was setting exceeded in many cases what the hospitals themselves were choosing to charge. This anomalous situation arose partly from the erosion of the commission's regulatory program by statutory changes won by the hospital lobby and partly from the developing pressures of rapid structural change in the marketplace. The hospitals were able to argue, with some basis in fact, that the institutional environment in which the MHCFC was initially placed had ceased to exist and that the forces of competition had rendered public regulation redundant. In effect, trying to basically restructure healthcare finance and delivery during what amounts to an institutional revolution would be akin to performing open heart surgery on a moving bicyclist. The commission's preferred option of incremental change offers the least challenge to the flow of events in the healthcare industry and thus, regardless of its weaknesses, holds the most promise for avoiding rejection in the long-term were it to be adopted by the legislature.

### **Substantive Issues**

But while the commission's favored model may be the most politically realistic of the options available, it is vulnerable to criticism on several grounds, for the very reason that it does buy into the structural realignments of the healthcare industry that are already taking place. Here are some considerations that should be kept in mind as the legislature weighs the commission's favored proposal.

First, the commission wishes to count on the development of competitive forces to achieve cost containment. But the emerging structure of the healthcare industry is not competitive in the sense economists use the term. Competition requires a large number of buyers making informed choices among a large number of sellers. The healthcare delivery and finance systems are moving in quite the opposite direction. Although the amount of information about providers is improving, the choices available to buyers are becoming more and more limited as hospitals merge and doctors combine with hospitals and with each other in various forms of provider organizations. On the other side of the market, choices are being made not by the individual consumer, but by the major corporate payers: insurance companies, large self-insured employers and government entities and, in the commission's preferred model, a government-sponsored buyers' cooperative. The issues that should concern the public as this new regime emerges are these:

- Will the new market power of the corporate and governmental buyers simply be neutralized by the accelerating consolidation on the supply side? Being a big buyer is of little use if there are not multiple sellers from which to choose.

- Will consumers--the ultimate payers--be able to exercise effective control of the decisions of the corporate and governmental buyers? Can individual consumers/citizens/patients expect that the system will work in their interest and not in the sometimes conflicting interests of the organizations which nominally represent them?

The commission's responses to these issues deserve close attention. Its endorsement of anti-trust scrutiny of provider consolidations is lukewarm at best. If the legislature adopts the commission's favored approach, it should mandate and fund an enhanced program of anti-trust enforcement to forestall the development of excessive market power among providers. Competition will only work if there are many providers from which to choose. On the other hand, the commission's recommended governance structure for the purchasing alliance it proposes is sensitive to the need for consumer control. The governance structure the commission describes--a non-governmental agency dominated by consumers and employers--appropriately seeks to ensure that consumers will be adequately represented and provider/insurer conflicts of interests will be avoided. This kind of governance structure is essential if there is to be any hope of insulating the proposed buyers' alliance from political and special interest pressure. It should be kept in mind, however, that most consumers will not be receiving coverage through the alliance and will not have a similarly democratic means of influencing the insurance options available to them. Collective bargaining will be the tool through which the nature and scope of health insurance coverage will be determined in the private sector for those in unionized industries. Those working in non-unionized situations will have still less control over the terms on which healthcare will be provided to them, if it is provided at all.

Second, as more and more people experience the constraints of managed care, it is becoming apparent that this highly touted solution to the cost problem is a mixed blessing. The old system of incentives for providers to do more is being replaced by a new system of incentives-- and direct controls--that induce providers to do less. As in most economic matters, the issue is balance: to do neither too little nor too much. The mechanisms that will achieve this balance in a managed care regime are unclear at this point. Already, utilization guidelines have become politicized. Concerns about early discharge after childbirth have led to calls for legislative intervention and, according to a recent news reports, the entire budget of the Agency for Health Care Policy and Research is threatened as a result of provider objections to the agency's published spinal surgery guidelines. Although some ethicists believe that public debates on these difficult economic/ethical issues are desirable in principle, it is not clear that their outcomes, dependent as they are on the vagaries of the political process, will be in the patient/payer's best interest.

Third, the incremental approach espoused by the commission offers little or nothing by way of decreased bureaucracy and reduced administrative cost and complexity. The evolving system the commission endorses is decentralized and pluralistic, offering none of the administrative economies that would be available from a single-payer system.

Fourth, for most advocates of healthcare reform, the commission's recommendations will not be seen as going far enough in the direction of universal coverage. The suggestion that universal coverage be left to the federal government will be seen as a counsel of despair in light of the current political climate in Washington. Indeed, the commission could have done more for access even in the context of its own favored model. By its consultant's estimate, the incremental model is expected to generate a .5 percent increase in state per capita income by the year 2002.

Given the baseline projection of \$16,453 for per capita income for that year, this means an increase in income of \$82.26 per capita, or nearly \$100 million in total, based on 1990 Census population data. If this sum were retained in the healthcare system, it could be used to make substantial further inroads into the problem of the uninsured. By uncoupling equity of access from cost containment, the commission may have missed an opportunity that the legislature may wish to pursue.

Finally, the commission will be criticized for not reporting on additional variants of its basic models, variants that might render one or the other more attractive in terms of cost. For example, it would be useful to know how sensitive cost estimates would be to variations in the standard benefit package. Although the commission met the letter of its mandate by costing out the same benefit package for each option, it would be useful for legislators to look further into expanding the number of people who might be covered in a mandatory system by requiring a more modest set of benefits than the expansive package the commission examined. Oregon's experience with developing a more limited benefit package for those receiving subsidized healthcare suggests that this approach would entail a painful political process, but it may be worth a try.

All things considered, the commission's cautious approach, embracing market forces for cost containment and a modest expansion of coverage for the uninsured, does provide some realistic hope of movement from the status quo; but, if the commission's recommendations are accepted by the Maine legislature, implementation should be watched with equal caution.



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## Endnotes

<sup>1</sup> The commission's consultants, Health Systems Research and Coopers and Lybrand, are appropriately cautious in presenting their results, pointing out with respect to their estimates of economic impact that "...the process of projecting effects far out into the future is far from precise and heavily reliant on assumptions about the future environment and behavioral responses to possible policy changes." There is indeed little basis in past experience for generating behavioral assumptions for the multiple-payer model and no basis in past experience for generating behavioral assumptions for a state-run single payer model. Readers of the commission's report should bear these caveats in mind.

**Full cite:** Wihry, David F. 1996. *Commentary: Reaction to the MHCRC draft report*. Vo1. 5(1): 27-32.