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# A Political Process That Worked: Comprehensive Healthcare Reform in Progress

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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.*

## A Political Process That Worked: Comprehensive Healthcare Reform in Progress

*Richard H. Campbell*

The draft recommendations of the Maine Health Care Reform Commission were both shocking and encouraging. I was shocked at the recommendation not to pursue single or multiple-payer universal coverage systems, yet encouraged to learn that the process of fact finding--which pursued a particular benefit package along with a definition of cost to the citizens--had produced recommendations whereby reality prevailed. I was pleased the outcome had not been determined by emotions and a political environment out of touch with the financial means of Maine's people.

The commission's conclusion: "the attempt to establish universal healthcare through the resources of the state alone cannot be accomplished without putting us at a significant disadvantage vis-a-vis other states," is in my assessment a fair conclusion. This recommendation has been unfairly criticized by advocacy groups promoting the concept of universal healthcare.

Groups who tried to manipulate the process and had commissioners publicly advocating their cause are now disenchanted.

## **Background and History**

The 1992 election thrust me into an arena which could alter an industry accountable for over 15 percent of Maine's gross state product (GSP). Having been elected to my first term in the Maine House of Representatives and assigned to the Legislative Joint Standing Committee on Banking and Insurance, we were assigned the task of providing a solution to our state's number one issue--healthcare reform. In Washington, President Clinton and a Democratically-controlled Congress had put healthcare reform at the top of the national agenda. Their universal healthcare concept had bi-partisan interest along with substantial public support.

Augusta had similar momentum. John Martin had been re-elected House Speaker and Senator Dale McCormick had been appointed Chair of the Banking and Insurance Committee. A bill before the Banking and Insurance Committee, LD 1285: An Act to Provide Family Security Through Quality Affordable Healthcare, co-sponsored by Senator McCormick, had the legislature buzzing. The stars seemed to be aligned properly with the Democrats controlling both bodies of the legislature. Except for the Republican governor's promised veto and the element of time, it appeared universal healthcare for Maine was inevitable. However, because of my business experience and awareness of the adverse effects that government regulatory processes can have on the economy, a mandated universal coverage, single payer healthcare system run by the government had little to no appeal to me.

Comprehensive healthcare reform, however, became significantly important to me. I have been in business for 20 years and have observed healthcare costs rise at triple the rate of inflation. I was now in a position to move along further reform of the healthcare system and to bring creative common sense solutions to a process historically driven by politicians without actual experience in a field upon which they would have significant impact.

Committee debate began with community-based public hearings, first in Augusta, then moving to Portland, Lewiston, Bangor, and concluding in Presque Isle. Early in the process, hearing halls and council chambers were filled with advocates for universal healthcare. In Portland a demonstration was staged outside City Hall sporting a mock hanging of a figure with a sign indicating the ultimate demise of anyone who dared oppose the pending legislation (LD 1285).

A more rational and sensible perspective on the issue began to emerge at Bangor's forum. Opening remarks by a local legislator essentially reprimanded those in opposition to this legislation and challenged opponents to offer a better solution or they need not speak. This individual also predicted that due to the crucial nature and immediate need to correct a system so totally out of control, LD 1285 would be enacted by the end of the 1993 first regular session of the 116th legislature. If Speaker Martin had been stronger and the newly elected moderate freshman legislators were less tenacious, this probably would have been the case.

The Bangor hearings provided real insight into the problems of healthcare. Testimony offered by consumers, providers, and insurers expressed concerns about access, rising costs, abuse, duplicate documentation, out-of-touch regulatory systems, and essentially an industry fraught with frustration but genuinely committed to comprehensive reform.

A woman in Presque Isle finally drove the point home. In a much less formal and adversarial atmosphere she spoke on behalf of herself and the other hardworking rural citizens of Maine. She was a bookkeeper and office manager for a local small businessman. She told her story with respect to the financial and regulatory burdens state and federal governments place on small businesses. She succinctly told us to stop trying to provide citizens with political solutions. Leaving her and her employer alone, stopping the mandates, leaving the money in their paychecks, and allowing them to solve their own problems made more sense to her.

Thus, our regional exposure to the issue of healthcare reform defined a need to further examine the issues and eventually LD 1285 was carried over to the second regular session of the 116th legislature. Throughout the summer and winter of 1993 and 1994, national reform was foremost in the media and minds of citizens. President and Mrs. Clinton's plan revealed the issue's complexity as well as the nation's commitment to change. I attended two town meetings with Mrs. Clinton. In Boston and Orono we heard the same frustrations with a system which was viewed by many to be the best healthcare system in the world. Clearly issues of access and cost containment had come to the forefront.

The legislature reconvened for the second regular session and began deliberations on healthcare reform in committee work sessions. The momentum at the national level had waned and in Augusta the lack of support for universal healthcare was becoming apparent.

It didn't make sense to create a completely new system of healthcare administered by a government entity. Medicaid, Medicare, and the Social Security system illustrate how cumbersome large bureaucracies can become. My desire for a common sense approach created frustration as I watched the political process. In a meeting with Republican members of the committee and representatives of Governor McKernan's Administration, I suggested that we separate the legislature from this process by creating a forum in which consumers, providers, and insurers could reform themselves. I was told this couldn't be done. Representative Edward Pineau, Democratic House Chair of the Banking and Insurance Committee had also been working on a similar concept.

The committee recognized a need to advance comprehensive healthcare reform. Through a true collaborative bi-partisan effort, the Maine Health Care Reform Commission was created specifically to engage all stakeholders to research and draft legislation for a system increasing access and containing costs. The mandate was clear, explore three models: single payer--universal coverage, multi payer--universal coverage, and an incremental reform of our existing system. Each model would have a standard benefit package. The commission was required to provide costs for each model.

## **Early Frustration and Growing Pains**

Bi-partisan support for passage of the commission's recommendations is critical, especially since the 117th legislature's balance of power combining the Republican Senate and the 75-75-1 House of Representatives is two seats. While commissioners needed to maintain the highest level of credibility, an unexpected development occurred early in the appointment process and it began to erode. The appointment of Representative Charlene Rydell, co-sponsor of LD 1285, to the commission provoked disappointment and suspicion. The president of the Senate and the Speaker of the House not only created questions about the commission's ultimate recommendations but also the appropriateness of appointing a standing legislator to a compensated post created by the legislature itself.

Another unusual event occurred soon after organizational meetings had begun. The three commissioners decided to forgo their compensation and donate those funds to a consumer advocacy group. This group, in turn, would administer those funds for the purpose of transporting its members to public hearings. This smacked of undue lobby influence and conjured up recollections of earlier committee hearings.

Well before the data collection was completed the commission's advocacy for universal coverage became apparent. Commissioners' individual statements and press releases continued to potentially compromise the process.

## **Observations of Draft Recommendations**

This commission was also charged with understanding the ramifications of its actions on the state's economy by defining the costs of each model. This tool will be extremely valuable for the legislature's examination of healthcare reform. My review of the draft recommendations revealed some inconsistencies with actions taken by the first regular session of the 117th Legislature. The proposed "model of incremental reform, provides the opportunity to increase access, stimulate the use of managed care and conserve costs through the administrative efficiencies and purchasing power of an Alliance." In the early implementation years of this proposal, the Maine Health Care Finance Commission (MHCFC) was to assist this alliance. MHCFC administrative functions were eliminated by the 117th legislature and therefore will not be in place for that assistance. Also mental health parity suggested by the draft was an insurance reform recommended by the Banking and Insurance Committee, passed by the 117th legislature.

The legislature's task will be to secure answers to many questions before passing healthcare legislation. The Maine Health Care Reform Commission has provided valuable data and will prompt many questions. For example, how does the plan "to provide additional coverage for children under age 19 by expanding medical eligibility for kids up to 250 percent of federal poverty level" affect medical costs? What is the definition of "Public Health Expenditures" in the general fund budget? How was the 145,000 uninsured Maine residents estimated and what is the breakdown of this figure? Has rural healthcare been addressed considering the shortage of primary care physicians in those areas? Will the alliance model provide a board of directors with an ability to function decisively on such matters as competitiveness and separation of Medicaid risk pools from any other risk pools? Specifically how will the statute "avoid the issue of

creating a new or bigger state bureaucracy while possibly enjoying privileges such as limited tort immunity?" How would the alliance's public accountability be addressed? Will "distancing the alliance from mainstream state government to insulate it from political and other pressures that allow special interest influence to separate and pressure five members of the board" render them dysfunctional, similar to the Workers Compensation Board. Will the commissioner of the Department of Human Services be unbiased enough to prevent that? How broad is the premium assessment? Does it include all health policies or only those sold through the alliance? Is this a hidden form of taxation for the purpose of financing a quasi-public/private agency in competition with private business? Will minimum benefit packages be offered for those wishing to take responsibility for themselves? Are all insured expected to participate in co-payments to the extent of their ability to pay? How does this model affect self-insured groups? Will this model significantly reduce the charity care aspects of healthcare which now are inflating provider costs? What further insurance reforms are necessary for this model to achieve its goal? Has preventive healthcare been sufficiently employed? Will this legislation make advances in containing long-term healthcare costs? And ultimately, with public sentiment moving toward less government, will this model satisfy that demand or are we pursuing a solution which is in conflict with the public's desire?

### **Healthcare Reform to Date**

The 115th, 116th, and 117th Maine legislatures have made important progress toward increasing access and containing costs. The Workers Compensation reform legislation of the 115th legislature restructured Maine's worst-in-the-nation compensation system, helped reduce workplace injuries, and continues to reduce insurance costs ahead of schedule. The mandated community ratings plus adjustments implemented by the 116th and 117th legislatures has helped to reduce the band on premiums, which in some cases was up to a 600 percent differential. Legislation permanently fixed the band at 20 percent, allowing no greater than 40 percent differentials charged for insurance premiums. Portability and pre-existing conditions have also been addressed. Most recently the mental health parity legislation passed by the 117th legislature and enacted this summer could have tremendous effect on healthcare costs. Institutional costs could diminish with early treatment and preventive care, thus reducing the impact on families, taxpayers, the state, and the healthcare industry. Elimination of the Maine Health Care Finance Commission, an outdated regulatory agency, has provided the industry with the flexibility to pursue its own solutions to runaway healthcare costs without bureaucratic regulations on what should be service driven issues.

The provider sector of the healthcare industry in recent years has also dedicated itself to the concerns of access and cost containment. Recognition and response to a changing industry, political pressure, competitiveness, and demands for better services by an informed consumer, have led providers to creative concepts of managed care, alliances, and technology advances. Consumer driven healthcare reform will continue to increase access and contain costs through responsible regulatory reform, industry cooperation, and continued stakeholder communication.

One concern expressed by many consumers and business people who share the burden of supporting increased premium costs, is mutually understanding the goal and collaboratively achieving solutions. Often, the enactment of healthcare reform legislation is in the form of

mandates that are designed to improve access, treat all in a non-discriminatory manner, and spread the high cost for a few over many. Obviously this penalizes young healthy people starting families, businesses, or people willing to take responsibility for improving their own health by eliminating high risk activities. This system of mandates, especially by removing factors of responsibility like copayments, or by implementing no pay policies, rewards the irresponsible.

Maine can now explore further healthcare reform, including mandated-offers, instead of mandating that policies include all coverage. With community rating, portability, pre-existing conditions, and hopefully a handle on abuse and charity care, individual responsibility may be an important component to affordable healthcare.

In conclusion, I sincerely believe that the Maine Health Care Reform Commission has diligently explored a very complex issue in an extremely short period of time. I commend them on their efforts and hope to see thoughtfully-drafted legislation for our review. The second regular session of the 117th Maine legislature will provide Maine people with a tremendous opportunity to continue the task of increasing access and containing healthcare costs through sensible regulatory reform. I look forward to the challenge.



*Richard H. Campbell is the ranking republican on the Maine legislature's Banking and Insurance Committee and played a major role in the creation of the Maine Health Care Reform Commission. He has been a contractor and developer for over 25 years.*

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