Maine Policy Review

Volume 5 | Issue 2

1996

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Robert Keller

Neil Rolde

Peter Hayes

News and Commentary

Maine Policy Review (1996). Volume 5, Number 2

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In its February, 1996 issue, *Maine Policy Review* published several commentaries reviewing the draft reform proposals of the Maine Health Care Reform Commission.[1] Each commentary offered a distinct and stimulating perspective on the Commission's proposals. We appreciate those comments and gratefully acknowledge *Maine Policy Review* for making this continued dialogue possible.

While meaningful health care reform still eludes this state and this nation, we strongly support a continued and vigorous battle to achieve universal health care coverage. We are disappointed that our call for federal health care reform has been partially overshadowed by our conclusion that state-level universal coverage is not realistic.

Many objections to the Commission's findings have focused on the cost-estimates of our single-payer plan, asserting that it significantly overstates the cost. These critiques are often based on a mistaken analysis of our work. More fundamental, however, is the failure to recognize that, separate from the issue of cost, the economy of a single state implementing universal coverage on its own would suffer without federal help. The commentary written by Peter Millard, Clifford Rosen, and Susan Thomas, *Playing with a Stacked Deck: Why Was a Single Payer Plan Dealt Such Bad Cards?*, offers us a welcomed opportunity to clarify some of these misunderstandings.

Mistaken assumptions and measuring the cost of the single-payer plan

Millard et al. assert that the Commission has calculated the single-payer system to cost 48% more than baseline costs. They then critique a number of assumptions that they consider unreasonable and which they believe lead to this overestimate.

1. We estimated a 17.8%, not 48%, difference in cost between the single-payer system and the baseline estimate.

Millard et al., calculate the difference between estimated single-payer and baseline costs incorrectly:

- They compared 1996 baseline costs with 1997 single-payer estimates, obscuring the cost difference attributable to inflation.

- Comparing 1997 baseline estimates with 1997 single-payer estimates would also be misleading. There is a short-term adjustment period to phase out the cost-shift for Medicaid and uncompensated care. (Medicaid currently pays only a fraction of provider charges. Under our plan, Medicaid would pay rates comparable to commercial rates.) This adjustment period exaggerates the difference between baseline and single-payer cost estimates.
- A more accurate comparison would be in the year 2006, after the adjustment period and after the global budget has restrained the rate of increase. In 2006, our single-payer system would cost 17.8% more than the current system. (Over time, as the global budget continues to restrain the rate of increase, the difference in cost would shrink even further.)

2. Our cost-estimates are based on reasonable assumptions.

Making assumptions about the future invites dispute. We believe, however, that our cost-estimates were based on reasonable and well-founded assumptions:

- **Increased utilization for the uninsured.** The Millard commentary critiques what they believe to be the Reform Commission's starting assumption: that "[t]he increased utilization that will result from a single payer system will bankrupt the system." It should be noted that the Reform Commission never started with that assumption, nor is it an accurate conclusion to be drawn from our findings.

  Based on the experience of the uninsured under the Washington State Basic Health Plan, we estimated that the previously uninsured populations would increase their use of care by 30% under universal coverage, to approximately 95% of average commercial utilization.[2] This is probably a conservative estimate, since many believe that those without insurance have a pent-up demand for health care and tend to be in poorer health. In one study cited by Millard et al., the researchers assumed that use of health services would equal 100% of utilization for insured persons with similar demographics.[3]
- **Increased utilization because of better benefits/ no copayment.** Millard et al. suggest that the Commission "endorsed" copayments as a means of limiting utilization of health services and saving money. For better or for worse, copayments do limit utilization.[4] However, it is a misstatement to say that we "endorsed" limiting utilization through this means. In fact, in our single-payer plan, no copayments would be required. As a result, however, our single-payer plan would experience higher utilization-- and higher costs.

  We also assumed that costs would go up because more services would be covered. Our benefit package covers services usually found only in the more comprehensive health plans.

  The cost increase resulting from better benefits and no copayments, 13% of total premium price, was actuarially derived based on current premium and benefit designs in Maine.[5]

- **Administrative costs.** In our analysis, we estimated administrative costs under our single-payer plan at 4% of total health care costs. To arrive at 4%, we examined the

results of a number of different studies, including studies by the Congressional Budget Office (CBO), the General Accounting Office, the Office of Management and Budget and Lewin VHI.[6] On average, these studies found that administrative costs under a single-payer system would result in about a 7% reduction in total health expendi-tures. Based on these findings we calculated that, instead of the current administrative cost ratio of 11%, under a single-payer plan adminis-trative costs would be only 4% of total health expenditures in Maine.

Some compare studies of the Canadian system to conclude that 4% is unreasonably high. Using the Canadian system as a model for determining administrative costs can be misleading. First of all, even the administrators of the Canadian health plan are unable to accurately estimate their administrative costs.[7] Some contend that the Canadian plan suffers from "administrative anorexia"[8] administrative costs are so low that they do not have enough information to evaluate the quality, efficiency, or effectiveness of their plan.[9]

In addition, there is considerable variation in the assumptions and methodologies used to measure administrative costs resulting in a wide disparity of cost estimates.[10] For example, relative to Canada, Maine's health care system devotes a higher percentage of resources to health data and to budget analysis, including case-mix adjustment. These costs would probably not go away in a single-payer system. Further, a number of studies have under-estimated Canadian administrative costs because they have failed to account for overhead costs such as buildings, equipment, fringe benefits and personnel services.[11]

- **The impact of managed care.** Part of the difference in cost-estimates results from assumptions about our other reform models, rather than assumptions about the single-payer system. In particular, based on the work of the Clinton Health Care Task Force and Lewin -VHI (consultants for Minnesota and New Mexico) we assumed that managed care would bring about significant cost-savings under the current system, under our multiple-payer model, and under our incremental proposal. Because we assumed the single-payer plan would be primarily fee-for-service, our single-payer system appears expensive by comparison.
- **The impact of the global budget.** Millard et al. discuss the usefulness of the global budget as a cost-containment mechanism for a single-payer plan. Our global budget was limited to the growth in the Gross Domestic Product plus 2 percentage points. The global budget for the single-payer plan would quickly restrain the rate of increase in health care costs through the final years of the estimate. Because the rate of increase is thus limited by the global budget, presumably over an extended period of time (greater than the 10 years we estimated) the difference between the single-payer system and the other plans would diminish. Some might argue that our global budget was set too high. That is certainly an issue open to discussion. However, we set our global budget based on the reasoning that too severely limiting the growth in health care spending might dangerously restrict access to and the quality of care.[12]

3. Simple comparisons with other studies are misleading.

The Millard commentary compared a number of different single-payer cost-estimates with that calculated by the Commission. These studies, however, for a number of different reasons, cannot offer direct comparisons with the cost-estimate done by the Commission. For example, the market may be different. Minnesota has relatively fewer uninsured. As a result, the cost of universal coverage would be comparatively lower in Minnesota. Minnesota also has a much more advanced managed care market than that in Maine, meaning that projected cost savings from further managed care penetration will be higher for Maine. In addition, study methodologies may differ. Some studies, done in the hypothetical, have the luxury of making assumptions that cannot be readily implemented. The CBO study, for example, assumed that payments to providers would be based on the cost of services.[13] Because measuring the cost of services is an extremely difficult task, and because Maine is far from having the data necessary to do so, we could not adopt that assumption in a cost-estimate for real-world implementation.

The real issue: The federal government must act.

Discussing the cost of the single-payer plan distracts from the more important point--universal coverage is impossible without the active participation of the federal government.

Even if the Commission's single-payer plan cost considerably less than we estimated, the impact on the state's economy would almost certainly be negative. Funding universal coverage through a state personal in-come tax would shift money out of consumers' pockets and into the single-payer system, particularly for the middle-class. Reduced disposable income means decreased demand for other consumer goods, which in turn means a negative impact on employment and Gross State Product. Funding universal coverage through a state employer tax would drive businesses to other states where the cost of doing business would be lower. These negative impacts result despite the fact that businesses and individuals would no longer bear the cost of insurance premiums. Only the federal government can mitigate these negative impacts.

Federal law is also a barrier. Even if there were no economic impact, or even if Maine had the political will to implement universal coverage in spite of the economic impact, the Employee Retirement Income Security Act makes any direct or indirect requirement to participate in universal coverage vulnerable to legal challenge. A state has little incentive to build universal coverage upon such a precarious foundation.

Delivering the message

When we came together as Commissioners of the Maine Health Care Reform Commission, we each had very different perspectives, but very similar goals. We each believed strongly that universal health care coverage is the only sensible solution--from both an ethical and fiscal perspective. We also reached exactly the same conclusion: universal health care coverage, whether under a single-payer plan or under a multiple-payer plan, is out of reach for Maine at this time. Universal coverage is not out of reach simply because it costs too much. It is out of reach because the federal government has put it out of reach.

With one voice, Maine needs to deliver that message to the rest of the nation.

Other comments

We would like to briefly reply to some of the other commentaries on our draft proposal:

- **David Wihry:** We would like to make two points with respect to Dr. Wihry's commentary. First, if the Commission stepped beyond its legislative charge it was to strongly endorse and to advocate for universal coverage. The fact that we felt obligated to make clear that universal coverage was not possible in Maine without the help of the federal government does not mean that we advocated our incremental plan. Second, we certainly agree with Dr. Wihry's statement that it would have been very informa-tive to have measured the economic impact for multiple variations of our proposed plans. Unfortunately, given the Commission's limited resources and the price tag associated with producing multiple economic models, we were unable to do so. Having only one chance to "get it right" made public participation in the development of the benefit package and the alternative models of reform all the more important.
- **Richard Campbell:** Representative Campbell made two comments that invite response. First, he expresses his disapproval of the Commission's attempt to help pay for the transportation cost of interested consumers. While Rep. Campbell might disagree with the avowed agenda of the "consumer lobby," as a legislator he must agree that consumers are very often not at the table when issues vital to their interests are decided upon. Lobbyists paid to attend legislative work sessions or this Commission's public hearings clearly have the advantage over the consumer who must take time off from work and pay for transportation. This Commission hoped to "level the playing field" in some small way by contributing our stipend to promote consumer participation. Because of objections from the Legislative Council, that money instead went to supplement our very tight budget.

  Second, we are perplexed by Rep. Campbell's concern that our outspoken support for universal coverage would "compromise the process." Does he suggest that we should believe otherwise-- that it is appropriate that some Maine citizens have access to health care while others do not? We remain steadfast in our belief that universal access is the only moral and practical approach to health care. Our acknowledgment that Maine cannot achieve universal coverage on its own demonstrates that our support for universal coverage did not "compromise" our judgment as to the best approach for health reform in Maine.
- **Elizabeth Shorr:** Ms. Shorr objected to the Commission's recommendation to create a purchasing alliance. She cites the experience of Florida and California as evidence that an alliance will only invite adverse selection, with no impact on access or affordability. We under-stand that the Florida model has been handicapped by political problems not of its own making. Its difficulties are compounded by a design feature that establishes the Florida alliances as "price takers," rather than as proactive purchasers. We therefore did not adopt the Florida approach. We modeled our alliance after the aggressive bargaining model used in California. We do have preliminary evidence that California's purchasing cooperative has had considerable success at saving money for its members-- premium rates for members were 15% lower than for similar products sold outside the cooperative.[14]

Ms. Shorr also argues that insurers will continue to maintain administrative services to serve non-alliance members, and that the alliance will therefore add one more layer of administrative costs. We respond that an alliance is designed to maximize administrative efficiency. At present, insurance carriers expend considerable, duplicative resources on selling and administering their product to the small group market. An alliance would consolidate those administrative functions and treat small employers as one large group, reducing administrative costs associated with that market.15 The "duplicate" administrative costs that Ms. Shorr objects to are not unlike the administrative costs associated with a new insurance company competing with her company.

- Dale Gordon and Kimberly Boothby-Ballentyne: In the 18 months of this Commission's existence we heard from a variety of health care providers, all with different perspectives, as to how their particular profession can contribute to the improvement of the health care system. As we did throughout that process, we recognize the important contribution of the nursing profession. We must disagree with Ms. Boothby-Ballentyne and Ms. Gordon that our failure to advocate for the expanded role of nurses, or any other profession, indicates an unfair bias. It was not our charge to determine the correct composition of the health workforce.[16]

  Nor did the Commission advocate medical care over public health. In fact, our public health proposal, which would have tripled public health expenditures, was one of our most ambitious proposals--and enthusiastically received by the public health community. This proposal, which would have raised the tobacco tax by 200%, was, in and of itself, a public health measure and demonstrates our commitment to the promotion of prevention and wellness.

The members of the Reform Commission gratefully acknowledge the efforts of our consultant, Eileen Griffin and Executive Director, Ellen Schneiter, who were extensively involved in the preparation of this paper.

Endnotes:

1. Unfortunately, the commentators did not have an opportunity to review our Final Report which, at least for our incremental proposal, was considerably changed from the draft.
2. Coopers & Lybrand. *Maine Health Care Reform Commission: Discussion of Modeling Methods.* (March 9, 1995) [unpublished memorandum].
3. Sheils, Lewin & Haught. "Potential Public Expenditures under Managed Competition," *Health Affairs,* (Supplement 1993): 229-242.
4. Manning, Newhouse, Duan, Keeler, Leibowitz & Marquis. "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment." *American Economic Review*, vol. 77, no. 3 (June, 1987): 251-277.
5. Other studies have made similar assumptions. For example, in a Minnesota study, based on the findings from the RAND Health Insurance Experiment, it was assumed that, without cost-sharing, physician services would increase 31% and inpatient hospital services would increase 10% for those persons currently in plans that require cost-sharing. Program Evaluation Division, Office of the Legislative Auditor, State of Minnesota. *Health Care Administrative Costs*, (February, 1995).

6. Program Evaluation Division, Office of the Legislative Auditor, State of Minnesota. *Health Care Administrative Costs*, (February, 1995): 22-23.
7. Letter from Geoff Ballinger, Research Analyst, Canadian Institute for Health Information, to Ellen Schneiter, Executive Director, Maine Health Care Reform Commission (September 18, 1995).
8. Evans. "Canada: The Real Issues." *Journal of Health Politics, Policy and Law*, vol. 17, no. 4 (Winter 1992): 739-762, 749.
9. *Id.*
10. Sheils, Young & Rubin. "O Canada: Do We Expect Too Much From Its Health System?" *Health Affairs*, vol. 11, no. 1 (Spring 1992): 7-20.
11. *Id.*
12. See, Physician Payment Review Commission. *Annual Report to Congress*, (1994) for a discussion of the trade-offs associated with expenditure limits.
13. Congressional Budget Office, Staff Memorandum. Single-Payer and All-Payer Health Insurance Systems Using Medicare Payment Rates, (April, 1993).
14. Lipson & De Sa. *The Health Insurance Plan of California: First Year Results of a Purchasing Cooperative*, (January, 1995).
15. Here again, the experience of California lends support. In California, administrative costs for the small group market run as high as 25-40%. Within the alliance, administrative costs are only 3%. *Id.*
16. In our final report, we did recommend that the Department of Human Services convene a forum to discuss issues of workforce planning. This recommendation was enacted by the legislature.

Full cite: Keller, Robert, Neil Rolde and Peter Hayes. 1996. ***Commentary: Health care reform in Maine: Continuing the dialogue.*** Vol. 5(2): 71-76.