Recommendations for Health System Reform

FINAL REPORT

November, 1995

MAINE HEALTH CARE REFORM COMMISSION

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Robert B. Keller, M.D., Chairman
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November, 1995

To All Those Interested in Health System Reform:

It is my pleasure to present the Maine Health Care Reform Commission's Final Report, *Recommendations For Health System Reform.* This report describes three approaches to reforming Maine's health system. These approaches include the implementation of a single payer model of financing care that offers coverage to all citizens of the State, and, alternatively, the implementation of a multiple payer system also offering universal access to coverage. The third approach represents incremental reform, focusing on market improvements and an expansion of coverage to Maine's most vulnerable citizens and most important resource -- our children.

Further, we present our recommendations for a statewide health information system for Maine. This initiative is fundamental to any reform; without adequate and reliable data, policy makers will be unable to evaluate the impact of reforms or to design strategies to most effectively address the problems of the health care system.

Finally, we offer specific proposals for improving public health in Maine, for a comprehensive quality assurance and improvement effort, and for facilitating improvements in health professionals workforce and education planning. We also suggest specific evaluation activities in the area of medical liability reforms.

Our final recommendations are based on the draft proposals which we issued earlier this year and on the comments on the draft proposals that we received during the public comment period. Many of the draft recommendations appear in this Final Report relatively unchanged. However, our recommendations for incremental reform have been modified substantially. The character of the purchasing alliance has been altered, but it still allows for an effective aggregate of purchasers which, in turn, should make affordable insurance coverage available to a greater number of people. We have also included a number of additional market reforms which we feel are necessary to improve the functioning of the health insurance market.

In our draft recommendations we proposed fundamental reforms related to medical liability. We had been interested in attempting to improve the medical liability system for consumers, and our proposal had been presented in that spirit. However, based on the many

comments we received voicing opposition to those recommendations, it appears that continued advocacy of that proposal would not contribute positively to the debate on medical liability. We have therefore decided to withdraw the recommendation.

The Final Report represents the culmination of an incredible effort by many dedicated people. The Commission and its staff acknowledge the hard work of the Commission's many advisory committee members -- this report would not have been possible without them. We also thank the many people who took the time to attend our meetings, to review the draft recommendations and who offered constructive suggestions about them. With their assistance and consideration, we feel that we have developed models for health reform that reflect the needs and preferences of Maine citizens. Assistance provided by other state agencies as well as our consultants has been invaluable as well.

We also acknowledge the generous assistance of the Robert Wood Johnson Foundation and the Commonwealth Fund which provided substantial financial support for the Commission's work. The recommendations, however, are the Commission's own and in no way represent the views of our funders, their directors, officers or staff.

In January, 1996 we will be submitting proposed legislation for each of the major initiatives presented in the Final Report. We look forward to working with the Legislature on these proposals and to an improved health system for Maine.

Sincerely,

Robert B. Keller, M.D.
Chairman
for the Commission

MAINE HEALTH CARE REFORM COMMISSION

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PRINTED UNDER APPROPRIATION NO. 010 30A 1125 012

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Introduction

In 1994, the Maine Legislature established the Maine Health Care Reform Commission and assigned it the task of designing at least three proposals for changing Maine's present health care system. The Commission was mandated to offer:

- a single-payer universal coverage bill;
- a multiple-payer universal coverage bill; and
- incremental reforms to the existing system, emphasizing cost containment, managed care and improved access;
- a standard benefit package, used to estimate cost for each reform model;
- a proposal for a uniform health care data system.

In addition to the required recommendations, the Commission is making other recommendations for reforming health care in Maine.

- A quality assessment program to measure the outcomes and efficacy of health care procedures relative to their cost;
- A strategy to improve public health in Maine, to be funded by an increase in taxes on tobacco products;
- The creation of a health workforce forum to better coordinate workforce education and planning;
- A study of the pre-litigation screening panels for medical malpractice, to be designed and commissioned by the Bureau of Insurance;
- A commission to study the cost-effectiveness of the mandated benefits, reporting back to the Legislature for adoption or rejection of the commission's findings;
- Recommendations to the State's Congressional delegation for modifications to the federal ERISA statute.

Using a Washington, D.C. consulting firm, Health Systems Research, Inc., actuaries from the accounting firm of Coopers & Lybrand, L.L.P., and with the help of Maine's State Planning Office, the Commission has estimated not only the cost of the three plans, but also the means of paying for them and their specific effect on the economy of the State.

As a result of this analysis, one conclusion has become inescapable: any attempt to establish universal health care through the resources of the State alone, cannot be accomplished without putting Maine at a significant economic disadvantage *vis à vis* other states. For both a single-payer and a multiple-payer universal plan, taxes would have to be raised significantly. In addition, federal law, particularly the ERISA statute, does not allow states to mandate coverage for those of its citizens who are under self-insured company plans.

Based on these findings the Commission concludes that an individual state cannot implement universal coverage by itself. While states can play a critical role, universal coverage must be initiated and supported at the federal level.

Although the Commission does not believe universal coverage possible at this time, it will present legislation for both a single-payer and a multiple-payer universal coverage system, in accordance with our legislative mandate. We believe the principle of universal coverage is an all-important goal and that the mechanisms for accomplishing it, as designed by this Commission, can serve as models for future action.

The third, incremental, model of health reform, will not achieve universal coverage. However, the incremental measures recommended are important steps toward expanding coverage and containing costs.

Below summarizes each of the Commission's recommendations.

Standard Benefit Package

As directed by the Legislature, the Maine Health Care Reform Commission, with guidance from its advisory committees, developed a standard benefit package to be used for estimating the cost and economic impact of each of the three alternative proposals for reform.

The Commission has incorporated this benefit package as the standard package for both of the universal plans. The incremental plan does not prescribe a standard benefit package, although the Commission endorses this benefit package as a model for comprehensive health benefit coverage.

The benefit package:

- Covers a broad range of services. It is similar to the State Employees Health Insurance Plan and other comprehensive plans. However, it covers more services than many of the plans currently available to consumers.

- Includes services felt to be essential for meeting the health care needs of Maine's citizens. In addition to covering most medical services, basic preventive dental health care, and prescription drugs, this benefit design emphasizes preventive care, education and wellness.

- Incorporates mental health and substance abuse services at full parity with other medical services through a managed care model.

The Single-Payer Plan with Universal Coverage

As required by its enabling statute, the Commission has developed a single-payer model that is similar, but not identical to, the Canadian system.

The economic analysis of the single-payer plan illustrates that, in the absence of meaningful national reform, this system, of the three reform options considered, would have the most significant negative impact on Maine's economy. This impact is measured in terms of employment, Gross State Product, and *per capita* income. In addition, as discussed elsewhere, federal law limits the State's ability to implement a single-payer model. Federal action to eliminate these barriers is unlikely at this time. For that reason the Commission believes that implementation of this plan is economically, legally, and politically untenable on an individual state level.

If Maine were to implement a single-payer plan, the Commission recommends the following design:

- All persons will be covered by the standard benefit package recommended by the Commission.

- There will be no copayments or deductibles for medical services and modest copayments for prescription drugs.

- A private entity will administer the single-payer plan with oversight by the new Maine Health Care Authority, an independent state agency modeled after the Public Utilities Commission.

- The Maine Health Care Authority will set the global budget and will coordinate a proactive health planning process to include workforce planning, diffusion of technology and capital investments.

- Instead of health insurance premiums and out-of-pocket payments, the single-payer system will be financed by broad based tax increases. Personal income taxes will triple to 10.5 percent. Corporate taxes will more than double with a new 5 percent payroll tax and an increase in the corporate tax rate to 14.25 percent. "Sin taxes" will double and the sales tax will increase by 1 percent.

The Multiple-Payer Plan with Universal Coverage

The second reform option developed by the Commission is a multiple-payer model. The multiple-payer model employs the concept of "managed competition" to achieve the highest quality care at the lowest possible cost. Like the single-payer model, this option assumes that the federal ERISA statute will be reformed, in this case to enable the State to mandate that self-insured employers provide and pay for 50 percent of the cost of health care coverage for all employees. Given the current national political climate, it is unlikely that ERISA will be changed to support this type of reform initiative.

The economic modeling illustrates the problems Maine would face if it tried to "go it alone" to achieve universal coverage. This model has a significant negative economic impact on the State when measured in terms of the employment rate, gross domestic product and *per capita* income levels. Because of the impediments imposed by ERISA and the economic impact, the Commission believe the multiple-payer model is not a viable option at this time.

If Maine were to implement a multiple-payer plan at this time, the Commission recommends the following design:

- All persons will be covered by the standard benefit package recommended by the Commission.

- Copayments and deductibles would apply. In fee-for-service plans, after a $500 per person annual deductible is satisfied, coverage will be provided with a 20 percent patient copayment. Annual out-of-pocket expenditures for individuals will be limited to $1,500. Managed care products will have a $10 office visit copayment and a copayment required for inpatient hospital stays.

- Consumers will have a choice of at least one fee-for-service and one managed care plan.

- An Alliance will administer the day-to-day operation of the multiple-payer system. The Alliance will negotiate with health plans, enroll participants, collect and distribute premium payments and subsidies, and monitor the quality and outcomes of care.

- The Alliance will be part of an independent state agency, to be called the Maine Health Care Authority. The Authority will set an annual global health care budget for the State and will coordinate a proactive health care planning process to include workforce issues, diffusion of technology and capital investments.

- The system will be financed by evenly splitting the premium (50/50) between the employer and the employee.

- Premium subsidies will be given to individuals up to 250 percent of the federal poverty line and to businesses with health care premium contributions exceeding 7.5 percent of payroll. The subsidies will be funded by broad based tax increases including an increase in the personal income tax from an effective rate of 3.5 percent to 4.3 percent (dropping to 4 percent in the year 2002), a new payroll tax of 2.25 percent (falling to 1.25 percent in the year 2002), a 1 percentage point increase in the sales and meals taxes (falling to a .5 percentage point increase in the year 2002), a 100 percent increase in "sin taxes" on tobacco and alcohol, and an extension of the application of a "premium tax" to those health insurance plans currently exempt from that tax.

The Incremental Reform Model

While the Commission believes that universal coverage is unobtainable at this time, the Commission also believes that there are several steps the State can take to improve the health care system in Maine. The third model of reform, the incremental model, does not provide for universal coverage. However, we believe these incremental measures can increase access, stimulate the use of managed care and conserve costs by maximizing administrative efficiencies and increasing the purchasing power of the State, small businesses, and individuals.

There are two main features of the Commission's incremental reforms. The first is the creation of a voluntary community purchasing alliance which will negotiate the purchase of health insurance jointly with the State Employees Health Commission (SEHC). The second is an expansion of the Medicaid program to cover children up to 250 percent of poverty. These proposals are summarized below.

The Community Alliance and State Employees Health Commission

The Commission believes that Maine's employers, individuals and state employees will benefit if they join forces to buy health insurance. At the same time, the Commission recognizes that state employees and other members of the community may wish to retain control over their own health insurance program. For that reason, the Commission proposes that Maine create a Community Alliance to purchase health insurance on behalf of employers and individuals. The State Employees Health

Commission will continue to purchase health insurance on behalf of state employees. The two groups will join their respective bargaining power to negotiate price with bidding health plans.

i. The Community Alliance

- The Community Alliance will:
  - Lower health insurance costs for Alliance members and state employees because of joined bargaining power;
  - Maximize administrative efficiency for small employers and individuals;
  - Allow employers to offer employees a wide range of health plans rather than just one.
- The Community Alliance will purchase health insurance on behalf of employers and individuals.
  - The Community Alliance will be a public, non-profit corporation governed by a board.
  - The first board of the Community Alliance will be appointed by the Governor. All subsequent boards will be elected by Community Alliance members.
  - The public will retain oversight through an annual audit submitted to the Legislature, the Governor and the State Auditor.
- The Community Alliance membership will be in separate risk pools.
  - There will be a separate pool for small businesses and for individuals.
  - After three years the Community Alliance will consider whether or not to merge the risk pools.
- The Community Alliance will provide a number of services:
  - Marketing selected plans;
  - Enrolling participants;

- Approving marketing materials offered by plans;
- Collecting premiums from participants;
- Forwarding premium payments to the plans;
- Conducting quality oversight;
- Providing ombudsman services to consumers;
- Applying a risk-adjustment process to correct for adverse selection.

ii. The joint bargaining power of the Community Alliance and the SEHC

- The Community Alliance will purchase health insurance jointly with state employees.
  - The board of the Community Alliance and the SEHC will each be responsible for designing the benefit packages that will be offered to their own membership.
  - Carriers must offer health insurance to both state employees and members of the Community Alliance if they want to participate.
  - Each board will assign two representatives to a joint negotiating committee that will solicit and negotiate bids with interested health plans.
  - Both the Community Alliance board and the SEHC, not the joint negotiating committee, will retain ultimate authority to accept or reject the final bid package.

iii. Necessary market reforms

- To minimize adverse selection, the health insurance market rules must be the same both inside and outside the Community Alliance. The Commission recommends, therefore, that small group reforms such as community rating, guaranteed issue and renewal be expanded to include groups of 25 to 99 employees.
- Also to avoid adverse selection, purchasers of health insurance need to know about all of their options. Insurance agents and brokers, therefore, will be required to disclose all products that they sell. They will also be required to disclose their fees.

Expanding Medicaid for children up to 250 percent of poverty

- The Commission recommends that Maine expand its Medicaid program to cover children under age 19, up to 250 percent of the federal poverty level. The State can make this expansion without applying for a waiver from the federal government.

- This Medicaid expansion will extend Medicaid coverage to an estimated 25,000 children. Preliminary experience in Minnesota suggests that parents may find it easier to leave welfare programs if their children have health insurance.

Other reforms

- The Department of Human Services (DHS) will be required to develop a State Health Plan based on the best available data. DHS will update that plan on a biennial basis.

- The Certificate of Need (CON) Program will be maintained in its current form. The Department of Human Services will coordinate the State Health Plan with the CON process so that the CON standards may be applied proactively.

- All employers will be required to offer payroll deduction for employees to purchase health insurance, although they will not be required to pay for that benefit.

- A new commission will be appointed to evaluate the mandated health insurance benefits currently required by statute. This commission will determine, to the extent possible, whether these mandates are cost-effective or otherwise justified. The Legislature will accept or reject the commission's findings in whole.

- Disclosure requirements, and other patient and provider protections will be imposed on health plans.

- The tax exempt status for non-profit health insurers will be eliminated. Because of market reforms regulating the conduct of both for-profit and non-profit health insurers, the tax exempt status is no longer justified.

Financing

- Elimination of the tax exempt status for non-profit health insurers and HMOs will fund the incremental package. An estimated $8 million will be needed to fund the Medicaid expansion. The remainder, at least in the first year of the alliance's existence, will provide start-up funds for the alliance.

A New Health Information System

The Legislature directed the Commission to develop recommendations for a health information system. Compared to many states, Maine has a very good data system, but many components of an ideal information system are missing. As the Legislature recognized, health data are critical to understanding and analyzing the three critical components of health care -- access, cost and quality. We consider the development of the Maine Health Data Organization (MHDO) to be one of our most important recommendations.

- The Maine Health Data Organization will be an independent, state agency, governed by a board composed of both public and private sector stakeholders.
- Data on utilization, including costs and charges should be reported by all providers of services.
    - Facilities and providers currently required to provide data should continue to do so.
    - The MHDO will develop a plan for requiring other providers to also supply these data.
    - The MHDO will work with providers to establish a reasonable and workable implementation plan.
    - Pharmaceutical data will be collected on a statewide basis.
- Population surveys will collect data relevant to:
    - Health care quality, outcomes and satisfaction;
    - Access to care, including insurance coverage;
    - Health status, health risk behaviors, and the economic impact of poor physical and emotional health.

- The MHDO will work with licensing boards and agencies to coordinate and improve the data collected by those agencies.

- Initially, the hospital assessment currently funding the data collection activities of the Maine Health Care Finance Commission will be continued as funding for the MHDO. After just a few years, the MHDO will become self-supporting by charging user fees or obtaining other sources of funding.

Public Health

The Commission believes that preventive health care, through an effective public health program, is essential to the quality of life in Maine.

Maine currently devotes less than 1 percent of total health care spending to public health, and our match of federal dollars is one of the lowest in the nation. This minimal emphasis on prevention coincides with significant health expenditures to treat preventable disease. Smoking-related illnesses alone cost the State $257 million annually.

For all three models, the Commission recommends an increase in the amount of financial support for public health:

- The Commission recommends that public health spending be increased to approximately 3 percent of health care costs, a public health spending level consistent with that recommended by leading health care authorities.

- For the incremental model, funding for the public health measure is, in and of itself, a public health measure. Finances will be raised by increasing the tax on cigarettes to $1 and by increasing the tax on other tobacco products by 200 percent. *Because raising the cost of tobacco products will deter teenage smoking, the Commission believes that making tobacco products more expensive is, in and of itself, a public health measure.* (In the universal coverage models, funding is built into the broad based financing design.)

- The public health funds will be used to develop a comprehensive strategic plan to improve the health status of Maine's population. The strategic plan will be based on a survey designed to determine Maine's current performance in the core areas of public health. The actual expenditure of funds will be based on comprehensive and rigorous application of cost/benefit analysis and justification on a program by program basis.

Quality Assurance

While the cost of health care is of great importance, the quality of care should be the highest priority. A health care market based on competition has spread across the

nation and is rapidly developing in Maine. The competitive market inevitably stresses cost reduction as its major feature. The Commission believes it essential that the State ensure a counterbalancing emphasis on quality.

The Commission believes that it is possible to conserve costs and improve quality through the development of quality assurance programs. To support these efforts, a high quality health information system will be required. In addition, the Commission recommends three separate approaches to quality measurement, assurance and improvement:

- Health plans should provide "report cards," containing standardized reports of quality and access. The reports should be subject to external audits. These report cards will help consumers make informed health care purchasing decisions.

- A Quality Improvement Foundation (QIF) should be designated in the State. The QIF will work with the provider community on a wide range of data analyses, continuing education, outcomes research and rural provider support.

- Depending on which of the three models, the Alliance or another administrative body should conduct "quality performance reports" on the quality of care plan participants receive.

Medical Liability Reform

The Commission has made a number of findings regarding the medical liability system. We believe that the current tort-based system fails to compensate many patients who sustain injuries while sometimes providing excessive awards to others. Defensive medical practices and high transaction costs increase the overall cost of medical care with only 30 percent of the malpractice premium dollars being returned to patients. Because it is based on the concept of "fault," the present system inhibits physicians and hospitals from participating in research and educational activities that would potentially decrease the rate of injury and encourage prompt settlement when they occur.

In its draft recommendations, the Commission proposed an "early-offer" model of liability reform. Under this model, an offer of settlement for economic damages by a provider within 180 days of an adverse event would preclude recovery of non-economic damages. In recommending this concept, the Commission hoped that there would be broad public interest in a liability system which had the potential to provide compensation to injured persons without the long delay, high transaction costs and uncertainty of the current tort system. However, the generally negative response to our proposal has lead us to conclude that our proposal will not contribute to the ongoing debate over medical liability in a useful way. The Commission has decided, therefore, to withdraw the "early offer" proposal from its Final Report.

In response to many comments and suggestions about the pre-litigation screening panels, the Commission recommends that the Bureau of Insurance be charged with the duty of assessing their success. The Bureau will be required to collect data on the screening panels and commission an unbiased, scientific evaluation of their performance.

The Commission also recommends the development of information and quality improvement programs that would encourage the health system to develop programs of prevention and continuous quality improvement to address issues of medical injury and liability.

Workforce Planning

The ability to pay for health care does not assure access to health care providers. A shortage of health care professionals in rural areas may mean that rural residents are deprived of needed services. At the same time, an oversupply of health professionals can produce upward pressure on cost. The Commission believes Maine suffers from an inappropriate distribution of its health professionals: some urban areas have an oversupply while many rural areas suffer from a shortage of health professionals.

The Commission believes that Maine should do a better job at coordinating the supply of health professionals. The Commission recommends that the Commissioner of the Department of Human Services convene a Healthcare Workforce Forum to discuss health workforce planning. The forum would:

- include participants from a broad range of health professions and educational programs;
- serve as a clearinghouse of information gathered through the process, creating a single access point for anyone interested in workforce issues;
- develop an inventory of the present health workforce and educational programs in the State;
- develop research and analytic methods for understanding population-based needs on an ongoing basis;
- consider the usefulness of forming a "federation" of licensing boards to facilitate communication across medical disciplines;
- provide a foundation for assisting stakeholders to make appropriate decisions about the best use of health care personnel in Maine and the need for health education.

ERISA

It is clear that without national reform of the Employee Retirement Income Security Act (ERISA), states are unable to implement universal coverage. Self-insured companies (employing as much as 50 percent of the total insured population) are exempt from state regulation and control. The following are recommended changes to ERISA that preserve those features of the Act that are most important to businesses (i.e. administrative simplicity for multi-state employers) while giving states more flexibility in reforming the health care marketplace. These recommendations will be forwarded to Maine's Congressional delegation for consideration and action.

- The ERISA statute should require a standard "minimum benefit package" that includes preventive care, guaranteed insurance portability and eliminates pre-existing condition limitations.

- ERISA should require self-insured companies to participate in data collection efforts, on both a state and federal level. Standards should be set for uniform requirements and a standardized claims form.

- ERISA should establish more rigorous consumer protections, including an improved grievance procedure.

- States should be given limited authority to tax ERISA plans, to the same extent other insurers are taxed (currently a 2 percent premium tax), to help finance extensions of coverage to the uninsured.

Conclusion

This Commission believes strongly that all Maine citizens should have access to health care. This belief is based on both humanitarian and practical considerations. Not only is access to health care essential to the quality of life for Maine's citizens, it is only with universal coverage will we be able to understand and address cost-containment and quality assurance. It is therefore with considerable reluctance that the Commission concludes that universal coverage is unobtainable in Maine without assistance from the federal government. We believe that the incremental measures recommended here will improve access to health care in this State. However, we call upon the federal government to provide coverage for those who fall through the cracks. We hope that all Maine citizens will join in that call.

CHAPTER ONE

The Case for Health Care Reform in Maine

Introduction

The Commission was charged with the responsibility of making broad recommendations for health care reform in Maine. To fulfill that mandate, it is necessary first to identify the need for reform. The Commission finds that Maine's health care system is afflicted by a number of problems.

Health care costs consume an increasingly large portion of the State's Gross State Product. The State, its citizens and its businesses have all had to spend more on health care, and less on other priorities.

As health costs rise, the number of people unable to afford health care insurance for themselves or their families also increases. Many of the uninsured do not have access to needed health care. But the cost of health insurance is not the only barrier to health care. Some parts of the State have too few providers, while others enjoy a surplus.

Maine also needs to reevaluate the way in which it spends money on health care. At the same time that Maine spends billions of dollars on treating illnesses and injuries, it invests far too little in preventing these harms through its public health program. The State needs to improve and expand its health data resources so that it can better monitor the quality and cost of health care in Maine.

While Maine can make significant steps to correct some of the problems it faces, it cannot remedy the plight of the uninsured without assistance from the federal government. Federal law, in particular, the ERISA statute, imposes a barrier to universal coverage on a state-by-state basis. In addition, an individual state implementing universal coverage risks placing itself at a significant economic disadvantage *vis à vis* other states. Below, the Commission outlines recommended action at the federal level.

Health Care Expenditures in Maine

Relative to many other states, Maine has had some success at keeping total health care expenditures down. At the same time, health care costs have risen well above the rate of inflation. As health care costs continue to rise, more and more of Maine's resources are used to pay for health care, leaving less money for consumers, businesses and the state government to spend on other worthwhile undertakings.

Total Health Care Spending

In 1993, Maine spent $3.57 billion on health care.[1] Of that amount, 27.8 percent ($993 million) paid for private health insurance and 25.6 percent ($914 million) was spent on Medicaid coverage.[2] A total of $523 million, or 14.7 percent, of total health expenditures were direct out-of-pocket costs paid by Maine's citizens.[3]

Maine appears to be doing better than many states at keeping costs down. In 1993 Maine ranked fortieth in *per capita* health expenditures.[4] Nevertheless, in that same year, health care costs accounted for over 15 percent of Maine's Gross State Product (GSP).[5] This represents an increase from 1991, when health care expenditures accounted for 13.1 percent of GSP.[6]

Between 1980 and 1993, *per capita* health care expenditures in Maine increased from $952 to $2,855, an increase of almost 300 percent.[7] During that same period, the Consumer Price Index rose by 175 percent.[8]

According to national estimates, general inflation accounts for only 31 percent of the growth in total health care expenditures.[9] Population growth, technology, increased use per person and demographic composition, together, account for another 19 percent of growth.[10] Most growth in health care expenditures can be attributed to the increasing complexity of services and the number of services which are provided.[11] Increased intensity of services, when combined with other growth in medical prices above inflation, accounted for 50 percent of the increase in costs.[12]

In addition to the factors that contribute to higher total costs, cost-shifting contributes to increased charges for each service. In many cases patients cannot afford to or decline to pay for care. The Medicare and Medicaid programs frequently pay providers at less than their cost. In

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[1] FAMILIES USA REPORT, SKYROCKETING HEALTH INFLATION 1980-1993-2000: THE BURDEN ON FAMILIES AND BUSINESS, (November 1993) Appendix, Table 2 [hereinafter SKYROCKETING HEALTH INFLATION].
[2] *Id.* at Appendix, Table 3b.
[3] *Id.*
[4] *Id.* at Appendix, Table 1.
[5] Assistant Secretary for Policy and Evaluation, U.S. Department of Health and Human Services, State Health Data Base [hereinafter State Health Date Base].
[6] NATIONAL INSTITUTE FOR HEALTH CARE MANAGEMENT, HEALTH CARE PROBLEMS: VARIATIONS ACROSS STATES (December, 1994) at B-1.
[7] SKYROCKETING HEALTH INFLATION, *supra* note 1, at Appendix, Table 1.
[8] In real dollars, this translates to a 71 percent increase in health care expenditures for this period. Telephone conversation with Galen Rose, Maine State Planning Office (June 16, 1995).
[9] PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS (1994) at 8.
[10] *Id.*
[11] *Id.*
[12] *Id.*

the most recent period for which data is available, Medicaid paid Maine hospitals a little more than 83 percent of the amount the hospital was due.[13] Medicare paid less than 72 percent.[14]

Because of these shortfalls, providers must attempt to collect more money from other patients. According to one estimate, in 1991 the nation's employers subsidized $17 billion of health care for public programs and the uninsured.[15] For large firms, more than four-fifths of this subsidy was in the form of higher premiums covering the cost-shift.[16]

Family Health Expenses

In 1993 Maine families spent an average of $4,357 on health care, or about 11.3 percent of average family income for that year.[17] In 1980, health care accounted for only 9.0 percent of average family income.[18]

The impact of these expenditures varies across income levels. Families with the lowest income spend one fifth of their income on health care while those families with the highest income spend only one twelfth.[19] On average, all families are spending an increasing proportion of income on health care. In 1991, the average employee worked 28 days to pay for health care, an increase of 8 days from 1987.[20]

Since 1973, wages and other benefits, excluding health benefits, have dropped 6 percent to pay for a doubling of health benefit costs.[21] Individuals, therefore, are losing more and more of their discretionary income to cover their health care costs.

Business Health Expenses

The burden of higher health care costs for Maine businesses is significant, although depending upon the size of the firm, the impact differs.

A total of 518,700 persons in Maine were employed in 1993.[22] According to a recent survey, over 5000 Maine businesses, with 101,000 workers, are spending at least 12 percent of

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[13] Maine Health Care Finance Commission, Memorandum regarding governmental payer shortfalls (February 8, 1995). This data measures the shortfall during each hospital's ninth payment year, which, depending on the hospital, covers any one year period between the first day of October, 1992 and the last day of September, 1994.
[14] *Id.*
[15] CENTER FOR HEALTH ECONOMICS RESEARCH, THE NATION'S HEALTH CARE BILL: WHO BEARS THE BURDEN? (July 1994) at 38 [hereinafter THE NATION'S HEALTH CARE BILL].
[16] *Id.*
[17] SKYROCKETING HEALTH INFLATION, *supra* note 1, at Table 3.
[18] *Id.*
[19] THE NATION'S HEALTH CARE BILL, *supra* note 15, at 60.
[20] *Id.* at 51.
[21] *Id.* at 32.
[22] State Health Data Base, *supra* note 5.

payroll on health care.[23] Eight thousand businesses, employing 165,000 workers, pay at least 8 percent of payroll for health insurance costs.[24]

Twenty-five percent of Maine's employees work for businesses with fewer than 20 employees and 45 percent work for businesses with fewer than 100 employees.[25] Small firms tend to face higher health care costs than large companies. Small firms are often charged higher premiums for their workers since health risk is spread across a smaller group. In addition, administrative costs are proportionately higher, since those costs, too, must be spread across a smaller group. If Maine's experience is consistent with that of the rest of the nation, almost nine out of ten (89 percent) of the firms paying over 12 percent of payroll toward health insurance are small businesses with less than 20 workers.[26]

Because of these high costs, many small employers find it too expensive to offer health insurance. In Maine, 50 percent of uninsured workers are employed by firms with less than 25 workers.[27]

At the same time that many employers are not offering insurance to their workers, some employers may be subsidizing other businesses by covering dependents under family insurance plans. In fact, some firms offer their employees a bonus if they obtain coverage from another source, such as a spouse's employer. According to one study, it is estimated that, nationally, large employers paid $13 billion for the health insurance of workers in small firms, through family health insurance.[28] Presumably, some of Maine's employers have experienced this phenomenon. In addition, because of the cost-shift, the uninsured employees of some firms create higher health care costs for businesses that do buy health insurance.

For businesses, more money spent on health care means fewer resources to invest in other priorities like higher wages, capital, research and development or job training. Nationally, if health care costs had grown at the same rate as gross domestic product between 1980 and 1990, businesses could have increased wages by 53 percent or enjoyed a 16 percent higher pretax business profit.[29] The same money might have been used to increase plant and equipment investment by 9 percent or job training by 174 percent.[30]

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[23] FAMILIES USA FOUNDATION, 411,000 BUSINESSES WITH 10,436,000 WORKERS AT RISK TODAY: THE CRUSHING BURDEN OF HEALTH INSURANCE, (June, 1994) at 3, Table 1 [hereinafter WORKERS AT RISK].
[24] *Id.* at 7, Table 3.
[25] *Id.*
[26] *Id.* at 5, Table 2.
[27] THE URBAN INSTITUTE, STATE-LEVEL DATABOOK ON HEALTH CARE ACCESS AND FINANCING (2d ed. 1995) at 100, Table C7 (based on three-year merged March Current Population Survey, 1991,1992 and 1993) [hereinafter STATE-LEVEL DATABOOK].
[28] THE NATION'S HEALTH CARE BILL, *supra* note 15, at 38.
[29] *Id.* at 48.
[30] *Id.*

Government Health Spending

Higher health care costs have also eroded the State's budget. A large portion of the State's expenditures on health care are direct payment for services. The State has limited control over these costs. As health care costs consume more State dollars, there is less money to pay for other priorities such as education, welfare and highways.

i. Medicaid

In the form of direct payments Medicaid alone consumes over 20 percent of the General Fund budget.[31] The Medicaid program covers a broad range of services for its recipients. In addition to primary and acute care, Medicaid also covers long-term care. In fact, a large portion of Medicaid expenditures pays for the long-term care needs of a relatively small population.

Between 1991 and 1994, exclusive of money spent to maximize federal dollars, state costs per Medicaid recipient increased at an average annual rate of 5.4 percent above general inflation.[32] Much of the growth in Medicaid spending is beyond the State's control. According to a recent national study, approximately 34 percent of the increase in Medicaid spending between 1988 and 1991 was the result of increases in eligibility and program enrollment, and 31 percent was due to general medical inflation. Intensity of care, advances in technology, and increases in provider reimbursement rates account for the remaining increase.[33]

Because many of the factors which contribute to the rise in health care costs are outside of the State's control, Maine's options for controlling costs are limited. Reducing enrollment means tightening the eligibility standards for mandatory Medicaid programs like AFDC and SSI. This reduces both income and health care for an already vulnerable population. In addition, reducing Medicaid expenditures in the state budget would not make those costs go away but merely shift them to other payers. If the State chose to reduce already extremely low provider reimbursement rates, it would only aggravate cost-shifting. As it is, Medicaid currently reimburses physicians for only about 30 to 40 percent of their charges, some of which is made up by charging other patients more.

The State has taken steps to control costs by instituting a primary care case management program on a pilot basis. Pursuant to Section 1915(b) of the United States Social Security Act, the Department of Human Services recently won approval of a Medicaid waiver that will permit the Department to enroll AFDC and AFDC-related Medicaid recipients in managed care plans.[34]

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[31] Schneiter & Kilbreth, *Hard Choices for Medicaid in Maine* in MAINE CHOICES: 1995 (1994) at 69.

[32] *Id.* at 70.

[33] *Id.* at 74.

[34] Under a Section 1915(b) waiver, Maine is not allowed to expand Medicaid eligibility to those who would not ordinarily qualify for Medicaid. Other states have obtained waivers under Section 1115 of the Social Security Act that have expanded their Medicaid programs to cover people not traditionally eligible for Medicaid. Maine's Department of Human Services does not plan to seek an additional waiver expanding eligibility. The Department is, however, planning to submit a §1115 waiver request in 1996 to establish a case mix adjusted managed care program

The waiver is slated for implementation in January, 1996, targeting a Medicaid population of 120,000 in 10 of Maine's 16 counties. Under the managed care program, the State hopes to save $6,000,000 over a two year period. However, as long as this reform is not in the context of system-wide change, the problem of cost-shifting to other payers remains.

ii. Other State Expenditures

Maine pays $80 million dollars annually in medical, dental, disability and worker's compensation coverage to its employees and retirees.[35] The cost of providing health coverage for the State's employees has risen by nearly 240 percent in the last decade with combined increases since 1990 and into the next fiscal year estimated at 54 percent.[36] Part of this increase can be attributed to changes in the State's benefit package and part can be attributed to the rise in health care costs generally.

Maine spends approximately $6 million in general fund dollars on public health. Other sources of revenue, including federal money, special funds and grants, are also devoted public health expenditures.[37] Some of these expenditures are in the form of direct medical services. Money also goes to local public health efforts and toward maintaining clean air and water.

The Uninsured and the Underinsured

Although Maine devotes over 15 percent of its GSP to health care, a significant number of Maine citizens have no insurance coverage or, if they have insurance coverage, that coverage is inadequate. As a result, many of these uninsured and underinsured forego needed health care and ultimately contribute to the increasing costs of health care for others.

The Uninsured

The number of uninsured in Maine increased from a little over 92,120 in 1987 to over 141,340 in 1992.[38] Currently, it is estimated that 145,000 Maine residents are uninsured.[39] In addition, health insurance coverage can be sporadic. For example, those people that experience periodic unemployment probably also experience a periodic lack of insurance coverage. According to one estimate, in Maine each month an average of 11,000 persons lose their insurance coverage at least temporarily.[40]

For many of these citizens, the lack of insurance is not a matter of choice. They simply cannot afford health insurance premiums. The indemnity plan endorsed by the Commission,

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for Medicaid's elderly and disabled populations. The waiver project, which would constitute a demonstration program, would not result in expanded eligibility for Medicaid coverage for any group.

[35] *Id.*

[36] Facsimile from Jo A. Gill, Executive Director, Employees' Health Insurance Program (June 16, 1995).

[37] Facsimile from Lani Graham, Director, Bureau of Health (March 7, 1995).

[38] State Health Data Base, *supra* note 5.

[39] Health Systems Research, Inc. and Coopers & Lybrand, L.L.P., *see* Appendix Three .

[40] FAMILIES USA REPORT, HOW AMERICANS LOSE HEALTH INSURANCE (April 1994) at 3, Table 1.

with minimal cost-sharing, would cost approximately 29 percent of family income for a family of four at a poverty level income.

Being uninsured does not necessarily mean being unemployed. In fact, 78 percent of Maine's uninsured have at least one family member employed full-time.[41] Only 9 percent of the uninsured have no workers in the family.[42] The largest portion of the uninsured appear to be low income workers who do not qualify for Medicaid, but cannot afford insurance. Twenty-six percent of the uninsured have income below the poverty level and 41 percent have income between one and two times the poverty level.

In Maine approximately 36,000 of the uninsured are children under age 18.[43]

Another category of the uninsured are those who can probably afford health insurance but who have chosen not to purchase it. These uninsured tend to be young and healthy persons who appear to be willing to take the risk that they will not need health care. In Maine three percent of the uninsured have income four times the poverty level or higher.[44]

For many uninsured, the lack of health insurance coverage contributes to poor health and ultimately to increased health care expenditures for the State. Generally, the uninsured tend to be sicker than those with insurance coverage, but they see a physician less often, and will delay or forego medical care, even with serious symptoms.[45] Typically, they do not seek preventive screenings or prompt medical treatment and are more likely to experience an avoidable hospitalization.[46] Lack of insurance is believed to increase chances of an early death by as much as 25 percent.[47]

In addition to poor health status, lack of insurance contributes to higher costs for the insured. When the uninsured cannot afford to pay their bills, health care providers cover their costs by charging more to other patients. Thus, as the number of uninsured increase, the cost of health care grows in turn, making it that much more difficult to afford health care. Lack of insurance, then, may have a two-fold negative impact: not only higher costs, but, also, more uninsured.

The Underinsured

Many persons with insurance do not have adequate coverage. For these underinsured, deductibles, copayments or other cost-sharing arrangements may be too expensive to provide

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[41] STATE-LEVEL DATABOOK, *supra* note 27, at 94, Table C4;
[42] *Id.*
[43] Health Systems Research, Memorandum dated June 15, 1995 (Analysis of combined 1993 and 1994 Current Population Survey).
[44] *Id.* at 46, Tables A6d.
[45] Franks, Clancy & Gold, *Health Insurance and Mortality: Evidence from a National Cohort*, 270 J. AM. MED. A. 737 (1993).
[46] *Id.*
[47] *Id.* at 740.

effective protection against unexpected health care needs. Approximately 13 percent of privately insured individuals are underinsured.[48] The underinsured will be subject to many of the same problems faced by the uninsured. Like the uninsured, the underinsured might also delay treatment, and when they receive treatment, fail to pay because they cannot afford it.

Access to Health Care

Having insurance is no guarantee that the residents of Maine will receive adequate health care. Many Maine residents must travel long distances to find a health care provider.

For Maine, inadequate access to primary care is not as much the result of a shortage of primary care physicians but a maldistribution of those physicians. According to a recent study, the urban and coastal parts of the State may have an excess of primary care physicians while other parts of the State experience shortages.[49]

In 1993, according to federal designation, 145,310 Maine residents lived in a primary care health professional shortage area (HPSA).[50] The shortage of primary care physicians may render universal insurance coverage an empty promise. Universal coverage will increase the demand for primary care physicians in all parts of the State, and make access a continuing and, perhaps, growing problem in the shortage areas. According to one report, an additional 60 primary care physicians would be needed to meet the demand in those areas.[51] Even without universal coverage, the growth in managed care, with its emphasis on primary care, has already created more and more competition for the services of primary care practitioners in the urban areas of Maine.

For rural residents, the shortage of health care providers is further exacerbated by the difficulty of travel and poverty. Over 55 percent of Maine's population lives in rural areas.[52] In many rural areas, travel is rendered difficult by the lack of primary roads, the absence of public transportation and the difficult terrain and winter climate. The fact that the most rural regions of the State also tend to be the poorest makes overcoming those barriers much harder.

Access to health care for those insured under Medicaid may also be limited. Medicaid reimburses physicians for as little as 30 to 40 percent of physicians' charges. As a result, some physicians cannot afford to accept Medicaid patients.

In addition to the concern about health professionals, access to hospital care may also be jeopardized. Many Maine residents live in an area with only one hospital within reasonable distance. Low utilization rates, shifts in the delivery of care away from inpatient hospital

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[48] Farley, *Who are the Underinsured*, 63 MILBANK MEM. FUND Q. 476 (1985).

[49] Horiszney, *Primary Care Physician Requirements in Maine,* (Nov. 30, 1994) (unpublished manuscript) at 4.

[50] State Health Data Base, *supra* note 5 (based upon *Selected Statistics on Health Professional Shortage Areas as of December 31, 1993* issued by Bureau of Primary Health Care, Health Resources and Services Administration).

[51] Horiszney, *supra* note 49, at 5.

[52] 1990 Census of Population, General Population Characteristics, Maine, U.S. Department of Commerce.

services, the difficulty of maintaining medical staff and other factors have all contributed to the uncertain viability of some of those small, rural hospitals.

Workforce Planning in Maine

Efforts to remedy the misallocation of health care professionals have been hampered by a number of problems. The challenge of recruiting and retaining health care professionals in rural Maine is not limited just to a question of income. For many, the choice between practicing in rural or urban Maine is a life style choice, making it a difficult problem to address. To date, loan forgiveness programs and other efforts to attract health professionals have not achieved sufficient long-term success.

Like all states and the nation as a whole, Maine has not coordinated its health workforce training with its health workforce needs. Part of this problem is attributable to inadequate data, as well as lack of communication. Since, to some degree, demand for health care services is a function of the supply of these services as opposed to actual need, the failure to adequately coordinate Maine's health care education with the needs of the population not only results in a misallocation of resources, but may also have an upward pressure on costs.

Public Health Expenditures

Relative to other states, Maine spends more of its health care dollars on sickness than it does on health. Maine spends only 1 percent of total health care expenditures on preventing illness and injury through its public health program.

In addition to improving the quality of life, preventive care is often much more cost-effective than treatment. For example, the cost of water fluoridation for an individual's entire lifetime costs about $38, which is about the same cost as treating just one tooth with a cavity.[53] Each dollar spent on helping a pregnant woman stop smoking saves about $6 in intensive hospital costs and long-term care for low birth weight babies.[54] Annually, vaccines prevent nearly 7 million cases of measles, mumps and rubella, saving $14 in medical costs for every dollar spent on immunization.[55]

In Maine preventable diseases consume a large portion of health care expenditures and diminish the quality of life for many Maine citizens. For example, Maine has the sixth highest smoking-attributable mortality rate in the nation.[56] Tobacco use is the leading cause of preventable death in Maine and smoking-related illnesses cost the State $257 million annually.[57] Maine also has the twelfth highest rate of coronary heart disease and smoking is the leading

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[53] WASHINGTON STATE DEPARTMENT OF HEALTH, PUBLIC HEALTH IMPROVEMENT PLAN (Nov. 29, 1994) at 21.
[54] *Id.*
[55] *Id.*
[56] BUREAU OF HEALTH SERVICES, DEPARTMENT OF HUMAN SERVICES, HEALTHY MAINE 2000: A HEALTH AGENDA FOR THE DECADE (1993) at 124.
[57] *Id.*

modifiable risk factor associated with heart disease. In 1990, a quarter of all hospital costs were related to treating heart disease.[58] Heart disease can be disabling, making work impossible and long-term care or other personal assistance necessary.[59] Data also indicate that Maine has seen an increase in the number of low birth-weight babies caused by smoking during pregnancy.[60]

Devoting more resources to the prevention of tobacco-related illnesses, and to the prevention of other avoidable health problems, might be one of the most cost-effective uses of the health care dollar. However, Maine's "match" of state dollars to federal dollars for public health ranks forty-second in the nation. Maine has also been slow to implement a coordinated state and local public health effort. In many parts of the State there is no local agency monitoring public health. In those parts of the State with local health officers, there can be overlapping functions and lack of coordination with the State. Private efforts, sometimes initiated by providers or other members of the health care community, often are not coordinated with other state and local activities.

Health Data Resources

Compared to many other states, Maine has excellent health data resources. However, there are many gaps in the data necessary to completely understand and analyze our health care system.

The collection of health care data is complicated by the fact that claims forms are not standardized, so that collecting comparable data across providers and plans is extremely difficult. Also, many providers do not use computerized billing, making their data difficult to access.

To monitor the growth in health care costs it is important to determine how that money is spent. Currently, Maine has no statewide data by which to measure service use and cost. Nor is Maine able to track how much employers are paying for health insurance premiums.

To improve access to services, Maine needs to have better data on all health care resources. In particular, Maine needs to improve and expand its collection of data relating to workforce composition, including practice location, occupational settings, hours spent in direct patient care. While Maine does collect some fragmentary workforce data, the State has not computerized much of that data, nor are they available for linkage with other data files.

As more people become covered under managed care plans, the importance of measuring health care quality and outcomes becomes more important. Maine has no data relating to patient satisfaction, a valuable yardstick for measuring quality. Nor is there a data system measuring outcomes of care that can be used to implement systematic quality improvement. In addition, while Maine has excellent utilization data for inpatient hospital services, outpatient utilization data has been generally unavailable, as are utilization data for other providers.

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[58] *Id.* at 43.
[59] *Id.*
[60] *Id.* at 124

Among the problems identified above, lack of universal insurance coverage stands out as one of the most critical. Universal coverage was adopted as one of the Commission's guiding principles. It is with considerable regret that the Commission concludes that Maine cannot implement universal coverage by itself.

As discussed below, there are at least two barriers to universal coverage, both of which suggest the need for federal action.

The Economic Impact of Universal Coverage

As part of its mandate, the Commission was required to estimate the economic impact the three health reform proposals would have on the State of Maine. As discussed at length in Chapter Six, the Commission, through its consultants, has conducted that analysis. Unfortunately, the results of this work provide ample evidence that an individual state implementing universal coverage places its economy at a major disadvantage *vis à vis* other states. Both the single-payer and the multiple-payer plans proposed by the Commission would implement universal coverage by raising taxes. Increasing the tax burden in Maine would make Maine a less attractive place for business and many individuals. Some businesses would leave Maine and others would be deterred from coming. Other economic consequences, to individuals and the medical sector, would also burden the economy.

The Employee Retirement Income Security Act (ERISA)

In 1974 Congress enacted the Employee Retirement Income Security Act (ERISA). As is apparent from its title, this legislation was primarily intended to regulate employee pension plans. Nonetheless, ERISA has had major consequences for state-level health care reform.

Although aimed at pensions, ERISA explicitly preempts almost all state laws "insofar as they may now or hereafter relate to any employee benefit plan . . . ." Those categories of state laws not preempted are specifically listed and include insurance. Thus, a state can regulate fully insured commercial products but not health benefits offered by a self-insured business.

This preemption provision offers a number of advantages to those businesses that operate in more than one state. Instead of complying with different requirements in 50 different states, those businesses can provide one benefit package for all employees. At the same time, exempting a self-insured business from state regulation means that states are unable to require employers to offer health benefits or set standards for those benefits offered. There are severe limitations on the states' ability to require self-insured companies to contribute to health care coverage for the uninsured. States are also unable to enforce consumer protections or to require participation in data collection efforts or implementation of uniform claims procedures.

A recent Supreme Court case, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* has opened the door to greater flexibility in implementing universal coverage. While employer mandates are still barred, according to at least one expert, a publicly funded single-payer program is "less likely" to be invalidated.[61] The Commission believes that, while *Travelers* offers states greater latitude than previously believed, that latitude is still fundamentally limited. Any state pursuing universal coverage does so at the risk of an almost certain, costly and, very possibly, successful, challenge.

The Commission recommends that the ERISA statute be amended to give states a minimum level of flexibility. The Commission's proposed amendments are designed to preserve one of the primary advantages of the preemption statute -- administrative simplicity for multi-state employers -- while giving states more flexibility in reforming the health care marketplace. These recommendations have been forwarded to Maine's Congressional delegation for consideration and action.

- The ERISA statute should create a standard "minimum benefit package" that includes preventive care, guaranteed insurance portability and eliminates pre-existing condition limitations.

- ERISA should require self-insured companies to participate in data collection efforts, on both a state and federal level. Standards should be set for uniform data requirements and a standardized claims form.

- ERISA should establish more rigorous consumer protections, including an improved grievance procedure.

- States should be given limited authority to tax ERISA plans, to the same extent other insurers are taxed (currently a 2 percent premium tax), to help finance extensions of coverage to the uninsured.

Conclusion

While amending the ERISA statute will give states some of the flexibility they need, it will not alleviate states of the tremendous economic disadvantage they face if they attempt to implement universal coverage on their own. Only federal action, implementing universal coverage nationwide, will "level the playing field" so that all states may reap the benefit of universal coverage without suffering a disadvantage relative to other states. The Commission urges Maine's Congressional delegation, and our other national leaders, to take the necessary steps that would make universal coverage a reality for all citizens, in Maine and the Nation.

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[61] BUTLER, NATIONAL GOVERNORS' ASSOCIATION ISSUE BRIEF (July 21, 1995).

CHAPTER TWO

Standard Benefit Package

Introduction

The Legislature directed the Commission to design a standard benefit package to apply to all proposals on the same basis. Each model is required to incorporate a similar set of benefits, designed to adequately "ensure necessary health services for the citizens of the State." The enabling statute states, however, that the standard benefit package is intended only as the basis for costing out each of the reform proposals and for comparing one plan against another.

Background

In Phase One of its work, the Commission, with guidance from its advisory committees, developed "guiding principles" for health care reform (*see* Appendix One). These principles were intended to serve as the framework for the development of specific recommendations for health care reform in Maine. One of the principles articulated by the Commission was: *All benefit packages should, at a minimum, include coverage of essential health services and should emphasize prevention and wellness.* It is this principle, along with the stated position of the Commission endorsing universal access for all residents of Maine and a commitment to increased support for and emphasis on public health, education and prevention, that helped to shape the standard benefit package presented here.

In November, 1994 the Commission convened a Phase Two advisory committee to formulate recommendations for three benefit packages: a comprehensive set of benefits; a minimum benefit set; and a median benefit package. The committee comprised representatives of the business community, payers, institutional providers, health professionals, government agencies and consumers. In February, the committee presented recommendations for a comprehensive and a minimum benefit set. Their recommendations represented a compromise of the disparate interests held by committee members. The comprehensive package comprised an extremely broad range of health care services. The minimum package trimmed the comprehensive benefit set. The proposals made by the advisory committee may be found in Appendix Two.[1]

With the assistance of its actuarial consultants, the Commission considered the proposals made by the advisory committee in light of the relevant guiding principles for reform. It was estimated that the spread in price difference between the comprehensive and minimum benefit package designs did not exceed five percent. For this reason, the advisory committee was

[1] It should be noted that some members of the Standard Benefits Advisory Committee felt that both of the packages submitted for the Commission's consideration were too broad or "rich." This subgroup had advocated for a much less comprehensive benefit configuration in the interest of keeping the product price as low as possible.

relieved of the task of formulating the third option. The Commission chose to modify the minimum benefit plan recommendations of the Committee to create a standard package.

Policy Recommendations

The Maine Health Care Reform Commission adopted as one of its guiding principles, the tenet that all Maine residents should have coverage for, and access to, affordable and high quality health care services. This access is facilitated by a second principle, stating that all benefit packages should include coverage of essential health services, with an emphasis on wellness and prevention.

The standard benefit plan must include a package of benefits that is "adequate to ensure necessary health services"[2] to the people of Maine. This statutory requirement, taken with the Commission's guiding principles, leads to the conclusion that the exclusion of entire categories of health care services from coverage without regard to their capacity to meet fundamental health care needs is inappropriate. As suggested by Brock and Daniels,[3] "meeting need" is what imbues health care with its special importance in our society. Therefore, limitations in coverage become a difficult proposition. The use of limitations should be restricted to those services that provide the least benefit relative to cost. "Comprehensiveness" of benefits does not imply that that all services are of equal value or that every service must be covered or provided without regard to its level of benefit or its cost.

The Commission believes that provision should be made for the delivery of effective services, with an active avoidance of the delivery of ineffective care. Limited resources must not be devoted to treatments whose effectiveness cannot be supported by empirical, scientific data. Further, medical research directed at the identification of new and effective treatments for disease must be supported.

Finally, the provision of equal benefits across the population is important. The coverage of health care should reflect differences in people's health care needs, not differences based on factors such as geography or income. Ability to pay should not advantage certain subpopulations with regard to access to fundamental medical services. The poor should not face lower quality services or restricted access. Such limitations result in limited opportunities, can lead to pain and suffering and even loss of life. They can also lead to increases in total costs of health and welfare programs.

Based on these "findings," the Commission has designed the benefit package discussed below. While the breadth of the package is greater than many other commonly marketed products, it is inclusive of those services felt to be essential in meeting the health care needs of the Maine community and improving health status statewide. It is important to note, however, that the primary purpose of the exercise of defining a benefit package is the fulfillment of a

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[2] 1994 ME. LAWS 707, § AA-6 (Enabling statute, Maine Health Care Reform Commission).

[3] Brock & Daniels, *Ethical Foundations of the Clinton Administration's Proposed Health Care System*, 271 J. AM. MED. A. (1994).

statutory obligation to provide a common basis upon which alternative reform strategies might be compared and contrasted. The recommended package satisfies that requirement.

Standard Benefit Design

The standard benefit package adopted for use in the modeling of the reform options and presented in TABLE 2A, has several important characteristics. First, the package is broad based, including coverage of those services deemed by the Commission to be essential to the health of Maine residents. While covered benefits include comprehensive institutional services, the package also incorporates a well defined and strong emphasis on preventive care, education and wellness.

Preventive services are often excluded from insurance coverage. This exclusion relates to an underlying premise regarding the function of insurance -- the provision of protection from the impact of unexpected events. People pay small premium amounts at regular, planned intervals to avoid the risk of incurring a large financial obligation for health services when they are needed.[4] It has been argued that insurance should be limited to unpredictable events rather than extending to routine preventive care expenses that are able to be planned for and scheduled. The inclusion of such services serves to increase premiums without a concomitant increase in the utility of the insurance coverage, that is, without an increase in protection from financial hardship.

We believe that the arguments for building prevention and wellness into a benefit package outweigh these utility arguments. The potential for improving health status that results from the removal of significant financial barriers to preventive services is demonstrable and important.[5] The improvement and maintenance of health is an overriding objective of a reformed health care system.[6] Improving financial access to such services does increase the cost of the coverage but will, in the longer term, lead to lower health system costs by promoting wellness, reducing severity and even averting episodes of illness altogether.

Coverage provided by the standard benefit package is described primarily in terms of covered *services* as opposed to covered *providers.* The package would provide coverage of medically necessary professional services delivered by any licensed, certified or registered professional within his or her legal scope of practice. Certain limitations, such as the exclusion of experimental diagnosis and treatment outside of an established clinical trial, are specified.

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[4] OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, BENEFIT DESIGN: CLINICAL PREVENTIVE SERVICES (September, 1993) [hereinafter BENEFIT DESIGN].

[5] MACRO SYSTEMS, INC., OBTAINING RESOURCES FOR PREVENTION: A MICHIGAN CASE STUDY (January, 1990) (Report to the Centers for Disease Control); BENEFIT DESIGN, *supra* note 4; MINNESOTA DEPARTMENT OF HEALTH UNIVERSAL STANDARD BENEFITS SET, ENROLLEE COST SHARING AND AFFORDABILITY REPORT (February, 1995).

[6] This view was shared by each of the Commission's Advisory Committees which unanimously stressed the importance of an emphasis on preventive care and wellness in any reformed health care system.

The benefit package does include coverage for mental health and substance abuse services at parity with other medical services. There are no mental health service limitations such as a maximum number of covered inpatient days or outpatient visits. There is, however, a provision in the package description that specifies that all mental health services will be provided within a managed care framework. The benefit as described constitutes approximately six percent of the total premium cost; in the absence of the managed care requirement the same benefit would cost two to three times as much.

TABLE 2A
MAINE HEALTH CARE REFORM COMMISSION
STANDARD BENEFIT PACKAGE

Note: This package has been formulated for pricing purposes only.

SERVICE TYPE	STANDARD BENEFIT PLAN
MAXIMUM DOLLAR COVERAGE LIMITS	None
INSTITUTION INPATIENT SERVICES	
• Medical, surgical, intensive and emergency care	Room and board limited to average semi-private room rate. Includes coverage of special care services when provided in SCUs or private rooms when medically necessary. Includes established organ transplants. Excludes cosmetic surgery (except congenital anomalies and repair of traumatic injuries sustained while covered); infertility diagnosis and treatment; experimental diagnosis and treatment other than that provided within the framework of an established clinical trial as well as services provided under such a trial that are covered by another party, non-acute ventilator support provided solely for the purposes of prolonging life, and personal comfort items.
• Rehabilitation for disease or injury	Room and board limited to average semi-private room rate. Excludes long term in-hospital rehabilitation, experimental treatments other than that provided within the framework of an established clinical trial and services provided under such a trial that are covered by another party, and personal comfort items.
• Skilled Nursing Facility Care	Includes coverage for skilled nursing facility care required for continued recovery after an acute inpatient hospitalization. Room and board limited to average semi-private room rate. Excludes supportive ADL care, non-acute ventilator support provided solely for the purposes of prolonging life, and personal comfort items.
OUTPATIENT/AMBULATORY SERVICES	Includes coverage of diagnostic, surgical and emergency care. Excludes non-emergent emergency room care, ambulance services determined to be non-medically necessary, cosmetic surgery (except congenital anomalies and repair of accident while covered), experimental diagnosis and treatment other than that performed as part of an established clinical trial as well as services provided as part of such a trial that is covered by another party, reversal of sterilization, random health screens for specific conditions for which no risk factors or indicators exist, and infertility diagnosis and treatment.

PROFESSIONAL SERVICES	
• Health Provider visits at all sites	Includes coverage of medically necessary professional services delivered by any licensed, certified or registered professional within his or her legal scope of practice. Excludes: experimental diagnostic and treatment services other than that provided as part of an established clinical trial and services provided as part of such a trial that are covered by another party, infertility diagnosis and treatment. Specific limitations in coverage are noted below.
• Surgery and Anesthesiology	Excludes experimental services unless provided as part of an established clinical trial as well as services provided as part of such a trial that are covered by another party.
• Audiology, physical, speech, occupational and respiratory therapy	Excludes speech and occupational therapy beyond age five for chronic conditions, physical, occupational and speech therapy for non-acute rehabilitation.
• Vision care services	Includes coverage of services for the treatment of disease or injury only. Excludes radial keratotomy, routine eye care services including refractive eye exams, glasses and lenses, experimental diagnostic and treatment services unless provided as part of an established clinical trial as well as services provided as part of such a trial that are covered by another party.
• Counseling and Health Education	Includes coverage of services of care providers and family members that are integral to the care of an individual as a result of illness, injury or other health condition.
• Chiropractic Services	Excludes chiropractic services provided as maintenance (non-acute) care only.
• Podiatry Services	Includes coverage for podiatry services that is equivalent to that provided by Medicare.
• Christian Science Care and Treatment	Includes coverage of accredited Christian Science facilities' services, equivalent to Medicare coverage.
• Acupuncture Services	Excludes coverage of acupuncture services for maintenance (non-acute) care only.
• Massage Therapy	Excludes coverage of massage therapy services for maintenance (non-acute) care only.
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Parity with other services in terms of benefit levels. In all cases, a managed care mechanism will be employed in conjunction with the delivery of these services. Room and board for inpatient services will be limited to the average semi-private mental health/substance abuse room rate. Includes coverage of both detoxification and rehabilitation. Excludes coverage of experimental diagnosis and treatment services unless provided as part of an established clinical trial and services provided as part of such a trial covered by another party, and personal comfort items.
PREVENTIVE SERVICES	
• General preventive services	Preventive medical services for both children and adults will be provided in accordance with the U.S. Task Force on Preventive Services Guidelines will be covered. The one exception relates to screening mammograms. Such screening tests provided in accordance with the guidelines of the American Cancer Society will be covered.
• Counseling and Education	Limited to individuals, rather than individuals or populations. Services must be integral to the care of the individuals to whom the services are provided.
• Dental Services	
Children	Examinations, cleanings, fluoride treatments, sealants and education at six month intervals covered to age 21. Radiographs covered on an annual basis.
Adults	Examinations, cleanings, sealants, fluoride treatments, cleaning and education covered on a once annual basis.

REPRODUCTIVE SERVICES	Includes coverage of pre-natal, delivery and post-partum care, the diagnosis and treatment of sexually transmitted disease, birth control procedures (including sterilization), birth control devices, and abortion. Coverage of prescribed birth control methods are covered under the pharmaceutical benefit. Excludes coverage of infertility diagnosis and treatment, reversal of sterilization, experimental diagnosis and treatment unless provided as part of an established clinical trial and services provided as part of such a trial that are covered by another financing mechanism.
LABORATORY/RADIOLOGY AND SPECIAL DIAGNOSTIC PROCEDURES	Coverage provided for special diagnostic procedures including but not limited to EMG, nerve conduction studies, nuclear medicine procedures, pulmonary function studies, electrophysiology studies. Coverage provided only for procedures that are medically necessary and appropriate. Excludes coverage of experimental tests and procedures unless provided as part of an established clinical trial as well as services provided as part of such a trial that are covered by another financing mechanism.
HOME HEALTH CARE	Covered only when medically necessary and appropriate and in lieu of more costly inpatient care. Subject to case management. Services of skilled nursing, physical, occupational and speech therapy, medical social work and home health aide personal care covered when part of a plan of care prescribed by a physician or other authorized prescriber and provided in the patient's place of residence.
HOSPICE AND PALLIATIVE CARE	Coverage includes medical supplies, drugs and medications, equipment and care for pain control and symptom management in the last six months of life. Covered only when medically necessary and appropriate.
SUPPLEMENTAL SERVICES	
• Prosthetic Devices	Covered only when medically necessary and appropriate.
• Durable Medical Equipment	Covered only when medically necessary and appropriate. Includes rental or purchase of necessary DME for therapeutic use. Includes oxygen equipment and hearing aids.
• Medical Transportation	Coverage provided for appropriate level of transportation to nearest appropriate facility that can render necessary and appropriate emergency medical treatment.
PRESCRIPTION DRUGS	Coverage of prescription legend drugs, prescribed non-legend drugs, as well as insulin and diabetic syringes that are defined by a state formulary. Excludes experimental and investigational drugs unless prescribed as part of an established clinical trial and drugs prescribes as part of such a trial that are covered by another financing mechanism, non-prescription legend vitamins with the exception of those used to supplement the diets of pregnant women, hair growth supplements smoking deterrent agents, weight control drugs, non-routine immunization agents and infertility treatments.

Prescription drugs are included as a covered benefit within the proposed standard package. The benefit described contemplates the development of a state formulary for covered drugs, but would also include coverage of insulin and diabetic syringes and prenatal vitamins (including those available over-the-counter).

Coverage of skilled nursing facility care required for the continuation of recovery after an acute inpatient hospitalization is included. Inpatient rehabilitation for disease or injury is also included but does not contemplate long term in-hospital rehabilitation stays. Home health care is

covered when medically necessary and appropriate and when provided in lieu of more costly inpatient care. Similarly, hospice and palliative care is a covered benefit.

Importantly, the standard package does not include any long-term care benefits. Long-term nursing facility care is not covered by this package. The resources available in terms of time and funding precluded the Commission from addressing the complex issues of long-term care and the reform of its financing and delivery. It is recommended that long-term care be addressed in the future.

Cost Sharing

In addition to the benefit configuration outlined above and detailed in TABLE 2A, there is a cost-sharing design that complements the benefit package. A number of alternatives for cost sharing were considered. The standard benefit package with no deductibles or copayments ("high option") was considered as the most comprehensive package under review. A second option would overlay substantial deductibles and copayment requirements on program participants ("low option"). This option was viewed as the minimum package. Although the breadth of the services covered is quite comprehensive, the point at which coverage is actually realized is quite high. That is, an individual would have to incur significant out-of-pocket expenses before coverage became meaningful.

The third option considered was a mid-level cost-sharing option (the "medium option"). For indemnity products, there is a $500 per person deductible with an 80/20 copayment provision and a $1,500 out-of-pocket maximum per individual per year, $3,000 per family. For HMO/managed care products the medium option requires a $10 per visit copayment for every ambulatory visit with the exception of preventive care visits, to which no copayments apply. There is also a copayment of $100 per inpatient day, up to a maximum of $500 per admission. This level of cost sharing, in conjunction with the scope of benefits included in the standard plan results in a coverage option that equates to the median level of benefit plans offered by small businesses across the nation.[7]

There are also copayments that complement the prescription drug benefit: a $5 copayment on each prescription for a generic drug and a $10 copayment on each prescription for a non-generic drug. We are aware that there are other models for structuring copayment requirements. For example, with respect to prescription copayments, a 100 percent copayment for a non-generic drug could be required when a generic equivalent is available and appropriate. Some argue that the use of any copayments at all severely compromises the ability of poorer citizens to access care while others argue that copayments have no effect on utilization. Other copayment designs might result in greater or lesser degrees of impact on utilization. The design used in this modeling exercise reflects our best judgment regarding appropriate levels of copayments that are likely to contribute to efficient utilization of services while not behaving as an absolute barrier to care for lower income patients.

[7] The universe of small businesses considered here are those businesses which do, in fact, provide a health insurance benefit to their employees.

The Commission retained the firm of Coopers & Lybrand to provide actuarial consultation and technical assistance. The consultants were asked to develop premium rates[8] for the standard benefit package, both as an indemnity product and as an HMO or managed care product, within each of the three alternative cost-sharing frameworks under consideration. A four tiered rate structure was constructed specifying premium costs for a single adult, a single adult with one or more children, couples and families. There is no cross subsidization of premium between the four tiers. Finally, rates were developed for each of the six options within the context of the alternative reform models. Therefore, rates were developed for the standard package with each of the three levels of cost sharing under a single-payer system and under a multiple payer system. The average monthly cost of an adult under a single-payer plan in a fee-for-service, no cost-sharing environment was calculated to be $205.15; the comparable cost for children is $98.55.[9] The monthly premium rates that would apply under a multiple payer system are shown in TABLE 2B, below.

The cost differential between the single-payer system rates and the multiple payer rates is attributable to differences in administrative costs and the prevalence and effectiveness of managed care. Other factors reflect assumptions regarding the reduction of cost-shifting within the different systems, utilization of services, trend rates in the cost of services, and the ability of managed care systems to contain the rate of increase in costs. The relevant assumptions are outlined in Appendix Three.

TABLE 2B: Tiered Monthly Premium Rates -- Multiple Payer System

	Medium Option Indemnity	Medium Option Managed Care
Single Adult	$163.20	$158.30
Single Adult with Child(ren)	286.83	278.33
Couple	326.40	316.61
Family	474.21	459.99

One further consideration that must be taken into account when assessing the alternative benefit configurations is that of out-of-pocket expenses. These expenses are the costs for services paid by the individual at the time services are sought and rendered. The level of such costs are considerably lower under the "high option" cost-sharing design because there are few copayment and deductible requirements and a broadly defined benefit package. They are higher under the "medium option" where there are both copayments and deductibles in place. Out-of-

[8] In the context of a single-payer system, the term "premium" is a misnomer; the financing of such a system relies on tax revenues rather than premium payments. A more appropriate term would simply be "rate" or "average monthly cost."

[9] This figure includes only cost to the system, not out-of-pocket costs. Out of pocket expenditures in the single-payer system contemplated by the Commission would be low: $3.37 per month for adults, $2.32 per month for children.

pocket expenditures are considerably lower under the managed care products than under the indemnity plans. They are also significantly lower for children than for adults.

TABLE 2C: Monthly Out-of-Pocket Expenditures Under Varying Cost-sharing Options

	Cost Sharing: High Option Indemnity	Cost Sharing: High Option Managed Care	Cost Sharing: Medium Option Indemnity	Cost Sharing: Medium Option Managed Care	Cost Sharing: Low Option Indemnity	Cost Sharing: Low Option Managed Care
Out-of-pocket Expense Per Adult	$3.37	$3.37	$30.47	$9.99	$44.29	$27.91
Out-of-pocket Expense Per Child	$2.32	$2.32	$25.22	$6.63	$32.56	$16.89

Because not all possible services are covered under the standard benefit package, some out-of-pocket expenditures are projected even under the most comprehensive cost-sharing option (i.e. no cost sharing for covered services). Under each scenario modeled, a modest copayment for prescription drugs is assumed. Other services, such as elective cosmetic surgery or private hospital rooms, are specifically excluded from the standard benefit design. Patients wishing to purchase such services will have to do so with their own resources, paying for them "out-of-pocket."

CHAPTER THREE

A Single-Payer Universal Health Care System for Maine

Introduction

The Maine Health Care Reform Commission is mandated to design three models of health care reform. One of those models is a single-payer health care system that provides universal coverage for all Maine citizens.

The single-payer model has a number of advantages over the current system and over a multi-payer system. Because it would eliminate the duplicative roles of multiple insurance companies, it would minimize administrative costs. (The Commission's consultants estimated that, in Canada, administrative costs are estimated to account for only 4 percent of total health care expenditures. In the United States, because of the multiplicity of payers, administrative costs are estimated to be as high as 12 percent.) The single-payer model also concentrates all bargaining power into one entity, maximizing the ability to negotiate with providers. In addition, consumers of health care benefit from the simplicity a single-payer offers because the enrollment process would be straightforward and multiple claim forms would be unnecessary.

In discussing a single-payer model, it is necessary, first to address a common misconception. Many think of a single-payer system as "socialized" medicine. There is a belief that under a single-payer system, the government controls both the delivery and the financing of health care. That need not be the case. "Single-payer" means only exactly what it says: there is simply one entity that pays health care within a jurisdiction. A single-payer system need not be run by the government.

When considering a single-payer health care system people often think of the Canadian system. Canada combines federal and provincial tax-based financing of health care with the private delivery of health care. In Canada, physicians are not employed by the government and hospitals are not generally government owned. However, the government completely controls the financing of health care. As discussed below, the Commission's single-payer model will vary from the Canadian model, shifting most control over the administration of health care to the private sector.

Although many associate a single-payer model with government, the single-payer concept in Canada was developed in the private sector. It began in a small farming and ranching community in the Province of Saskatchewan. That community's philosophy was of shared effort, with all citizens benefiting. In Maine, there are approximately 145,000 uninsured citizens. Many of these uninsured persons may pay taxes which help to provide health care to the very disadvantaged through Medicaid, or they may pay health care bills that help to cover the costs of uncompensated care or charity care for those that cannot or do not pay. At the same time, they

may earn too little to purchase insurance themselves. A single-payer system would cover all citizens in the State and remove these inequities.

The main difficulty with a single-payer plan is the up-front cost to the tax system. The tax-based single-payer system makes explicit the cost of health care. Currently, most citizens receive health insurance through employers. Salaries and wages are lower because employers pay insurance premiums. As a result, this "tax" is hidden and employees often consider health insurance a "free" benefit. Shifting these expenditures to the tax system might appear to constitute a huge increase in health care costs, but in large measure, this step simply converts insurance premiums from a hidden limit on wages to a manifest tax expenditure. Although opponents of a single-payer model might highlight this large tax increase, obscured in the rhetoric will be the fact that people will no longer be paying direct insurance premiums, substantial copayments and deductibles.

As discussed elsewhere in this report,[1] implementation of universal coverage in a single or multiple payer plan would be extremely difficult for the State of Maine to accomplish on its own. Both the negative economic impact on the State and the preemption statute under ERISA mitigate against any state proceeding with major reform in isolation. In response to the legislative mandate and because we strongly support the concept of universal coverage, the Commission presents a model for single-payer coverage.

Governance of the Single Payer

The Commission recommends that the single-payer plan in Maine be administered by a private entity, either for-profit or not-for-profit. The Single Payer may be chosen among competing, existing companies based on a bidding process or it may be created specifically to serve as the Single Payer.[2] It will effectively be given a monopoly over the health insurance market in Maine, because all Maine citizens will be insured under this one plan. Its administrative budget will be determined through contractual negotiations with a new state agency, discussed at length below. The new state agency will be called the Maine Health Care Authority.

As discussed below, the Maine Health Care Authority will set the global budget. The Single Payer will negotiate with providers to determine reimbursement rates within the constraints of that budget. The Authority will have the power to intervene if the providers and the Authority cannot reach an agreement.

When appropriate, provider services will be paid based on the Resource Based Relative Value Scale (RBRVS) developed for the Medicare program, augmented as necessary by the Single Payer. If total expenditures in a given year exceed the global budget, reimbursement levels in subsequent years will be decreased to recapture the excess expenditures in a subsequent

[1] *See* Chapter Six.

[2] For example, enabling legislation could be enacted to establish a new public corporation or a new company could be formed to assume the role of the Single Payer administrator.

year. Likewise, savings would be returned to providers through an increase in the subsequent RBRVS conversion factor. Reimbursement schedules for other providers, such as hospitals, will be negotiated separately.

Government oversight and other government roles are discussed below.

The Delivery of Care

To the average health care consumer the delivery of health care will be similar to what it is now, with some important exceptions. First, under this model, access to health care is unrestricted with almost no cost sharing.[3] Each individual will have free choice of provider. There will be a single benefit plan providing comprehensive coverage. Coverage will be universal and will no longer be provided by one's employer. Coverage will not change when an individual loses or changes jobs.

The most significant difference will be in the payment mechanism. Each citizen, after meeting a one-year residency requirement, will receive a health insurance card, entitling that person to health care under Maine's single-payer system. Rather than a three-way transaction between consumer, provider and insurance company, reimbursement will only require two parties: the provider and the Single Payer. The provider will be paid based on the fee schedule as described above. Administrative costs and paperwork will be minimized and multiple billing eliminated.

Private insurance for services covered under the single-payer plan will be illegal, except for those persons who have not yet met the residency requirements qualifying them for participation under the single-payer plan.[4] Providers will be able to withdraw from the single-payer plan but, if they do so, they will no longer be eligible for any reimbursement by the Single Payer. Those providers participating in the plan will charge the same rates to all patients, regardless of insurer (except in the case of Medicare recipients). In this way, those persons who have not yet met the residency requirements will not be burdened by a cost-shift. Supplemental insurance plans may still be marketed.

The State will seek a waiver from the federal government, expanding financial eligibility for Medicaid and allowing Medicaid recipients to participate in the single-payer system. In this way, Maine will continue to receive federal matching funds to cover those eligible for Medicaid. Providers will be reimbursed at the same rate for all participants covered by the plan.

Medicare will continue to be a federally administered plan, and Medicare recipients will not be covered under the single-payer plan.

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[3] Under the benefit package designed by the Commission, there will be some cost-sharing for prescription drugs There are also some benefits (e.g. elective cosmetic surgery, private hospital rooms) that fall outside the scope of the benefit package. These services would have to be purchased with out-of-pocket expenditures.

[4] If private insurance were allowed, low-risk individuals could select themselves out of the state pool, reducing the effectiveness of risk spreading.

Paying for a Single-Payer System

In considering this universal coverage plan, a significant question for the Commission was whether there will be any out-of-pocket costs for consumers, in addition to what they will pay in taxes to fund the program. On one side, many believe that without cost sharing, people are not as sensitive to the costs of health care and they may over-use health care services. Others argue that cost sharing discourages consumers from using health care in the early, less expensive stages of the disease process and results in the use of more expensive services when their conditions become severe.

The Commission modeled two types of single-payer plans, one with moderate levels of cost sharing and one without.[5] In creating these two models it was assumed that universal coverage without cost sharing would result in higher utilization and higher overall costs. However, for a single-payer system to build on its greatest strength -- the simplicity of administration and the savings to be realized from it -- it seems advantageous to eliminate most out-of-pocket costs such as copayments, deductibles and coinsurance. Otherwise, to achieve universal coverage, those unable to pay those charges will require subsidies, resulting in added administrative costs and the risk of cost-shifting. In addition, the Commission believes that minimal cost sharing would result in a better quality of life, since Maine's citizens would have easier access to care, receiving earlier treatment in order to avoid more serious illness. The Commission therefore recommends that Maine's single-payer plan be free of cost sharing.

The funding for universal coverage under a single-payer plan will come from a broad-based tax program. Together, an increase to the effective personal income tax rate, tripled from 3 percent to 10 percent, and a new payroll tax of 4.75 percent, contribute almost 80 percent of the $2.5 billion necessary to finance the program. The remaining revenue will come from a 3.75 percentage point increase in the sales and meals tax, an increase in the effective corporate income tax by 3.75 percentage points, and a doubling of the taxes on tobacco products and alcohol.

Converting to a single-payer system might mean that some businesses currently paying a portion of employees' health insurance premiums will reap a windfall. Individuals will now be paying a direct portion of their health insurance premium while the employer will now pay a higher payroll tax. It is anticipated that where an employer would pay less under the single-payer plan than before, the employer will pass those savings on to the employee by paying higher wages and salaries. This would be appropriate because the employer's contribution to health insurance premiums is a form of employee compensation. Because these individuals will now be paying higher income and consumption taxes, they will need this compensation to help meet the increased tax burden. Forcing the business to pass these savings on, however, would be difficult. In addition, because wage and salary increases will also be taxable by the federal government, some of this money will be diverted to pay federal taxes. This is a disadvantage not experienced in Canada where insurance reform was implemented on a national level.

[5] For further discussion of these two models, *see* Appendix Three.

The State's Role

Although the Single Payer will not be a state entity, the State will play an important role with respect to the single-payer system. The State will need to decide which benefits will be covered under the universal plan. The State will be responsible for developing a global budget, raising the revenue to fund that budget, working with the Single Payer to plan and develop the necessary health workforce, technology and infrastructure, and to monitor quality. Most importantly, the State will oversee the Single Payer, to make sure that it does not abuse the monopoly power it has been granted. Consumer input will be vital to these government functions. Some state agencies currently perform some of these functions. The Commission recommends that all of these functions now be shifted into a new agency, the Maine Health Care Authority.

The Maine Health Care Authority will be an independent, executive agency composed of seven voting members and three non-voting members, all serving part-time. Three of the voting members will be consumer representatives, two will represent providers and two will represent business interests. These seven members will be appointed jointly by the Governor, the Senate President and the Speaker of the House. The three non-voting members will be the Commissioner of the Department of Human Services, the Commissioner of the Department of Mental Health and Mental Retardation and the Director of the State Planning Office. These three members will all serve *ex officio*. The Authority will hire appropriate staff to conduct the day-to-day operation of the Authority.

The oversight functions of the Authority will be modeled after the Public Utilities Commission. Like a public utility, the Single Payer will have a monopoly over health insurance and will therefore have a major impact on health care services. The Authority will be charged with the responsibility of making sure that the Single Payer remains responsive to consumer demands. The Authority will establish a grievance process, under which consumer complaints can be addressed. In addition, the Authority can address specific concerns in its annual contract negotiations with the Single Payer.

The Authority will have primary responsibility for determining, through a public process, which health care benefits will be covered by the universal plan. A minimum plan could be set by the Legislature. As technology, populations, and practices change over time, the Authority will also have responsibility for adjusting the benefit package. It will be the first avenue of redress for any person disputing the level of coverage. The court system will provide an opportunity to appeal. Providers will have recourse to the judicial system to resolve any disputes they might have with the Single Payer or with the Authority.

The Authority will set the global budget through a public process. To ensure the effectiveness of the global budget, the Authority will also establish incentives for the appropriate use of health care resources by all participants.

For the purpose of modeling the projected costs of a single-payer plan, the Commission assumed that the maximum global budget would be set at the rate of growth in Maine's Gross Domestic Product (GDP) plus 2 percentage points. If the Authority adhered to that budget, over the next ten years health expenditures would be allowed to grow at a projected average of 7.7 percent. The Authority may wish to deviate from that budget limit after it has considered the input of various stakeholders and examined the available data. For example, the Authority could find that the budget limit could be lower without negatively impacting the availability and quality of care. Or the Authority could find that the budget limit would dangerously restrict the availability of care and should be higher. The Authority will also be responsible for enforcing compliance with the budget. The Authority's control over the flow of money provides it with a meaningful enforcement mechanism.

Related to the global budget, the Authority will also have a health planning function. In consultation with the Single Payer, the Authority will develop a health plan that would identify deficiencies in the health workforce, capital infrastructure and the diffusion of technology and set goals for how those needs will be addressed. For example, the Authority could determine that primary care should be emphasized. Together, they could develop a reimbursement strategy that would encourage the growth and use of primary care. Similarly, while most capital investment decisions would be made by the providers based on their reimbursement and their perceptions of the market for services, the Authority and the Single Payer could develop incentives for the development of one type of capital investment over another. In addition, the Authority may consider it necessary to set aside a certain amount each year for capital improvements to be determined on a proactive basis. As part of this planning process, the Single Payer and Authority will also identify unmet needs in the rural parts of the State, and take steps to address those needs. The Authority and the Single Payer will also have to integrate benefits under the health plan with the public health goals set by the Bureau of Health, within the Department of Human Services.

As discussed more fully in Chapter Nine, the Authority will also monitor the quality of the health care provided and will make that information available to all consumers.

As in the other two reform models designed by the Commission, the Commission recommends that a statewide health data system be created. This system is discussed at length in Chapter Seven. The significance of the data to the quality and viability of any health care system cannot be overstated.

The Commission recommends the creation of the Office of the Health Consumer Ombudsman, to be housed in the Department of Financial and Professional Regulation. The Commission recommends that this office also be responsible for receiving and monitoring consumer complaints. This office shall also keep the Authority apprised of the type and number of complaints received.

Because the Authority will now be performing a number of functions currently served in other agencies, those agencies could be scaled back. Savings from these reductions can be used to finance the administration of the Authority. For example, the Department of Human Services

will no longer need as many people to administer the Medicaid program, because most Medicaid recipients will be covered under the single-payer plan. Additionally, the Bureau of Insurance will no longer need to regulate as many health insurance plans because, except for supplemental policies, private health insurance will be illegal. Because the Authority will set the global budget, the rate setting, formerly administered by the Maine Health Care Finance Commission, will not be needed. The Certificate of Need program will also become superfluous and can be eliminated.

CHAPTER FOUR

A Multiple-Payer Universal Health Care System

Introduction

Under its legislative mandate, the Maine Health Care Reform Commission is required to design three alternative reform proposals. Two of those models, the single-payer model and the multiple-payer model, were to provide universal coverage to all Maine citizens. The single-payer plan is discussed in Chapter Three. The third model is based on the present health care system, incorporating managed care and other mechanisms to control costs and improve access for the uninsured. This third model is discussed in Chapter Five. In this chapter we discuss the multiple-payer model with universal coverage.

Unlike the single-payer plan, under the multiple-payer plan, any number of insurance companies are allowed to exist. In the Commission's single-payer plan, competition among insurance companies is replaced by a cap on health expenditures. In the multiple-payer plan, the goal is to maximize competition by correcting some of the market's inadequacies, so that the benefits of the market can be maintained. Often termed "managed competition," this model of health care reform uses competition to reward health plans for providing the best quality at the lowest cost.[1]

Traditionally, health care has suffered from significant market failures. Unlike a typical market, most health care consumers are not sensitive to price because their insurance premiums have been paid by their employer and their medical bills have been paid by their insurance plan. The parties most in control of supply and demand in a health care market, the provider and the patient, have known few of the normal market's constraints on price. For those consumers who are price-conscious, the ability to compare "products" in the health care market is very limited. Variations in benefit design across different plans have made price comparison difficult. Information on the quality of providers or plans is largely unavailable.

To correct these market failures, managed competition, like the single-payer model, requires regulatory oversight. The managed competition model requires the creation of a purchasing alliance. The Alliance will act as purchasing agent for all subscribers. The Alliance also sets the rules for the system. Benefit plans will be standardized so that consumers will be able to compare insurance plans based on price and quality. "Report cards" will be published, providing information that will assist in choosing a health plan. Consumers will see how much insurance costs because they will contribute to their health insurance premium -- paying more for more expensive plans. As a result of these reforms, providers will be forced to respond to market

[1] For helpful background on managed competition, *see* Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFFAIRS 24 (1993 Supplement).

pressures. Increasingly, providers will be paid on a capitated rate for a set of services provided to each individual, rather than for each service provided.

This multiple-payer model will bear many similarities to the third option designed by the Commission -- incremental reform. In that model, the State will also create an Alliance that is designed to correct some of the market failures. That model, however, does not contemplate universal coverage. For incremental reform, participation in the Alliance is voluntary. In the multiple-payer plan with universal coverage, participation in the Alliance is mandatory.

Like the single-payer model discussed in Chapter Three, implementing the multiple-payer plan with universal coverage is extremely difficult without the assistance of the federal government. First of all, the ERISA laws prevent the State from mandating employer participation in the Alliance and restrict Maine's ability to finance universal coverage.[2] Secondly, analysis of the impact of the multiple-payer model reveals that Maine, implementing universal coverage by itself, will suffer significant negative economic consequences.[3]

The Maine Health Care Authority

Relying on market forces for the delivery of health care may offer a number of advantages. At the same time, although the Commission believes that reforming the health care market will make a difference, it is difficult to know how quickly change will come or what its exact impact will be. Because participation in the Alliance will be mandatory, all citizens will have a stake in the performance of the health care market and the Alliance. The State will also want to make sure that its money, in the form of insurance premiums for its employees and premiums subsidies for qualifying businesses and individuals, is being spent appropriately. The Commission believes that, to ensure that health care costs are contained and that health care services are properly allocated, the Alliance should be part of the state government. For that reason, the Commission recommends that a new agency, the Maine Health Care Authority (MHCA), be created.

The Maine Health Care Authority will serve several functions. Most importantly, the MHCA will oversee the functions of the Alliance, which will be a division within the MHCA. The MHCA will design the standard benefit packages to be permitted in the Alliance. The MHCA will be responsible for developing a global budget which will cap health care expenditures and, in conjunction with the budget, design a health plan that will foster the development of the necessary health workforce and capital infrastructure and encourage the diffusion of technology. The MHCA will also be responsible for monitoring the quality of health care.

The Maine Health Care Authority will be an independent, executive agency, governed by a Board of Directors with twelve members. The seats will be distributed as follows:

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[2] The ERISA statute and its impact on state-level health care reform is discussed further in Chapter One.

[3] For further discussion of the economic impact of the multiple payer plan, *see* Appendix Three.

- ten "at large" seats, with five assigned to consumers and five assigned to employers.[4] Employer representation will include a representative of one large business (1,000+ employees), one medium sized business (100 - 999 employees), one business with fewer than 100 employees, one public employer and one self-employed business representative;

- these ten members will jointly select an eleventh member, who may be either a consumer or a business representative;

- the Commissioner of Human Services will hold an *ex officio* non-voting seat, assuring some linkage between the MHCA and other state health activities; and

- the Executive Director of the MHCA will hold an *ex officio* non-voting seat.

The ten consumer and employer board members will initially be appointed by the Governor and confirmed by the Legislature. The first Chair will be named by the Governor. No person actively working for, or as, a health care provider or having a financial interest in a health insurance carrier or provider will be eligible for membership on the Board. Candidates should be knowledgeable about health coverage purchasing. These conditions of eligibility will serve to assure that the MHCA will remain purchaser-oriented. At the same time, the MHCA will need the input of providers and payers to perform some of its functions. For that reason, the MHCA will create appropriate advisory panels, including one for providers and another for payers.

Board members of the Maine Health Care Authority will be appointed for staggered terms of three years each.[5] They may not be removed without good cause and may serve for a maximum of two consecutive terms. After the initial appointments, vacancies will be filled through membership elections. The number of seats set aside for consumers and for employers will be maintained. When the seat of the eleventh member -- that member jointly selected by the other ten members -- becomes vacant or is due to be replaced, the ten designated business and consumer representatives comprising the balance of the Board shall, again, jointly select the eleventh member. The Board will determine the process governing the technical aspects of the nomination and election process. Each subscriber enrolled in the Alliance and each employer participating in the purchase of coverage through the Alliance on behalf of his or her employees will be eligible to cast one vote.[6] Consumers, each having a single vote per contract or policy, will cast votes only for consumer representatives. Employers, including the self-employed policy holders, again each having a single vote, will vote only for business representatives. The Board will elect subsequent Chairs.

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[4] "Employer" is intended to refer to either a firm or an association (such as the New England Business Association, the Maine Lobsterman's Association or the Maine Education Association).

[5] To achieve the stagger, some initial appointments will be made for less than five years.

[6] By using the term "subscriber" the Commission intends that each contract holder will get one vote. Therefore, a family of five will get one vote, being cast by the subscriber; an enrolled individual will get one vote. Firms and associations will each get one vote, regardless of the size of the group it represents.

The day to day operations of the Maine Health Care Authority will be the responsibility of an Executive Director, or Chief Executive, who will serve at the pleasure of the Board of Directors. The Executive Director will serve as an *ex officio* member of the Board, without voting privileges. This assures that the Board and the Executive Director will have an interactive relationship, but maintains a "check and balance" between the Board and the MHCA administrator.

The Executive Director will hire staff with the necessary expertise and skills to carry out the duties of the organization in an efficient and effective manner. The MHCA Board will establish personnel policies and pay scales. The MHCA may also enter into contractual agreements for services, may sue and be sued, and may apply for and receive gifts and grants.

The Alliance

The Alliance will be a division within the Maine Health Care Authority. As a purchasing sponsor, the Alliance will have no regulatory capacity.

The Alliance will be responsible for issuing requests for bids from qualified insurance plans or carriers for each of the standard benefit products to be offered. The Alliance will also be responsible for evaluating each of the bids submitted and for identifying the successful bidders. All bidding will be carried out on a competitive basis. Before a plan can offer a product in the Alliance, the Bureau of Insurance must certify that the plan is solvent and meets other legislative requirements for insurance companies.

Health plans contracting with the Alliance will be required to show that they have a broad range of participating providers for all parts of the State in which they are licensed. To participate, each health plan will be required to demonstrate that it has made all best efforts to expand its area of coverage to rural and underserved areas designated by the Alliance.

The Alliance can play an important role in stimulating the development of cost-effective, integrated health plans across the State of Maine. An aggressive purchasing alliance establishes an environment in which health plans are held accountable for the cost and quality of the services they cover or provide, thereby encouraging the development of better integrated, more cost-effective plans. This accountability is ensured through the periodic requests for bids, negotiations with potential contracting health plans over salient plan features such as price, quality and access, as well as through the collection, analysis and dissemination of data on health plan performance. This gives even the smallest purchasers accurate and sufficient information, expertise and leverage to ensure that their needs will be important to health plans.

The Alliance will be responsible for marketing the selected plans and for enrollment of Alliance participants in their selected insurance program. Any marketing or informational materials used by participating insurers will be pre-approved by the Alliance to assure that clear, concise and accurate information is being conveyed. The Alliance will also collect premiums from participating businesses and individuals and will forward premium payments to the relevant health plans.

It is recognized that, when people are offered a choice among competing insurance products, one or more plans might enroll more than their share of the unhealthy population. Sometimes adverse selection results by accident, sometimes because of the insurer's marketing strategy and sometimes because the unhealthy might find one insurer's product more attractive than others. As discussed below, the MHCA will design a risk-adjustment mechanism to appropriately compensate carriers for adverse selection.[7] The Alliance will implement this methodology, either on its own or in contract with a third party. Plans with complaints about how risk adjustment was applied in their case may seek review by the MHCA Board. Appeal of a MHCA decision may be sought in the judicial system.

The Alliance will need to be able to provide some assurance to participants that the health plans offered are, in fact, providing high quality services to all enrollees. The Alliance will publish and distribute "report cards." The report cards will be prepared by each participating plan, subject to audit by the MHCA. They will provide basic information that consumers and employers should consider when choosing a health plan, such as plan type, access to providers in the plan "network," consumer satisfaction with the plan and its providers, service utilization and the cost of the plan over time.[8] These reports should be presented in a "user friendly" manner, in straightforward language free of medical and insurance jargon, understandable by the average Alliance participant.

The Alliance will also provide ombudsman services to address the complaints of individual enrollees and participating employers that can not be otherwise addressed.. Although many disputes might be resolved through this grievance procedure, the grievance procedures of the Bureau of Insurance will offer an administrative "review" of any claim. As discussed below, the Consumer Ombudsman will assist the health consumer in this process. The judicial system will offer a final avenue of redress.

The importance of the Alliance's quality and oversight functions cannot be overstated. As competition for enrollment becomes heightened and pressure to hold costs down increases, there will be pressure to deny services or possibly to provide less than optimal care. The job of the Alliance is to provide a counterbalance to that pressure, and to provide assurances to participants that their purchasing agent is watching out for their interests.

Independent insurance brokers and agents will be able to "sell" Alliance products to interested businesses and individuals. The fee associated with that sale will not be built into the premium cost. Rather it will be treated as a separate transaction cost that is a matter to be negotiated between the agent and the business or individual purchasing the coverage. The fee may not vary with the premium price of the product sold or with any other rating factor of the client. Instead, the maximum allowable fee will be predicated on the average premium price for all Alliance offerings. Clients will pay the brokerage fee and will be free to negotiate a lower

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[7] The Alliance will begin to implement risk adjustment over the gradual, five-year implementation of premium limits. Premium limits and the global budget are discussed at length below.

[8] For example, the National Committee on Quality Assurance has developed HEDIS, Version 2.0, detailing "standard" utilization measures that would prove helpful to consumers.

rate if they so desire. This limitation is intended to remove any incentive that might exist for any particular product. The broker or agent will be required to disclose to the client the level of their fee, separate from the premium cost of the insurance product.

The agent will forward the premium payment and appropriate enrollment forms to the Alliance and will collect any fees due to him or her directly from the client. Renewal of contracts made through the Alliance may be done with or without an agent or broker, at the enrollee's discretion. This allows consumers and businesses the flexibility of accessing the Alliance products in a manner most efficient for them. At the discretion of the Board, the Alliance will sponsor training and informational programs for brokers and agents regarding Alliance operation and products.

The Alliance's administrative budget will be set by the Maine Health Care Authority, subject to review by the Legislature.

The Global Budget

One of the primary responsibilities of the Maine Health Care Authority will be to establish a global budget that will limit health care expenditures. Some consider a global budget inconsistent with the philosophy of managed competition. At the same time, given the market's inadequacies, others would be reluctant to yield control over costs to market forces alone. The Commission believes that a global budget is a necessary tool for ensuring control over expenditures in the event market forces do not function as anticipated.

The broad parameters for the global budget will be set by statute. These parameters should include the fact that the budget will be enforced through a limit on insurance premiums, and that the budget will include the core services within the standard benefit packages.

The Maine Health Care Authority will set the baseline global budget through a public process. To ensure the effectiveness of the global budget, the Authority will also establish incentives for the appropriate use of health care resources by all participants.

To set the global budget, the MHCA will have to consider current premium expenditures as well as the projected costs of the standardized benefit packages. It will need to anticipate any increases or decreases in spending resulting from reform measures. For example, it will have to take into account increased utilization by those who are currently uninsured. It will have to factor in the competitive impact of standardized benefit packages. In addition to these changes resulting from reform measures, the MHCA will also need to consider the impact of changing technology, population and other factors.

In establishing these limits, the MHCA will also need to determine an appropriate limit on the rate of growth. For the purpose of modeling the projected costs of the multi-payer plan, the Commission assumed that the global budget would be set at the rate of growth not to exceed the Gross Domestic Product of the United States (GDP) plus 2 percentage points. If the MHCA adhered to that budget, over the next ten years health expenditures would be allowed to grow at

no more than a projected annual average of 7.7 percent. The Commission believes that health expenditures over the next ten years will likely fall below this cap under this multiple-payer model.[9] After it has considered the input of various stakeholders and examined available data, the MHCA may wish to deviate from this limit on budget growth. For example, the MHCA could find that the budget limit could be lower without negatively impacting the availability and quality of care. Or the MHCA could find that this budget limit would inappropriately restrict the availability of care and should be set at a higher level. The MHCA will have an ongoing responsibility to monitor the impact of the global budget on the quality of and access to health care and insurance products.

The MHCA will be responsible for enforcing compliance with the budget. To do so, it will establish premium limits for each of the standard benefit packages. The MHCA will design a risk-adjustment mechanism. The Alliance will be responsible for implementing this risk-adjustment methodology.

Fee-for-service reimbursement will be based upon the Resource Based Relative Value Scale (RBRVS). The RBRVS is a schedule of services developed for the Medicare program. The MHCA may add additional services to the RBRVS as necessary. Each provider will be required to disclose his or her fees so that consumers will be able to compare services based upon price.

Other MHCA Functions

Health planning is inextricably tied to the global budget. Currently, Maine does not have a health plan that establishes a framework for the health system or a vision for the diffusion of technology in this State. The Commission believes that the State must play a role in making sure that the State's health workforce and technology are appropriately allocated. It therefore recommends that the MHCA be assigned the role of devising a health plan. The plan should be updated on a biennial basis. The plan must be based on a data-driven, population-based needs analysis and must include proactive recommendations for the siting of expensive services and technology. These features will make the new State Health Plan an effective and useful tool.

Related to health planning, the Commission recommends that the MHCA have responsibility for implementing the Certificate of Need (CON) program. Under its health planning function, the MHCA will determine the appropriate level of investment in new technologies and where those technologies should be located. Under the CON program, the MHCA will make sure that its health plan is properly implemented.

The CON function will be expanded to all providers. Currently, only hospitals are required to obtain a Certificate of Need. This policy has given other providers an unfair advantage over hospitals, because their purchase of new technologies has been unrestricted. In addition, the health care market is in a period of transition. Health care networks that join hospitals with other providers are beginning to form across Maine. As the line between hospitals

[9] *See* Appendix Three for the economic projections associated with the multiple payer model.

and other providers becomes less distinct it makes little sense to continue applying the CON program to only hospitals.

The MHCA will be responsible for integrating the health planning function, the CON program and the global budgeting process. The Maine Health Care Authority will also be responsible for working with other agencies to make sure policies of the Alliance, and the MHCA as a whole, are consistent with those of other state agencies.

The Legislature will design an initial standard benefit package. The MHCA will be authorized, through a public process, to modify this package and design and develop additional standard benefit plans.[10] At least one of the plans will be a fee-for-service plan, and at least one will be a managed care plan. Insurers could offer one, some or all of the allowed products, but would be precluded from marketing and selling products other than those allowed by rule.

Another primary role for the MHCA will be in the area of quality. The MHCA will be responsible for auditing the "report cards" submitted by participating health plans. As mentioned above, those report cards will be published to assist subscribers in choosing among the available plans. The MHCA will also be responsible for the production of Quality Performance Reports.[11] These reports will be much more detailed and complex than the report cards, which are intended for a very broad audience. The primary use of the Quality Performance Reports will be to afford the MHCA Board the level of data and information necessary to assess performance of participating plans and to inform their decisionmaking regarding future contracting. The MHCA will also have the ability to contract with an independent Quality Improvement Foundation to pursue quality improvement activities at the provider and population level.

The MHCA will have jurisdiction over subscribers' complaints against the Alliance. It will also hear any complaints plans will have over implementation of risk adjustment and premium limits or any other Alliance activity. Appeal from any MHCA decision may be made to the judicial system.

The MHCA will be required by statute to commission a yearly independent financial audit of the Alliance. The audit report will be forwarded to the Legislature and the Governor along with an annual report of Alliance and MHCA activities. The report will address the MHCA's performance in setting and enforcing the global budget, the health plan, and the CON program. It will provide a summary of the MHCA's quality assurance activities and an assessment of the performance of the Alliance. Further audits or studies could be ordered by the Legislature if found warranted.

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[10] The Commission's recommended Standard Benefit Package, described in Chapter Two, was used to estimate the costs and economic impact of the multiple payer model. The Commission strongly endorses the use of that core package of benefits in conjunction with a variety of cost-sharing configurations to arrive at the set of standard benefit options to be sold in the Maine market. Cost-sharing here refers to levels of copayments, deductibles, out-of-pocket limits and lifetime maximums.

[11] The concept of quality performance reports was suggested to the Commission by its Advisory Committee on Quality Assurance/Improvement. For a discussion of Quality Improvement Foundations, *see* Chapter Nine.

Participation in the Alliance

Participation in the Alliance will be mandatory for all employers and Maine citizens, with few exceptions. To maximize competition among health plans, individuals, not employers, will choose which health plan they prefer. That means that the demand for a particular product will be more responsive to changes in quality and price.

There will be an annual open enrollment period during which consumers may change health plans. Changing plans during the remainder of the year can occur only with the specific permission of the Alliance. The Alliance will assign a plan to those individuals who do not choose one.

Medicare will continue to be a federally administered plan. The State may seek permission from the federal government to integrate Medicare into the State's multi-payer plan. With a waiver, the Alliance could certify and monitor managed care plans that wish to enroll Medicare beneficiaries. Or Medicare beneficiaries could purchase coverage through the Alliance using vouchers.

Medicaid will continue as a state-administered program under the Bureau of Medical Services. The Medicaid program is currently developing managed care contracts for the coverage of certain of its subpopulations. Under the multiple-payer plan, coverage for these Medicaid recipients will be purchased through the Alliance. In addition, in order to maximize the federal matching funds, the State will expand the Medicaid program to its outer limits. To implement these two changes, Maine will need to obtain an Section 1115 demonstration waiver from the federal government.

Insurance companies will no longer be allowed to compete based on risk. Community rating will be established so that the same premium is paid for the same coverage regardless of health status. No plan will be allowed to deny or withdraw coverage from any individual.

Financing Health Care Premiums

Employers and employees will share equally in premium costs. They each must pay at least 50 percent of the required premium rates for the lowest cost health plan available. The employer or the employee may choose to pay more for a more expensive plan. Part-time employees will receive a premium contribution corresponding to their part-time status. For example, a person employed half time would receive a 25 percent employer contribution.

The State will provide subsidies to businesses to cover premium contribution costs that exceed 7.5 percent of total employee salaries. Maine citizens and families with incomes below 250 percent of the federal poverty level would also be eligible for state premium subsidies. Persons with income below poverty will be required to pay only 1 percent of total family income toward their premiums. Persons between 100 and 250 percent of poverty would be partially subsidized on an income-related, sliding-scale basis. The Commission believes that, to ensure

true universal coverage, the State must also subsidize those who cannot afford their copayments and deductibles. Copayments and deductibles would be waived for persons up to 125 percent of poverty.[12] The Commission also recommends that personal premium expenditures be made deductible from federal and state income taxes. While the State would be able to enact this, the federal tax deduction must await reform at the national level.[13]

The Commission recommends that the necessary insurance premium subsidies be financed primarily through an increase in the effective rate of personal income taxes (increasing to 4.3 percent through the year 2001, falling to 4.0 percent thereafter), payroll taxes (2.25 percent through the year 2001, falling to 1.25 percent thereafter) and an increase in the sales and meals taxes (increasing 1 percentage point through 2001, .5 percentage point thereafter). Together, these three sources of revenue could raise as much as 87 percent of the $740 million in necessary revenue. Doubling the "sin" taxes, raising the corporate tax by .5 percentage point and eliminating the tax-exempt status for non-profit plans would make up the difference.[14]

New Roles for Other State Agencies

The State will provide other functions related to the Alliance. As mentioned above, the Legislature will hold ultimate oversight over the Alliance since it will annually review its performance and its audit. The Legislature will also be able to exert some control over the Alliance through its expenditures on health insurance for public employees and its control over subsidies for insurance premiums.

Consumers who have complaints about the Alliance may seek redress with the MHCA. For those consumers who have a complaint about their health plan, the first step is the Alliance's grievance procedure. The Bureau of Insurance will provide an opportunity for "appeal" from an Alliance decision. This "appeal" will not be substantively different from the grievance process the Bureau currently offers consumers. The court system will provide the ultimate review.

The Bureau of Insurance also certifies health plans for solvency and other requirements for licensing. This certification will continue to be a prerequisite for participation in the Alliance.

The Bureau of Insurance will retain oversight of all supplemental health policies. It will need to consult with the MHCA, below, in approving benefit packages for supplemental coverage, because the supplemental packages should not overlap or duplicate the standard packages allowed in the Alliance.

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[12] Although the Commission reported to the contrary in its draft report, the additional cost of subsidies for copayments and deductibles were factored into the economic modeling of this multiple payer plan.

[13] Currently self-employed individuals receive a 25 percent deduction from their federal taxes for their health insurance premiums.

[14] *See* Appendix Three for a more detailed discussion of the financing for this model.

The State will collect the tax revenues for the premium subsidies and allocate those subsidies.

The State will participate in creating a joint public/private statewide health data system. This system is discussed at length in Chapter Seven. The significance of the data to the quality and viability of any health care system cannot be overstated. Because the Commission recommends that a global budget be imposed, this data will become essential.

Because the MHCA will now be performing a number of functions currently housed in other agencies, those agencies should be scaled back. Savings from those agencies can be used to fund the administrative budget for the MHCA. For example, the Department of Human Services will no longer need to administer the Certificate of Need program.

Protections for Patients and Providers in a Market-Driven System

The multiple-payer model relies heavily on competition among health plans as a means of controlling cost. As a result, health plans will face growing pressure to maintain tight controls on utilization of services. This emphasis on cost containment is desirable to the extent that it is achieved appropriately, through reductions in the inappropriate use of services and by an efficient use of resources. It is possible, however, that efforts to contain costs can result in unfair constraints on patients and providers. In the interest of maintaining a balance between cost-control and an appropriate level of protection for patients and providers, the Commission recommends the adoption of a series of additional market reforms. We believe that these reforms should extend to all health care plans doing business in Maine. All plans face similar pressures to keep costs down and they all may take steps to achieve that objective that inappropriately impact their subscribers and participating providers.

We recommend that all health care plans be required to disclose meaningful information to the public regarding coverage provisions and exclusions, requirements for prior approval of services, copayment and deductible requirements as well as information about financial arrangements between the plan and its providers that might potentially influence the decision-making behavior of the provider to limit services or referral options. Financial information on the individual lines of business carried by each insurer will also be made available. Such information would include disclosure of the use of provider withholds. This recommendation does not imply that a plan should be expected to provide detailed information regarding the complexities of financial arrangements. Such details are likely considered proprietary and would be likely to overwhelm the typical consumer. Still, enough information must be made available to allow even unsophisticated purchasers to make reasonable and informed decisions about the health plan they buy. Premium cost, in and of itself, does not convey a complete picture of the value a particular product may hold for a consumer, and incomplete information contributes to the perpetuation of an inefficient market.

Plans should also be required to establish reasonable internal procedures for resolving enrollee grievances as well as a process for appealing coverage determinations. Information regarding these processes should be made available to the consumer at the time the consumer is considering purchasing the plan product, as well as on demand.

All health plans should be required to establish procedures that are designed to promote fairness toward providers. These provisions should include the use of an appropriate process for accepting and reviewing applications for credentials or participation in a health plan, and a requirement for the disclosure of the standards the plan will use to make the credentialling decision. Each plan should implement an appeals process by which a provider may appeal an adverse decision regarding credentialling.

Health plans should be prohibited from discriminating against persons on the basis of health status by excluding a provider from its network solely on the basis that his or her patient panel has a substantial number of patients with high risk or chronic medical conditions. Similarly, health plans should be limited in their ability to terminate agreements with providers solely because a provider acts as an advocate for his or her patients, such as appealing coverage decisions made by the plan. Providers must be guaranteed the freedom to discuss with patients the full range of treatment options appropriate for their medical conditions, without regard to the extent of coverage of any one of those options by the patient's health care plan. Health plans may not attempt to restrict this ability through contractual language in participating agreements.

We also recommend that certain safeguards be established to assure that utilization review processes operate effectively and with regard to patients' interests. In those instances where a plan requires prior authorization for a service, a decision regarding authorization or denial must be made within a reasonable period of time. Denials of authorization that are not simply matters of straight-forward coverage policies[15] should be made with input from providers who have training and expertise in the area of care for which the patient is seeking coverage. For example, a decision to deny a neurosurgical procedure should be made by a neurosurgeon, rather than by a primary care physician or other surgeon. This will assure that the patient will receive the benefit of having his or her request for coverage reviewed by a provider who can competently assess the situation.

Finally, we believe that health plans should be accountable for their own negligence and should be precluded from shifting liability for their own negligence to providers.

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[15] For example, if a plan does not cover pharmaceuticals, a request for coverage of a particular drug could be denied simply on the basis of the limitations of the plan, provided the patient was made aware of that limitation at the time they enrolled in the plan. If the disclosure requirements recommended earlier in this chapter are adopted, all consumers will be made aware of coverage limitations at the time of purchase.

CHAPTER FIVE

Incremental Reforms to the Current System

Introduction

The charge to the Maine Health Care Reform Commission was to develop at least three models for reform of the health care delivery system. Two of the models were to be a single and a multi-payer system providing universal coverage for all Maine citizens. The remaining model was to be based on the present health care delivery system, incorporating managed care and other mechanisms to control costs and improve access for the uninsured citizens of Maine.

The first two models require universal coverage. These models would be very difficult to implement successfully without meaningful federal reform of the Employee Retirement Income Security Act (ERISA) statute.[1] In the absence of ERISA reform, states are precluded from implementing any reform initiatives that mandate self-insured businesses to either provide or finance insurance coverage.[2] In addition, our economic analyses indicate significant adverse impacts on the state economy if Maine were to act on its own to adopt either of these models.[3]

In the absence of national initiatives, the most likely avenue of reform will be incremental reforms of the existing delivery and financing systems. The model outlined below addresses the issue of cost containment and improved access through a variety of reforms including the establishment, through legislation, of a statewide purchasing alliance. In developing this approach to reform the Commission considered issues of demographics and geography, the needs of both urban and rural residents of Maine, consumer choice of health care plan, and the importance of preventive health care.

Although this reform option does not approach the goal of universal coverage (a principle held by the Commission), it will result in enhanced access to coverage for many Maine citizens. The funding developed in the incremental option will be used to finance a Medicaid expansion that would extend coverage to approximately 25,000 low-income children. These funds would be raised through a modification in the application of the current health insurance premium tax. With the exception of this modest expansion, there is no provision in this option for financial subsidies to other low income individuals or to businesses (although these could be added, if desired). The plan would, however, lay a firm foundation for further, more

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[1] For a discussion of ERISA, *see* Chapter One.

[2] The recent Supreme Court decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* (decided April 26, 1995), has changed the implications ERISA presents to states attempting to undertake health systems reform. Certain levels of broad based taxes now appear to be allowable under ERISA.

[3] This is certainly not to say that such an investment would not be a wise one. In fact, the Commission firmly believes that it would be. However, political realities and competing priorities make such an investment highly unlikely.

comprehensive reform should the State decide at some point in the future to pursue such an initiative.

The Alliance Model

The centerpiece of the incremental reform model is a cooperative purchasing initiative, joining the negotiating power of the state employees with a statewide, voluntary alliance of private sector businesses and individuals. The purpose of the initiative is to empower consumers of health care, by strengthening the demand side of the purchasing equation. The initiative aligns the State Employee Health Insurance Program (SEHIP) with the "Community Alliance," a voluntary purchasing cooperative comprising "pools" of employees of private businesses, association members and individuals wishing to purchase Alliance-sponsored insurance products. The alignment of the SEHIP and the Community Alliance will be formalized through the use of a Cooperative Purchasing Committee, that will include representatives of the State Employee Health Commission (which governs the SEHIP) and the Community Alliance. The structure of the Community Alliance and the Cooperative Purchasing Committee as well as a discussion of the relationship between the Community Alliance and the State Employee Health Insurance Program is presented below.

This proposal for incremental reform considers the development of a cooperative purchasing effort between a private alliance of purchasers and the state employees, and does not include other public employees. We draw a distinction between state employees and other groups such as the university system employees, public school teachers and municipal employees. The former are primarily supported by state and federal revenues; the other groups rely heavily on tuition (university personnel) and local revenue, with governance carried out at a level other than state government. However, should other public sector groups such as teachers, municipal or university employees wish to maximize their purchasing power through participation in this cooperative initiative, they certainly could, while retaining the integrity of their independent benefit programs. This model is specifically designed to allow groups such as the state employees to maintain their current governance structures; participation in the purchasing program does not demand that they cede control of their programs.

Maine's Medicaid program could also be integrated into the model. The Medicaid program is currently developing managed care contracts for the coverage of certain of its subpopulations. The Department of Human Services initially intends to enroll the Aid to Families With Dependent Children (AFDC) statewide population in commercial managed care products, following several years later with the development of appropriate products for its disabled and elderly populations. The Commission recommends that the Administration give careful consideration to the pursuit of these purchasing activities through the cooperative purchasing model presented in this report.

It is important to the success of the market that the State become an aggressive and responsible purchaser. The inclusion of the Medicaid program's external purchasing activities in the joint purchasing initiative assures that the State is maximizing its purchasing/negotiating

power through the consolidation of its purchasing activities. Furthermore, this consolidation will streamline the purchasing process. Requests for Bids (RFBs) for the provision of coverage can be developed simultaneously and the Medicaid program can take advantage of the contracting and actuarial expertise that will reside within the initiative to develop those "RFBs." Bidders will know that there will be a single bidding process for all state health insurance programs, thus simplifying the process for them as well. Finally, this approach is expected to result in a greater range of products for Medicaid clients, as qualified bidders will have to prepare bids for all lines of business within the initiative.

It is important to make clear that, should the State decide to purchase commercial coverage for medical assistance clients through the initiative, ***the Medicaid risk pool will be kept separate and will not be merged with the risk pool(s) of any other participating group.*** The range of benefits that must be made available to Medicaid enrollees may be substantially different from those available to other Alliance participants. Moreover, certain subpopulations of Medicaid recipients are eligible for Medicaid specifically because they have significant medical problems.[4] To merge the Medicaid risk pool with any other might skew the composition of the resulting pool, spreading the cost of the "sicker" pool of participants regressively onto state employees, other public employees or any other participating group.

Further, the Commission recommends that the State adopt a system-wide policy regarding certain of its contracting provisions. Both the Department of Human Services and the Department of Mental Health and Mental Retardation maintain contracts with providers that include provisions for the direct reimbursement of the contractor's administrative costs.[5] These overhead costs may include the cost of health insurance where it is provided as an employee benefit. With certain exceptions, the State should mandate that contractors purchase coverage through the Alliance or disallow those costs. The purchase of these benefits through the Alliance will not only serve to strengthen the purchasing power of the Alliance but is expected to result in lower costs to contractors. The State will benefit through lower contracting costs.

Governance of the Community Alliance

The Community Alliance will be established, by statute, as a public, nonprofit corporation.[6] The corporation will be governed by a thirteen-member Board of Directors, with seats distributed as follows:

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[4] This is not true of all Medicaid clients. The majority of Medicaid recipients are eligible for benefits as a result of their eligibility for the federal Aid to Families With Dependent Children (AFDC) program. This population comprises primarily children and their caretakers -- usually their mothers -- and are generally a healthy group.

[5] It is likely that other agencies have similar agreements with contractors. To the extent that is the case, the recommended policy change would apply to those agencies as well.

[6] In deciding on the governance structure for the Alliance, the Commission considered a range of other options including housing the Alliance within an executive or independent State agency, or within a private corporation. The Commission also considered the recommendations of its Phase Two Advisory Committee on Governance/Administration. The draft recommendations of this Commission contemplated an Alliance that would have merged the State Employee Health Plan into a community alliance, altering the governance of the government plan. Refinements to that proposal are reflected in the cooperative model presented in this final report.

- ten "at large" seats, with five assigned to consumers and five assigned to employers.[7] Employer representation will include a representative of one large business (1,000+ employees), one medium sized business (100 - 999 employees), one business with fewer than 100 employees, one public employer and one representative of the self-employed;
- these ten members will jointly select an eleventh member, who may be either a consumer or a business representative;
- the Commissioner of Human Services will hold an *ex officio* non-voting seat, assuring some linkage between the Alliance and state health planning activities; and
- the Executive Director of the Alliance will hold an *ex officio* non-voting seat.

The persons filling the ten "at large" consumer and employer seats will initially be appointed by the Governor and confirmed by the Legislature; the first Chairperson of the Board will be named by the Governor. Interested persons and organizations will be allowed to submit suggestions for board appointments for the Governor's consideration. No person currently working for or having a significant financial interest in a health insurance carrier or a health care provider in active practice will be eligible for board membership; candidates should have demonstrated experience in health care purchasing and delivery systems. This condition of eligibility will serve to assure that the Alliance will remain purchaser-oriented. This entity will negotiate with insurers (who, in turn, will negotiate with providers), and it is therefore inappropriate to include insurers/providers on the governing body. The eleventh member -- to be selected by the ten members at large -- must have similar credentials.

Board members will be appointed for staggered terms of three years each.[8] They may not be removed without good cause and may serve for a maximum of two consecutive terms. After the initial appointments, vacancies will be filled through membership elections; the number of seats set aside for consumers and for employers will be maintained. When the seat of the "eleventh member" -- that member jointly selected by the other ten members -- becomes vacant or is due to be replaced, the ten designated business and consumer representatives comprising the balance of the Board shall, again, jointly select the eleventh member. The Board will determine the process governing the technical aspects of the nomination and election processes. Each subscriber[9] enrolled in the Alliance and each employer participating in the purchase of coverage through the Alliance on behalf of his or her employees will be eligible to cast one vote. Consumers, each having a single vote per contract or policy, will cast votes only for consumer representatives. Employers, including self-employed policy holders, again each having a single vote, will vote only for business representatives. Self-employed subscribers will vote only for

[7] "Employer" is intended to refer to either a firm or an association (such as the New England Business Association, the Maine Lobsterman's Association or the Maine Education Association).

[8] To achieve the stagger, some initial appointments will be made for less than three years.

[9] This implies that each contract holder will get one vote. Thus, a family of five will get one vote, being cast by the subscriber; an enrolled individual will get one vote. Firms and associations will each get one vote, regardless of the size of the group they represent.

the self-employed representative; other business participants will vote for the other four business seats. The Board will elect subsequent Chairs.

The day-to-day operations of the Community Alliance will be the responsibility of an Executive Director/Chief Executive who will serve at the pleasure of the Board of Directors. This person will serve as an *ex officio* member of the Board, without voting privileges. This assures that the Board and the Executive Director will have an interactive relationship, but maintains an appropriate balance of power and a "check and balance" between the Board and the Alliance administrator.

This structure accomplishes a number of important purposes:

- First, although it would be established by state statute, the Alliance would not be a part of state government.[10] This avoids the issue of creating a new or bigger state bureaucracy. At the same time, the enabling legislation would create certain standards for performance that would demand public accountability for the organization.

- By distancing the Alliance from "mainstream" state government, it is insulated from many of the political and other pressures that may be exercised on state agencies. This structure will also help foster an organizational culture that is different and apart from the culture of a state agency. The Alliance would be free to design its own operational system including policies for contracting, purchasing and personnel.

- Although the Executive Director serves as a member of the Alliance Board, he or she does not have a vote. Policy decision-making is vested in a Board that is composed of consumers and purchasers. The Executive Director is hired and evaluated by the Board. As a result of its composition, the Alliance Board will have the greatest motivation to ensure a cost-effective, high quality and efficient organization -- providing an effective check and balance with the Alliance administration and staff.

- Finally, the Alliance will be required, by statute, to commission an annual, independent financial audit. The audit report will be forwarded to the Legislature, the Governor and the State Auditor for review, along with an annual report of the Alliance's activities.

Participation in the Community Alliance

Businesses of any size and in any industry will be eligible to enroll in the Community Alliance and will be placed in a business risk pool. It is expected that Alliance membership will not only be attractive to the smallest businesses -- those with one (the self-employed) to twenty-five employees -- but to larger businesses as well. Businesses participating in the Alliance will

[10] It could, however, enjoy some of the "privileges" set aside for agencies of State government, such as limited tort immunity.

be precluded from offering or purchasing standard health benefits to subsets of their workforce outside of the Alliance mechanism. This does not prevent a firm from moving its entire workforce into the Alliance even if it had previously purchased a commercial product; it only prohibits a business from moving a portion of its employees into the Alliance while keeping others outside of the cooperative.[11] This requirement provides a degree of protection against the "dumping" of poor risks into the Alliance.

There will be a statewide "mandate to offer" imposed on all employers who are not currently offering their employees access to health insurance coverage. This implies only that those employers must inform employees of the opportunity to purchase coverage either through the Alliance or through some other insurance program and provide a payroll deduction mechanism for the collection of premiums for those employees wishing to enroll. It does not require employers to contribute toward the cost of the premium.[12] There will be no minimum participation requirement[13] for businesses enrolling in the purchasing cooperative, nor will there be any minimum required level of employer premium cost sharing. However, enrollees from businesses where the employer does not meet a minimum premium contribution level[14] will be placed, for rating purposes, in the individual risk pool rather than in the business risk pool. This will help avert adverse selection into the Alliance.

Individuals will also be eligible to participate in the Alliance. They will be placed into a separate risk pool for individual enrollees.[15] In at least the initial years of operation, this risk pool will be maintained as a separate group for rating purposes. After three years, the Board will examine the experience of the various risk pools and consider the merging of these pools. This consideration will be made in light of an objective of attaining the broadest possible "community" over which risk may be spread. It is conceivable that the experience of the pools will not be significantly different.[16] If this is the case, the Board could merge the risk pools. If a merger is not found to be prudent, the issue will be reconsidered each subsequent year.[17]

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[11] In firms with multiple bargaining units, complete units would be required to enroll in the Alliance, although the firm could decide to enroll only certain bargaining units in the Alliance.

[12] The use of payroll deduction facilitates the purchase of coverage for employees. The Alliance will establish automatic withdrawal mechanisms to facilitate payment for those enrollees who do not have access to a payroll deduction option.

[13] Often insurers require that a certain percentage of eligible employees in a business participate in the insurance program. This practice is designed to minimize the risk of adverse selection into the product. The Commission recognizes that the decision to forego minimum participation requirements will likely invite some adverse selection, but has recommended doing so to achieve a greater degree of access to coverage for Maine citizens.

[14] This minimum level will be determined by the Board of the Community Alliance.

[15] This proposal defines self-insured individuals as business groups of one, rather than individuals.

[16] The experience of Washington's Basic Health Plan and the MaineCare project demonstrates that under certain circumstances, that claims experience is not entirely related to size of business. While the reasons underlying this experience are the subject of some debate among experts, it is possible that the Community Alliance will have a similar experience.

[17] A merger of risk pools does not imply the merger of the state employee pool or any other public sector pool with its own governance structure into the Community Alliance pool. The Board of the Community Alliance governs only the private, voluntary alliance.

The opportunity to enroll in the Community Alliance will be made available to businesses and individuals on an on-going basis. All of the same continuity of coverage provisions applicable to the standard insurance market will apply to the Alliance "market" as well. Therefore, the application of pre-existing condition limitations will be the same both within and without the Alliance, although the Alliance Board would have the discretion to adopt "looser" underwriting provisions.[18] The opportunity to switch carriers or plans from one Alliance product to another, without good cause, will be limited to an annual re-enrollment period defined by the Board. If a group or individual disenrolls from the Alliance (or is involuntarily disenrolled due to nonpayment of premium, for example), re-enrollment will not be allowed for a twelve-month period. This safeguard will "protect" the Alliance from severe adverse selection by precluding enrollment that is generated by an occurrence of medical need for coverage. Again, the same continuity of coverage, guarantee renewal and underwriting provisions currently applicable to commercial insurance products will apply to the conditions the Alliance may impose on members. Similarly, each insurance product offered through the Alliance will be subject to all applicable statutes and regulations governing health insurance products in Maine.[19]

Alliance Function, Operation and Financing

The Community Alliance is intended to bring employers and consumers together to collectively purchase health care coverage. This Alliance will enjoy enhanced purchasing power by virtue of an association with the State Employee Health Insurance Program, which purchases coverage for over 30,000 people. The basic functions of the Community Alliance are fairly simple:

- the Board of the Alliance will establish a range of standardized benefit packages, specifications and data submission requirements that participating health plans must satisfy, and will establish criteria for the selection of participating plans;
- the Alliance, through the Cooperative Purchasing Committee (discussed on page 53 of this report), will issue a Request for Bids, inviting interested health plans to specify the price, provider network and other plan characteristics for each of the standardized Alliance products they are bidding on;
- the Alliance, through the Cooperative Purchasing Committee, will negotiate with the bidding health plans and will enter into contracts with those plans that offer the best value;
- the Alliance will provide consumers and employers with information that easily allows a comparison of the price, characteristics and performance of each participating plan and each standardized benefit option;
- the Alliance will enroll members into the participating plan of their choice, collect the required premium payments, distribute premium payments to participating plans and resolve problems between consumers and health plans that are not resolved through other mechanisms; and

[18] These provisions would be implemented through contractual provisions with participating health plans.

[19] This includes satisfaction of any mandated benefits or offerings.

- the Alliance will produce and disseminate "performance reports" for each participating plan.[20]

As noted above, persons purchasing coverage through the Community Alliance will be able to choose from a number of standardized benefit options.[21] These options will include a product that is equivalent to the product offered to state employees under their health plan as well as at least two other options, one being a fee for service product and the other being a managed care product, designed by the Alliance. Additionally, supplemental coverage policies may also be offered. While a range of options will be made available, the absolute number of choices available within the Alliance will be maintained at a reasonable level, to be determined by the Board. Experience of other large buying groups -- such as the Federal Employees Health Benefit Program -- has shown that enrollees like choice, but dissatisfaction increases when the number of choices rises to an overwhelming level.

The Alliance will serve as consumer/business friendly "shopping mall" for health insurance products. All offered options will be available to all Community Alliance participants. Again, the Board will develop a range of benefit packages with options designed to meet varying levels of need for coverage. It is important to recognize that, due to different benefit configurations such as varying levels of cost sharing, the standard options will range in price. Those employers making a contribution to the premium cost may wish to design a contribution level that keys off of the lowest priced plan; however, no minimum level of employer premium cost participation will be required.

We wish to emphasize several important points. First, participation in the Community Alliance is voluntary. No business or individual will be required to join the Alliance; any business wishing to instead purchase health care coverage in the "traditional" marketplace is free to do so. Therefore, while the range of benefit options and insurers available through the Alliance will be determined by the Board and will be somewhat limited, there is no true restriction of choice for those persons who voluntarily purchase through the cooperative. The choice to purchase Alliance coverage will be made on a business by business, individual by individual basis, factoring considerations of economics, convenience and quality of service. Finally, nothing in this recommended model requires the restriction of Alliance offerings to a single, comprehensive or costly health benefit plan. In fact, the Alliance is required to offer a range of products in an effort to accommodate the various tastes, preferences, and needs of potential members.

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[20] This description of the basic operation of a purchasing alliance is derived from a background paper prepared for the Commission by one of its consultants, Richard Curtis, Institute for Health Policy Solutions. The paper was presented to the Commission at a regular meeting held in October, 1995.

[21] The Commission's recommended Standard Benefit Package, described elsewhere in this document, was used to estimate the costs and economic impact of the incremental reform option. The Maine Health Care Reform Commission strongly endorses the use of that core package of benefits in conjunction with a variety of cost-sharing configurations to arrive at the set of standard benefit options to be allowed to be sold in the Maine market. However, *this model does not require the use of that package.*

The Alliance, through its participation in the Cooperative Purchasing Committee, will be responsible for issuing Requests for Bids from qualified insurance plans or carriers for each of the standard benefit products to be offered to Alliance participants. The Alliance, through the Cooperative Purchasing Committee, will also be responsible for evaluating each of the bids submitted and for identifying the successful bidders. All bidding will be carried out on a competitive basis.

The Alliance will also be responsible for implementing and enforcing contracts with participating health plans. One aspect of these contracts will be a provision requiring participating insurers to grant the Alliance "most favored nation" status with regard to product price. Participating insurers will be precluded from underbidding the Alliance by offering lower prices on their own, actuarially equivalent, products outside of the Alliance. This measure represents another safeguard against severe adverse selection into the Alliance.

The Alliance will be responsible for the marketing of the selected plans and for the enrollment of Alliance participants in the insurance program they select. Disclosure of the characteristics of all available plans must be made to any party purchasing coverage through the Alliance.[22] Any marketing or informational materials used by participating insurers with Alliance participants must be pre-approved by the Alliance to assure that clear, concise and accurate information is being conveyed. The Alliance will collect premiums from participating businesses[23] and individuals and will forward premium payments to the relevant health plans. The Alliance will also establish the mechanisms necessary to offer voluntary automatic bank or credit union account withdrawals to facilitate premium payment for those individuals who do not have access to payroll deduction plans.

The Alliance will be required to establish and administer an internal ombudsman process to address the problems of individual enrollees, participating employers and health plans. While many of the issues that individuals might have with their health plan may be able to be resolved through the plan's own grievance procedures, the Alliance mechanism will provide an avenue for resolution of problems that are not able to be "grieved." Parties with grievances will still be free to "appeal" to the Superintendent of Insurance (either with plan specific problems or with Alliance-related issues) and will still have access to the judicial system as a final arbiter.

An assessment will be added to the premium cost of Alliance products to support to operation of the Alliance. The level of this surcharge should be targeted at three percent, including the cost of marketing and enrollment; the actual level of surcharge will be determined by the Board which will have every interest in assuring that the rates charged for Alliance products are competitive. Independent insurance brokers and agents will also be able to "sell" Alliance products to interested businesses and individuals. The broker/agent fee associated with that sale, however, will not be built into the premium cost of any insurance product, but will be

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[22] This disclosure requirement is identical to that which we recommend be required in the market outside of the Alliance, addressed later in this chapter.

[23] Again, an employer *will not be required* to contribute financially to the cost of the plan, but many premium payments are expected to be forwarded to the Alliance through the payroll deduction mechanism.

treated as a separate transaction cost that is a matter to be negotiated between the broker/agent and the business or individual purchasing the coverage. The brokerage fee for Alliance products may not vary with the premium price of the product sold or with any other rating factor of the client. Instead, the maximum allowable fee will be predicated on the average premium price for all Alliance offerings. Clients will pay the brokerage fee and will be free to negotiate a lower rate if they so desire. This limitation is intended to remove any incentive that might exist for placing clients in higher cost products or for steering certain types of clients toward or away from any particular product. The broker/agent will be required to disclose to the client the level of their fee, separate from the premium cost of the insurance product.

The broker/agent or subscriber will forward appropriate payment and enrollment forms to the Alliance and the broker/agent will collect any fees due to him/her directly from the client. Renewal of contracts made through the Alliance may be done with or without an agent or broker, at the enrollee's discretion. This allows consumers and businesses the flexibility of accessing the Alliance products in the manner most efficient for them and does not obviate the role of the independent agents. At the discretion of the Board, the Alliance will sponsor training and informational programs for brokers and agents regarding Alliance operations and products.

The Executive Director will be responsible for the day-to-day operation of the Alliance and will hire staff with the necessary expertise and skills to carry out the duties of the organization in an efficient and effective manner. The Board of the Alliance will establish personnel policies and pay scales. The Alliance will also have the ability to enter into contractual agreements for services, will be able to sue and to be sued and will be able to apply for and receive gifts and grants. The policies governing the operation of the Alliance will be set out by the Board, guided by the enabling legislation.

Other Functions of the Alliance

It is recognized that any situation in which people are offered a choice among competing insurance products holds the prospect of adverse selection among plans. This implies that there is the possibility that one or more Alliance plans might be "selected against," enrolling a generally less healthy population. Similarly, other plans might experience unexpectedly "good" selection. These enrollment patterns may be the result of marketing practices or the composition of the provider network offered by particular plans or may simply be accidental. Regardless of the reason for the selection outcome, it is important to eliminate the disadvantage that selection generates. To accomplish this goal, the Alliance will develop and implement a risk-adjustment process applying it across all carriers within each separate Alliance risk pool.

One of the most important functions of the Alliance will be in the area of quality oversight -- providing assurances to participants that the health plans offered through the Alliance are, in fact, providing access to high quality services for all enrollees. This may be accomplished through a number of mechanisms but will include the preparation and publication of "report cards" by each participating plan, subject to review and audit by the Alliance. These reports are intended to provide basic information on plan type, access to providers in the plan

"network," consumer satisfaction with the plan and its providers, service utilization and the cost of the plan over time -- the type of information consumers and employers consider when choosing a health plan.[24] They are to be presented in a "user friendly" manner, in language free of medical and insurance jargon and understandable by the average Alliance participant.

The Alliance will also be responsible for the production of "Quality Performance Reports."[25] These reports will be much more detailed and complex than the report cards described above, which are intended for a very broad audience. The primary use of these reports will be to afford the Alliance Board the level of data and information necessary to assess performance of participating plans and to inform their decisionmaking regarding future contracting. The Alliance will also have the ability to contract with an independent Quality Improvement Foundation to pursue quality improvement activities at the levels of providers and populations. For a discussion of Quality Improvement Foundations and quality performance reports, please refer to Chapter Nine.

The importance of these functions cannot be overstated. As competition for enrollment becomes heightened and pressures to hold premium costs down increases, there may be an incentive for insurers and providers to restrict services or possibly to provide less than optimal care. The job of the Alliance is to provide a counterbalance to that pressure, and to provide assurances to participants that their purchasing sponsor is watching out for their interests.

Finally, the Alliance can play an important role in stimulating the development of cost-effective, integrated health plans across the State of Maine.[26] An aggressive purchasing alliance establishes an environment in which health plans are held accountable for the cost and quality of the services they cover and/or provide, thereby encouraging the development of better integrated, more cost-effective plans. This accountability is ensured through the periodic requests for bids, negotiations with potential contracting health plans over salient plan features such as price, quality and access, as well as through the collection, analysis and dissemination of data on health plan performance. This empowers even the smallest purchasers with accurate and sufficient information, expertise and leverage to ensure that their needs will be important to health plans.

Because an aggressive purchaser like the Alliance contemplated in this model will encourage cost-effectiveness, health plans will likely be encouraged to build better integrated delivery systems. A plan that can provide quality, comprehensive, accessible care at a reasonable price may be more attractive to purchasers than other options. In a competitive environment, the more integrated a health plan is, the more likely it is to successfully achieve these objectives. In less competitive environments, such as rural locations with few providers, an aggressive alliance can leverage its purchasing role as a way of assisting providers to develop more integrated, better

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[24] For example, the National Committee on Quality Assurance has developed HEDIS, Version 2.0, detailing "standard" utilization measures that would prove helpful to consumers.

[25] The concept of quality performance reports was suggested to the Commission by its Advisory Committee on Quality Assurance/Improvement.

[26] This discussion is derived from a background paper prepared for the Commission by Richard Curtis, Institute for Health Policy Solutions, October 1995.

systems of care by offering these plans the prospect of a potentially significant share of the local market.

In this sense, the Alliance contributes to the realization of system-wide cost savings while encouraging the development of better systems of care and improved access for the citizens of rural Maine. This broader context should be considered when reviewing the alliance model; it not only represents value to its members, but to the State, generally.

The State Employees Health Insurance Program

Maine's state employees are provided a health insurance benefit through the Maine State Employees Health Insurance Program, which is functionally administered by the Department of Administration. All executive and independent agency employees (including management), legislators, Legislative Council employees and employees of the judiciary system are eligible for enrollment in this program.[27] Other public employees such as public school teachers, municipal employees and university system employees are covered under separate and distinct benefit programs. The level of premium contribution to be made by the State is set forth in statute; the benefits to be covered by the program are subject, by law, to collective bargaining. It is important to note that the health-related benefits extended to state employees include dental insurance and disability insurance, as well as health insurance.

The State Employee Health Insurance Program (SEHIP) is governed by the State Employee Health Commission (SEHC). This Commission comprises an equal number (9) of labor representatives and management representatives. Each "side," labor and management, is allocated a single vote. This requires that the two sides work collaboratively to effectively oversee the Health Program. The Commission is responsible for implementing the collective bargaining agreement by soliciting bids from insurers for coverage that meets the specifications of that agreement.

As mentioned above, the Department of Administration, an Executive agency, is responsible for the day-to-day administration of the program. Under our proposed model for a cooperative purchasing initiative, the staff of the State Employee Health Insurance Program would continue its present functions. If, at some point in the future, the SEHC decided that affording state employees a choice of products was cost-effective and desirable, the SEHIP staff would have the added task of providing enrollees with information regarding their options. Under the proposed model, state employees will have a choice of vendor (*not* a choice of benefit packages or products).

Currently, the SEHIP/SEHC process of developing a Request for Proposals, of evaluating any bids submitted, and of negotiating with potential contractors must be carried out in a manner

[27] There are currently over 35,000 enrollees in this group, including 4,000 retirees.

open to any interested member of the public.[28] The bidding and contracting processes themselves are matters that are governed by the SEHC's enabling legislation, rather than the State's general contracting policies.

The State Employee Health Insurance Program is funded through general fund appropriations and through employee premium contributions.

The Cooperative Purchasing Committee

We recommend that the State Employee Health Commission and the Community Alliance implement a cooperative purchasing initiative through the formation and maintenance of a joint committee. This group, which we refer to as the Cooperative Purchasing Committee, would comprise four members: one labor representative from the SEHC; one management representative from the SEHC; one consumer representative from the Community Alliance Board; and one employer representative from the Community Alliance Board. The Committee will function under "rules" developed by the SEHC and the Alliance Board, establishing the working relationship between the SEHC and the Alliance. It is likely that a consensus model of decision-making will be most effective for this group, but that will be left to the two governing boards to decide.

This committee will be responsible for developing a single Request for Proposals (RFP), seeking bids from interested health plans for the State Employee Health Insurance Program and for the products to be offered by the Community Alliance. The RFP will define all of the relevant bid considerations for each of the programs; these considerations may, in some cases, overlap and in other instances, may diverge from one another. The SEHC will develop the bid specifications for its program and the Board of the Alliance will develop specifications for its products. The process of developing the RFP will take place outside of the range of "sunshine" rules that currently impact the SEHC. This is designed to allow for a more competitive bidding process that more closely resembles that of large private businesses. The inclusion of the private sector Community Alliance in the process should allay the concerns some might have regarding the potential for impropriety in the bidding and negotiating process if it is not open and accessible to the general public.

The Cooperative Purchasing Committee will also be responsible for receiving the bids and for evaluating them in light of the criteria defined in the RFP. Further, the Committee will jointly negotiate with bidders, subject to final approval by the SEHC (on the SEHIP product or products) and the Board of the Community Alliance (with respect to Alliance products). Separate contracts with health plans, however, will be maintained.

If other public sector groups such as the Maine Education Association's insurance trust, the Maine Municipal Association or the University of Maine system decided to maximize their

[28] In 1993, the Court found that certain competitive bidding requirements did apply to the SEHC. As a remedy in a case brought by Healthsource Maine, Inc., the Court ordered the SEHC to employ open bidding and negotiating procedures.

purchasing power through joining the cooperative purchasing initiative, they could be allowed to assume a role in the joint committee. Similarly, if the Medicaid program were to become part of the initiative, it, too, could be given a seat on the committee.

This organizational mechanism is intended to allow for a leveraging of the purchasing power represented by a very large group -- the state employees -- to negotiate favorable coverage arrangements for businesses and individuals in the private sector who do not enjoy as favorable a negotiating advantage. The keen interest among insurers and health plans for the business of the state employee group, and a tying of access to that group to an offering of products to the membership of the Alliance, should increase access to more affordable coverage for a broad segment of Maine's private sector. Moreover, we expect that all participating groups, *including the State Employee Health Insurance Program,* will come to see lowered health care costs and higher quality of care as a result of the implementation of this type of purchasing initiative. As mentioned elsewhere, this model is specifically designed to increase competition between health plans. As competition is heightened, so is the emphasis on cost-effectiveness. Those plans that will be most successful in realizing enhanced cost-effectiveness are those which develop better integrated delivery systems which, in turn, are able to deliver better quality services.

The premise for this model is one which is employed by many of the country's largest businesses: the bigger the purchaser, the better the value of the product offered by the insurers will be. Our economic modeling of this market approach suggests that it will contribute to a potentially significant impact on the rate of premium increases, with premiums projected to decline by 8 percent. The private sector will realize obvious benefit from the formation of an Alliance that maintains a cooperative relationship with a large purchasing bloc -- the state employee group. The SEHIP will enjoy potentially lower costs and better delivery systems for its beneficiaries. The public, generally, will enjoy the residual effect generated by the introduction of a larger purchasing bloc. In addition to potentially lowering the rate of increase in the cost of state-paid benefits (and thus a demand for scarce general fund revenues), the market place reforms that occur as a result of this strategy will work to make coverage and costs more affordable.

The Reformed Market for Health Insurance

General Market Reforms

A range of insurance market reforms is recommended to accompany the formation and implementation of the Alliance. These reforms will complement the Alliance and serve as a necessary foundation for its successful operation. First, we recommend that the recently enacted small-group reforms related to continuity and guaranteed issue be expanded in application to include groups of 25 to 99 employees.[29] This effectively re-defines "small group" to be any group of fewer than 100 employees and extends the reforms to those groups which are least

[29] Currently, these small-group reforms apply only to groups of 1 to 24.

likely to self-insure for health benefits.[30] The phase-in of community rating that began in 1994 should continue and, like the other small-group reforms, apply to all groups of fewer than 100. It is essential that the rules governing insurance practices are the same inside the Alliance and in the external market. In that way, the risk of adverse selection against the Alliance is minimized.

Current law provides continuity of coverage for those persons replacing an insurance policy within a 90 day period following the cessation of coverage under a different policy.[31] The statute prohibits the replacement insurer from denying coverage on the basis of insurability or from imposing a pre-existing condition exclusion on the person seeking enrollment, provided that the person had been covered for 90 continuous days before discontinuing the old coverage.[32] We recommend that this provision be amended to allow replacement of a policy within a 180 day period, without the imposition of medical underwriting (except to the extent that it is currently allowed) for certain persons. Those people qualifying for the extension would have had to have lost employer-sponsored coverage due to separation from employment, and must have been collecting unemployment benefits.

Staff of the Bureau of Insurance have stated that, in their view, there is no actuarial basis for limiting the time period to 90 days as opposed to some other time period, and, therefore, saw no reason to advise against such an extension.[33] Six months is the maximum time period that a person may ordinarily qualify for unemployment benefits.[34] The lengthening of the time period within which a policy may be replaced to parallel the unemployment benefit period recognizes that many persons who are unemployed simply cannot afford to purchase replacement coverage. However, people receiving unemployment benefits must be actively seeking employment and must be willing to accept employment. In the interest of making health care coverage more accessible to such persons, the continuity of coverage provisions should be amended.

We also recommend that insurance brokers/agents and insurers that directly market their own products be required, by law, to disclose certain information to the businesses and consumers they are working with. This information would include the transaction fee that is being charged (either directly or as part of the premium) for a broker writing the policy. Often, this fee is blended into the premium price and it is difficult for a consumer to understand what he or she is paying for the brokerage services. It would also include information regarding the relative value of the product based on an index of actuarial value to be developed by the Superintendent of Insurance. Clear and meaningful information regarding coverage limitations and exclusions, copayments, deductibles and prior authorization requirements should also be conveyed, along with information regarding the price of the product. Next, all those persons/plans marketing policies should be required to disclose to the consumer information

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[30] Although some firms with fewer than 100 employees do self-insure, the long term financial viability of such a benefit program is, in the opinion of some experts, questionable.

[31] 24-A MRSA §2849.

[32] An insurer can impose a waiting period on a person who had been continuously insured under an old policy for less than 90 days , provided that the waiting period imposed reflects a credit for the extent to which a waiting period had been satisfied under the old policy. 24-A MRSA §2849.

[33] Personal communication with Glen Griswold and Brian Atchinson, Bureau of Insurance, October, 1995.

[34] However, the average time period for collection of unemployment benefits, in Maine, is 14.4 weeks.

regarding all relevant coverage options handled by that broker or available through the carrier doing the marketing. In addition, disclosure of the availability of all relevant Alliance products would be required. For instance, if a broker handles three products for individual coverage, the broker would be required to inform an individual about all three of those products. This will avoid any potential that exists for "steering" consumers toward one product and away from others, minimizing the potential for adverse selection against a particular product.

We also recommend that model language drafted by the National Association of Insurance Commissioners be adopted, giving definition to the term "stop loss insurance." This language sets the attachment point for stop loss insurance at $20,000; any policy with a lower attachment point would be considered a health insurance policy rather than stop loss. The effect of this language would be to preclude businesses from claiming they were self-insured when they purchase what really is only a high deductible policy, which, under ERISA, exempts their benefit plan from state regulation. This should discourage those businesses without sufficient capital reserves to fund a risk retention pool from doing so, providing a greater degree of protection to the beneficiaries of the plan.

Protections for Patients and Providers in a Market-Driven System

As the health care insurance market becomes increasingly more competitive, health plans will be facing growing pressure to maintain tight controls on utilization of services. This emphasis on cost containment is desirable to the extent that it is achieved appropriately, through reductions in the inappropriate use of services and by an efficient use of resources. It is possible, however, that efforts to contain costs can result in the imposition of unfair constraints on patients and providers. In the interest of maintaining a balance between plan desires to keep costs under control and an appropriate level of protection and fairness for patients and providers, the Commission recommends the adoption of a series of additional market reforms, outlined below. While some will argue that these reforms should apply only to managed care plans, we believe that they, instead, should extend to all health care plans doing business in Maine. All plans face similar pressures to keep costs down and they all may take steps to achieve that objective that inappropriately impact their subscribers and participating providers.

Some of these provisions are taken from a legislative proposal that was carried over from the first session of the 117th Legislature, and that will be considered in the upcoming session. That bill, entitled *An Act to Ensure Fairness and Choice to Patients and Providers Under Managed Care Plans,* enjoys broad bipartisan support. The scope of the bill is confined to the managed care industry. As stated above, we believe these reforms are broadly applicable to all health care plans; our proposal reflects that broader view. Further, there are provisions of this legislative proposal that are not included here. It is important to note that the exclusion of any given portion of the bill does not necessarily connote our tacit agreement or disagreement with the provision. In some instances, we have chosen simply not to address a particular issue due to a shortage of time or expertise on our parts. In other instances, we may be opposed to the provision. In still other instances, we may agree in concept with the proposal but have addressed the issue elsewhere in our recommendations.

We recommend that all health care plans be required to disclose meaningful information to the public regarding coverage provisions and exclusions, requirements for prior approval of services, copayment and deductible requirements as well as information about financial arrangements between the plan and its providers that might potentially influence the decision-making behavior of the provider to limit services or referral options. Financial information on the individual lines of business carried by each insurer will also be made available. Such information would include disclosure of the use of provider withholds. This recommendation does not imply that a plan should be expected to provide detailed information regarding the complexities of financial arrangements. Such details are likely considered proprietary and would be likely to overwhelm the typical consumer. Still, enough information must be made available to allow even unsophisticated purchasers to make reasonable and informed decisions about the health plan they will buy. Premium cost, in and of itself, simply does not convey a complete picture of the value any particular product may hold for a consumer, and incomplete information contributes to the perpetuation of an inefficient market.

Plans should also be required to establish reasonable internal procedures for resolving enrollee grievances as well as appeals processes for the appeal of coverage determinations. Information regarding these processes should be made available to the consumer at the point in time when the consumer is considering purchasing the plan product, as well as on demand.

All health plans should be required to establish procedures that are designed to promote fairness toward providers. These provisions should include the use of an appropriate process for accepting and reviewing applications for credentials or participation in a health plan, and a requirement for the disclosure of the standards the plan will use to make the credentialling decision. Each plan should implement an appeals process by which a provider may appeal an adverse decision regarding credentialling.

Health plans should be prohibited from discriminating against persons on the basis of health status by excluding a provider from its network solely on the basis of the fact that his or her patient panel has a substantial number of patients with high risk or chronic medical conditions. Similarly, health plans should be limited in their ability to terminate participating agreements with providers solely because a provider acts as an advocate for his or her patients, such as appealing coverage decisions made by the plan. Providers must be guaranteed the freedom to discuss with patients the full range of treatment options appropriate for their medical conditions, without regard to the extent of coverage of any one of those options by the patient's health care plan. Health plans may not attempt to restrict this ability through contractual language in participating agreements.

We also recommend that certain safeguards be established to assure that utilization review processes operate effectively and with regard to patients' interests. In those instances where a plan requires prior authorization for a service, a decision regarding authorization or denial must be made within a reasonable period of time. Denials of authorization that are not

simply matters of straight-forward coverage policies[35] should be made with input from providers who have training and expertise in the area of care for which the patient is seeking coverage. For example, a decision to deny a neurosurgical procedure should be made by a neurosurgeon, rather than by a primary care physician or other surgeon. This will assure that the patient will receive the benefit of having his or her request for coverage reviewed by a provider who can competently assess the situation.

Finally, we recommend that statutory provisions be enacted to assure that health plans be precluded from shifting the full burden of liability resulting from a plan's negligent decisions or actions to participating providers. While a provider should not be made immune from liability arising from his or her own negligent actions, a plan should not be able to escape liability arising from its own actions.

It is important to stress that we believe that these provisions apply to all health care plans. While some of them seem more relevant to managed care plans, most are universally applicable. All plans must play under the same guidelines to assure that each has equal footing in the marketplace.

Mandated Benefits Review Commission

Mandated benefits are those benefits that insurers are required to include in all offerings to commercially insured groups or individuals.[36] There are a variety of mandated benefits specified in law in Maine, some of which apply only to group policies, some to individual policies and some to both. Certain mandates also apply to health maintenance organizations. Mandates either require insurers to cover specific classes of people or providers or certain types of services, or they require insurers to offer such coverage. In the case of the latter, coverage is only provided if the subscriber affirmatively elects to purchase that coverage.

Many people argue that mandated benefits add significantly to the cost of health insurance and contribute to the coverage affordability issues facing Maine's businesses and individuals. While self-insurance is a realistic option for large businesses, smaller businesses are faced with a decision of trying to afford group coverage or electing not to participate at all in the purchase of health insurance for employees. The more affordable coverage is, the more likely businesses may be to offer it to employees, and the more likely it may be that employees will be able to afford to underwrite their cost of plan participation. In the interest of making coverage as affordable as possible, we believe it is important to take stock of the statutory mandates, and to reassess their value in light of the most current information available.

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[35] For example, if a plan does not cover pharmaceuticals, a request for coverage of a particular drug could be denied simply on the basis of the limitations of the plan, provided the patient was made aware of that limitation at the time they enrolled in the plan. If the disclosure requirements recommended earlier in this chapter are adopted, all consumers will be made aware of coverage limitations at the time of purchase.

[36] Self-insured groups are exempt from the provisions of mandated benefits laws by the federal ERISA statute.

Currently, the law contains certain "mandated health legislation procedures."[37] These provisions prescribe that any legislative proposal, that would mandate coverage "for specific health services, specific diseases or certain providers of health care services as part of individual or group health insurance policies"[38] and which enjoys substantial support from the committee of jurisdiction, may not be enacted unless a review and evaluation of the proposal has been completed.[39] The review and evaluation is to be done by the Bureau of Insurance and reported to the relevant legislative committee in a timely manner.

While the statute requires that a comprehensive evaluation of the social impact of mandating the benefit, the financial impact of mandating the benefit, the medical efficacy of mandating the benefit and the effects of balancing these three considerations, the evaluation is necessarily limited by the time and resources available to the Bureau. Often, too, there is a significant lack of information upon which an objective evaluation may be made. Information that was available may now be outdated; new research may lead evaluators to different conclusions about the advisability of mandating certain benefits than those reached in the past. Finally, it is important to remember that decisions regarding the mandating of benefits are made in a highly charged political context. While legislators make the best decisions they can with the information available, the compressed time frame of the legislative session combined with the emotional appeal of certain of the mandates lends to the difficulty of reaching objective evaluations of proposals.

For all of these reasons, we recommend that the mandated benefits currently in statute be subject to a careful review. A special commission on mandated benefits should be created by the Legislature and given the charge of reviewing all benefits for which coverage is mandated with respect to the criteria which now apply to the evaluation carried out by the Bureau of Insurance (which will staff the commission in its work) with regard to proposed mandates. The review is to incorporate the most current information available regarding cost, social considerations and efficacy. This commission, which would be appointed by the Legislature, will represent the interests of consumers, providers and commercially insured businesses.

The Mandated Benefits Commission will be required to report its findings to the Legislature no later than one year after the Commission members are appointed and the Commission is convened. These findings are to include a comprehensive recommendation regarding the advisability of continuing the current mandated benefits. The Legislature would then have the opportunity to either wholly accept or wholly reject the recommendation of the task force, but would not have the option of accepting only "pieces" of the report and rejecting others.[40] This process is intended to create an opportunity for a careful and deliberate review of each of the mandates without the temporal constraints presented by a legislative session. This process will undoubtedly be subject to political pressures, but should not be as highly charged as

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[37] 24-A MRSA §2752.

[38] *Id.*

[39] This provision does not apply to proposals that would only mandate the *offering* of certain coverage options.

[40] This model is intended to parallel that used for the federal base closings commission.

a legislative session might be. This will contribute to a reasoned evaluative process that stakeholders can have confidence in.

Other Reform Measures

The Children's Program

Our incremental reform option includes the expansion of Medicaid coverage to all children below the age of 19 who reside in households with incomes at or below 250 percent of federal poverty guidelines. We propose this be accomplished through the State's use of the "1902 (r)(2)" option in the Social Security Act. Section 1902(r)(2) allows states to apply more liberal standards of assessing income and assets than are ordinarily used when determining Medicaid eligibility for persons who are not eligible to receive cash benefits (welfare payments). Section 1902(r)(2) affords states the flexibility of disregarding income and assets in any amount when evaluating an individual's eligibility for Medicaid coverage. By applying such a "disregard," people who would not otherwise be eligible for coverage, become so.

We recommend that Maine apply a disregard in determining Medicaid eligibility for all children under age 19 residing in households with income less than or equal to 250 percent of the federal poverty guidelines. This implies that the State would disregard all income and assets between the applicable standard income guideline and the 250 percent poverty limit for each individual child's household. It does not imply that the families, older siblings or parents of the eligible child will become Medicaid eligible. The application of the disregard will apply only when determining a minor's Medicaid eligibility status.

A number of other states have relied on the flexibility extended by Section 1902(r)(2) to achieve Medicaid expansions for children. Vermont's "Dr. Dynosaur" program, which covers all children under age 19 in families with incomes at or below 275 percent of poverty, was implemented using the 1902(r)(2) option. Washington, Delaware and Virginia have all used 1902(r)(2) to accomplish the accelerated extension of coverage to all minors living below the poverty limit. Similarly, Michigan has used 1902(r)(2) to extend Medicaid benefits to all children under age 16 in families with incomes below 150 percent of poverty, and Minnesota, through the "MinnesotaCare" initiative, covers all infants and pregnant women below 275 percent of poverty by employing Section 1902(r)(2).

The eligibility expansion can easily be implemented by the State's filing of an amendment to its existing Medicaid State Plan. It is important to note that this is not a waiver process. Although it is simple and straightforward, it does not allow the State the flexibility to apply programmatic restrictions to the new group of eligible persons. It only addresses financial eligibility for Medicaid. The same coverage provided to other Medicaid beneficiaries must be extended to the new group. Similarly, all of the current restrictions will apply to the new enrollees. They cannot be treated any differently than any other Medicaid recipient; to

accomplish that would require the federal government granting a demonstration waiver -- a difficult and lengthy process.[41]

The required State share of the cost of our proposed Medicaid expansion -- an estimated $8 million -- would be generated via the extension of the premium tax that is applied to most insurers in the market to include the few classes of insurers now exempt from this tax. Currently, for-profit health insurance carriers (other than health maintenance organizations) are subject to a 2 percent premium tax. Instead of this premium tax, for-profit HMOs are required to pay a 2 percent corporate tax. Non-profit HMOs and health and medical services corporations are exempt from these two taxes. The application of the tax to currently exempt organizations[42] is expected to generate approximately $11 million in revenue in the first years of application. These funds should be dedicated to the funding of the children's expansion program.[43]

This expansion program is an important investment opportunity for Maine. It will allow for the provision of coverage to some of Maine's most vulnerable residents with an investment of State dollars that will be matched by the federal government at almost 2 to 1. Although this program does not approach the goal of universal coverage, it does represent a significant improvement. Approximately one-half of all Maine children live below 250 percent of the federal poverty line. An estimated 25,000 of these children are currently uninsured. Current household poverty guidelines are:

$7,470	one person
$10,030	two people
$12,590	three people
$15,150	four people

Under the proposed expansion, a child under age 19 living in a three-person household where income fell below $31,475 would be eligible for coverage. This program is targeted at a population that has limited resources and is not eligible for public assistance. It is this population that has the most difficult time accessing affordable health care and coverage.

This program may complement welfare reform by removing one of the most significant barriers for recipients facing the decision to leave welfare -- the loss of health coverage for their children. This program may serve to ease that transition and serve as an important mechanism for decreasing dependency on the Aid To Families With Dependent Children (AFDC) program, generating substantial decreases in welfare expenditures. Although subject to interpretation, this

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[41] This proposal is offered at a time when the future of the Medicaid program is in a state of flux. We have designed the recommended expansion based on the only reliable information about Medicaid that is available: the characteristics of the current program.

[42] Currently exempt insurers include Blue Cross and Blue Shield of Maine and Harvard Community Health Plan. Healthsource Maine, Inc. is a for-profit company and pays the corporate income tax rather than the premium tax. This proposal does not contemplate the application of the tax to those entities like Healthsource, which are paying a tax through an alternative mechanism.

[43] Revenues in excess of the $8 million required to fund the children's expansion should be used to provide the Community Alliance, described earlier in this chapter, with start-up funding.

expectation is supported by the experience of the State of Minnesota, which in 1993 expanded the MinnesotaCare Program -- a state sponsored health coverage initiative -- to persons in families at or below 275 percent of federal poverty guidelines. By the fall of 1994, Minnesota's average monthly AFDC caseload was three and one-half percent lower -- 2,400 cases or 6,700 people lower -- than would otherwise have been expected. Analysis has shown that the reduction in the expected rate of growth in the case load is related to the MinnesotaCare program, and that the change is statistically significant.[44] The "averted" case load represents an estimated savings of $900,000/month ($10.8 million annually) in AFDC welfare payments. Minnesota officials expect this level of savings to grow over time.[45] If the same effect were to be exercised on Maine's AFDC program, there would be an estimated annual savings attributable to averted welfare payments of $3.3 million -- $1.2 million in State funds and $2.1 million in federal funds.[46] This effort would be consistent with the Legislature's current plans to reform the State's welfare system.

Other Waiver Initiatives

When preparing our draft recommendations earlier in the year, it had appeared that the Department of Human Services was considering the expansion opportunities that might be available through a "Section 1115" waiver. This type of waiver allows a Medicaid program to waive a broader range of federal requirements than does a Section 1915 (b) waiver, which the State has recently been granted. A Section 1115 waiver allows a state to use, on a demonstration basis, entirely different guidelines for benefit eligibility. Not only can income disregards be used, but other characteristics of individuals or families that would ordinarily make someone ineligible for coverage may also be disregarded, to allow an expansion of the population covered by the program. Additionally, this type of waiver allows a program to offer a different range and/or scope of benefits to the Medicaid population than is prescribed by federal laws and rules. Under this waiver, a state must assure the federal government that it will not be caused to spend any more federal funds than it would have in the absence of a waiver award; in other words, expansions must be Medicaid-revenue neutral from the federal government's point of view.

A number of states across the country have applied for and received Section 1115 waivers, with the objective of extending health benefit coverage to a greater proportion of their population. It is our understanding that the Department currently has no plans to pursue an expansion through a Section 1115 waiver application. It is in the process of developing an application under Section 1115 to allow for the demonstration of an alternative method of financing the care of elderly and disabled Medicaid beneficiaries, but this initiative, known as MaineNet, does not contemplate any eligibility expansions.

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[44] Some believe that welfare rolls were reduced because health insurance was available for both children and adults and question whether extending coverage to only children would have the same result.

[45] Telephone conversation with George Hoffman, State of Minnesota Department of Health, June 7, 1995.

[46] These computations are based on a telephone conversation with Sue Dustin, Department of Human Services, AFDC Division, June 8, 1995. In 1995, the average monthly AFDC caseload has been 20,892, three percent of which equals 731 cases. The average monthly grant payment has been $379. The Federal and State shares of AFDC grant payments in 1995 are .63 (Federal) and .37 (State), respectively.

We do not specifically recommend that the Legislature direct the Department to pursue a Section 1115 waiver in this report. To do so would have required us to develop a sophisticated actuarial analysis to support the recommendation; any such initiative, set in statute would require a fiscal note that could be relied on with a high degree of confidence. Such a task is beyond our expertise and financial resources. However, we have reviewed several proposals for Medicaid expansions that appear to us to have merit.[47] Each of these proposals would extend coverage to certain low income populations currently without coverage and with only a marginal ability to afford the cost of health care. The difficulty we encountered in assessing those proposals was not related to merit or the premise underlying any one of them, but rather was related to our inability to identify which group was the most appropriate "target" for an expansion. While we are firm in our belief that extension of coverage to our most vulnerable citizens -- Maine's children -- should be the first expansion effort, we have been unable to come to any decision regarding the prioritization of other population groups. Some may believe that the adults associated with the children targeted in our proposed expansion should be the next group to whom coverage would be extended; others may argue that adults below the poverty line who do not otherwise qualify for Medicaid should be a priority.

Despite our inability to resolve this question, we strongly urge the Department to actively pursue the issue of identifying priority populations and to investigate any avenue for expanding Medicaid coverage to a greater proportion of Maine's population. It is imperative that Maine take advantage of any federal funding available to achieve expansion of coverage; current Medicaid funding represents a valuable resource to a relatively poor state, which enjoys a favorable federal matching rate. The issue of funding the state share of additional expansions also remains unresolved in our minds. However, only by working toward universal coverage will we be able to realize a decline in uncompensated care and an improvement in health status which will yield significant savings in the future.

We are also aware that Congress is on the verge of passing legislation that would fundamentally alter the nature of the Medicaid program. If that legislation becomes law, states will likely receive block grants from the federal government that can be used to finance health care for needy persons. Should this be the case, we urge the Department, the Administration and the Legislature to carefully consider priority populations for coverage, and to provide adequate coverage for the broadest possible population.

Health Information System

Elsewhere in this report, a proposal for a statewide health information system is presented. That proposal holds important implications for this incremental reform strategy. Reliable data and information are a necessary condition for creating and understanding an efficient market. The importance of the data proposal cannot be overstated.

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[47] For a discussion of these proposals, *see* Chapter Twelve, where the Commission's responses to public comments are presented.

Rate Regulation

At the end of the first session of the 117th Legislature, a statute was enacted that eliminated the Maine Health Care Finance Commission, the independent agency that regulated the rates of Maine hospitals. The repeal of rate regulation was implemented effective July 1, 1995; however, the monitoring of hospital restructurings and the on-going collection of hospital data will continue until at least June 30, 1996. These changes would seem to signal an interest on the part of lawmakers in a greater reliance on competitive forces to govern the market for health care. This only increases the importance of strengthening the role of the consumer as purchaser in this market, and makes implementation of the Alliance strategy recommended here more desirable.

Certificate of Need

The contribution of new technology to the "cost-push" in health care is extremely significant. An efficient market will respond to the demands of consumers and will provide those new services and technologies that the purchasing public demands. However, competition in health care has historically tended to express itself in terms of breadth of services rather than in terms of price. That is, providers have sought to attract consumers through the provision of high quality services reflecting the most current technology available. This has been especially true of large, institutional providers such as hospitals which have access to the capital required to invest in expensive new technologies.

The State has also witnessed the investment in expensive technologies by non-hospital entities. Ambulatory surgical units and advanced imaging facilities are examples of facilities developed outside of hospitals. Presently, they are not subject to any form of review or pre-certification. They are not guaranteed reimbursement and must negotiate payment levels with payers.

There are other forms of high technology services for which there may be less expensive alternatives. Until recently, there has been little incentive for the provider community to consider the cost-effectiveness of these alternatives in their choices of drugs and treatments.

There is no doubt that many of these new technologies are of great value and should be available to Maine's citizens. However, it must be understood that increasing costs in health care often occur at the expense of other valuable societal programs such as education, housing and the State's infrastructure. It is important to consider carefully and balance the costs of new technologies and other capital investments in health care against the overall needs of the population.

One approach to this is through health planning. Maine, like many other states across the country, has made a number of attempts at comprehensive, statewide health planning efforts. None of these efforts have been particularly successful or long-lived. This may be due to the fact that, during the era in which these efforts took place, the cost of health care was not viewed as having reached crisis proportions. The result, however, is that Maine does not have a health

"plan" that establishes a framework for the health system or a vision for the diffusion of technology in this State. Without such a framework, the Certificate of Need Program is left to operate in relative darkness. The Commission recommends that the Department of Human Services prepare an updated State Health Plan, and that that plan be updated on a biennial basis. This Plan must be based on a data-driven, population-based needs analysis and must include proactive recommendations for the siting of expensive services and technology. These features will make the new State Health Plan an effective and useful document.

Another method of monitoring and control is through the Certificate of Need (CON) program, itself. The fact that that investments in technology carry such a significant cost for citizens suggests that regulation may be useful. The Commission, therefore recommends that the Certificate of Need program be continued, in its present form. While the precise utility of this program is the subject of some debate, oversight of investments made on the part of those market participants with the greatest capacity to fund them is an important function to maintain.

Anti-Trust Regulation

Finally, we have considered the issue of the current anti-trust statutes in Maine. This regulation is currently the responsibility of the Attorney General's Office, which enforces the anti-trust statutes and the Maine Hospital Cooperation Act. There is a concern on the part of some that network formation activity compels a greater level of regulatory oversight. Others argue that the current regulatory structure is, perhaps, too confining and should be relaxed. We believe that the current regulatory structure in the area of anti-trust is working reasonably well and should not be changed at this time.

As the market continues to moves through this period of rapid change, the Attorney General should continue to monitor carefully the activities of both providers and payers. This will indicate if any modifications in the regulations are required to allow the market to operate more efficiently or to provide further consumer protections.

CHAPTER SIX

Financial and Economic Impact Analyses

Introduction

P.L. 707, Part AA directs the Commission to present information regarding projections of the costs and economic impact of each reform model proposed. The Maine Health Care Reform Commission retained the firms of Health Systems Research, Inc. and Coopers & Lybrand (C&L) to assist it in this required task. Health Systems Research (HSR) is a Washington, D.C. based firm specializing in health care policy and has had significant experience in the design and analysis of state-level reform initiatives. Coopers & Lybrand's San Francisco office provided the Commission with actuarial services; the C & L consulting team also has considerable experience in developing actuarial rates and in providing assistance to state task forces and commissions in the design and analysis of state-level health care reform strategies.

These consultants assisted the Commission in its deliberations about specific design features of the reform models being developed. C & L had lead responsibility for developing projections of future health care costs associated with each of the models. HSR was responsible for the analysis of baseline health care expenditures in Maine, public subsidy requirements, alternative financing arrangements, and the projected impact of different reform strategies on the State's economy.

The economic impact analyses were carried out with major assistance from the Maine State Planning Office. The analyses were done using a forecasting model developed by Regional Economic Modeling, Inc. (REMI). The REMI model is a computer simulation that estimates the effect of specific policies and/or economic changes on the Maine economy. The Maine State Planning Office currently uses the REMI model to forecast the Maine economy and to assess various policy proposals that might impact the economy.[1]

The conclusion of these analyses is inescapable: any attempt to establish universal health care through the resources of the State alone, cannot be accomplished without placing Maine at a significant economic disadvantage *vis à vis* other states. Both the single-payer and the multiple-payer plans proposed by the Commission provide universal coverage, but at a very high cost. Because of the tax revenues necessary to fund either of these systems, they are projected to produce a negative impact on Maine's economy. Tax increases of the order required to support these universal plans would encourage business, where possible, to shift resources away from wages and into capital, leading to a loss of jobs. They would also discourage new businesses from moving into Maine and might lead businesses presently located here to leave the State. There would also be effects on individuals and on the medical sector, each of which are discussed below.

[1] For a more complete discussion of the REMI model, *see* Chapter VII of Appendix Three, the HSR report.

The analysis of the incremental reform option described in Chapter Five, produced very different results. This option does not require the generation of public revenue of the type or magnitude required by either the single or multiple-payer plans. Neither does it accomplish universal coverage, although a significant expansion of coverage for children would be achieved. Because of the relatively "modest" cost of this option and the fact that the only change in taxation required to implement it is the extension of the health insurance premium tax, the model does not result in an adverse effect on the economy. On the contrary, implementation of this proposal is projected to have a slightly positive effect on the economy. This result is attributable to the fact that the model would improve the economic status of the health care sector of the economy, which comprises approximately 8 percent of total state employment. This "boost" helps to stimulate the overall economy. In addition, improvements in the insurance market are expected to lead to lower non-wage costs for businesses, encouraging them to move resources into wages, which would stimulate the economy.

Key Cost Assumptions

Coopers & Lybrand developed cost projections for each of the three reform options as well as a "baseline" estimate of health care costs that assumed no reforms to the system. The cost estimates were based on a number of variables, including the design features of each reform model, information regarding the costs of the current system, and underlying assumptions about cost trends that were developed by the Commission with the assistance of its consultants.[2] A summary of the most important trend assumptions for the baseline estimate and the two universal plans is presented in TABLE 6A, below. These assumptions represent a "best estimate" of what might be expected to happen in the future. Assumptions for pessimistic scenarios and optimistic scenarios were also prepared but are not presented here. The cost shift analysis excludes the cost-shifting generated by the Medicare program. These reform proposals do not include the Medicare population nor do they attempt to "reform" that federal program. Reform of the Medicare program at the state level must await enabling legislation at the federal level.

The assumptions displayed below include projections of managed care penetration rates. The type of managed care considered here is assumed to be loosely organized and controlled. We did not assume a significant penetration of more highly structured or strictly controlled plans in the State but we did assume that the delivery system under a managed competition model such as the multiple-payer option would be more tightly managed than the current managed care system now appears to be.[3]

[2] For a complete discussion of the methodology used by C&L, *see* Chapter V of Appendix Three.

[3] The basis for each of these assumptions is described in Chapter IV of Appendix Three.

TABLE 6A: Key Assumptions

	Baseline	Single Payer	Multiple Payer
Administrative Costs	12%	4%	11%
Cost-shifting/ Uncompensated Care	17% of charges	Recover 100% in 4 Years	Recover 70% over 4 Years
Market Competition Effect	N/A	N/A	Reduces base cost 10% over 3 Years
Provider Cost Savings	N/A	Admin. Savings = 7.7%	Admin. Savings = 6.7%
Utilization	N/A	Increase due to broader benefit design	N/A
Managed Care Penetration	55%	0%	70%
Cost Trend Rates - Indemnity Insurance	+10% to '98 +9% to '00 +8% to '06	+10% to '98 +9% to '00 +8% to '06	+10% to '98 +9% to '00 +8% to '06
Trend Rates - Managed Care	+6% to '06	N/A	+5% to '06

In addition to the assumptions developed for the baseline and universal coverage plans, a set of assumptions was also developed for the incremental reform proposal. These assumptions incorporated the design features of the proposal (e.g. an expansion of Medicaid for children, the formation of a voluntary purchasing Alliance, further reforms of the small group insurance market, etc.) but also reflected an expectation that the proposed reforms would stimulate high levels of competition and significant reductions in premium trend rates, especially for smaller employer groups. Cost trend rates similar to those used for the single and multiple-payer models were used for the incremental model.

The Costs of the Reform Models

Based on the assumptions described above, the actuarial consultants estimated the costs of each of the reform models and developed baseline, comparative cost projections as well. The results of this modeling is presented in TABLE 6B.

Table 6B: Best Estimate Cost Projections for the State (in Billions)

Year	Baseline Benefit Cost	Baseline Out-of-Pocket Cost	Single Payer Benefit Cost	Single Payer Out-of-Pocket Cost	Multiple Payer Benefit Cost	Multiple Payer Out-of-Pocket Cost	Incremental Benefit Cost	Incremental Out-of-Pocket Cost
1995	$1.7	$0.264						
1996	$1.9	$0.288						
1997	$2.0	$0.315	$3.2	$0.036	$2.4	$0.509	$2.0	$0.307
1998	$2.2	$0.334	$3.2	$0.036	$2.2	$0.451	$2.1	$0.315
1999	$2.3	$0.351	$3.3	$0.038	$2.3	$0.450	$2.2	$0.316
2000	$2.5	$0.368	$3.3	$0.040	$2.3	$0.448	$2.3	$0.317
2001	$2.6	$0.383	$3.5	$0.042	$2.4	$0.459	$2.3	$0.317
2002	$2.8	$0.398	$3.8	$0.045	$2.5	$0.475	$2.4	$0.317
2003	$3.0	$0.421	$4.0	$0.048	$2.7	$0.499	$2.5	$0.329
2004	$3.3	$0.445	$4.3	$0.051	$2.8	$0.525	$2.7	$0.348
2005	$3.5	$0.471	$4.7	$0.055	$3.0	$0.551	$2.9	$0.368
2006	$3.8	$0.496	$5.0	$0.059	$3.2	$0.577	$3.2	$0.389

As can be noted from TABLE 6B, total baseline costs (both benefit costs and out-of-pocket costs[4]) in the year 2002 are estimated at just under $3.2 billion. This total compares to $3.8 billion under the single-payer system, $3.0 billion under the multiple-payer system and $2.7 billion under the incremental reform plan. The disparity in projected costs continues to increase in the more distant future. In the year 2006,[5] baseline costs, in total, are expected to increase to $4.3 billion. Single-payer model costs in the same year are anticipated to reach $5.1 billion, multiple-payer system costs $3.8 billion and incremental model costs $3.6 billion. The reader should note that the cost projections presented here represent "best" estimates. That is, they reflect what might be best expected to occur in the future. Should certain of our key assumptions, such as the diffusion of managed care in Maine or its effectiveness in controlling costs, vary significantly from what actually occurs, costs might turn out to be different from those projected. This is especially true of the two universal models; the comprehensive nature of these proposals complicate projections.

When comparing the expected costs of each of the systems, it is very important to bear in mind that both the single-payer and the multiple-payer models contemplate universal coverage for Maine citizens under a comprehensive benefit structure. The baseline and incremental model cost estimates reflect large numbers of uninsured and underinsured individuals. They also presume the existence of continuing Medicaid (and uncompensated care) shortfalls in provider payments.

While each of the reform alternatives carries with it certain implications for total health care costs, each alternative will also have an effect on the distribution of health care spending. Spending is distributed across three broad categories:

- Business spending -- primarily through contributions to employee health premiums;
- Individual spending in the form of premium contributions or payments, the payment of deductibles and required copayments and payment for non-covered health care services;
- Government spending on public health coverage programs such as Medicaid, and on premium contributions for public employees.

Under both of the universal plans, business spending on health care is sharply reduced over baseline costs. There is a level of residual spending under the single-payer model for business that is attributable to an expected continuation on the part of some employers to provide supplemental benefit coverage to employees who currently have health benefits that are more comprehensive than the Commission's standard package.

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[4] It is important to note that "out-of-pocket costs," as the term is being used here, refers only to the cost of care paid for by the patient when services are rendered. It does not refer to payment made by individuals or firms toward the financing of the health care system, either through tax dollars or premium payments.

[5] Projections of costs in the distant future are subject to a greater degree of uncertainty than are estimates of costs for years in the near future.

Under the single-payer model, nearly all direct spending for health care is eliminated; the residual spending arises from the limited copayments on prescription drugs contemplated in the standard benefit design. The reduction in direct spending is expected to equal $1.5 billion by the year 2006. Individual spending under the multiple-payer plan would be very different, with an expected reduction of $134 million in 2006. This is due to the fact that the benefit design under the multiple-payer option incorporates copayments and deductibles. Under incremental reform, more modest reductions in individual spending are anticipated.

The declines in individual and business spending under the universal plans are recovered through a shifting of costs to the government and, in turn, through increased taxation. The single-payer plan is financed through the generation of tax revenues: business and individuals would be financing the system through taxation rather than through premium contributions, copayments or deductibles. The multiple-payer plan retains premium contributions (distributed equally between employers and employees) and generates the monies required to fund the subsidy program through taxation. In either of these cases, businesses and individuals may "feel" like they are paying less for health care.[6] That, however, is not the case as business and individuals alike, share in paying the new taxes.

The savings under the incremental plan are attributable to improvements in the functioning of the health insurance market. Increased purchasing power gained through an Alliance structure and expanded market reforms will lead to modest savings. While this strategy significantly improves access to health coverage for Maine's children, it does not alleviate the problems facing a majority of the uninsured and underinsured citizens of Maine.

Financing Reform

The Commission designed a financing strategy for each of the reform proposals developed. A set of five criteria were used in crafting the financing packages. First, any financing package had to be sufficient to meet all anticipated system costs, as described in the previous section. The revenue sources need to be as stable as possible, providing a consistent source of funds that will not vary widely from one year to the next. Third, the financing mechanisms should be efficient, avoiding the creation of price distortions that might disrupt the economy. Fourth, the mechanisms should be equitable and avoid favoring one sector of Maine's economy over another. Finally, the financing design should be broad-based so as to help assure a consistent revenue stream.

Several key assumptions were also used in building the financing options. We assumed that the Maine economy will grow at a rate of 4 percent each year through 2007; this assumption is consistent with the State Planning Office's expectations. We also assumed that all tax changes in the financing plans would go into effect three months prior to the implementation of the relevant reform plan. This allows for an opening "surplus" in the health care spending account.

[6] Some businesses and individuals previously paying less than one-half of the premium cost will be required, under this proposal to actually increase their contribution level.

Finally, we assumed that the new tax revenue called for would be dedicated to funding the health care system; surplus revenues at the end of a fiscal year would carry forward and would accrue interest earnings.

Finally, the Commission believes that, as a matter of policy and with an eye toward improving the health status of Maine citizens, so-called "sin taxes," taxes on cigarettes, other tobacco products and alcohol, should be substantially increased. With these criteria and assumptions in mind, financing packages were developed. These packages for the universal plans are outlined in TABLE 6C.[7]

TABLE 6C: Financing Designs for Reform Options

	Single Payer	Multiple Payer[8]	Incremental Model
Personal Income Tax	Increase effective rate from 3.5% to 10%	Increase effective rate to 4.3% through 2001, 4% thereafter	No Change
New Employer Payroll Tax	4.75%	2.25% through 2001, 1.25% thereafter	No Change
Sales and Meals Taxes	Increase by 3.75 percentage points	Increase by 1 percentage point through 2001, 0.5 percentage points thereafter	No Change
Corporate Income Tax	Increase effective rate from 8.75% to 12.5%	Increase effective rate from 8.75% to 9.25%	No Change
Tax on Tobacco and Alcohol	Double	Double	Increase cigarette tax from $0.37 to $1 and increase tax on other tobacco products 200%[9]
Elimination of Premium Tax Exemption	N/A	Health insurance premium tax extended to non-profit carriers[10]	Health insurance premium tax extended to non-profit carriers[10]

The incremental reform option does not require a sophisticated and comprehensive financing approach primarily because the model seeks only to improve access to health coverage for low income children rather than for Maine's broader uninsured population. To fund the

[7] For a detailed discussion of financing, *see* Chapter VI of Appendix Three.

[8] It is important to note that no financing mechanism for the cost of subsidies to low income individual to assist them in the payment of required copayments and deductibles was included in the modeling exercise. If such subsidies were to be made available, the taxes shown below would have to be increased.

[9] This increase in the cigarette tax will generate approximately $68.2 million and the tax increase on other tobacco products is expected to raise an additional $1.85 million in revenue.

[10] This is expected to generate approximately $11,000,000.

children's expansion, the Commission recommends that the current exemption from the health insurance premium tax that is extended to non-profit insurers such as Blue Cross and Blue Shield and Harvard Community Health Plan, be eliminated. This change will generate the revenue required to fund the Medicaid state share of the expansion program. Funds required to underwrite the administrative expenses of the purchasing alliance will be generated through an assessment on products sold through the Alliance.

The financing models for the single-payer and multiple-payer systems were designed to generate additional funds that would be used to improve public health in Maine. [11] We recommend that, should the incremental reform model be adopted, the additional funding required for public health will be raised through an increase in the cigarette tax to $1 (from $0.37) and a 200 percent increase in the tax on other tobacco products.

Economic Impact of the Reform Models

The implementation of any of the three health reform proposals would have an impact on Maine's economy. Maine's health care system is financed by business, individuals and government. The reform models developed by the Commission each alter the distribution of financing "responsibility" among these three groups; the reallocation of the financing burden holds implications for the economy that are dynamic and complex. This section presents a summary of the findings of the economic analyses conducted as part of the Commission's evaluation of reform options. For an in-depth discussion of the analyses, see Chapter VII of Appendix Three.

The economic modeling involved an examination of four "scenarios." First a baseline economic outlook was developed that incorporated the Commission's key assumptions for the health care system in the absence of reform. This baseline picture, extending out to the year 2007, was used as the basis of comparison for each of the other economic impact analyses.

An analysis was conducted for each of the Commission's three reform proposals: the single-payer model, the multiple-payer model and the incremental model.[12] The impacts of the contemplated reforms were examined relative to their effects on businesses, their effects on individuals and their effects on the medical sector of Maine's economy.

As noted earlier, the impact on the economy of any of these proposals is dynamic. Each of the direct effects generated by a model leads to second-, third- and fourth order effects to the economy. The reform options developed by the Commission will tend to exercise broad, system-wide effects on the economy, rather than focusing impact on a small number of industries and the broad based nature of the impacts is related to the comprehensive nature of the proposals. The direction and magnitude of the impacts are similar across all sectors of the economy.

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[11] *See* Chapter Eight for a discussion of the Commission's recommendations regarding public health.

[12] Two additional analyses were run -- one for the multiple payer model under a "worst case" scenario with regard to the effectiveness of managed care and one for an incremental model that assumed a very conservative migration of businesses into the Alliance. The results of these additional exercises may be found in Appendix Three.

In assessing the economic impact of the alternative proposals, three major economic indicators were examined:

- Changes in Gross State Product, which measures the total value of all goods and services produced in Maine. A drop in Gross State Product (GSP) indicates downward pressure on the economy and on the ability of Maine business to remain competitive.
- Changes in total employment, which measures how health reforms will effect overall employment. To the extent that reform changes the non-wage cost of labor (i.e. health care benefits costs), business might change the mix of labor and capital they use to make themselves as competitive as possible.
- Changes in *per capita* income, which measures after-tax wealth or the amount of money available to individuals to use to purchase goods and services. These changes were measured in constant, 1987 dollars so as to adjust for the impact of inflation and to allow comparisons of income across years.

These measures, taken together, provide insight into the economic impact implied by each of the reform options. A summary of the findings of the modeling exercises is presented in TABLES 6D, 6E, and 6F.

TABLE 6D: Projected Change in Maine's Gross State Product Resulting From Reform

	1997	2002	2007
Baseline Projection (in billions)	$32.296	$46.760	$74.424
Single Payer	-3.5%	-4.8%	-5.4%
Multiple Payer	-0.6%	-1.1%	-1.4%
Incremental Model	0.0%	0.1%	0.2%

Both of the universal coverage plans will lead to a reduction in Gross State Product with the most significant impact seen under the single-payer plan; this is a result of the high cost of that plan attributable to the lack of copayments and deductibles. Under incremental reform, a slight contraction in the economy will be felt in the early years of implementation. This is because, under the proposed reforms, the medical sector of the economy will grow at a much slower rate than will the rest of the economy. However, in later years, improvement in the State's competitive position and improvements in individual purchasing power lead to growth in the Gross State Product.

TABLE 6E: Projected Change in Total State Employment Due to Reform

	1997	2002	2007
Baseline Projection	720,408	743,630	753,413
Single Payer	-3.4%	-4.5%	-6.6%
Multiple Payer	-0.5%	-1.3%	-1.8%
Incremental Model	0.2%	-0.5%	0.1%

The effect on total state employment resulting from the implementation of health reform are shown in TABLE 6E. A pattern similar to that seen with impact on Gross State Product is observed here. The single-payer model is expected to result in a significant negative impact on job growth. The multiple-payer model also exerts a negative impact, although a much more modest one than the single-payer. This result points out an interesting dilemma: while uncontrolled health care costs exert negative effects on the economy, aggressive cost controls would negatively impact a very significant portion of the economy -- the medical sector, which provides more than 8 percent of total state employment.

REMI modeling projects a slight increase in employment under the incremental reform option. This is attributable to a reduction in costs facing business and an increase in individual purchasing power. In the early phases of implementation, however, a modest loss of jobs may be expected due to reductions in employment in the medical sector. By the year 2007, this decline is offset by employment growth in other sectors.

TABLE 6F: Projected Changes in *Per Capita* Income Due to Reform (in constant 1987 dollars) Adjusted for Changes in Individual Health Care Spending

	1997	2002	2007
Baseline Projection	$15,427	$16,453	$17,367
Single Payer	-7.4%	-9.9%	-9.9%
Multiple Payer	-2.4%	-0.2%	-0.7%
Incremental Model	0.1%	0.5%	0.4%

In examining the likely impact of each reform option on *per capita* income, the universal single and multiple-payer plans again have negative consequences. The single-payer plan, despite the fact that it contemplates virtually no copayment and no deductible requirements, generates significant downward pressure on *per capita* income. The multiple-payer model also has a negative impact, but a much more modest one. In contrast, under the incremental reform model, *per capita* income actually exhibits a slight increase over the entire forecasting period. It is important to note that the impacts displayed in TABLE 6F are adjusted for changes in personal or individual health care spending that is expected under the various reform options. When one considers the single-payer plan, for example, without making such an adjustment, there is an expected impact of -11.6 percent on *per capita* income in 1997. By adjusting for anticipated

changes in levels of out-of-pocket spending, we are recognizing the fact that reductions in such spending serve to increase disposable income.

Conclusion

The economic analyses performed by HSR and the State Planning Office provides policymakers with important information regarding the implementation of health reform in Maine. First, universal coverage plans may be expected to exert downward pressure on Maine's economy. The taxes required to finance these expansion plans more than offset any economic stimulation that results from lower health care costs facing individuals or businesses. Nor are savings in later years sufficient to offset the early and significant economic effects of these programs.

Successful cost containment efforts will lead to reductions in business costs and improve individual purchasing power. However, cost containment also results in decreased medical sector output and fewer jobs.

The incremental reform model is projected to have moderate, positive impacts on Maine's economy. The slower growth in health care costs arising from market reform will lower business costs and increase individual purchasing power. This, in turn, will increase the competitiveness of Maine industry; it will also provide stimulus to local businesses as individuals use dollars that they would have used to purchase medical services or coverage for other purchases. Further, only limited "taxes" are required to fund the Medicaid expansion for low income children. Still, even with this expansion an estimated 120,000 people will remain uninsured, and many more will remain underinsured.

The achievement of universal coverage remains an extremely important goal. The attainment of that goal, however, comes at the price of slowed growth in Maine's economy. We have concluded that universal coverage must be initiated at the federal level; Maine simply cannot afford to pursue this objective on its own. Still, there are steps that we can take that will improve the health care system. The incremental model will reduce health care costs, expand access to children, and reduce welfare costs while exercising a positive impact on the economy. Moreover, this model will provide a foundation for future health care reform, putting Maine on solid footing to undertake more comprehensive reform as the fiscal and political climate permits.

CHAPTER SEVEN

A Health Information System for Maine

Introduction

The key to reforming Maine's health care system is comprehensive, high quality health data. Health care consumes a large and increasing portion of Maine's financial resources. Despite these enormous expenditures, Maine is unable to evaluate what services are being provided, to whom, the cost, or the appropriateness and quality of those services. Without this information, Maine cannot make informed decisions about how it spends its health care dollars.

The Legislature recognized the central role of data systems when it created the Maine Health Care Reform Commission. It charged the Commission with the task of developing a plan for a comprehensive health data system. The Legislature again acknowledged the importance of health data this past legislative session when, in dissolving the regulatory role of the Maine Health Care Finance Commission (MHCFC), it preserved that commission's data collection activities. A comprehensive health data system is critically important to this State regardless of what specific reforms or regulatory regimes are instituted.

Compared to many other states, Maine has excellent health data resources. For example, for over twenty years Maine has collected valuable data on hospital services and charges. In addition to public sector data collection efforts, the private sector in Maine has take significant steps to improve Maine's data collection capabilities. For example, Maine is developing a Community Health Information Network (MCHIN) project. The MCHIN is a private sector initiative that focuses on the technical aspects of a statewide data system, such as computerization, standardization and compatibility. By addressing the technical needs of a data system, the MCHIN is setting the stage for the development of an efficient and compatible data system that will electronically transmit standardized clinical, administrative and financial data to those who wish to use it.

Although Maine has a head start relative to most other states, as discussed below, its data resources still fall far short of what is needed for effective cost-containment, quality assurance and health planning. To address these shortfalls the Commission convened an Advisory Committee on Health Data Systems. This advisory committee was built around a nucleus of health data experts, already meeting to address the shortfalls in Maine's data system. This Advisory Committee brought together, from both the public and private sector, those who collect and use data, and those who provide it. Through consensus, this committee developed a blueprint for building upon Maine's current health data systems.[1]

[1] The Advisory Committee on Health Data Systems drafted a report which provides the foundation for this chapter. The original of that report, with only minor modification, appeared in the Commission's DRAFT

In response to the Legislature's mandate, and based upon the recommendations of the Advisory Committee, the Commission makes several specific recommendations to improve Maine's health data system. As discussed in detail below, the Commission recommends that Maine create a new health data organization to oversee the collection of Maine's health data. The Commission also recommends that Maine expand and enhance its data collection activities by building upon the resources that it has now.

Types of Information Needed from a Comprehensive Health Data System

The Commission finds that, while Maine has relatively good data resources, it is missing some important data elements. This section reviews Maine's data needs, emphasizing the relevance of health data to health policy, clinical decision-making, and public health. By building on Maine's existing data resources, the Commission believes this State can take significant steps toward meaningfully addressing these needs.

When considering health data needs, it is useful to distinguish between the types of information and the substantive questions that are of interest, as opposed to the sources from which that information may be obtained. Often a single source of information can be used to help answer a variety of questions, as illustrated by TABLE 7A below. The five sources of data may all be used in multiple ways to inform the six categories of research across the top.

TABLE 7A: Types of Information -- Comprehensive Health Data System

Data Source	Health Status	Economic Impact	Resources	Outcomes and Quality	Access to Care	Health Behaviors
Resource Inventories			X		X	
Vital Records and Disease Surveillance	X	X		X	X	X
Population Surveys	X	X		X	X	X
Utilization Data	X	X		X	X	X
Costs and Charge Reports		X	X		X	X

RECOMMENDATIONS FOR HEALTH SYSTEM REFORM (June, 1995) [hereinafter DRAFT RECOMMENDATIONS]. That Committee's guiding principles are included as Appendix Four.

Health Status

A comprehensive health data system should provide for ongoing assessment of the overall health status of the State's population. To do this, the system must provide summary measures that track time trends, demographics, and geographic patterns of diseases and disease risk factors. For example, the system must be able to provide timely and accurate information on these patterns for communicable diseases, chronic diseases, mortality, natality, mental health status, injuries, disability, nutritional status, dental health status, work-related health conditions, and personal health risk behavior. Information on environmental health risks may be collected by other data systems, but the health data system should provide data that can be integrated with such environmental risk data. The system should provide data in sufficiently fine detail so that public health risks can be rapidly identified and acted upon and so that the effect of interventions to improve public health can be monitored.

Economic Impact

Comprehensive health care reform of any kind presumes change in the health care financing and delivery systems, with a resulting impact on the use and cost of services. Without accurate and comprehensive statewide expenditure and cost data, it is impossible to confidently project the impact of these reforms. Statewide expenditure data are currently not available in Maine. State-by-state expenditure estimates have been released by the Health Care Financing Administration for care provided in hospitals and physicians' offices as well as prescription drugs. However, these expenditures account for only 70 percent of total health care expenditures. In addition, these estimates are also limited by the fact that they are derived from national estimates.

Charge and payment data are available through various third-party payers, including Medicare and Medicaid, but calculating these amounts varies by insurer and measuring the relationship of charges to cost varies by provider. In addition to fee-for-service payments, increasingly payments are being made based on capitation, reconciliations, and bonuses to providers. As managed care becomes more prevalent in Maine, this trend will continue, making measurement of health care expenditures more and more complex.

In addition to expenditure and payment data, a method for determining the payments made by employers for health care premiums is not readily available.

Health Resources

In the face of current efforts at improving access, performance, and the effectiveness of the health services delivery system, information relating to the availability of health resources is of utmost importance. The State of Maine suffers from regional discrepancies in the availability of health care services. Policy options to address these discrepancies must take into consideration not only the importance of the distribution of services but also the mix of services.

While past policies have focused primarily on the supply of inpatient beds and

physicians, the focus has now broadened to include the mix of generalists and specialists, the use of mid-level providers, integration of services, and the availability of wrap-around and enabling services such as transportation, respite care, and home care. To support the design and implementation of such policies, accurate and complete data must be available on workforce composition, practice location, occupational settings, hours spent in direct patient care versus other activities, facilities and settings, and the interrelation of providers, organizations, and facilities. Such data must have the flexibility to tabulate information by various geographic regions (counties, service areas, municipalities, etc.), by demographic factors, and by time period.

Outcomes and Quality

Over the past decade, a number of factors have converged to change our concept of quality. First, the health care environment is changing rapidly as both corporate and government payers seek to increase competition, decrease costs, and improve the quality of services. These pressures will only increase as managed care and capitated arrangements expand. Second, more and more health and service organizations have embraced and implemented the principles of quality improvement. The foundation of these principles is that consumer feedback and evaluation of goods and services is necessary in order to identify problems and needed design improvements in health care. Finally, and as important, the voices of consumers of health care services have entered the discussion about the quality of health care. In this new environment, individual providers, consumers, organizations, and entire systems of care will need to have information about the quality of services in order to compete on the basis of both costs and value.

The concept of quality is an evolving one and is multidimensional. The domains of quality include: (1) efficacy or outcome of health care interventions; (2) the appropriateness of care based on professional consensus; and (3) patient satisfaction. Some current formulations also include measures of patient-defined outcomes and patient assessment of technical quality. However, there is less consensus in the field about including these domains in the measurement of quality.

The outcome or efficacy of health care is often evaluated through expensive randomized clinical trials. However, less expensive epidemiological methods using claims data and hospital data are now being used as well. Examples of such methods include studies of hospital-specific mortality rates and population-based mortality rates. Controlling for differences in the mix of patients and for severity of illness is important in these studies.

The appropriateness of care is evaluated using consensus-based professional standards for certain interventions. In places where hospital discharge or claims data are available, epidemiological methods of small-area analysis may be used to determine utilization, costs, and quality of certain interventions in specific hospital service areas. This information may be fed back to area clinicians and providers to improve and change practice patterns and quality. Interpretation of such findings requires knowledge of the external factors that influence

clinical decisions. Such factors include area differences in capacity and health care alternatives and differences in the populations served.

Patient satisfaction is measured using survey techniques, although other methods such as focus groups may also be used. Satisfaction has been measured in hospital and outpatient programs, health maintenance organizations, and by individual and group practices. A review of satisfaction surveys demonstrates that patient satisfaction includes several features. These include: (1) the accessibility and availability of services and providers; (2) choice and continuity of services and providers; (3) communication from providers (explanation, attention, advice); (4) interpersonal aspects (friendliness, respect, time spent); (5) patient judgments of outcome (how much they were helped, assessment of technical quality); and (6) financial impact. In a highly competitive environment and as patients acquire more information and more are willing to ask questions, the issue of whether providers and systems meet the expectations of patients will become increasingly important.

Access to Care

Access is a shorthand term for a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the medical care system. Limited access to care, especially primary care, is related not only to poor medical outcomes, but also to increased use of costly services such as emergency rooms and inpatient care. While some indicators of access to care such as screening for breast cancer, vaccination rates, and low birth weight babies provide some encouraging information regarding access in Maine, many of Maine's poor, working poor, elderly, and disabled citizens, as well as those living in remote rural areas, have limited access to health care.

While policy options under health care reform are directly aimed at improving access to care, others may threaten access. Policy options such as large integrated networks and managed care must address the potential that individuals and groups will fall through the cracks of a reformed system of health care.

In order to systematically evaluate the size and changing nature of access problems, comprehensive state-wide data are needed on how individuals and groups are able to obtain needed services. The requisite information includes: rates of successful birth outcomes, incidence of preventable diseases, early detection and diagnosis of treatable diseases, and longevity. Data should be available for all populations and from all services regardless of reimbursement source. The data must be compiled in such a way that it can be tabulated for subgroups of the population based on geographic regions (counties, service areas, municipalities, etc.), by demographic factors, and over time.

A thorough evaluation of issues of access requires integration of data from multiple sources. For example, resource directories in combination with census data help to identify areas with clear shortages of specific types of facilities or health care professionals. However, where certain services are theoretically available, data on costs and utilization need to be scrutinized in order to identify financial, cultural, and behavioral barriers to appropriate care.

Health Behaviors

Although genetic make-up and the quality and accessibility of health care services are important determinants of an individual's health status, behavioral factors also have a substantial impact. Maine must have the capacity to measure health-relevant behaviors in order to identify those areas most in need of intervention by the public health community. This capacity is also needed in order to ensure that the impact of interventions can be evaluated appropriately.

Not all aspects of behavior should necessarily be measured on an ongoing basis. Instead, it is most important that a core set of behaviors (as well as attitudes and knowledge) be measured consistently over time. To ensure the availability of this core information, a survey system with statewide capabilities must be maintained. As the need arises, information on other behaviors could be obtained promptly by adding relevant items to these ongoing population surveys.

Maine's Data Resources

While we have many questions about the performance of our health care system, our ability to answer those questions is very limited. This section reviews Maine's health data resources and identifies those areas most in need of expansion.

Health Resource Inventories

State agencies are the primary source for health workforce and health resource data. These agencies include various licensing and certification boards and affiliated boards under the Department of Professional and Financial Regulation and the Division of Licensing and Certification within DHS.

Health professional licensing boards under the Department of Professional and Financial Regulation include the Board of Counseling Professionals, Board of Chiropractic Examination and Registration, Board of Examiners in Physical Therapy, and others. Affiliated boards include the Board of Registration in Medicine, Board of Osteopathic Examination and Registration and the Board of Nursing. These boards administer state licensing procedures, investigate possible violations of law and undertake enforcement actions.

Within DHS, the Division of Licensure and Certification is responsible for regulating state-licensed Medicare facilities. Such health related facilities include: nursing facilities, intermediate-care facilities for the mentally retarded, hospitals, ambulatory care centers, ambulatory surgical centers, federally qualified health centers, home health agencies, occupational and physical therapists, rural health clinics and boarding homes.

At the present time, with the exception of recent changes at the Board of Registration in Medicine and the Board of Nursing, only a small amount of data collected by Maine's hospital

and health professional licensing agencies are accessible in a computerized format. While the data may be stored on a computer, it is either stored on a word processing system or stored within a database that cannot exchange stored information. For example, the Division of Licensure and Certification reports and distributes data on licensed Medicare facilities; however, this information is maintained in a word processing file. The Division of Health Planning, also within DHS, compiles a report on nursing facility beds, boarding home beds and hospital beds using this information. However, to do so these data must be manually entered back into a computer and given a geographic code before being linked with any other planning data.

Most state health professional licensing boards do maintain computerized records for licensed individuals. However, computerized data represent only a limited portion of the data collected by these agencies. In fact, a great deal of information is kept on index cards. To a large degree, the computerized data are only accessible as a hard copy printout of names and addresses.

Even if data on licensed professionals are made more accessible, with limited exceptions, the information gathered generally is not intended for planning or research purposes. For a number of licensing boards, data collection activities are strictly limited to that data directly related to licensing and regulation. The exception, the Maine Cooperative Health Manpower Inventory, is a survey sent to all physicians upon renewing their license. The survey is produced by the Office of Data, Research and Vital Statistics in cooperation with the Board of Registration in Medicine and the Board of Osteopathic Examination. The survey asks detailed questions on provider and practice characteristics. This database is extremely useful for identifying providers in specific practice settings, specialties, patient types and practice hours and can serve as a model for the collection of data on health care resources.

Clearly, Maine would benefit greatly from augmenting, coordinating, collating, and distributing information on its health care professionals and facilities. Health care professionals are the most important element of any health care system, regardless of how it is organized. Accurate statewide information on the health care workforce is essential before Maine can identify areas with shortages, develop workable solutions, and plan appropriate educational programs to meet the needs of underserved populations. With relatively modest resources, the information available for these purposes can be enhanced considerably.

Similarly, accurate and up-to-date information on health care facilities is essential for the planning process and for identifying and correcting problems relating to access to services in specific areas of the State and by specific demographic groups.

Vital Records and Disease Surveillance

The Bureau of Health within DHS is the major source of vital records and disease surveillance data. The Bureau, as the State's primary public health agency, is responsible for infection control and epidemic prevention as well as the control of chronic diseases. To this end, the Bureau collects data and maintains databases on the incidence of certain infectious diseases including HIV and other sexually transmitted diseases, tuberculosis and environmental

toxicology. It also maintains a cancer registry. Other health status and risk factor data are collected through the Bureau, including vital statistics data such as birth and death certificates. These data collection activities are intimately related to the Bureau's statutory responsibility for promoting and protecting the public health, and to its ability to carry out the core functions of a public health agency.

The Commission believes that the Bureau of Health, within its means, has developed an excellent framework for disease surveillance. In Chapter Eight of this Report, the Commission addresses the need for Maine to further invest in this capacity, along with other core functions of public health.

Population Surveys

Since 1986, Maine has participated in the national Behavioral Risk Factor Survey (BRFS) sponsored by the Centers for Disease Control and Prevention. The major purpose of this survey is to assess health risk factors of Maine people, to compare these risks with national norms, and to measure progress toward state and national health goals as articulated in *Healthy People 2000*. This is an annual statewide telephone survey of 1260 Maine residents (about 0.1 percent of Maine's population). The survey covers 18 different health status, behavior, and attitude domains, including such areas as quality of life, health care utilization, smoking, health insurance, alcohol and drugs, women's health, and health screening. Currently, the survey consists of nine core domains that are surveyed each year, and two rotating cores that are administered on alternate years. Information from this survey is being used by local interests including acute care hospitals and hospital-based consortia to compare their communities with state and national norms and trends.

The BRFS provides Maine with a greater understanding of a number of important health issues, including accessibility, satisfaction and outcomes, stress, and personal and emotional health. This data can be used to develop policy decisions, assess outcomes, quality, and accessibility, and measure population norms.

i. Population Surveys and Public Health

Maine's most important resource is the health of its people. Policymakers in Maine have developed a broad range of strategies to improve the health status of the State's residents. This vision of healthy people is contained in *Healthy Maine 2000*. This report contains measurable health goals in thirteen priority areas, including such areas as substance abuse, maternal and child health, mental health, and women's health. Population surveys continue to be a major source of information for monitoring the attainment of these goals and the changing health status of Maine people across many areas of health. Surveys also allow comparisons in health status and goals by region and across segments of Maine's population.

ii. Population Surveys and Outcomes and Quality

Much recent attention has been focused on improving the quality and outcomes of health care, especially from the consumer's point of view. While utilization data provide information about the appropriateness of clinical care and clinical practice patterns, population surveys are a valuable source of information about people's experience with such aspects of health care as choice, continuity, and quality. This kind of information will become increasingly important as managed and integrated systems of care continue to evolve in Maine. Also, surveys give consumers an opportunity to say how much they believe they were helped by various health interventions.

iii. Population Surveys and Accessibility

Limited access to health care has been shown to result in poor health outcomes and increased use of more costly health services. Access is a function of many factors such as availability of services, income and insurance. Population surveys are an important tool for assessing and monitoring accessibility to health care, and currently represent the only source of information about those Maine residents who do not have health insurance or who do not use the health care delivery system, for whatever reason. It will be important to monitor access and choice in health care as integrated and managed care systems evolve. Also, as Maine and the nation struggle with how to expand access to care, accurate and reliable survey data about uninsured people will be critical.

iv. Population Surveys and Population Norms

Currently, major health insurers, hospitals, and local and regional planners all conduct surveys. These surveys assess the health status and behaviors of populations. Some surveys also assess satisfaction and outcomes from the consumer's point of view. As in other aspects of health data, policymakers, insurers, and others, are moving to develop standard population survey questions to assess health status and health behaviors, satisfaction, and outcomes. Statewide population surveys are valuable in that they provide statewide population norms for these aspects of health care. These norms give insurers and others a yardstick with which to measure health plan performance and a better target for improving health interventions and services.

Utilization, Cost and Charges Data

Maine has been fortunate to have statewide data for hospital discharges dating back to the mid-1970's, as well as several years of data on a range of ambulatory surgical procedures. These databases are mature and have established a strong base of users who update their information from these files each year.

Although information on hospital discharges is important, it is becoming less and less informative as the health care industry changes. Increasingly health care services and health care dollars are shifting away from the inpatient hospital setting. Today the majority of services are

delivered in outpatient and non-hospital settings. To gain a full understanding of health care expenditures, Maine needs to gather utilization data for these settings as well. Currently those data are unavailable.

The absence of data on prescription drugs is another gap in Maine's health care data. Without this data, Maine is unable to examine variations in prescribing patterns or costs.

As the health care industry changes data on utilization of services, along with cost and charges data, will become more and more important to sound clinical and policy decisions, as well as quality research.

i. Utilization Data and Clinical Care

Recent attention has been focused on the quality and appropriateness of medical care. There is broad agreement that quality medical care may be defined as the appropriate therapy delivered to the appropriate individual at the appropriate time. At the same time, there is considerable debate as to how to measure many aspects of quality care. However, valid utilization data are recognized as a critical element of that measurement. Utilization data, while an incomplete picture of clinical medicine, allow one to assess such important issues as the use of screening tests for breast, colon, cervical and prostate cancer, the timing and complete application of childhood immunizations and the use of blood lead screening for children. In addition, variations in utilization patterns can be used to highlight areas of clinical care which require further scrutiny. Collecting data on charges and costs in a uniform format would greatly enhance Maine's capacity for quantifying the economic aspects of health care delivery.

ii. Utilization Data and Policy

A comprehensive health data system that includes all providers would be an invaluable resource for health planning and assessment activities. From the standpoint of resource availability and distribution, utilization data allow one to identify the location and referral markets for the health workforce. This information would allow one to assess current workforce distribution, including both type and number of providers. Decisionmakers would be able to design workforce policy and plans in a comprehensive, informed manner. Similarly, this data could be used to inform appropriate decisions concerning health technologies. For example, if properly constructed, this database can be used to identify the location of mammography machines. With this information, one could assess the relationship between distribution of resources and utilization patterns for screening mammographies.

A complete utilization data set would also assist the State in its public health activities. One could better assess utilization patterns for the population of Maine, identify unusual patterns (e.g. low utilization for preventive care, high utilization for chronic illnesses) and decide where interventions may be necessary. In the event an intervention is undertaken, the State would be able to monitor its effects.

Finally, there is a strong desire on the part of many to understand where health care resources are being consumed. The Uniform Hospital Discharge Data Set (UHDDS) gives a very good picture of inpatient costs and utilization patterns. However, over 50 percent of current health care expenditures occur outside of the hospital setting, Ambulatory care is experiencing the largest rate of growth in the health sector. Without information from non-hospital based settings, it is impossible to obtain a complete picture of health care expenditures.

iii. Utilization Data and Research

For researchers involved with understanding processes and outcomes of care, utilization data for all providers would be a unique resource for evaluating medical care across a broad segment of the population. While the Medicare and Medicaid data sets are available for certain subsets of the population, there are currently no comparable data sets available for the balance of the population. This data would serve for research in areas of quality, effectiveness and utilization.

The Maine Health Data Organization

The above review of Maine's health data resources demonstrates a solid foundation of data. At the same time, it becomes more and more clear that Maine must build upon that foundation to respond to the rapid changes in the health care industry. To know more about the cost and quality of the changing delivery of health care, Maine needs to expand the scope of utilization and cost data. It needs to be better informed about its health resources to encourage their most cost-effective use. And it needs to know more about the health of its citizens to better address their health care needs.

To address the increasing need for health data, Maine needs to develop one organization with the responsibility for planning and coordinating Maine's health data collection activities. This organization should be charged with the task of working with both the public and private sectors to coordinate and implement an expanded, comprehensive data system. To this end the Commission recommends that Maine create a new health data organization.

In making this recommendation, the Commission endorses the criteria considered by the Data Advisory Committee. The Advisory Committee considered several criteria in addressing the issue of governance for a new data organization: accountability, operational flexibility, enforcement, fiscal independence, grant eligibility, tort immunity and visibility. Based on each of these criteria, three alternative forms of governance were considered: the state agency, the private corporation and the public corporation.[2] Each of these three forms of governance offered different advantages and disadvantages. However, the Commission believes that an independent state agency would offer the best form of governance. Because the usefulness and integrity of data resources depend heavily on the level of compliance, the data organization must be able to effectively enforce data collection requirements. At the same time, as an independent agency,

[2] The Advisory Committee considered the relative benefits of these alternative governance structures at great length. For that discussion, *see* Chapter Eight of the Commission's DRAFT RECOMMENDATIONS.

the data organization could be insulated from political influences that might jeopardize the credibility of the data.

The Commission therefore recommends the creation of an independent state agency called the Maine Health Data Organization (MHDO). The MHDO will be governed by a Board of Directors comprised of fifteen seats. The distribution of Board seats should be as follows:

- two consumer representatives,
- two employer representatives,
- two payer representatives,
- two *ex officio* but voting state government representatives (one of whom must have medical and epidemiological credentials and expertise in public health);
- four provider representatives;

While providers will not enjoy a majority of seats, because data will be obtained primarily at the provider level, they will make up a larger share of the Board. The provider seats will be distributed across a variety of health disciplines and types. This composition should provide adequate representation of all major stakeholders; individual members should be selected so as to ensure a broad perspective that is population-based and serves primarily the public good.

With the exception of the state government representatives, board members will be appointed by the Governor, subject to confirmation by the Legislature. They will serve staggered terms.

The Board shall establish at least three policy advisory committees. One of the advisory committees will be composed of providers of data. Another will focus on issues of confidentiality. And a third will be composed of data users. In addition these committees will work together to advise the Board on methods of data collection that minimize administrative burden, address data privacy concerns, and meet the needs of health service researchers. The Board may also appoint other policy advisory committees to lend the Board insight and expertise that might not necessarily reside within the Board itself.

Subject to the Administrative Procedures Act, the Board will establish policies and procedures for collecting data enforcement procedures and enforcing data collection requirements against providers and others violating the data statutory requirements.

The Board will have the authority to develop a budget and hire an Executive Director, staff and services, as necessary to carry out the mission of the organization. The Board will be able to apply for and receive grants and will be able to enter into contracts as necessary. The Commission notes that, in the short term, the Board will be performing much the same data

function now performed by the MHCFC. The cumulative expertise currently housed within the MHCFC may be a very important resource for the MHDO and the Board may wish to avail itself of that expertise.

To the maximum extent feasible the Board shall enter into contracts to carry out data collection, data cleaning, file construction and other activities. As a result, the staff and administrative structure necessary to carry out the work of the data system will not have to be centralized or recreated at the level of the MHDO. Competent and vigilant contract administration will be necessary to ensure that contractors are fulfilling their obligations.

One of the most critical issues that the Board must consider is the issue of patient and provider confidentiality. In consultation with appropriate policy advisory committees, the Board will develop rules to determine whether information is confidential medical information. The Board will develop rules governing the conditions under which and purposes for which persons may have access to confidential information. These rules should ensure that, in the absence consent, identifying information is available only for research of substantial public importance such as public health investigations and quality improvement efforts. The Board may also report to appropriate authorities identifying information if the data it collects demonstrate that a health provider poses a serious harm to the public, based on practice patterns or outcomes substantially inconsistent with prevailing medical practice. The Board will establish protocols for the appropriate use of identifying information. The development of unique patient identifiers will be part of this process.

The Board will set user fees and establish rules governing access to the data. Consistent with the rules of confidentiality, the data will be available to the public. The user fees will be discounted for research of value to the general public. Potential economic and technical barriers to optimal utilization of the data resources for the public good should be actively identified and eliminated.

Annually the Board will issue an annual report using the data collected. This report will provide a resource for the consumers of Maine, summarizing the current status of key indicators relating to the cost and quality of health care, the health status of Maine's citizens, and the allocation of the health workforce.

Recommendations for the Expansion of Maine's Data Resources

The Commission believes that the MHDO should build upon Maine's existing resources by expanding the collection of utilization data, population surveys and resource data.

Recommendations for the Collection of Utilization Data

The Commission believes that Maine should build upon its existing utilization database by expanding its utilization data collection activities to all providers. Those providers currently reporting data to MHCFC (hospitals, free-standing surgical units and physicians' offices) shall

continue to do so. Overtime, all other health care providers recognized by the Health Care Financing Administration (HCFA) will be added to that list. Pharmacies, most of which are now computerized, should be added relatively easily. Other providers, such as long-term care facilities, home health agencies, mental health providers, chiropractors and others will be phased into the data system based on their computer capabilities and reporting compatibility with the statewide system.

The decision to collect data from providers rather than payers is purposeful. Federal statute, in particular, the Employee Retirement Income Security Act (ERISA), exempts self-insured businesses from mandatory data collection efforts. As a result, the best way to collect utilization data for persons employed by self-insured companies is to collect that data at the provider level. Similarly, gathering data from payers would omit information on those that do not have insurance. In addition, the closer the data collection is to the source, the better the reporting will be. Finally, this approach will increase the ability to obtain information for procedures that are not routinely covered across all payers, such as chiropractic services, mental health service delivery, etc.

The disadvantage of collecting data at the provider level is the fact that an unknown number of non-hospital providers do not have computerized billing. However, over time, more and more providers without computers are merging with practices that are computerized or contract with a computerized billing service. The efforts of MCHIN and other initiatives to address the technical needs of a health data system should also help to lower this barrier. The MHDO can explore ways to facilitate the collection of a provider-based utilization data, including assistance or incentives for those providers not currently capable of electronic data transfer.

Below the Commission outlines its specific recommendations with respect to utilization data.

i. Hospital Discharge Data

This recommendation builds on the current system of reporting: Maine hospitals should continue to report all discharges from their facilities. Hospitals have been reporting a data set on all discharges from their hospitals since 1973. At present, hospitals are reporting this data to MHCFC. The Commission recommends that hospitals be required to report this data to MHDO, which will be responsible for editing, processing and maintaining the statewide file.

The Commission also recommends that the MHDO conduct a thorough review of the data elements being reported, their definitions, and coding schemes. The review shall include a comparison with federal data elements required by the UB92.

ii. Hospital-based Ambulatory Units and Free-standing Surgical Centers

Hospital-based ambulatory surgical units (ASU) and free-standing surgical centers have been reporting selected surgical procedures provided in those settings since 1988. Recently, the

mandated data set has been revised to be consistent with the UB92 standard data set. The Commission recommends that the UB92 data set requirement be continued and that this data be reported to the MHDO for editing, processing and maintenance.

Currently reporting is required for a list of surgical procedures. Advancing technology and the burden of selecting specific codes rather than reporting all procedures makes this list unnecessarily burdensome. The Commission therefore recommends that the reporting be required for all surgical procedures rather than just the list of selected procedures currently used.

iii. Hospital Outpatient Services

Hospitals should continue to report all outpatient services. Hospitals have been reporting this data to the MHCFC and recently the specifications for reporting were changed to require the UB92 data set. It is recommended that this reporting continue in the UB92 format and that the data be reported to the MHDO.

iv. Non-hospital Outpatient Services

Providers rendering services on a non-hospital outpatient basis should report a data set consistent with HCFA 1500. Data on non-hospital outpatient services are currently not available on a statewide basis. There is strong consensus that a statewide integrated data system should include data on all contacts in all settings. It is recommended that this reporting be consistent with current claims reporting. This recommendation should be implemented over time based on the computerized reporting capabilities of providers. Although mandating reporting on all services in all settings may be somewhat of a burden on providers, it is believed that requiring the data reported to be consistent with standard billing data sets will lessen that burden. In many cases, it is expected that a copy of the billing data may be made and filed with the MHDO.

v. Claims Forms

Major payers should accept the national standard claim form/data sets (UB92, HCFA 1500, and ANSI ASC X12 837) with a minimum amount of payer specific codes. Payers should adhere to implementation guidelines for the ANSI ASC X12 837 transaction set that have been endorsed by the Workgroup for Electronic Data Interchange (WEDI). Providers now keep track of a large number of different formats for different payers at considerable administrative expense. If all payers accepted the same data set or claim form, providers could increase their reporting efficiency, decrease the chance of error and provide more comparability across payers. Payers have expressed preliminary interest in cooperating with this recommendation, which could result in cost savings to providers.

vi. Pharmaceutical Data

Pharmaceutical data should be collected on a statewide basis. The majority of pharmacies in Maine are computerized and are capable of reporting a data set on prescriptions directly or through a vendor. It is agreed that this data could be easily obtained and would

provide an important information source on a component of health care practices and costs in Maine.

Recommendations for the Expansion of Population Surveys

i. The Behavioral Risk Factor Survey

The BRFS conducted by the Department of Human Services should be expanded through the development of additional questions and rotating core questions in the following areas: (1) health care quality, outcomes, and satisfaction; (2) access to health care, including insurance status; (3) health status; (4) health risk behaviors, including stress and emotional problems; and (5) the economic impact of poor physical or emotional health. This recommendation is based on an economical approach designed to: (1) build on existing resources; (2) use national 'gold standard' questions and sources; (3) coordinate with satisfaction and outcome items currently used by private payers so that a statewide population survey would provide norms useful to all.

Questions dealing with health care quality, outcomes, and satisfaction are available from the Group Health Association of America (GHAA) Satisfaction Survey. Items from that survey are also part of the Health Plan Employer Data Information System (HEDIS 2.0). Their use for a statewide survey would allow payers, insurers, and other groups to compare their satisfaction and outcome survey data with statewide norms. BRFS questions dealing with access should also be expanded to include additional questions from the GHAA Satisfaction Survey or a similar instrument. Questions about health care coverage should be expanded to include information about type of insurance.

Rotating core questions should also address such psycho-social issues as the adverse health effects from stress and steps individuals have taken to reduce or to control their stress. These questions will allow Maine to monitor *Healthy People 2000* state and national goals for behavioral risk reduction.

It is especially important to augment the survey, at least on an intermittent basis, to facilitate the collection of information on individuals under the age of 18.

Not all necessary surveys of the population can be achieved through enhancements of the BRFS. Because of the constraints imposed by the current funding mechanism for the BRFS through the revenues from the federal Centers for Disease Control, and because of the need to avoid burdensome and lengthy interviews of individuals, special surveys are likely to be needed as well.

The MHDO should have an overall advisory and coordinating role regarding contemplated augmentations of the BRFS and regarding other health-related surveys of Maine's population.

ii. Worksite Surveys

It is recommended that the MHDO periodically conduct surveys of worksites around the State to obtain data relating to occupational health and to health promotion programs in the workplace. Although some important risk factors in the area of occupational health have been identified, populations at risk have not always been clearly delineated. Because of the importance of occupational health to employers and workers, detailed information specific to Maine would be an important basis for monitoring the success of efforts in this area. Employer worksite programs in health promotion and stress reduction are an important health system resource. However, there currently is no systematic information about the nature, extent, cost, or outcomes of these programs in Maine. Identification of employer-sponsored worksite programs would promote controlled intervention studies of the outcomes of job redesign, health promotion activities, and organizational change on workers.

Data on Workforce and Other Resources

It is recommended that boards and other agencies responsible for licensing or certifying health care professionals and facilities collect an additional core of information useful for planning and other purposes. Further, those boards and other agencies should be required to transfer that data, in computerized form, to the MHDO on a regular basis. The most logical method for collecting information on health resources is through the various boards related to licensing and regulation of health professions. Any other source of data collection would represent a duplication of regulatory activities. Key pieces of information that are not currently collected routinely for all health care professions but that are essential are the following: employer(s), work setting, practice specialty, and amount of time spent providing direct patient care.

This core of information would be in addition to personal identifiers and basic demographic information on the individual. It is envisioned that this basic set of data elements would be collected on an ongoing basis. Additional information of a more specialized nature could be included for a limited time period. The MHDO would work with the relevant agencies and bureaus to identify which types of more extensive information on specific professions would be useful to obtain during a single round of license renewal. For example, use of strategies for early detection in primary care was identified by as one such area for special emphasis.

Financing the Maine Health Data Organization

As discussed below, the Commission believes that the MHDO's data collection activities can be financed through several sources.

Financing the Utilization, Cost and Charges Data Set

We recommend that the collection and maintenance of the hospital discharge data base, the currently collected outpatient surgical database, and the current database for selected other outpatient services can be supported, at least initially, by the assessment revenue currently collected by the MHCFC and by revenue generated by user fees paid to the MHDO. These databases will ultimately be supported by only user fees.

Start-up funds will be needed for developing the other databases. The ambulatory services data for non-hospital providers should require development funding for at least three years. To pay for this the MHDO may be able to obtain a grant of other funding from private initiatives or other sources of funding. Some developmental funds will be needed to transfer pharmaceutical data to the MHDO, and to edit and link that data to other databases.

Ultimately, however, as the databases mature, the Commission believes that the MHDO can be self-supporting based on user fees. Based on the experiences of the MHCFC and the Maine Health Information Center, it is believed that a sufficient amount of revenue can be generated to provide ongoing support of these databases.

Financing of Population Surveys

The BRFS is currently funded by the Center for Disease Control. The MHDO could readily add brief modules to the existing survey at virtually no cost. Increasing the sample size for special purposes and conducting separate surveys would, however, require additional funding. These costs should be covered primarily through fees assessed for non-public use of the survey data.

Financing of the Workforce and Resource Data Set

Some initial start-up funding will be needed to enhance the State's computer capabilities for its health resource data. However, as described above, improvements in this area are already underway.

The costs of coordinating and collating information for the various professional groups and the various types of facilities would be paid through user fees assessed for non-public use of the data.

CHAPTER EIGHT

Public Health and Health Systems Reform

The Reform of Maine's Public Health System

Much of the focus of health reform efforts has been on the design of "improvements" to the financing and delivery of medical services. Public health is a critical piece of the health reform puzzle. If the goal of the health care system reform effort is the realization of a healthy population, system reforms addressing financing and delivery that exclude reform of the public health system will do relatively little in bringing us significantly closer to the stated goal of improved health status. This is due to the fact that many deaths, illnesses and injuries are attributable to underlying causes that are not particularly responsive to clinical interventions. Study of the causes of premature disability and death among people in Maine, as for the nation as a whole, informs us that only 10 percent of these occurrences are due to a lack of access to health care and 20 percent are due to congenital or genetic factors. Importantly, 50 percent are attributable to behavioral causes and the remaining 20 percent are caused by environmental factors -- factors that have historically not been controlled in meaningful ways by medical care.[1]

Each year in Maine, billions of dollars are spent on health care goods and related services. Of the total dollars spent, less than 1 percent is invested in public health activities. It is largely an invisible activity.[2] The funding of public health in Maine has, historically, been a tenuous proposition. Maine's "match" of state dollars to federal dollars for public health is among the lowest (42nd) in the nation. As the State faces severe budget shortfalls and increasing pressure to provide medical care for the poor and uninsured, the public health system is increasingly compromised. Its deterioration has serious implications for the State's citizens. The ability to respond rapidly to public health problems and emergencies requires an appropriate public health infrastructure.

Public health funding and activity tends to be categorical in nature. That is, there is a significant array of programs each addressing a particular health issue. We have programs for HIV/Sexually Transmitted Diseases, for Radiological Health, for Diabetes, Tuberculosis and Refugee Health, to name just a few. While categorical programs serve an important role, categorization inevitably leads to problems in assuring coordination of efforts, and to "holes" in the infrastructure. We need to be able to anticipate, assess, and address any problem that might

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[1] McGinnis & Foege, *Actual Causes of Death in the United States*, 270 J. AM. MED. A. 2207-2212 (Nov. 10, 1993); Reference to 1982 Institute of Medicine report in WASHINGTON STATE DEPARTMENT OF HEALTH, PUBLIC HEALTH IMPROVEMENT PLAN (Nov. 29, 1994) [hereinafter WASHINGTON STATE PUBLIC HEALTH IMPROVEMENT PLAN].

[2] This "invisibility" is, in part, a function of the centralized form of government which characterizes Maine. The result of this tendency to hold authority at a state level has resulted in limited public health infrastructure and services at the local or county levels.

arise. Health problems vary over time and from place to place and Maine needs to improve its capacity to keep stride with such a dynamic environment.

Not only will improvements in the health status of Maine residents be frustrated if the state of the public health system deteriorates, there are negative implications for individual providers, hospitals and managed care providers as well. As the health care system experiences the introduction and implementation of financial incentives that encourage keeping patients as healthy as possible, providers can succeed only where there is a complementary effort to improve and maintain the health of the general population. Therein lies the basis for a strong and vital partnership between the medical care and the public health systems.

The "vision" of public health in Maine is that of healthy people in healthy communities. The mission of public health is the preservation, protection and promotion of the health and well-being of Maine's residents through the organization and delivery of services designed to reduce the risk of disease. The three primary focus areas for public health in Maine are: (1) the modification of physiological and behavioral characteristics of population groups (or "hosts") of disease; (2) the control of environmental hazards to human health ("agents" of disease); and (3) the promotion of health and wellness through education, counseling and access to health services.[3]

This vision and mission are integral to health care reform in Maine. While other system reforms will address individual concerns around financing and access issues, public health is focused on promoting conditions that enable communities and their residents to remain healthy. Increased access and cost containment do not, in and of themselves, make for comprehensive reform if they fail to improve the health of the people of the State of Maine. We can choose to wait passively until people become sick or injured and then treat them in expensive settings with expensive interventions. Alternatively, we can opt to act early, identify the causes of disease and injury and work to keep them from occurring in the first place. Prevention often costs far less than does providing treatment.[4]

Following is a framework for integrating public health into a reformed health care system. The essential elements of this framework do not vary with the alternative financing systems (single-payer, multiple-payer and so on). While this proposal complements each of the reform options presented by the Commission, it can stand on its own merits, regardless of any action taken on the proposals to reform the financing and delivery system.

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[3] From comments made by Lani Graham, M.D., Director of the Bureau of Health, Maine Department of Human Services, in testimony before the Commission, January 17, 1995, Augusta, Maine.

[4] We are aware of the argument that an emphasis on prevention does not necessarily imply a reduction in expenditures for health services. While the improvement of health status is, in and of itself, a worthwhile outcome, the benefits to be gained by investment in prevention and promotion can certainly be augmented by assuring that excess capacity in the medical system -- a by-product of successful public health programs -- be eliminated.

Core Functions of Public Health

The goal of public health is prevention of disease, injury, disability, and premature death. The most common and effective public health activities are in the area of primary prevention -- reducing susceptibility or exposure to health threats. Primary prevention has two main components: health promotion and health protection.

Health promotion includes health education and the fostering of healthy living conditions and life-styles. Activities are sometimes directed toward entire communities, helping people identify needs, get useful information and resources, and take action to achieve change.

Health protection services and programs control and reduce the exposure of the population to environmental or personal hazards, conditions, or factors that may cause health problems. Health protection includes immunization, infectious disease surveillance and outbreak investigations, water purification, sewage treatment, control of toxic wastes, inspection of restaurant food service, and numerous other activities.

It is difficult to determine in advance where and when threats to public health will occur. Health assessment is one way to find, understand and deal with potential problems -- before they produce major crises. Assessment includes collection, analysis, and dissemination of information on health status, personal health problems, population groups at greatest risk, availability and quality of services, resource availability, and concerns of individuals.

Further, assessment leads to policy development, a process of considering alternatives for action and deciding which to pursue. Policy development involves many individuals and organizations in decisionmaking about the relative importance of various public health problems.

After policies are formulated, the next step is assurance -- seeing that those policies are carried out. Public health agencies may carry out a policy themselves or they may monitor its implementation by other community partners.

While health assessment, policy development and assurance comprise the three broad categories of core functions, these functions can be articulated in a more proscribed manner. Specifically, the core functions of public health include:

- the prevention of epidemics;
- the protection of the environment, workplace, housing, food and water;
- the promotion of healthy behaviors;
- the monitoring of the health status of the population;
- mobilizing community action for health;
- responding to disasters;
- reaching out to link high risk, disadvantaged people to needed services;
- providing medical care in certain settings and circumstances;

- securing a skilled public health workforce;
- research for new insights and innovative solutions to health problems;
- participating in the development of sound health policy and planning.

Health promotion, the protection of communities against health threats and the administration of the public health infrastructure are also considered core functions of public health.[5] As noted earlier, these functions are essential to the realization of favorable outcomes from health systems reform: reduced system costs and improved health status.

The Maine Health Care Reform Commission recommends that the State of Maine, through the Bureau of Health, conduct a survey to gather information regarding the State's performance in each of the core function areas. The Centers for Disease Control have designed such a survey instrument but the State has not had the resources to undertake such a project. This survey will assist the State in estimating the extent to which core capacity standards are being met across the State, and will provide a basis for estimating the resources needed to meet the capacity standards. Without such a survey, it is only possible to approximate the financial resources required to operate an effective public health system.

We further recommend that the Legislature direct the Department of Human Services to develop an action plan for the improvement of public health in Maine.[6] The State of Washington has undertaken a similar effort that could serve as a model for our State. The enabling legislation should require the Department to consult with local health departments, other state agencies, health providers and professionals and consumers in the development of the plan. The plan should provide an assessment of the status of core public health functions in Maine, provide recommendations for how additional public health funding might be allocated and detail the expected benefits resulting from such expenditures.

Strategies for addressing the deficiencies and improving Maine's public health system should be clearly laid out in the action plan, with a schedule for their implementation, as well as outcomes measurements to be used to evaluate the relative success or failure of the plan. Finally, the plan should provide a refined estimate of the level of expenditures necessary to operate an effective public health system. The plan would be presented to the Legislature for review and approval one year after the enabling legislation goes into effect.

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[5] WASHINGTON STATE PUBLIC HEALTH IMPROVEMENT PLAN, *supra* note 1.

[6] This plan is intended to complement and strengthen the *Healthy Maine 2000* goals by developing strategies to improve the core functions necessary to attain those goals; this plan is not intended to supplant those goals.

Financing for Public Health

Experts agree that the minimum level of funding for public health is 3 percent of total health expenditures.[7] (As noted, Maine currently spends less than 1 percent of total health expenditures on public health.) It is important that Maine begin to make an increased investment in public health, preferably by establishing a dedicated pool of revenue for public health activity.

In the universal coverage reform options -- the single and multiple-payer plans -- increased financing for public health is incorporated in the modifications to taxation used to raise revenue for the entire range of reforms contemplated in each option. An additional $70 million dollars is expected to be generated for public health through these broad based tax mechanisms. The incremental plan described in Chapter Five does not include a revenue source for enhancing the finances of Maine's public health activities. We recommend that, should the incremental reform plan be implemented, the additional monies for public health be raised through an increase in the tax on tobacco products. The use of tobacco products has a clear and direct association with poor health status. Taxing these products to raise revenue to support public health, therefore, is a sound policy decision. Increasing the tax on cigarettes to $1 and a 200 percent increase in the tax other tobacco products will generate the required revenue. The act of increasing these taxes is a public health measure in and of itself. Consumption of these products is elastic -- that is, consumption of tobacco products will fall as the price of the products increase. As a result, the revenues generated in this manner will decline somewhat over time. The potential for a shrinking of the revenues is not troublesome; as tobacco consumption drops, health status will improve, generating system-wide cost savings.

As noted earlier, this proposal for strengthening and improving public health in Maine should stand on its own merits and should not be tied to the adoption of any of the Commission's other recommendations for health reform. The Commission's recognition of and commitment to the importance of public health is further demonstrated in the standard benefit package designed for use in the three reform models. This package, described in detail in Chapter Two, emphasizes prevention, education and wellness.

A Center for Public Health Practice

In many states, university-based schools of public health provide support for state health policy development and the state public health infrastructure. This is accomplished through health education and training programs and through research and technical assistance relevant to the objectives of the public health system. Maine has no such academic resource, but does have the capacity to stimulate the formation of a sustainable organizational base to accomplish the same tasks. The Legislature should consider and enact statutory language allowing the development of a new non-profit organization charged with the responsibility of assisting the

[7] THE CALIFORNIA WELLNESS FOUNDATION, HEALTH PROMOTION AND DISEASE PREVENTION IN HEALTH CARE REFORM (October, 1993) and CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH IN THE NEW AMERICAN HEALTH CARE SYSTEM (March, 1993).

Maine Department of Human Services, other state agencies engaged in public health activities, academic institutions, health care organizations and Maine communities in developing and maintaining the capacity to prevent illness, injury, disability and death, and to promote public health.

The mission of this new organization would not be to supplant the services provided by existing public and private entities. Instead, it will be a center for coordinating efforts to address the State's health problems. This center, a public/private partnership, would be a cooperative venture between the State -- through the Department of Human Services -- other public entities such as the University of Maine system, as well as private entities, such as the University of New England (the State's only medical school) and other health organizations. It would be modeled on the Centers for Public Health Practice that already exist in a number of states across the country. These centers are, like the one proposed here, intended to bridge the gap between educational resources and research institutions and community health initiatives . The objectives of the center would include:

- the identification and examination of public policies that directly impact Maine's priority public health problems or issues;
- the establishment of a technical assistance network of practitioners, educators, researchers, and others who can assist each other in the design and implementation of effective measures to improve the public health;
- the provision of a broad range of educational programs and activities designed to meet the needs of health care providers and others; and
- the development and implementation of a research agenda that is defined by leading issues in public health planning and service delivery.

Importantly, the center can serve as an private sector advocate for the promotion of public health. While the Bureau of Health and other organizations such as the Maine Public Health Association have traditionally carried out that function, constrained resources and increasing demands have limited their ability to effectively educate the public and the policymakers about critical public health issues. The Maine Center for Public Health Policy could assist in that vital activity.

While funding for this center is not specifically recommended in this report, the legislation enabling the Department to establish such a corporation should specify that it would be able to apply for and accept gifts and grants. It is assumed that the Department and other participating state agencies would provide some level of support for the center's activities, but that private monies would provide a substantial portion of needed funding.

CHAPTER NINE

Quality Assurance Programs

Introduction

Much of the discussion and debate around health care reform centers on issues of financing and cost containment. In fact, discussions about "health reform" most often focus on the financial aspects of the system as opposed to quality aspects of the delivery system. However, financing reforms, especially those that involve meaningful cost containment, carry potentially significant implications for the delivery of care, creating a tension between minimizing cost and the delivery of high quality services. The pursuit of cost containment does not necessarily produce a decline in quality of care but it does result in the need to implement quality assurance mechanisms. It is important that Maine take this opportunity to consider and adopt system wide quality assurance programs that will serve to improve and maintain quality of care. This is an essential objective, even in the absence of the adoption of other reform initiatives.

While the quality assurance and improvement function is a common element of any health system model, the administration of that function might differ from one model to another. The Maine Health Care Reform Commission has been required to present three alternative models for reform. Under a single-payer health care model, the Maine Health Care Authority would likely be responsible for overseeing quality assurance and improvement programs. Under a multiple-payer model, these responsibilities would fall primarily to health plans and the Alliance. The focus of this portion of the report will be on our recommendations for a "generic" quality assurance/improvement mechanism; differences in administrative structures generated by the peculiarities of the various financing systems, while noted, are not given an exhaustive review.

Background

Measuring the performance of health care systems -- its providers and plans -- is a complex problem. Despite the attention paid to this subject, the challenge inherent in defining quality and how to measure it remains significant. Arriving at a definition of "quality" is a difficult proposition in itself. At a fundamental level, definitions of quality are premised on two interrelated constructs: appropriate processes of care and patient outcomes.[1] Underlying these concepts are the scientific aspects of medical care and the less tangible, but still critical, "art" of delivering care -- the human aspect. Their interplay works, to a large degree, to determine patient outcomes.

[1] Lohr, Kathleen, et al., *Current Issues in Quality of Care*, 7 HEALTH AFFAIRS (Spring 1988).

There are three essential components in defining and measuring quality - structure, process, and outcome. "Structure" refers to the physical features of a health system: whether a facility satisfies safety and physical health industry standards. State licensing agencies and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have traditionally concerned themselves with structural quality in hospitals. Licensing and certification of health care providers is another "structural" quality factor. Presently, these activities are regulated by various boards of registration and certification. The Commission will make recommendations relevant to these activities in its forthcoming report on health education, workforce and regulation. We wish to emphasize that the Quality Improvement Foundation concept discussed in this chapter does not relate to the licensing and regulation of providers. These activities should remain a separate function.

"Process" of care refers to the actual conduct of care. For example the stages of care of an injured person, beginning with emergency care and transportation by an EMS service, treatment in a hospital emergence room, surgical care in an operating room and post-operative care on a hospital unit, physician, nursing and other inpatient services and post-hospital medical and rehabilitative care are all part of a complex and interrelated series of processes of care.

"Outcome" refers to the end result of structure and processes of care. It is concerned with the medical result of treatment. Did the patient's injuries heal correctly and without complications? In recent years a new component has been added to outcome. It is concerned with patient-oriented outcomes of treatment and asks the question, "what is the outcome from the perspective of the individual undergoing care?" Research in this area has centered on the patient's perception of function, pain, satisfaction with care, expectations, and quality of life. The focus thus shifts from the health system's measures of structure and process to the patient's assessment of the result of the treatment received. There is also an emphasis on offering patients relevant and understandable information regarding alternative choices of health care, thereby empowering them to make better health care decisions based on their own evaluation of the risks and benefits of treatments.

All three of these quality measures are important. Because it is a relatively new and less well developed concept, there has been an increasing emphasis on outcome evaluation and research. Physicians and patients in Maine have been major participants in the field of outcomes research.[2] The Commission believes that any health system reform in Maine should include a strong focus on all aspects of quality of care - including current licensing and regulation of health care facilities and providers, monitoring of plans (report cards), and research and assessments of patient-oriented health outcomes.

As previously noted, changes in the health care market have placed increased importance on efforts to assure quality of care. If market competition is to be relied on as a basis for reform,

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[2] Fowler, F.J., et al., *Symptom Status and Quality of Life Following Prostatectomy*, 259 J. AM. MED. A. 3018-3022; Keller, R. B., et al, *Outcomes Research in Orthopaedics*, 75-A J. BONE & JOINT SURGERY 1562-1574; Carlson, K.J., et al, *The Maine Women's Health Study: I. Outcomes of Hysterectomy,* 83 OBSTETRICS & GYNECOLOGY 556 (1994).

the need to measure and assess quality of care, including performance measurement of competing plans, becomes more important.

A Reformed Approach to Quality Assurance

The 1994 Annual Report of the Physician Payment Review Commission (PPRC) indicated a clear need to develop a quality assurance system that will provide external monitoring of health plans in addition to internal quality assessment methods (known as report cards). A balance between these two approaches is necessary and both are needed to stimulate a high quality health care system.

As set out by the PPRC, a multifaceted approach is recommended for ensuring the quality of health care. First, a process for measuring and reporting health plan performance in accordance with a defined set of quality indicators is required. Next, a system-wide quality improvement strategy must be implemented. Finally, certain external quality assurance/review mechanisms must be used to provide a "check" on internal quality assessment and assurance programs.

If the system continues to rely on independent, competitive private health plans for the financing and/or delivery of care, internal and external quality assurance programs become increasingly important factors in any systematic quality program. This will be especially true as the number of managed care plans grow, as cost containment pressures increase and as downward pressure on premium prices intensifies. Health plans increasingly find themselves in the position of having to document their quality to enrollees in a manner that allows comparison to competitors. This phenomenon will become more commonplace if the State chooses to pursue the implementation of either the multiple-payer, managed competition system reform or the incremental reform option recommended elsewhere in this report. Competition among health plans is anticipated to control costs in the marketplace. In these reform models, plans would compete only on the basis of price and quality as the content of the benefit package would be pre-defined and consistent across all health plans.

In any market where purchasers must make decisions regarding choice of health plan or providers, information regarding quality will offer an opportunity for improving the purchasing decision and thereby improving the operation of the market. It is not presently clear, however, what information would prove to be most helpful to purchasers in formulating their buying decisions. Certainly some information would prove more meaningful to certain consumers than to others. For this reason, a range of material must be made available to consumers, allowing for the variety of informational needs to be addressed.

Many plans across the country are beginning to generate their own quality self assessments or "report cards." The development of uniform standards for this type of reporting is proceeding. The National Committee for Quality Assurance (NCQA) has developed and continues to refine the Health Plan Employer Data and Information Set (HEDIS), which is applicable to HMO's and managed care plans. This approach defines uniform measures of

quality, access, enrollee satisfaction and financial status for health plans that may be used to compare one plan to another. Similarly, the DEMPAQ project (Developing and Evaluating Methods to Promote Ambulatory Care Quality) has recently been completed. This project focused on using patient records and claims to develop performance measures for health plans.

At the level of physicians and other health providers, the Commission believes that different systems are required. This occurs because practitioners in Maine will have to participate in and relate to multiple health plans. Few, if any, doctors will be solely employed or provide services for a single organization, and most will need to participate in at least four to six different plans.

Quality information and other data that are developed at the plan level will be useful to administrators and purchasers of those services, but the individual practitioner will need to deal with quality issues at the level of his or her practice. In addition, data analyses and reports generated by health plans will not be standardized and the volume of information for each provider will often be too small to be statistically significant. Thus, there is a need to develop an organizational structure that can provide data and analytic support to providers. This entity can also serve as an important interface between providers, patients, plans and the State.

Essentially all of the national health system reform considered in 1994 supported the notion of state or regional Quality Improvement Foundations (QIF).The model is a familiar one in Maine. It was fashioned largely on the Maine Medical Assessment Foundation. Senator William Cohen has included this concept in his health reform legislation.

A fundamental aspect of the work of QIFs relates to the concept of continuous quality improvement (CQI). This method, articulated by Deming,[3] relies on the routine feedback of information to providers about their patterns of care. Such data include the utilization of health services, outcomes data, and other related information. Implicit in the CQI method is the notion that a non-punitive, participatory educational approach to the profiling of providers will produce voluntary and appropriate change in medical practice. Experience indicates that there is a significant reduction in excess utilization of services with simultaneous improvement in quality.

We recommend that a Quality Improvement Foundation be formally recognized in Maine. It should be a private (or a public/private) non-governmental, not-for-profit entity and can be modeled after existing organizations and the recommendations of the national QIF Coalition.[4] The QIF would be charged with a broad range of activities including, but not limited to monitoring of health care utilization, analyses of population-based care, analyses and studies of cost-effectiveness and patient-oriented outcomes of care, projects in CQI with provider groups and institutions, support of rural health care providers, coordination and support of educational and outreach activities of academic medical centers.

Finally, there is a need for external quality assurance mechanisms. The need for public accountability in the health care system demands some method of assuring that the internal

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[3] DEMING, OUT OF THE CRISIS (1986).

[4] Quality Improvement Foundation Coalition, *A National Network of Quality Improvement Foundations,* Unpubl.

quality assurance mechanisms of private organizations are working, are accurate and are fair. This may be accomplished by the government conducting its own assessments or by mandating that health plans and providers to comply with the quality assurance requirements of some other external entity such as NCQA. These "Quality Performance Reports" would provide the public with the knowledge that plans meet credentialling standards, satisfy certain standards for access and quality, maintain an effective grievance resolution system, and have a mechanism to address deficiencies.[5]

In order for any activities related to quality of care to be successful, there is a fundamental requirement for extensive, timely and accurate health care data. The need for better data systems has been an important component in all health reform initiatives at the national and state level. It is echoed by all experts in the health care field. Elsewhere in this report, the Commission has made recommendations for a public-private health data entity to be known as the *Maine Health Data Organization*. This organization should be established as an independent entity and not as part of a Quality Improvement Foundation or other health plan or organization.

It is important that health data be collected, certified for accuracy and controlled by an independent entity whose only interest is managing the quality, confidentiality and access to the data. Many eligible parties will wish to access the database, and the information will be useful for many purposes. It is for these reasons that the data organization must remain independent of any regulatory or political framework.

Recommendations

As we have described in this chapter, the Commission believes that expanded and enhanced quality assurance programs should be a major component of health reform in the State. All segments of the health care system should develop and participate in programs that measure and improve the quality of health care. To accomplish these tasks, we make the following recommendations:

- *Health Plan Report Cards.* Health plans should develop and implement internal mechanisms to measure aspects of quality specific to their plans. Nationally developed programs such as the HEDIS program of the NCQA will provide appropriate models for plans to adopt. These "report cards" should be made widely available to all interested parties. Financing of these reports would be the responsibility of the plans.

- *A Quality Program for Providers.* A Quality Improvement Foundation should be recognized in the State. This organization would undertake the tasks previously

[5] The public might wish, through legislation, to define its own standards for plan performance. A recent example of such an effort may be found in Leg. Doc. 1512, *An Act to Ensure Fairness and Choice to Patients and Providers Under Managed Health Care,* 117th Me.Legis., 1st. Sess. (1995). This bill proposes an extensive list of plan standards for access, quality, the handling of consumer grievances and so on. In Chapter Five, the Commission has endorsed some of these principles.

outlined, including epidemiologic analyses; monitoring and profiling of provider practice patterns; feedback of information; outcomes research; continuous quality improvement initiatives; and the development, implementation and monitoring of practice guidelines.

While the QIF would have primary responsibility for interacting with the provider community, there would be active monitoring and oversight of its activities by all stakeholders through advisory committees and a board of directors. Financing of the QIF would be generated through a combination of low level premium assessments on health plans. The QIF would also be eligible for other grants and contracts.

- *Quality Performance Reports.* In contrast to report cards, which are developed at the plan level, "Quality Performance Reports" will be developed by an independent entity. These reports will be more technical in nature than report cards and will involve detailed evaluations of health care organizations and interventions. These reports would focus on aspects of quality that are not covered by the QIF. In the case of a single-payer or multiple-payer system, the Health Care Authority would assume responsibility for this program.

Though desirable, we believe it would be difficult to implement broad scale Quality Performance Reports under the incremental reform option. To do so would require the creation of a new state-level organization. In the absence of broad-scale reform of the delivery system, the data reporting requirements would be difficult to mandate and implement. We do recommend that the newly created Alliance develop Quality Performance Reports for its participating plans. These would be financed through the administrative budget of the Alliance.

CHAPTER TEN

Medical Liability Reform

Introduction

In its authorizing legislation, the Commission was required to develop three models of health care reform. Because malpractice and malpractice liability have such obvious implications for the quality of and access to health care, the care available to those injured by malpractice and the cost of health care, the Commission considers evaluation of the malpractice liability system to be an important part of that mandate.

As discussed below, the Commission believes the current malpractice system is severely flawed. It is a very expensive, inefficient process that often produces inequitable results.

Background

Ideally, a medical liability system should serve at least two important functions. Primarily, it should diminish and deter the occurrence of adverse events in the first place. In addition, for those injuries that do occur, the malpractice system should provide a mechanism by which those injured can promptly and predictably recover for their loss. Optimally, the malpractice system would serve these two functions efficiently and at minimal cost to society. Under these standards, on almost all counts, the current malpractice system is a failure.

Medical Liability as a Deterrent to Malpractice

Evidence suggests that, as a deterrence mechanism, medical liability has had limited success. Although difficult to prove, in all likelihood, the prospect of liability does encourage a level of attention to quality that might not otherwise exist: "[j]ust as it is true for traffic law,. . .if it is known that some violations of a legal standard will be punished and it is impossible to predict which ones those will be, there is an incentive to comply with the standard at least most of the time."[1]

A study conducted by the Harvard Medical Practice Study Group found, however, that in New York one negligent adverse event, or incident of malpractice, occurred for every 100 patients hospitalized.[2] Extrapolating the experience of New York to the United States as a whole, this study suggests that "every year there are more than 150,000 fatalities and 30,000 serious disabilities precipitated by medical treatment in this country."[3] Part of this rate of injury

[1] WEILER, MEDICAL MALPRACTICE ON TRIAL (1991) at 74.
[2] *Id.* at 12.
[3] *Id.*

can be explained by the fact that medicine is an "inherently risky enterprise."[4] Although normal human error such as forgetfulness or momentary lapses in attention typically do not yield life-altering results for a teacher or a computer programmer, for a surgeon they may. Although the prospect of liability does exert pressure on a provider to provide quality care, it is unlikely that all errors can be eradicated by a liability system.

Some argue that the prospect of liability also provides a *disincentive* to improve quality -- the prospect of malpractice litigation renders some providers afraid to acknowledge that a mistake was made, making corrective action difficult. This problem results partly from the fact that our liability system is based on fault. To recover for an injury, a patient must prove, or a provider must admit, that the injury was the fault of the provider and not simply an injury occurring as part of treatment. Providers may be worried about the impact their admission of fault will have on their reputation, their ability to practice and their future insurability. Another contributing factor relates to the unpredictability of our jury system. A provider might wish to "do the right thing" and admit liability but, because a jury trial is unpredictable and lengthy, that provider may be reluctant to expose him or herself to unknown liability and the ordeal of litigation.

Compensating Victims of Malpractice

While medical malpractice may result in serious injury, few of those injured ever recover for their loss. Consistent with the findings of other studies, the Harvard study found that only two percent of those injured by medical negligence ever file a claim to recover for their loss.[5] Of that two percent, less than half can expect to receive any payment.[6] Even for the most serious, or the most costly, injuries, the malpractice system does not provide a reliable mechanism for recovery. For patients under seventy who suffered malpractice injuries resulting in death or disabilities lasting six months or more, only one in three received any payment.[7]

In many cases, those who do receive payment do not recover for their full loss. In exchange for the certainty of recovery, or speedy resolution of the case, many claimants choose to settle.[8] One study found that, on average, paid claims settled for 74 percent of the likely verdict.[9]

At the same time that many entitled to recover do not, others without valid claims do receive payment. As many as 40 to 60 percent of malpractice claims are nonmeritorious.[10] Although the majority of these suits are eliminated early in the process, some of these claimants

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[4] *Id.* at 14.

[5] Localio, Lawthers, Brennan, Laird, Hebert, Peterson, Newhouse, Weiler & Hiatt, *Relation Between Malpractice Claims and Adverse Events Due to Negligence,* 325 NEW ENG. J. MED. 245, 249.

[6] WEILER, *supra* note 1, at 13.

[7] *Id.*

[8] DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY (1985) at 42.

[9] *Id.* at 43.

[10] OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE (July, 1994) at 27 n7 [hereinafter DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE].

do recover. One study of anesthesia claims found that, even though 10 percent of valid claims were not paid, 42 percent of the claims that were settled were not the result of negligence.[11] Although low settlement value of these nonmeritorious cases did appear to reflect the weakness of the claims, the misallocation of payment further demonstrates the failings of the malpractice system. Other studies have found similar inconsistencies.[12]

For those cases going on to trial, the process has been compared to a lottery. For the most part, recovery for the plaintiff is difficult.[13] Evidence suggests that, for the defendant, juries are fairly predictable in establishing liability but are highly unpredictable in assessing damages.[14] Some claimants receive no award or an award falling far short of their economic loss; others receive awards in substantial excess of their loss. Unrelated factors can unfairly reduce or exaggerate a claim.[15] A General Accounting Office study found that, in 1984, recovery for patients suffering grave and permanent total disabilities ranged from $10,000 to $2.5 million.[16]

The Cost of Medical Liability

The tort system is exceedingly expensive. The cost of the tort system not only imposes a considerable barrier to recovery, but many believe that the threat of liability fosters the use of unnecessary, defensive medical services and, because of the high cost of malpractice insurance, forces some physicians out of practice.

i. Transaction Costs

The cost of recovering for a malpractice injury imposes a heavy burden on both the plaintiff and the defendant. The litigation costs associated with malpractice are higher than for other torts.[17] One Maine trial attorney warns his colleagues that because of the complexity, medical malpractice cases can cost as much as $20,000 to $100,000 to conduct.[18] Given the investment of time and money, at least for this attorney's firm, cases with an expected recovery of less than $100,000 are "not worth taking responsibility for."[19] The defendant also faces the high costs of investigating, litigating or settling claims.[20] Only 30 percent of the malpractice

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[11] WEILER, *supra* note 1, at 15

[12] DANZON, *supra* note 8, at 43. In Danzon's study, it was found that 39 to 53 percent of claims dropped without payment would have resulted in recovery at trial. At the same time, 30 percent of those that were paid something in settlement would have lost had the claim gone to trial.

[13] Bovbjerg, Sloan, Dor & Hsieh, *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?,* 54 DUKE L.J. 5, 22 (1991).

[14] Metzloff, *Resolving Malpractice Disputes: Imaging the Jury's Shadow*, 54 DUKE L.J. 43, 90.

[15] *Id.* at 74; Bovbjerg, Sloan, Dor & Hsieh, *supra* note 13, at 35.

[16] Johnson, Phillips, Orentlicher & Hatlie, *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims,* 42 VAND. L. REV. 1365, 1369 (1989).

[17] Bovbjerg, Sloan, Dor & Hsieh, *supra* note 13, at 26-27.

[18] BABCOCK & DUMAS, MEDICAL MALPRACTICE IN MAINE (1994) at 24.

[19] *Id.* at 28.

[20] Bovbjerg, Sloan, Dor & Hsieh, *supra* note 13, at 27.

premium dollar is left over to compensate the plaintiff for his or her injury.[21] A large portion of these costs are imposed even if the case settles because this usually occurs only after a costly and time-consuming investigation.[22] Because recovery is often based on age and wages, the barrier is all the greater for the elderly and those with low income.

ii. Defensive Medicine

In addition to the high transaction costs associated with recovery, many believe that the tort system encourages physicians to prescribe unnecessary tests or treatment to avoid a later claim of negligence.

The goal of a fault-based malpractice system is to deter negligence. Many question, however, whether or not the current system is an effective mechanism for setting the parameters of negligent behavior. First of all, the question of whether or not a physician was negligent is ultimately determined by a jury, usually composed of people without expertise in the medical field. Some jury verdicts have been found to be technically incorrect.[23] Secondly, the question of negligence is determined retrospectively, based on a standard that is determined anew in each case because each case is unique.[24] The provider, thus, is given little advance guidance as to what action is appropriate. Further complicating the standard applied are ongoing changes in technology: at what point does a new technology become the accepted standard of care? Because of these flaws, some physicians may feel that the only way to avoid liability is to do everything possible to avoid an adverse outcome, no matter how unlikely or how costly the treatment.[25] Measuring the cost of this defensive medicine is extremely difficult. Depending on the measure, estimates range from the insignificant to as much as 15 to 30 percent of the nation's annual health care expenditures.[26]

This evaluation of the malpractice system is confused by the difficulty of establishing precise criteria for when tests are unnecessary. For example, a radiologist may be confronted with a mammogram containing a suspicious, but equivocal, finding. The radiologist is faced with the dilemma of recommending a breast biopsy to determine whether or not there is cancer or waiting for the results of a follow-up exam in 6 to 12 months.[27] A breast biopsy is painful, scarring and can make future diagnosis of a malignancy more difficult.[28] However, according to the results of one study it is possible that "for every 1,000 biopsies avoided by not referring the less suspicious mammogram results, about eight already-invasive cancers would be missed, and a

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[21] Sapp, *Medical Malpractice Crisis: Rethinking Issues and Alternatives*, DEF. COUNS. J., October, 1988, 373, 374.
[22] BABCOCK & DUMAS, *supra* note 18, at 22.
[23] WEILER, *supra* note 1, at 115.
[24] DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, *supra* note 10, at 30.
[25] *Id.* at 30.
[26] J. Cost, Medical Liability in Maine (January 31, 1995) (Report to Maine Health Care Reform Commission) at 6 (citing Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues,"* 59 TEX. L. REV. 1401, 1408 (1981) and Wagner, *Defensive Medicine: Is Legal Protection the Only Motive?,* MOD. HEALTHCARE., Sept. 10, 1990, 41, 44-45).
[27] DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, *supra* note 10, at 24.
[28] *Id.*

small but unknown proportion of the 40 noninvasive cancers missed would progress to an invasive stage in the follow-up period."[29]

Heightened sensitivity to medical liability would probably tilt the radiologist's decision toward recommending a biopsy. Whether or not this is the right decision is unclear: "[w]hether the benefits from detection of more early breast cancers outweigh the pain and risks associated with negative biopsies is a value judgment, so it is not clear whether defensive medicine, [if it being practiced in this case], improves or worsens health outcomes. If on balance it does improve health outcomes, it is likely to do so at a high dollar cost. Whether the benefits are worth this high cost is also a value judgment."[30] Effectively, then, the threat of liability under a malpractice system is an imprecise, and, possibly, inaccurate reflection of the relative value that we place on these choices.

Some believe that the fee-for-service payment system has created incentives for the practice of defensive medicine.[31] Traditionally, physicians have not borne the costs of extra tests or procedures and may sometimes be reimbursed when they order them.[32] As a result, the current standard of care does not reflect a cost consciousness that alternative reimbursement mechanisms, such as capitation, might impose on physician practice.[33] It can be argued however that, if, as consumers of health care, we impose a greater emphasis on the cost effectiveness of the delivery of health care, a corresponding change in the standard of care must also be allowed. If a physician can show that a practice was justified based on an appropriate analysis of the risks, costs and benefits of a particular treatment, it is argued, the physician should be able to argue that he or she has met the standard of care.[34] As the market shifts in the direction of capitation and utilization review, we can expect this apparent tension between cost containment and the standard of care to be played out in the courtroom.

iii. Malpractice Insurance Premiums

The cost of malpractice insurance has two potential impacts on the delivery of health care. The most obvious is the impact on cost. Because premium costs are reflected in providers' fees, an increase in malpractice premiums puts upward pressure on health care costs. According to one report, approximately $9 billion is spent on medical malpractice insurance premiums annually.[35] Beginning in the early 1980s, the cost of malpractice insurance in Maine rose rapidly. Between 1983 and 1986, on a national level, premiums rose by 75 percent while the

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[29] *Id.* at 25.
[30] *Id.*
[31] Danzon, *The Medical Malpractice System: Facts and Reforms,* in THE EFFECTS OF LITIGATION ON HEALTH CARE COSTS (1985) 28, 33.
[32] DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, *supra* note 10, at 91-92.
[33] *Id.* at 92.
[34] Danzon, *supra* note 31, at 34.
[35] J. Cost, *supra* note 26, at 2 (citing Weiler, *The Case For No-Fault Medical Liability,* 52 MD. L. REV. 908, 909 (1993)).

Medical Care Price Index rose at only 21.3 percent.[36] In Maine, between 1984 and 1988, the average malpractice premium rose by 117 percent.[37] Since the end of the last decade, malpractice premiums appear to have steadied, and for some years, have actually declined.[38]

The cost of malpractice premiums also has an impact on access to health care. According to a 1989 report, for Maine physicians paying their own premiums, malpractice premiums totaled 11 percent of gross practice income.[39] On a national level, in 1983, premiums had only accounted for 4 percent of gross practice income and 6.2 percent in 1986.[40] For obstetricians/gynecologists, malpractice premiums totaled 22 percent of gross practice income.[41] At the same time, premium rates are erratic. Between 1979 and 1988, the annual increase in premium rates varied from a negative 20 percent to a positive 30 percent.[42] Because of this volatility in malpractice insurance premiums, and because of the impact on physician income, access to services can be jeopardized.[43]

Medical Liability Reform Measures in Maine

Perhaps because the problems with the medical liability system are so complex, to date the reforms in Maine have focused less on prevention of injury and compensation of patients and more on containing the costs associated with medical malpractice.

Screening Panels

Maine has implemented pre-litigation screening panels in order to encourage settlement and discourage nonmeritorious claims. Prior to litigation, all malpractice claims must be reviewed by a panel to determine whether or not a claim has merit. A unanimous decision by the panel may be introduced as evidence in a court proceeding. For those cases found unanimously to have merit, settlement is thus encouraged. Alternatively, dismissal is encouraged for those cases found not to have merit.

There is disagreement about the benefits gained from screening panels. At least one study has found that jury verdicts are usually consistent with the defendant's assessment of the merit of the claim.[44] A screening panel probably assesses merit more efficiently than would a jury. The cost of this efficiency, however, is an additional step meritorious claimants must go through to recover for their loss.

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[36] PUBLIC HEALTH RESOURCE GROUP, INC., FINAL REPORT, MEDICAL MALPRACTICE LIABILITY STUDY (1989) at 13.
[37] *Id.*
[38] Facsimile from Domenic Restuccia, Medical Mutual Insurance Company of Maine (November 2, 1995).
[39] *Id.* at 14.
[40] *Id.*
[41] *Id.* at 15.
[42] *Id.* at 14.
[43] *Id.* at 21.
[44] Metzloff, *supra* note 14, at 82.

It is also too soon to know whether or not the screening panels encourage settlement.[45] If the panels are appropriately encouraging settlement they may be reducing the costs associated with litigating a claim.[46] However, they may also be contributing to higher transactions costs, which in turn may prevent some injured patients from recovering their loss. In order to recover, a plaintiff must go through an additional, and sometimes costly, extra step. As a result, trying a malpractice case may be more expensive, and the patient may have a more difficult time finding an attorney willing to take on the case, especially if the expected recovery is low.

Caps on Attorneys' Fees

Maine has also introduced caps on plaintiff attorneys' fees. Ostensibly, limits on attorneys' fees are meant as a benefit to the plaintiff. However, attorney fee limits may add yet another barrier to recovery.

At present, contingency fees are the only available mechanism for financing recovery through the legal system. This means that the plaintiff must pay his or her attorney a sizable percent of the settlement, or jury award, in the event the plaintiff is victorious. Thus, if a jury awards the plaintiff for economic loss, after paying for attorneys' fees and court costs, the plaintiff might only recover two-thirds of actual economic injury.

Although contingency fees seem unfair to the plaintiff, they are not necessarily a windfall for the attorney.[47] Contingency fees subsidize the costs of services provided to the attorney's losing clients. When accepting tort cases, the attorney "assumes *de facto* the role of the financier-insurer of the legal costs" for his or her clients, "guaranteeing each of them the opportunity to pursue the case on its merits without having to worry about the risk of an enormous legal bill if he should lose."[48] The sometimes sizable contingency fee, therefore, is not only payment for services, but a cost-sharing mechanism that provides access to the judicial system to those who might otherwise not be able to afford it.

Relative to other torts, medical malpractice cases are more expensive and more difficult to prove.[49] Because the plaintiff's attorney bears the risk for losing cases, plaintiff attorneys typically turn away seven out of eight malpractice cases brought to them.[50] Imposing a cap on

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[45] J. Cost, *supra* note 26, at 11.

[46] In fact, based on preliminary evidence, it appears that the panels are screening out a higher than average number of claims. Experience in other states suggest that usually between 40 to 60 percent of claims are non-meritorious. In Maine, 87 percent of the screening panel's unanimous findings have been for the defendant. *See* DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, *supra* note 10, at 27 n7; *Hearings Before the Maine Health Care Reform Commission,* (February 7, 1995) (testimony of Patrick A. Dowling, M.D., Chairman of the Board of Directors, Medical Mutual Insurance Company of Maine).

[47] When the time spent by plaintiff attorneys in their losing cases is counted along with time spent on victorious cases, the overall return per hour is roughly the same for both plaintiff and defense lawyers. WEILER, *supra* note 1, at 65.

[48] WEILER, *supra* note 1, at 64.

[49] Bovbjerg, Sloan, Dor & Hsieh, *supra* note 13, at 22 and 26-27.

[50] *Id.* at 9.

how much an attorney can recover may make malpractice cases even less attractive to the attorney, meaning that more people will be turned away.

Practice Parameters

Through its Liability Demonstration Project, Maine has led the way in implementing practice parameters as a legal defense. Because medical liability is established after the fact, a provider often might not know what the tort system will consider the appropriate standard of care. At the same time, in some instances medical practice varies widely because many practitioners do not know the appropriate medical indications for many forms of treatment.[51] Practice parameters are designed to solve both problems. By defining and disseminating recommendations for the appropriate treatment for specific conditions, practice parameters could potentially improve the quality of care and reduce the use of defensive medicine.

Maine has implemented practice parameters in four specialty areas. If a physician can demonstrate that he or she acted consistently with the parameters, that fact can be used as an affirmative defense in a malpractice suit. The plaintiff bears the burden of demonstrating that the physician did not comply. Thus, the practice parameter may be used as the standard of care. It offers the physician explicit, advance notice of that standard and may also reduce the cost of litigation because the practice parameter, not the expert witnesses, might be used to establish the standard of care.[52] It is still too early to tell how effective the parameters are at achieving these goals.[53]

Collateral Source Rule

Maine has also introduced a collateral source offset rule. Under this rule, the defendant pays only those damages that are not otherwise covered by the plaintiff's other insurance, where the other insurer has not exercised its rights to subrogation. This rule is considered to be helpful in reducing the cost of medical liability.

The Commission's Recommendations for Liability Reform

Based on the information available to it, the Commission believes that the current medical liability system imposes substantial cost without adequately serving its purpose. The Commission recommends two modest steps toward improving Maine's liability system.[54]

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[51] Kuc, *Practice Parameters as a Shield Against Physician Liability,* 10 J. CONTEMP. HLTH. L. & POL'Y. 439, 445.

[52] J. Cost, *supra* note 26, at 17; 24 M.R.S.A. §§ 2971-2979.

[53] J. Cost, *supra* note 26, at 20.

[54] In its draft recommendations, the Commission proposed a different form of fault based liability system, modeled after the proposals of Jeffrey O'Connell. This model was an "early-offer" scheme that was aimed at addressing the shortcomings of the current system. This recommendation was thoroughly discussed in hearings following the release of the Draft Report. In view of the generally negative response to this recommendation, the Commission decided that continued advocacy of this proposal would not positively contribute to the ongoing debate over liability reform and, therefore, it has been withdrawn. The Commission also recommended an amendment to Maine's Rules of Evidence to make certain corrective action inadmissible. A recent amendment to Rule 407 by Maine's Supreme

Measuring the Effectiveness of the Pre-litigation Screening Panels

As discussed above, at present there is insufficient evidence available to measure the effectiveness of the pre-litigation screening panels. Some believe that the screening panels reduce transaction costs while appropriately screening out nonmeritorious claims. Others believe that screening panels unnecessarily increase transaction costs for meritorious claimants. The Commission believes that the State should continue the screening panels at this time. The Commission recommends that the Bureau of Insurance be required to prospectively design a study of the pre-litigation screening panels. Based on the study design, the Bureau of Insurance should collect detailed information about the process and the outcomes of the screening panels. After it has collected sufficient data the Superintendent should commission a non-biased, external analysis of the success or failure of the screening panel process. With this information Maine will know better whether to continue the screening panels or implement alternative reforms.

Deterring Malpractice Through Quality Improvement

Because the tort system is erratic in imposing medical liability, many question its value as a deterrent of malpractice. In addition, some medical injuries occur as the result of factors beyond the provider's control. The Commission recommends, therefore, that the deterrent function of the liability system be augmented by a systematic approach to improving quality.

This approach will take time and research to develop. Better data will be required to help detect preventable injuries and determine their causes. Providers and institutions should be encouraged to carefully study and evaluate untoward events with the goal of improving all aspects of medical care in order to avoid future similar injuries. These data can be used to develop a better understanding of the causes of preventable injury. Based on that knowledge, administrative policies and medical practice guidelines can be designed to minimize the risk of avoidable injury.

While we are a long way from achieving these goals, there are steps that can be taken now. In Chapter Seven, the Commission recommends the creation of a statewide health data organization. The Commission has also set forth its recommendations for quality assurance in Chapter Nine. There, the Commission recommends that a Quality Improvement Foundation (QIF) be established. The QIF could work with hospitals, physicians and others to assist in the analysis of the data, comparisons of treatment patterns and outcomes across institutions and peer groups, provide a forum for the development of "best practices" and participate in the development of practice guidelines.

Judicial Court allows the Law Court to find such remedial measures inadmissible. For a detailed explanation of these earlier proposals, *see* the Commission's DRAFT RECOMMENDATIONS FOR HEALTH SYSTEM REFORM (June, 1995).

CHAPTER ELEVEN

Workforce Planning and Health Professionals Education

Introduction

The Maine Health Care Reform Commission was established by the 116th Legislature and assigned the task of developing alternative approaches to health system reform for Maine. In developing reform options, the Commission was directed to consider a number of factors including: the demographic character of Maine's population; the geography of the State; the rural/urban distribution of the population and the differing needs of these populations; the need for primary and preventive care; and health professions education.[1] While many of these factors are implicitly or explicitly addressed in the three draft reform options released in July of this year, the recommendations did not attempt to specifically discuss the issues of health professions education or workforce planning. This chapter presents the Commission's proposed recommendations to address what it has found to be a significant problem in the coordination of health/medical educational programs and in the numbers, types and distribution of health professionals across Maine.

To be truly effective, efforts to "reform" the financing and delivery of health care must involve critical analyses and understanding of the health professions workforce. To attain the most cost-effective system, there may need to be changes in the types, numbers and location of health professionals. More than any other sector, medical professionals hold the key to health systems cost, quality and access. A professional workforce that is well-educated, composed of appropriate numbers of providers and is well-distributed and integrated can serve as the foundation of an efficient, equitable and high quality health care system.[2] The corollary -- an unplanned and maldistributed, inefficient workforce -- has the potential to increase the cost of health care without additional benefit to the population. There are at least two aspects of the health professions workforce that are important to consider in this context: the current supply and distribution of health professionals and the education of future professionals.

The Health Workforce in Maine

In 1992, a total of 2,342 allopathic and osteopathic physicians reported that they were working in the State of Maine.[3] Of those reporting, 993 -- or just under 43 percent -- were working in primary care. This represents a 20 percent increase in the number of primary care physicians over the prior ten year period. The five most frequently reported specialties of allopathic (M.D.) physicians in that year were: family practice, internal medicine, psychiatry,

[1] P.L. 707, Section AA-9.

[2] PEW HEALTH PROFESSIONS COMMISSION, PRIMARY CARE WORKFORCE 2000: FEDERAL POLICY PAPER (April, 1994).

[3] OFFICE OF DATA, RESEARCH AND VITAL STATISTICS, DEPARTMENT OF HUMAN SERVICES, FACT SHEET - PHYSICIANS, No. 10 (1994).

general surgery and pediatrics.[4] In contrast, osteopathic (D.O.) physicians most frequently specialized in general practice, emergency medicine, osteopathic manipulative therapy, internal medicine, and obstetrics and gynecology.[5]

Statistics show that Maine's physician to population ratio increased between 1982 and 1992. In 1982, there was 1 active physician for every 606 residents; in 1992 there was 1 physician for every 528 residents. Despite this increase, Maine still has fewer physicians *per capita* than the rest of the nation which, in 1990, had a physician to population ratio of 1:427. The national ratio does not necessarily represent a "gold standard" against which the adequacy of physician supply may be gauged. In fact, many believe that this country has an over-supply of physicians, particularly those practicing in specialties other than primary care. [6,7] It may be that the provider/patient ratios in Maine are more appropriate.

There is also a tendency to use urban communities as a standard when assessing the needs of rural communities.[8] Rural communities are often described as being less affluent and under-doctored as compared to their urban counterparts. There is a suggestion that the impact of these factors on access to health care in rural areas needs to be corrected. However, it might very well be that in some respects, the characteristics of the rural community are appropriate and it is urban areas that have too many providers.

Analyses of the physician workforce in Maine reveal evidence of both excess and shortage of providers, depending on the way in which the measurements are made. These differences relate to both the availability and the geographic distribution of physicians. Analysis of one data source indicates that the addition of 30 primary care physicians in northern Maine would produce a ratio of one primary care physician to 1,000 residents.[9] One authoritative source recommends using a ratio of 1 primary care physician to every 1,800 residents as a standard for an adequate physician workforce. An analysis that used this recommended ratio indicated that there is an excess capacity of primary care physicians in areas of southern Maine, while the strategic addition of 60 physicians across the State would ensure an adequate supply of primary care physicians in each of Maine's 62 primary care analysis areas.[10,11]

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[4] *Id.* The number of physicians reporting practicing in these specialties comprises 45% of all active physicians reporting.

[5] *Id.* The number of osteopathic physicians reporting these specialties comprised over 70% of active D.O.s.

[6] Weiner, J.P., *Forecasting the Effects of Health Reform on US Physician Workforce Requirement: Evidence from HMO Staffing Patterns*, 272 J. AM. MED. A. (July 20, 1994).

[7] Wennberg, J. *et al, Finding Equilibrium in US Physician Supply,* 12 HEALTH AFFAIRS (1993).

[8] PEW HEALTH PROFESSIONS COMMISSION, RURAL HEALTH: IMPLICATIONS FOR EDUCATION AND WORKFORCE POLICY, (December, 1993).

[9] Northern New Engl. Primary Care Educ. Consortium, *Northern New England Partnerships for Training Initiative Proposal,* Proposal to Rbt. Wood Johnson Fund (April 7, 1995).

[10] A "primary care analysis area" or "PCAA" is a sub-unit of population designed to facilitate the study of patterns of use of services across a geographic area. In no case does a PCAA represent an aggregation of less than 10,000 people; this assures individual confidentiality.

[11] Horiszny, John, *Primary Care Physician Requirements in Maine,* Unpubl., Nov. 30, 1994.

An analysis of the national physician workforce has been developed by the Center for the Evaluative Clinical Sciences at the Dartmouth Medical School.[12] As shown in TABLE 11-A, this study compares the size of the physician workforce, by various specialty areas, in defined geographic regions across the country to the national mean. Maine is divided into two geographic regions: northern and southern. The study "ranks" the relative supply of physicians in an area by quintiles. Thus, a region noted as being in the first quintile for a specific specialty area would be in the top 20 percent of all geographic areas in the country in terms of the size of its workforce; that is, it would have a greater supply of physicians, on average, than do 80 percent of all other areas. Similarly, a region in the third quintile would have a larger workforce than 40 percent of all other regions, but a smaller workforce than 40 percent of all regions, nationally.

Table 11-A: ***Maine's Physician Workforce as Compared to the National Mean***

Physician Type	Northern Maine	Southern Maine
All physicians	top 60%	top 40%
Primary Care	top 40%	top 20%
Specialties	top 60%	top 40%
General surgeons	top 20%	top 40%
OB/GYN	bottom 40%	top 40%
Cardiologists	bottom 20%	top 40%
Orthopedic surgeons	top 40%	top 20%

These data indicate that the availability of various types of physicians in the geographic regions of the State is at or above the national mean for all those noted except cardiologists and obstetricians/gynecologists in northern Maine.

This analysis defines the overall availability of physicians in the two large regions of the State. It does not indicate the time or distances that some residents may be required to travel to receive health care services. Federal regulations governing the definition of medically underserved areas and sole community provider status have established guidelines for reasonable travel times and distances to access care. Some residents undoubtedly must travel further or longer than the federal guidelines specify to access a provider. It is important to recognize that the numbers or size of the physician workforce in Maine -- with but two notable exceptions -- compares favorably to the average workforce size nationally. However, it is also important to maintain an objective of assuring access to providers within reasonable parameters for time and travel, where feasible.

Other experts have tried to define the correct ratio of physicians to population. The staffing patterns of staff and/or group model health maintenance organizations have been used as a "yardstick" for measuring the adequacy of the clinical workforce. In one recent study, analysts conducted a nationwide survey of over fifty such health maintenance organizations (HMOs),

[12] CECS, Dartmouth Medical School, Hanover NH, *Dartmouth Atlas of Health Care*, Draft Document (1995).

examining physician to enrollee ratios as well as physician-extender to enrollee ratios. The findings of that study, echoing the conclusions of other studies, indicate that there is a surplus of specialty physicians in this country.[13] Indeed, anecdotal evidence in Maine indicates that the growing supply of specialty physicians, in tandem with the growth of managed care insurance products, is resulting in what might be termed a surplus of specialists here, as well. Not very many years ago, for example, hospitals had a relatively difficult time recruiting specialists such as anesthesiologists to their staffs. This seems to no longer be the case, with many physicians now applying for a single position.[14]

This discussion has centered around the issue of physician availability, primarily because much of the cost of the health care system is related to physician supply. However, there are many other types of health care providers who play very important roles in the provision of care to Maine citizens and in the cost of the health care system.

The supply of nurses has been an issue for Maine health facilities in the past. The nursing supply seems to fluctuate over time due to a number of factors such as alternative career opportunities, low wages and difficult working conditions. As is the case of physicians, the supply of certain nurse specialists has also become an issue. Maine currently has the sixth highest *per capita* ratio of nurse practitioners in the nation (21.5:100,000), and the fifteenth highest ratio of certified nurse midwives (2.6:100,000).[15] The high numbers of these nurse specialists may be attributable, in part, to the relatively favorable regulatory treatment in Maine of these professionals and a lesser degree of competition from physicians than occurs in more urban states.[16] The growth of managed care in Maine and the development of regional integrated provider networks may increase the demand for these types of practitioners. The evolving nature of hospital inpatient care will also influence the demand for certain nurse specialists. As more and more care is provided in ambulatory settings, only the most critically ill patients are admitted to the hospital. The high level of patient severity of illness combined with rapidly advancing technology demands highly trained nurses to provide this kind of inpatient care. It is not clear whether Maine has enough such professionals to answer these future needs.

Advanced practice nurses and physician assistants have also been viewed as a potential partial solution to solving provider access problems in remote locations. Some believe that it might be easier to recruit and retain a physician extender, such as a nurse practitioner, to such locations than to recruit a physician. There is no firm evidence, however, to indicate that this is the case. The same personal and professional issues face these professionals as confront physicians. Moreover, limitations in their scope of practice make it necessary for physician extenders to practice with some level of physician oversight. Recent statutory changes affecting the Nurse Practice Act may serve to address some of these issues.

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[13] Dial, T., *et al, Clinical Staffing In Staff- and Group-Model HMOs,* 14 HEALTH AFFAIRS (1995).
[14] Personal communication with Neil Rolde, Commissioner and Trustee of York Hospital.
[15] MAHONEY, E., ET. AL., POLICY OPTIONS FOR EXPANDING PRIMARY CARE ACCESS IN MAINE: THE ROLE AND CONTRIBUTION OF MID-LEVEL PRACTITIONERS (1995).
[16] *Id.*

In addition to nurses, physicians' assistants are an important element of the primary care system in Maine. Maine has the second highest ratio of physicians' assistants per 100,000 population in the country. As is the case with nurses, however, there are problems affecting the ability of rural sites to recruit and retain these practitioners. Professional isolation, salary levels and so on, all serve to diminish the attractiveness of rural locales for these individuals.

Maine does have a smaller number of dentists than do many other states. A 1994 survey conducted by the Maine Department of Human Services counted 573 active dentists in the State, 75 percent of whom were engaged in general practice.[17] The ratio of general practice dentists to population that year was 1:3,200; the comparable national statistic was 1:2,100. While the ratio of dentists to total population has improved over the past ten years, it is still significantly less than the national rate.[18] Moreover, the distribution of dentists varies from county to county. In Cumberland County, for example, there was one dentist for every 1,358 people in 1994. In Washington County, the ratio was 1:3,989.[19] Maine does not currently have a degree program in dental medicine, but does have a small number of programs for dental assistants and dental hygienists.

Approximately 8 percent of all jobs in Maine are in the health care sector. While not all those employed in this sector are involved in the provision of direct patient care, many are. Chiropractors, psychologists, pharmacists, massage therapists, personal care assistants, homeopathic physicians, acupuncturists, nutritionists, nurses' aides, radiology technicians and naturopaths are some of the many other types of providers who play important roles in the provision of services to Maine residents. In most instances, consideration of the numbers of providers needed in a community or region has focused on specific provider groups in isolation. The need for physicians is evaluated without considering that a number of other health professionals in that community provide similar or overlapping care. Estimates of workforce requirements that are conducted in this manner will be badly flawed.

For example, consideration of the need for primary care providers in a community predicated solely on the availability of physicians will be accurate only if there are no other available providers such as nurse practitioners, physicians' assistants, nurse specialists, etc. The Commission believes that analyses of workforce requirements should be conducted in an integrated manner.

Recruitment and Retention of Health Professionals

Maine -- particularly the rural areas of the State -- experiences a variety of challenges in recruiting and retaining health professionals. While the supply of specialists in urban centers does not seem to be a problem at present, there are some areas of the State where specialty care

[17] OFFICE OF DATA, RESEARCH, AND VITAL STATISTICS, MAINE DEPARTMENT OF HUMAN SERVICES, FACT SHEET -- DENTISTS, Series 3, No. 9.

[18] OFFICE OF DATA, RESEARCH, AND VITAL STATISTICS, MAINE DEPARTMENT OF HUMAN SERVICES, FACT SHEET - DENTISTS, Series 3, No. 8.

[19] *Id.*

may be limited. Also, it is often difficult for communities to attract and retain primary care practitioners.

Rural locales tend to be less affluent than other parts of the State, with proportionately denser Medicaid and Medicare populations. It is more difficult for providers in these communities to generate adequate practice incomes. This issue points up one role the State may play in supporting access to care in all areas of Maine. The State, through the Medicaid program's reimbursement policy, may influence provider interest in primary care and practice in rural areas by structuring fee schedules to incent such practice.[20] In the early 1990s, the Department of Human Services implemented a Resource Based Relative Value Scale as part of its physician fee schedule, weighting reimbursement away from specialty care and toward primary and obstetrical care. The effectiveness of this measure was undercut when reimbursement levels were cut shortly thereafter. However, the reallocation of dollars accomplished through the RBRVS adjustment assured that primary care services were favored.

The State has also played a role in improving the practice environment by providing a subsidy for malpractice premiums of providers practicing in rural areas, serving significant numbers of Medicaid patients. This plan has served to effectively increase the reimbursement rate for obstetrical care provided to Medicaid recipients for many providers, an initiative that will, hopefully, result in maintaining access to these services for our poorest residents.

The State also operates the Office of Rural Health and the Office of Primary Health Care, which administers many of the programs targeting the recruitment of providers to underserved areas of the State. The Office of Primary Care works in conjunction with the Maine Ambulatory Care Coalition to place physicians in underserved communities. It also coordinates the federal and state loan repayment programs and the National Health Service Corps scholarship program for the State.

The State could assume other active roles in promoting access to care, if it chose to do so. As the licenser and regulator of health professionals, the State could set the parameters for who can practice, what that practice may include and, potentially, where that practice may be located.[21] As the regulator of private health insurance carriers and as the Medicaid administrator, the State can incent and disincent health professionals to choose to practice certain specialties and locations by requiring reimbursement of particular classes of providers, setting reimbursement levels or by the rules, if any, it establishes for managed care contracting.

The State could provide financial support to primary care systems -- such as the community health center network -- in rural areas. It can also offer targeted funding, technical assistance and regulatory relief to providers willing to serve in rural, underserved sites. For several years, a program called the Health Occupations Training Program was sponsored by the

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[20] This discussion is focused on reimbursement levels for individual practitioners as opposed to rural health centers which are paid on a cost-reimbursement basis.

[21] WEISSERT, C., ET AL, HEALTH PROFESSIONS EDUCATION REFORM: UNDERSTANDING AND EXPLAINING STATES' POLICY OPTIONS (April, 1993).

Department of Human Services and the Department of Labor. The program provided reimbursement for loan repayment for nursing education for hospital-based nurses and certain allied health professionals. The program was initiated at the time Maine hospitals were experiencing difficulties in recruiting and retraining qualified nurses and was intended to make hospital practice more attractive to the nursing workforce. The nursing program was discontinued after several years as the nursing shortage eased. A more limited program still exists for allied professionals (Occupational Therapy Assistants and Physical Therapy Assistants).[22]

Finally, the State could take an active role in promoting the use of tele-medicine. Many of the technologies required for the implementation of tele-medical services are currently available. There are, however, some barriers which must be overcome. The equipment is expensive and, by its nature may be infrequently used, making the cost per event of use expensive. Questions have arisen about physician reimbursement, particularly when a referring and consulting physician are simultaneously involved. Liability and interstate licensing issues must also be resolved. The Maine Board of Registration in Medicine is currently reviewing licensing issues as they pertain to tele-medicine and will be making policy recommendations in the near future.

The above issues are not major barriers, and there are a number of states where successful demonstration programs are underway. This technology has the potential to bring highly sophisticated services to remote locations to patients who would normally have to travel great distances for care, perhaps at increased health risk and certainly at greater expense. An additional benefit is the educational and intellectual stimulation provided to rural practitioners who become participants in the tele-medicine consultation/treatment event as opposed to having to send their patients out of the community to be treated by other physicians.

It is important to recognize the potential impact that market forces may exercise on the health workforce. As managed care continues to grow and establish itself in the urban communities and then expand into less populated regions of the State, it is likely that there will be increased pressure on the labor market. As mentioned earlier, managed care plans typically employ low ratios of specialty physicians ratios, a feat accomplished via an emphasis on primary and preventive care. If managed care continues to expand strongly in the State, the current numbers of physicians and other providers may be in significant surplus. In the absence of planned health care reform, the "market" is undergoing rapid change. The impact of the evolving delivery system on requirements for physicians and other providers is likely to have a powerful effect on the market and opportunities for health care workers.

Maine's community health centers have been instrumental in helping to meet the health care needs of the State's rural residents. There are 27 federally funded community health centers, 3 Indian Health Service health centers, a mobile migrant health center and a health care for the homeless program at various sites around Maine. These centers receive no state funding other than Medicaid reimbursement. Most of them provide a comprehensive range of primary

[22] Personal communication, Nancy Kelleher, AHEC, September 28, 1995.

care services through the use of physicians and physician extenders, dentists, mental health professionals, technicians, and so on. They serve the public using a sliding fee schedule, affording access to low income individuals.[23] However, many of these centers experience difficulties in recruiting and retaining health professionals, and they are engaged in an on-going effort to attract new personnel to their practices.

Health Professions Education

The previous discussion centers on the current supply of health professionals. A second major area of concern is that of the future supply of health professionals. While future supply is, in one sense, contingent on the ability of communities to attract new providers and retain them, it is closely related to the educational preparation of students wishing to enter the various health professions. There have been some studies that have identified a correlation between the site of educational training for health professionals and the area in which individuals settle to practice. For instance, physicians are known to be more likely to practice near the site of their residency training. Educational programs and clinical training sites based in Maine may therefore be important in assuring a supply of practitioners who will engage in careers in the State.

There are a variety of educational programs across Maine that prepare students for careers in the health professions. Fourteen colleges and universities offer programs that result in either Associate Degrees, Bachelor Degrees Master Degrees, or Certificates.[24] The University of New England, a private school located in Biddeford, is home of the only medical school in the State. There has been discussion of a second medical school in Bangor.[25] Four medical centers offer hospital-based educational programs, awarding Associate degrees, certificates and diplomas in various areas. The six schools comprising the Maine Technical College System also offer a range of health professions educational programs, preparing students for careers in various medical technologies, therapies, and nursing.

There are nursing programs at fifteen sites around the State. Eight of these sites offer bachelor degrees in nursing, three have graduate-level programs (including programs for nurse practitioners and nurse anesthetists), seven offer associate degrees in nursing, four offer LPN programs, and a number offer programs designed to allow RNs to receive their BSNs or LPNs to upgrade their training to ADN level. Until recently, the State had little capacity to prepare mid-level providers for practice. Now, in addition to the University of Maine (Orono) program for rural family nurse practitioners (which has very small classes) there are new adult nurse practitioner and family/community nurse practitioner programs at the University of Southern Maine (with approximately 30 students) as well as at Westbrook and Husson Colleges. The

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[23] In contrast to federally funded health centers, certified rural health clinics do not necessarily provide services on a sliding fee scale basis.

[24] ACADIA HEALTH EDUCATION COALITION, MAINE HEALTH CAREERS: A GUIDE HEALTH PROFESSIONAL EDUCATION PROGRAMS (1993).

[25] This program is being developed by Tufts Medical School and Eastern Maine Medical Center; it is based on a "medical school without walls" model.

University of New England plans to accept students into a new PA program in the summer of 1996.

Another aspect of educational training for health professionals are the hospital-based programs for medical student clinical rotations and post-graduate residency programs. There are several family practice residency programs located in the State, and a number of specialty residencies are offered at the Maine Medical Center in Portland. The University of New England includes clinical rotations at rural sites (hospitals and ambulatory practices) in its undergraduate curriculum. The Internal Medicine residency program at The Maine Medical Center also offers a rural clinical preceptorship program at several practice sites in the State.

Discussions with representatives of several of the educational and post-graduate programs and with representatives of Maine's AHEC have led the Commission to conclude that, like the health workforce generally, there is a lack of information upon which educational institutions can base their decisions regarding which programs to develop, expand or downsize. In some instances, educational programs are being developed that other programs are not even aware of. This lack of information and communication leads to a situation in which program development is driven primarily by institutional needs, without regard for the impact that the production of professionals with will have on the health care of the population. Nor is the state of the health care market, *vis á vis* the relative numbers and need for certain types of personnel, given consideration. Students may graduate from programs and have difficulty finding jobs. Some may have difficulty finding post-graduate training sites or appropriate residency positions.

An additional issue relates to the fact that the current health care delivery system -- most of which is based in fee-for-service payment mechanisms -- provides an opportunity for providers to influence the volume and intensity of the services they provide to patients. An oversupply of providers in a community can result in increased utilization of services that may be inappropriate and significantly increase the cost of care.

The Need for Health Professions Workforce and Education Planning

The Commission held several sessions focusing on the issue of health professions workforce issues. It became very clear from these discussions that there is presently no coordinated, concerted effort to examine workforce needs on a population-specific basis. While there are efforts underway to form networks of providers in various areas, these efforts tend to be based on programmatic and institutional needs, rather than on the broader needs of the population and communities.

A contributing factor to this lack of communication and coordination that must be recognized is the potential violation of anti-trust regulations. Coordinated action to structure the workforce would run the risk of violating the anti-trust provisions of state and federal law. The Maine Office of the Attorney General is responsible for enforcing anti-trust regulations. The Deputy Attorney General overseeing the anti-trust division has indicated to the Commission that

coordinated attempts by professional associations or groups of professionals could result in anti-competitive markets, acting against consumer interests.[26]

The Attorney General's office has indicated that a public process by which workforce data would be gathered, analyzed, discussed and disseminated would not violate anti-trust regulations. At the present time, there exists no forum in the public or private sector that has a mandate to undertake this kind of process. As a result, decisions about workforce planning are made without adequate information and with no ability to understand the current workforce situation, much less attempt to plan for future needs.

The Commission suggests that the convening of a forum of all interested parties would be helpful in stimulating an exchange of information and ideas regarding Maine's health workforce. Representatives of health professions education programs and professional associations expressed unanimous interest in participating in this type of activity.

The Commission recommends that the Commissioner of the Department of Human Services convene a forum to generate discussions around issues pertaining to the health professions workforce. The Department is responsible for health planning in Maine and houses policy experts who can provide support for this process. The Department could also serve as a public clearinghouse of information gathered through this process, creating a single access point to information for anyone interested in workforce issues.

Participants in this process should include individuals from a broad range of health professions and educational programs. In addition, health planners, representatives of the State's AHEC program, payers and consumers should be included in these discussions. Participants should be named by the Commissioner from a panel of nominations offered by the participating organizations.[27] We recommend that the members of the "Healthcare Workforce Forum" be appointed for up to two three year terms. The specific process and functions of the Forum should be established by rulemaking with input from the Attorney General's office.

We further suggest that early efforts of the Forum should focus on creating an "inventory" of the present health workforce and educational programs in the State. Methods should also be developed to regularly update the inventory. Further, research and analytic methods should be developed and implemented in order that the Forum and interested parties can develop methods to understand population-based workforce needs on an ongoing basis.

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[26] Personal communication, Deputy Attorney General Stephen Wessler, August 21, 1995.

[27] Again, the use of the State as a convener does not negate anti-trust problems. If *individuals* choose independently to act in certain ways based on the information provided through the forum, no anti-trust problems should be presented. If, on the other hand, an entire *group or association* of professionals or a *group* of educational programs jointly agree to engage in a particular action based on the forum discussions, anti-trust violations will very likely become a problem.

The Commission's recommendation for a statewide health information system[28] is an essential prerequisite for development of the data that would be required to assist Forum participants in their tasks.

It is the Commission's expectation that the efforts of the Forum will provide the foundation for thoughtful decisions by those responsible for health planning, and by those making decisions regarding the best use of personnel in our health care system. With a broader view of the needs of Maine's population and all of the resources available to address those needs, workforce planning decisionmaking by the various constituencies should be facilitated and result in more rational planning. At the same time, the process would remain voluntary and non-regulatory.

Similarly, good information and communication will provide the opportunity to inject some rationality into the health professions educational system. The forum recommended above could serve not only to stimulate analysis and careful thought about the current workforce, but could also assist educators in assessing the needs of the health system and the needs of students. Good data and information regarding the projected system requirements will facilitate planning on the part of educators. The activities of the Forum would provide individual programs with information to make sound planning decisions.

Finally, we concur with the findings of the Maine Health Professions Regulation Project pertaining to the need for improved communications between the health professionals licensing boards in Maine.[29] That task force recommended the formation of a "federation" of licensing boards intended to facilitate communication, exchange of information and an understanding amongst the various boards. As part of its agenda, the Forum to be convened by the Commissioner of the Department of Human Services should consider this recommendation of the Maine Health Professions Regulation Project, as well as the other recommendations generated by that task force.

Further Recommendations

There are other strategies that the State could pursue to influence educational programs. Many of the programs mentioned above are based in public institutions. Obviously, through the funding of the University system and the Technical Colleges, the Legislature could exercise considerable influence over what programs are offered and how large those programs are to be. The State also maintains agreements with a number of medical schools across the northeast to provide preferred access to Maine residents to those medical education programs. The size of this program and the conditions placed on participants in the program might have greater influence on the number of Maine students pursue careers in medicine and on how many might

[28] MAINE HEALTH CARE REFORM COMMISSION, DRAFT RECOMMENDATIONS FOR HEALTH SYSTEM REFORM (June, 1995) [hereinafter DRAFT RECOMMENDATIONS].

[29] ME HLTH PROFESSIONS REG. PROJ., TOWARD A MORE RATIONAL STATE LICENSURE SYSTEM FOR MAINE'S HEALTH PROFESSIONALS (June, 1995).

return to practice in underserved areas of the State.[30] The State also maintains student loan programs that might be structured to help shape the future health professions workforce. Finally, through Medicaid payments, the State has the potential ability to support or discourage hospital-based educational programs.

It would be difficult for state government to exercise influence over the educational programs at private schools and colleges. This situation might result in a heightening of competition between public and private programs that, in turn, could generate problems for students in accessing affordable, quality educational programs. For these reasons, the Commission recommends that the initial strategy of convening an on-going forum, as described above, be tested before giving serious consideration to any more direct methods of intervention.

In July, 1995, this Commission released its draft recommendations for health system reform. Although the issue of health profession education and workforce planning was not explicitly addressed, many of the recommendations included in the Draft Report related to these areas. The recommendations presented in Chapter Seven, *A Health Information System for Maine,* address the great need for accurate and comprehensive data to support meaningful reform of the health care system. A subset of that data is comprised of resource inventories that will provide information about service availability across Maine, including workforce composition, practice location, occupational settings, and the interrelationships between providers, organizations and facilities.[31] This type of data and information will serve as the foundation for discussion amongst Forum participants and all those engaged in workforce planning activities.

Elsewhere in the draft recommendations, the Commission advocates for a proactive, data driven, population-based approach to health planning. The data described above in conjunction with data on health status, outcomes, quality and cost will fuel this planning process. While the planning process has not historically focused on workforce planning, there does not appear to be any reason why it would could not do so in the future. The health planning function contemplated in our earlier report would be carried out by the Department of Human Services with input from a variety of parties.

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[30] For example, there currently is a forgiveness under this program for specialists serving in Maine and primary care physicians who are not practicing in underserved areas. If this policy was "amended" to provide preferential treatment to rural practitioners it might be more effective in encouraging a more adequate workforce in less well-served areas of the State.

[31] *See* the Commission's DRAFT RECOMMENDATIONS *supra* at note 28, at 71 (June, 1995).

CHAPTER TWELVE

Representative Comments and Responses

Introduction

After releasing its draft recommendations early in July, 1995, the Commission held a period of public comment, allowing interested persons the opportunity to offer input regarding the findings of the Draft Report. The comment period began in early July and ended in mid-September.[1] During this time the Commission held a series of public hearings at various sites around the State, including Augusta, Lewiston, Presque Isle, Machias and Portland. The submission of written comments was encouraged as well.

The Commission received many comments on the draft recommendations for health systems reform.[2] Some were offered by representatives of health care providers, others by the insurance industry. The administration provided input as did the state employee union. The business community and private individuals participated as well. These commenters represent a broad cross-section of interests, expertise and concerns, providing the Commission with an assessment of the proposals from wide ranging points of view. These comments were instrumental in the effort to develop the final, refined recommendations which appear in the earlier chapters of this report.

Presented below are summaries of representative comments and the Commission's responses to those comments. Not all of the comments are specifically or individually addressed. Many of the comments could be categorized around several issue areas; those comments are addressed generally. Many other comments were very general in nature, commending the work of the Commission; those comments are not presented here. Despite specific attention in this chapter to some of the comments received, the Commission carefully reviewed and considered the criticisms and suggestions presented in each.

Universal Coverage

The Maine Health Care Reform Commission believes that all citizens of Maine should be guaranteed access to affordable and appropriate health care coverage. Until we achieve universal coverage, we will not be able to achieve control over the cost of our health care system. This principle helped guide the Commission through the process of developing alternative approaches to health system reform.

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[1] While this period of time was specifically designated as a public comment period, all of the Commission's work was conducted publically and in an open and participatory manner. Interested persons had extensive opportunity to provide input and comment throughout the development of the draft recommendations as well as during the Commission's consideration of the suggestions received during the public comment period.

[2] Copies of the written comments received as well as minutes from the hearings held during the public comment period are available for review, upon request, at the Commission's offices.

Two of the models for reform developed by the Commission incorporated mechanisms for guaranteeing universal access to coverage. Both the single-payer model and the multiple-payer model call for universal access to a standard benefit package. Both of these systems would rely on a financing package comprising a variety of personal and business taxes, and would provide subsidies to assist low income individuals and low-wage businesses in participating in the plan. Both of these models further assume that certain federal restrictions limiting a state's ability to regulate the activities of self-insured businesses would be lifted.

To our disappointment, our financial projections and economic impact forecasts indicate that either of these two models would likely have a negative impact on Maine's economy at the present time. This conclusion arises primarily from the fact that Maine, if it were to implement either of these two models, would be attempting to achieve very comprehensive health system reforms in the absence of similar activity in other states with which it competes. This imbalance translates into reductions in Maine's domestic product, in employment and in the personal income of Maine's residents. In light of these findings, comprehensive health system reform guaranteeing universal access to coverage seems unlikely at the present time.

Between July and mid-September, 1995 the Commission accepted public comment on its draft recommendations for reform. A series of public hearings was held at various sites around the State to solicit input; written comments were accepted as well. Many of the commenters expressed profound disappointment with our findings regarding the feasibility of Maine successfully implementing universal coverage in the near term. We heard many compelling accounts about the difficulties people encountered in paying for health care, despite their great need for services. Elderly Maine citizens have an especially hard time affording prescription drugs, which are not covered by Medicare. In some instances, monthly drug costs are almost equivalent to an elderly person's monthly income. They are left facing the choice between purchasing their needed medications, and paying the rent or utilities bill or buying groceries. We heard on a number of occasions from elderly people who, in an effort to make ends meet, took it upon themselves to cut back on their medication dosages. This situation can have tragic -- and costly -- results. Many of these people are not eligible for Medicaid benefits nor does the Drugs for the Elderly Program provide them with assistance.

Many other commenters echoed the Commission's own observation: Maine will not be able to gain substantial control over the cost of health care until all of our citizens are covered. We are in full agreement with this position. In our view, however, the nation's failure to enact meaningful reform on a federal level precludes our State -- and any other, for that matter -- from achieving universal coverage without either compromising the competitive position of the State and, hence, its economy, or by seriously compromising the many other extremely important activities that states underwrite, such as education and infrastructure.

We believe that tax increases would be necessary to raise the revenue required to extend a basic, standardized level of coverage to all citizens. Although we did have commenters tell us that they would be willing to pay higher taxes in order that Maine might have a program of universal coverage, it does not appear that the same willingness exists at the legislative or

administrative level. We find ourselves operating in a context where need is growing, resources to meet those needs are shrinking, and where there is a pervasive political aversion to increasing taxes as a means of generating new revenue.

Consumer advocates were critical of many of the operating assumptions used by the Commission in formulating baseline estimates and cost projections. They argue that the assumptions used by the Commission lead to an overestimate in the projected costs of the universal coverage programs and, hence, an overestimate of the magnitude of the tax increases required to fund such a program. Implicit in their criticism is the assumption that if the required revenue level was lower, there would be a greater likelihood that the legislative package (including required tax increases) would be passed by the Legislature and allowed by the Governor.

These commenters specifically directed their criticism at, first, our assumptions regarding savings in administrative costs that might be realized under a single-payer system. They believe that the experience of Medicare in this country, and the Canadian universal health plan indicates a much higher level of potential savings than we projected. We would note that we have had fairly extensive discussions with representatives of the Canadian federal government regarding the administrative costs of Canadian Medicare. The Canadian government is simply unable to quantify with any specificity what their costs are. This problem stems from a basic lack of agreement about the definition of administrative costs, but more fundamentally, from the fact that programmatic cost data is aggregated, and not broken down into components. That government is currently engaged in an effort to identify administrative costs, but cannot do so at the present time.

Canadian officials did acknowledge the work of Drs. Woolhandler and Himmelstein regarding quantification of administrative costs, noting that the definition of administrative costs used in the earlier studies conducted by those researchers was, in their view, fairly narrow. Canadian officials attempting to replicate Woolhandler and Himmelstein's most recent estimates of provider administrative costs in Canada and the U.S. using more the newest data available, found markedly different results. These studies found only a 10 percent difference in hospital administrative costs between Canadian and U.S. hospitals where Woolhandler and Himmelstein found almost a 25 percent difference.

Our cost projections include an assumption of administrative costs at the level of 11 percent under a multiple-payer universal health system model. Under a single-payer system with cost sharing requirements administrative costs were assumed to approximate 7 percent; without cost sharing requirements those costs were assumed to be 4 percent. It is important to remember that the single-payer model that we have proposed differs from the Canadian model in at least one important respect: under our single-payer model there would be an allowance for participation by multiple carriers while all health system-related revenues would flow through a single point. In addition, our model contemplates that the single-payer would not necessarily be the state government, rather a private concern could carry out this function. While we believe that these characteristics add to the political feasibility of a single-payer plan, we recognize that they do prevent maximization of administrative cost savings. We continue to endorse our

original conception of the design of these systems and believe that our cost assumptions regarding administration are appropriate and reasonable. Importantly, we recognize in our report that it is critical that those reviewing the models consider the range of projection results developed by our actuarial consultants. It is difficult to predict with precision what future costs might look like under a radically different health care delivery and financing system. In fact, the projections that we have made may be unduly optimistic in terms of cost savings. We attempted to make the most reasonable assumptions that we could and, using the best data available to us, develop cost estimates in which we could place reasonable reliance.

The commenters also note that our assumptions do not account for any savings by nursing homes with regard to administrative costs under a universal system of coverage. This observation is correct. Our plans specifically exclude long-term care services. We stated early in the process of developing these proposals that we could not address the very significant challenge of reform in the area of sub-acute care with the time and resources available to us. While the standard benefit package that we designed would include some limited coverage of nursing home services (short stays for recovery periods), it does not provide a "significant" long-term care benefit. Therefore, the opportunity for savings under our universal coverage proposals for these facilities is negligible.

We recognize that there will always be some level of disagreement regarding baseline assumptions; certain data may be used to support the assumptions that we rely on while others may be used to advance the position of those wishing to refute our findings.

The commenters also took exception to our estimates of projected rates of utilization under a universal system, stating that the present system simply lacks the capacity to accommodate the level of utilization that we predict. They contest our assumption that the overall costs of health care in Maine would increase significantly under either a single or multiple-payer universal coverage system. Our estimates project an increase of anywhere between 24.5 percent and 36.2 percent over projected baseline costs in the first implementation year of universal coverage. The commenters argued that our projections estimated increases in excess of 60 percent in the first year. We are unable to replicate their findings; however, the argument about the capacity of the system to accommodate such increases still demands a response.

Those reviewing our projections should note that the assumptions are multi-dimensional and interactive, combining to generate cost estimates that may be greater or less than the sum of the individual parts. In that regard, it is difficult for the casual observer to critique the cost estimates on their face, without intimate familiarity with the dynamics of the projection model. However, there are some points which these reviewers might have overlooked in their analysis of our estimates. Importantly, we assume that under either the single-payer system or the multiple-payer system, reimbursement to providers would be made at a constant rate across the entire population. Currently, Medicaid payments to providers approximate 30 cents on the dollar for non-hospital providers; without disproportionate share payments (which are facing cutbacks), hospital reimbursement by the State is below "cost." Aside from assuming any increase in utilization on the part of Medicaid recipients, there would be a substantial increase in costs from

the realignment of the reimbursement schedule. We further assume that Medicare reimbursement would remain at current levels (we did not contemplate the integration of Medicare into the newly modeled systems for reasons discussed elsewhere in this report).

The commenters also state that we did not account for the fact that the uninsured currently do contribute to the cost of their care. This statement is incorrect. Our assumptions explicitly adjust for the level of uncompensated care provided at hospitals currently and estimates the effect of the cost shift to those patients and payers who do pay for care. The model implicitly assumes that the payments made into the system by self-insured payers will remain in the system.

Because providers would receive reimbursement for essentially all individuals treated, the model used to estimate costs was designed to incorporate expected changes in contracting rates that would occur. Under the "best estimate" scenario, we assumed that 50 percent of the "new" funds would be offset through contracting at lower rates than currently used in commercial contracting. This assumption was designed with a recognition of both market constraints and practical limitations inherent in achieving revised provider contracts within a short time frame.

The single-payer model employed by the Commission also assumes a uniform benefit configuration to be determined at the state level. Provider reimbursement mechanisms would be expected to range from fee-for-service to full capitation through delivery systems of various levels of integration. Again, this design characteristic was chosen to introduce a greater degree of political feasibility to the model. Under our best estimate, we assume that the cost of utilization increases will be offset, in part, by administrative cost savings and by holding growth rates below baseline trend projections. We further assume that fee-for-service will continue to dominate the Maine market, with limited use of capitated reimbursement mechanisms.

Under all scenarios, we estimated that the previously uninsured will increase their use of care by 30 percent under universal coverage, to a level approximating 95 percent of average commercial utilization. We also assume that utilization will increase for populations eligible for more comprehensive benefits coverage under the reformed system. These utilization increases would be moderated by delivery system mechanisms, but would still be significant. Finally, we also assumed that there would be a 20 percent increase in utilization for populations that would receive more comprehensive benefits under the proposed standard benefit package within the context of a fee-for-service system.

Finally, the economic models incorporated a cap on cost increases, set at the Gross Domestic Product plus 2 percent. This cap is imposed by the global budget contemplated in the single- and multiple-payer models, and limits annual growth to approximately 7.7 percent.

Even if our cost estimates are off by a significant margin, implementation and maintenance of universal coverage will require significant revenues. Those revenues have to come from somewhere, most likely from new taxes. It seems highly unlikely that such monies could be diverted through the achievement of savings in other parts of the system.

These arguments aside, it seems altogether reasonable to assume that if the reimbursement stream is guaranteed that capacity will develop at some point in time—most likely sooner than later—to meet demand. At that time we would certainly experience a level of costs approximating those which we have forecasted, and the revenue to support that level of activity would have to be generated. If correct, the commenters' argument only pushes out the time line for having to raise the higher revenue levels. Perhaps a lower front end estimate would make passage of a program more likely; once the program is in place, some might argue that it would be very difficult to repeal or pull back on the promise of universal coverage. In our view, however, it is preferable to have a full and open discussion about the costs and benefits of such an initiative.

We would also point out that in addition to the political and economic problems inherent in enacting and implementing a significant new tax package, there are other barriers outside of the State's control that impinge on our ability to enact a comprehensive system of coverage. Despite a recent Supreme Court ruling that clarified ERISA somewhat, there remain numerous barriers to state activities that would facilitate the implementation of a universal coverage plan. We are aware that certain commenters disagree with our assessment of this situation, however we are basing that assessment on advice and information given to us by the leading national experts in this area. It does not seem to us to be prudent to build a program on a premise that can be brought to a halt by a single lawsuit. While the recent Supreme Court decision does provide a greater comfort level and flexibility to states, it does not eliminate the very significant problems presented by this statute. The Congress must act to amend ERISA to provide states with the latitude they need to implement universal coverage.

Reasonable people can disagree about assumptions and the complex details of any projection model. We carried out the task assigned to us absence of any intent to generate findings that would prejudice any one of the reform approaches. As we have mentioned on many occasions, we would have preferred to recommend comprehensive system reform, but we do not believe that it is feasible at present.

The Standard Benefit Package

The Commission received a substantial number of comments, both written and oral, relating to the standard benefit package described in the Draft Report. Some of the commenters were supportive of the benefit package, others were critical of it. Some argued that the package should be more comprehensive and should include expanded coverage for certain classes of patients, certain types of medical conditions or diseases, or certain classes of providers. Others argued that the breadth of the proposed package was inflationary, that it would provide coverage of services not deemed to be medically efficacious, and that it represented state government's reluctance to seriously address the issue of cost containment in health care.

While we respond to a subset of these comments (*see* below), we note that we find the level of attention focused on the benefit package to be somewhat misplaced. In understanding this position, it is helpful to review the purpose which the standard package was intended to

serve. The enabling legislation that established the Commission[3] directed us to design all alternative models of health system reform "on the same basis." The statute elaborates on this directive by continuing on to state that all models must incorporate similar benefits, "based upon a benefit package that the commission determines to be adequate to ensure necessary health services for the citizens of the State. *The benefit package serves the purposes of pricing and comparison only*" (emphasis added). In our view, the Legislature clearly contemplated a limited purpose for the Commission package, and that purpose did not include serving as a proposal for a state-mandated benefit design. The purpose of the package is, instead, to allow for a comparison of the relative differences in costs under each proposed approach to reforming the health care system.

While we approached the task of developing a standard benefit design from this rather narrow perspective, we recognized that the benefit package would, despite the legislative charge, be the focus of intense interest for many people. In an effort to assure that those interested in the issue had the opportunity to provide input into the development of the package, an advisory committee was formed to design proposed benefit designs for our review. That committee, comprising a diverse group of providers, consumers, business and payers, provided the Commission with two alternative proposals. From their proposals, we formulated the benefit package described in the draft recommendations issued in July.

We were limited in the number of benefit configurations that we could "cost out" due to the relatively small budget available to us. Actuarial services are expensive as is the process of projecting the economic impact of each reform approach. The use of two alternative benefit packages (for example, one comprehensive package and one "bare bones" package) would have doubled the number of scenarios that would have to be costed out. This simply was not an option for us.

Moreover, we would like to clearly state that we believe that the package we developed and used as the foundation for pricing comparisons is a good one. It is representative of the type of benefit made available by many of the larger businesses in the State and is very similar to the benefit offered to state employees, members of the Administration and Legislators. Further, it incorporates benefits that we view as important to the health of Maine's people in both the short and long term. The package emphasizes preventive and primary care, which we see as essential elements in the challenge to improve health status and in constraining the growth in future health care costs.

Below, we have summarized and responded to selected comments regarding the standard benefit package. Although we will not be altering the design of the standard benefit package, some of the comments raise issues that we believe will add to the debate and consideration of health reform proposals, generally.

COMMENT: A number of commenters, most notably the Maine Merchant's Association and the National Federation of Independent Businesses, raised the issue of mandated benefits in

[3] 1994 ME. LAWS 707, §AA-6

conjunction with the standard benefit package. The Merchant's Association alluded to the package as being a demonstration of the government's repeated failure to seriously address the challenge of health care cost containment. Similarly, the Maine Chapter of the NFIB stressed that any standard benefit package must be affordable to both employers and employees and argued that state mandated benefits are pushing premium prices to prohibitive levels.

These commenters take exception to state mandated benefits, viewing them as the product of lobbying by interest groups rather than being consumer driven. They are seen as being the outcome of political pressure and as limiting individuals and groups in their flexibility to design basic, more affordable health plans. The Merchant's Association also stated that mandates discriminate against smaller, less affluent businesses and individuals who cannot afford the luxury of self-insuring to avoid these state regulations. This results in higher prices facing the businesses least able to afford them, but who want to provide benefits programs for employees. The solution sought by these commenters would appear to be the repeal of mandated benefits.

RESPONSE: We agree with the commenters that mandates are sometimes enacted under stressful and politicized conditions. They are often intended to mend a narrow problem and act as a "Band-Aid" for a larger problem. This approach to designing coverage may not always result in health policy that is consistent or that works in conjunction with a larger goal, such as that of cost containment. The Maine statutes do require any legislative proposal that would institute a mandated benefit to undergo a review by the Bureau of Insurance. That review, which the Bureau has assured us is carried out, must examine the potential social impact of the proposed mandate, the estimated financial impact of the mandate, and the medical efficacy of the proposal, as well as an estimate of the effect of balancing these three considerations. There is no requirement that the legislative committee of jurisdiction must factor this review into its deliberations, however, only that the review must be completed before any such proposal may be enacted.

There are several general categories of mandates. First, there are mandates that require equal treatment for certain classes of insured individuals relative to others. For example, the law requires insurance policies covering maternity care to provide the same maternity benefits to unmarried women covered under the plan as it does for married women insured by the plan. There are mandates that establish equal treatment for certain classes of providers relative to others. For example, there are statutory provisions that require insurers to reimburse dentists for services they provide that the insurance plan covers when provided by a physician. There are mandates that require that certain services be covered by all insurance policies (e.g. screening mammograms) and others that require the coverage for certain services be offered (e.g. optometric services)[4]. There are also mandates that direct insurers to provide coverage for certain types of diseases or conditions at the same level as it provides coverage for other medical conditions. For example, insurers must provide the same level of coverage for sickness or disability related to AIDS, ARC or HIV as it does for other medical conditions. Similarly, a new

[4] These mandated offerings, seven of which are in current law, are not at issue here as the commenters expressed their support for mandated offerings.

mandate requires the coverage of mental health services to be at parity with coverage for other medical conditions.

While we would tend to believe that the public has a certain fundamental interest in certain of these mandates, especially those which establish equity for certain classes of purchasers, we think that a review of these mandates would be a worthwhile exercise. Therefore, we will recommend in our Final Report, that a special commission be established by the Legislature to review each of the current mandated coverage requirements. This task force, with staff assistance provided by the Bureau of Insurance, will make recommendations to the Governor and the Legislature regarding the maintenance or repeal of each of the individual mandates. The starting point for these reviews will be the evaluation completed by the Bureau of Insurance for the Legislature -- or its predecessor in this activity, the Mandated Benefits Review Committee -- prior to the proposals enactment. The special commission will be charged with re-evaluating the efficacy and effectiveness of each of the mandates in light of the most current information available. This will allow a careful consideration of the mandates in a less time-constrained manner than is allowed the Legislature.[5]

COMMENT: The Commission received several comments from parties representing various special interest groups. These commenters suggested that the services either provided or required by the groups they represented should be included in a standard benefit package either because of the quality and value of the service provided or because of the special needs of a particular patient population. For instance, an endocrinologist provided comments regarding the importance of coverage of diabetes education for diabetics as part of a benefit package. Similarly, a representative of physical therapists commented that the services of physical therapy assistants should be included in any standard benefit package because they provide quality services while allowing an extension of a necessary faction of the workforce to underserved areas.

RESPONSE: We appreciate the concerns and suggestions raised by these commenters. Each firmly believes in the appropriateness of including the services they argue for as part of a standard benefit package. In fact, some of the services suggested (such as the education for diabetic patients) would be covered under the benefit package we use for estimating the cost impact of our reform proposals. Many other services may not be included in the package, but may represent appropriate services. Again, we must emphasize that the standard benefit package designed as part of this planning process serves a very limited purpose: it represents a common foundation for cost estimation. Should one of the reform options that specifically incorporate this package (the single-payer or multiple-payer options) be adopted, we would anticipate that the content of the package would become the subject of intense legislative scrutiny. Those representing various patient and provider groups will, again, present their arguments for inclusion of their service(s) of interest. In the end, the Legislature, through the political process will decide the content of any standardized package of benefits.

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[5] Please see the section in this chapter on comments received regarding our recommendations for incremental health systems reform. A similar discussion regarding mandated benefits appears in that section.

COMMENT: Many people commented on the inclusion of preventive and primary care services in the standard benefit package, expressing their support for this type of coverage.

RESPONSE: The emphasis on primary and preventive care reflected in the standard benefit design is indicative of our recognition of the important role such care plays in improving health status and, in the longer term, in holding down increases in health care costs. The principles which guided us through this development process included the following: *all benefit packages should, at a minimum, include coverage of essential health services and should emphasize prevention and wellness.* This principle reflects not only our own personal views, but those of our advisory committee members who, almost unanimously, urged us to adopt this policy stance.

COMMENT: Both the Osteopathic Medical Association and Maine Medical Association commented on the content of the standard benefit package. The Maine Medical Association noted that the package resembled a proposal they had developed for a standard package some time ago. Both commenters noted that the package was comprehensive and therefore costly. Recognizing the challenges posed by a scarcity of resources, both suggested that limits on resources can be accounted for by prioritizing those services which may be affordably included in a benefit package. They specifically envision a prioritization of services based on medical necessity, rather than cost. The Maine Medical Association specifically alluded to the Oregon model of priority setting for its Medicaid program as one approach to consider.

RESPONSE: These commenters raise an important consideration -- the designing of an equitable approach to "rationing" access to services. We did not attempt to explicitly prioritize services or ration access when designing our benefit package. Our universal plans were designed to provide all citizens coverage with the standard benefit package. Rationing of services would not be desirable or necessary under these designs. Rationing of the type referred to by the commenters is not feasible under the incremental option.

COMMENT: A commenter representing the Christian Science Committee on Publication for Maine stated that many commercial insurance policies currently provide coverage for Christian Science practitioners. This commenter was concerned that the nothing be proposed by this Commission to discourage that practice.

RESPONSE: The standard benefit package proposed by the Commission includes coverage of Christian Science facilities to the extent they are covered by the Medicare program. It does not contemplate coverage of services provided by Christian Science practitioners. However, nothing in any of our proposals would prohibit the marketing or sale of supplemental policies that would cover those services not included in the standard benefit plan. Moreover, the incremental plan, which appears to be the most feasible alternative for reform facing us, would not fundamentally alter the nature or composition of the insurance products on the market today. Therefore, the concerns of this commenter should be lessened.

Incremental Reform

We received a great many comments on the draft recommendations for incremental health systems reform. Representative comments, and our responses to them, are presented below and have been arranged by broad subject area.

Comments Regarding the Formation of a Purchasing Alliance

The Commission received a large number and variety of comments regarding the recommendation for the formation of a single, statewide purchasing alliance. This alliance serves as the foundation for the incremental reform approach developed by the Commission and presented in the draft recommendations released early in July.

Many of the comments received were generally supportive of the concept of a purchasing alliance. These commenters stated that they believed there were efficiencies and cost-savings to be gained through the consolidation of purchasing power within an alliance. Other commenters, however, raised a number of concerns about the proposed alliance and presented suggestions for improving the proposal. These concerns and suggestions are outlined below as are our responses to these comments. Our responses are shaped, in part, by a recent consultation with Richard Curtis of the Institute for Health Policy Solutions and a leading expert in the area of the development and implementation of health purchasing cooperatives and health policy.

COMMENT: The King Administration commented that while it supports an alliance model on a conceptual level, it believes that the model is "premature" for Maine. The comments note that managed care in Maine is still in relative infancy, although the State is currently experiencing a tremendous increase in interest in and development of managed care products. The Administration expressed concern about the ability of the proposed alliance to effectively direct the growth of managed care in Maine in such a dynamic market and that the implementation of an alliance might influence the evolution of the developing managed care market. They would prefer to allow "competition take its course" and forgo the introduction of an alliance at the present time.

RESPONSE: While we can appreciate the Administration's concern about the development of a more mature managed care market in Maine, we disagree with the premise that the introduction of an alliance will thwart that development. To the contrary, we believe that an alliance can stimulate the development of a healthy and competitive market for insurance by constructively clarifying the roles and strengths of the purchasers and users of health services and those who finance, provide and manage those services.

First, the alliance empowers individual consumers by aggregating negotiating power and by providing them with the information they need to evaluate which insurance product best meets their particular needs. Currently, individuals and smaller groups of purchasers do not have the purchasing power needed to effectively bargain with large insurers. The information available to consumers about health insurance products is often extremely difficult to decipher,

with limitations and exclusions buried in fine print, making it frustrating -- if not almost impossible -- for a consumer to evaluate one product against another. This assures that health plans have the upper hand in the market equation. The alliance can establish a negotiating framework with health plans that addresses the issues that concern consumers (such as price, quality and access) by collecting, analyzing, and disseminating data on the performance of health plans. This will assure that alliance members -- down to the individual level -- will have sufficient information and hence market power to ensure that their needs and concerns will be considered by the insurers.

The restoration of balance between purchasers and insurers will encourage cost-effectiveness and is likely to provide an impetus for the development of better integrated delivery systems. These systems are more likely to be cost-effective, better at focusing on preventive care and more attuned to the provision of quality services, making them potentially more attractive to purchasers. The enhanced competitive environment stimulated by the implementation of an alliance will favor those plans that are more attractive to consumers and more cost-effective than less well-organized or well-integrated plans. This translates into an improvement in the market environment for the development of managed care alternatives -- an objective that seems to be of interest to the Administration. It will, however, place pressure on less effective, lower quality plans currently in the marketplace to improve performance.

The likelihood of strenuous competition developing in Maine's more rural communities is low, even with the introduction of a purchasing alliance. However, a powerful alliance can use its influence as a purchaser to encourage and assist in the development of local integrated systems of care by offering a new system the opportunity for a meaningful market share.

The introduction of an alliance can, as the Administration suggests, influence the growth of managed care in Maine. Whereas the Administration views that influence as likely being negative and as likely to restrict market innovation, we believe the opposite to be true -- a belief that is shared by some of the leading national experts in this area. An alliance should prove to be a mechanism to enhance the competitiveness of the market, empower consumers and make the market work more efficiently.

Finally, we would note that the our economic analyses indicated that this incremental approach to health system reform holds the promise of stimulating an improvement -- albeit a small one -- in Maine's economy. Using the economic forecasting programs housed at the State Planning Office, we have estimated that over a ten year period, the alliance model would contribute positively to the Gross State Product, to total state employment and to *per capita* income. This benefit is in addition to an expected 8 percent decline in the rate of growth of premiums that would result from the implementation of an alliance. In this sense, the implementation of an alliance may be viewed not only as a stepping stone to further health system reform, but as an economic tool.

COMMENT: The Administration commented that the success of most voluntary purchasing alliances has relied on a large core enrollee group to provide bargaining clout to the organization. They note that this Commission's proposed alliance model may be compromised

by a reliance on the state employee group as the core enrollment group for the alliance. They stated in their comments that the State Employee Health Insurance Plan is generous and expensive. They believe, though, that it in order for the proposal to gain the support of the state employees and for businesses and individuals to find the alliance attractive, the model may have to incorporate a comprehensive benefit package. They stress that it is important to balance the benefit package design with the cost implications of a comprehensive product.

RESPONSE: The model proposed by the Commission does build on the state employee group as a foundation for a larger, more powerful purchasing bloc that is accessible to private sector businesses and individuals. The model also contemplates that private sector alliance members would have access to the same product that is available to state employees and legislators. Because we recognized that consumers value choice and vary in their level of resources and needs, the draft recommendations included provisions for alliance members to have their choice of a *range of products,* including supplemental packages, not simply a single plan. This range of choices could include not only a range of benefit configurations, but varying copayment and deductible designs as well. Any given consumer member would be free to select the alliance-offered product that best suited his or her needs and resources. We therefore believe that the concern raised by the Administration was addressed in our Draft Report and appears, again, in our Final Report.

COMMENT: We received a number of comments regarding the proposed 3 percent surcharge on alliance products to fund the administration of the alliance. Most of these comments raised concerns about the adequacy of a 3 percent add-on in light of the many responsibilities laid out for the organization. One commenter suggested that instead of increasing the surcharge, the responsibilities assigned to the alliance be scaled back, thereby reducing the necessary funding level.

RESPONSE: In crafting the proposal for the 3 percent surcharge, we looked to the experience of other similar alliances around the country. The administrative costs of most of these organizations has averaged approximately 3 percent of total premium for on-going activity. Because of the level of concern expressed about this issue during the comment period, though, we have decided to modify the proposal to establish a 3 percent surcharge as a target funding level. The level of the surcharge would ultimately be left to the discretion of the alliance board. We consider each of the responsibilities charged to the alliance to be important and have therefore declined to modify that aspect of the proposed plan.

COMMENT: A representative of the Health Insurance Association of America commented about that organization's concern regarding the potential for adverse risk selection both against an alliance and against particular products within an alliance. Under the alliance as proposed, individual enrollees -- not their employers -- would choose among the range of product options offered through the alliance. HIAA believes that the movement of the locus of choice from the employer to the individual will result in adverse selection against indemnity products offered by the alliance. This selection will occur, according the HIAA, because sicker individuals desiring the freedom to choose among a wide variety and number of participating providers will opt for an indemnity benefit rather than a managed care product. The HIAA

argues that this will lead to an upward price spiral on alliance indemnity products (resulting from poor experience), and the eventual exclusion of those products from the range of alliance offerings due to their relatively higher price.

The commenter added that although the proposed incremental reform plan contemplates the application of a risk adjuster across alliance plans within each risk pool, the state of the art of risk adjustment is relatively immature. Because of this lack of sophistication, HIAA believes that risk adjustment will be unable to correct for the severe adverse selection that will occur.

RESPONSE: Adverse selection is a concern often associated with an alliance model, and one which the Commission was acutely aware of when designing the incremental reform proposal. The draft recommendations included many features, including new market reforms, that were designed to assure that adverse selection against the alliance is minimized. We believe that those recommendations represent a fundamentally sound model for minimizing the impact of adverse selection both against the alliance, generally, and against particular plans within the alliance.

However, as we considered the proposal further, several additional strategies suggested themselves and it became apparent that certain modifications to the draft proposal would be appropriate. First, in an effort to assure that consumers have the opportunity to consider all coverage options available to them, it is necessary to implement a mandatory disclosure requirement for health insurance brokers and agents. This requirement will assure that individuals will have sufficient information to make an informed purchasing decision, and will help minimize selection into certain products as a result of incomplete knowledge.

Next, brokers' fees for the sale of alliance products will be subject to an upper limit that equals the average premium price of all alliance products. This will remove any incentive facing brokers to steer consumers toward one product or another because of the product price (and consequently the fee).

We are also incorporating a provision that will convey "most favored nation" status to the alliance. Through contractual provisions, the alliance will be assured that products that are actuarially equivalent to alliance products are not offered by participating carriers at a lower price outside of the alliance. This strategy is designed to "level the playing field" between the alliance and the outside market, and is one which has been used successfully with the California HIPC.

Finally, individuals from businesses where the employer is not providing a contribution toward the cost of coverage will be placed in the individual risk pool. This change reflects an acknowledgment of the expectation that those individuals most motivated to purchase health coverage are often likely to have the greatest need for that coverage. If the employer is not sponsoring the purchase of insurance, the decision to purchase on the part of individual employees within that business group will probably be the result of actual or perceived need for the benefit, and a higher risk of exposure to the carrier. After several years, merger of the risk pools will be considered (although not automatically implemented, as was originally proposed).

If the experience of the individual pool is not substantially different from that of groups, the pools may be merged and the differential pricing between individuals and groups removed.

These reforms and those recommended in the Draft Report are expected to go a long way toward minimizing selection against the alliance. We acknowledge, however, that some possibility for adverse selection will always exist. For that reason, we have incorporated the use of risk adjusters across carriers and across risk pools. Although concerns about the adequacy of risk adjusters have some validity, we believe that the technology is advancing rapidly and that appropriate adjusters will be available to minimize harm to any one carrier within the alliance.

COMMENT: The Health Insurance Association of America expressed its disapproval of the proposed requirement that health plans participating in the alliance offer coverage to all types of alliance purchasers, including small employer groups, individuals and Medicaid recipients. The comment stated that "health plans should be permitted to serve only the groups they choose, and which they are best equipped to serve."

The commenter also noted that alliance members' choice of carriers and benefits would be limited to only those carriers chosen by the alliance as participating plans. The fact that the alliance would be able to limit the number of plans participating even if others meet alliance participation criteria will also work to limit consumer choice of type of coverage and carriers.

RESPONSE: It is correct that the alliance will require carriers participating in the alliance to serve any alliance member interested in enrolling in that plan. This requirement is intended to prevent plans from selectively picking and choosing among alliance members, an activity that can result in adverse selection against certain products.

HIAA believes that health plans should be permitted to choose who they wish to serve. This desire to avoid risk and exposure is a natural response to the incentives posed by the market -- to respond otherwise would be unexpected and irrational. Because the health insurance market is flawed, and does not enjoy all the requisite characteristics for efficiency, some form of intervention is required to further the objective of encouraging a sharing of risk and access to health coverage for a broader segment of the population. We therefore decline to modify our draft recommendation relative to this requirement.[6]

It is important to point out that the model that we have proposed is that of a *voluntary* purchasing alliance. Those businesses and individuals choosing to purchase coverage through the alliance will do so voluntarily. Their decision to participate will be predicated, in part, on the perceived costs and benefits of alliance membership; the participating health plans will undoubtedly figure into that calculation at some level. Further, alliance members may leave the cooperative at any time; the only restriction with regard to disenrolling will be a moratorium on their re-enrollment for the period of one year.

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[6] The exception to the "rule" would apply to alliance plans that are not licensed statewide. These plans would only be required to serve those portions of the State in which they were licensed to operate. In that situation, a plan would not be required to accept enrollment of a member who resides within a region that the plan is unable to serve.

It is true that the alliance will be able to restrict the number of health plans serving its membership. The model assumes that participation will be awarded on a competitive basis, with price, quality and access criteria utilized in the bid evaluation process. The limitation of health plans is important in at least two respects. First, by limiting the number of alliance plans, participating insurers will be assured of higher enrollment volumes. This should lead to more competitive bids in terms of product price. Second, studies of the federal employee group in particular, have found that enrollees like choice, but they do not like an overwhelming number of plans to choose from. When the number of options becomes very large, enrollees seem to have more difficulty in evaluating alternatives and satisfaction with the plans fall. One of the alliance's objectives will be the assurance of a reasonable range of options to members and the provision of a manageable information base upon which decisions regarding enrollment may be based. The alliance needs to facilitate and simplify the process for members; the inclusion of too many plans and, for that matter, too many benefit configurations, will unduly complicate the process. For these reasons, we remain convinced that the capacity of the alliance to limit participation by insurers is appropriate.

COMMENT: The Health Insurance Association of America commented that the implementation of a single large purchasing alliance would create an imbalance in the market between those who purchase insurance and those who provide insurance, with an unfair advantage accruing to purchasers. The Association goes on to state that the alliance's ability to restrict plan participation will result in small health plans being put out of business due to their inability to access those purchasers. They believe that this is especially true for those plans not selected for participation in the first year of alliance operation, because they will be unable to compete, will be compromised financially, and therefore will be unable to bid for participation status in the following year. They conclude that, within a few years, there will be only a handful of competitors remaining in the market, and those plans may not be the most efficient or effective, just the best at marketing themselves.

RESPONSE: We view the Association's stated concern regarding the potential for poor quality and high costs under the proposed alliance model misplaced. As we have stated elsewhere in this report, we believe that the development and implementation of an alliance will result in a fostering of more efficient, better integrated plans offering higher quality service to enrollees. Because complete disclosure of all products will be required, marketing acumen will likely be less of a concern than it now is. Further, the alliance will disseminate performance reports for participating plans, offering members access to information regarding enrollee satisfaction, outcomes, costs, etc. for all available plans. This information will help assist consumers in making rational purchasing decisions. Finally, the alliance will have the ability to selectively contract; if a participating plan fails to perform up to agreed upon standards there will be contractual avenues of redress. Moreover, the alliance can choose not to renew the contract with that plan.

One of the primary purposes of an alliance is to enhance the efficiency of the competitive market for health insurance. Individuals and smaller businesses simply do not have the expertise, resources or power to bargain effectively with insurers. This imbalance results in an inefficient market, with purchasers paying higher prices than they otherwise would if the relationship

between purchasers and suppliers were more equal, driving the market toward efficiency. The alliance is designed to increase competition between health plans. That may mean that certain plans that are less able to compete will fail or leave the market. That is simply a consequence of a competitive market approach and one which has occurred and will continue to occur with or without an alliance. To the extent that this model increases the competitiveness of the market and, hence, causes insurers to compete more vigorously with perhaps more extreme consequences, we have chosen to accept it as a result of the incremental approach to system reform that we are recommending.

COMMENT: A number of parties submitted comments regarding their opposition to mandated benefits. These commenters, who represented insurers and small businesses, argued that mandated benefits increase the cost of health coverage, adding anywhere from 6 to 30 percent to the cost of a plan. The mandates are viewed as unfairly discriminatory toward small employers. Large businesses have the option of viably self-insuring, thereby exempting themselves from state regulation, including mandates benefits. Smaller businesses, however, have a much more difficult time self-insuring and are left facing high prices for insurance and the decision of whether to try to sustain the higher cost (thus raising their cost of doing business, making them less competitive), or forgoing the purchase of coverage altogether.

The commenters noted that in the most recent legislative session, four additional mandates were enacted. A number of bills that propose the introduction of new mandates will apparently be considered in the second session. They view this increase in mandated benefit activity as a statement by state government that it is not seriously interested in health care cost containment. They also believe that frequently these mandates are enacted in the heat of the legislative arena, in the context of highly charged political and emotional debate. They do not believe that the decision to adopt these mandates is always made dispassionately or on a reasoned basis.

The commenters urged the Commission to recommend the repeal of all mandated benefits. They believe that such an action would do much to advance cost containment and would result in making more affordable insurance products available to a broader segment of the Maine community. Furthermore, they contend that this action would restore freedom of choice to consumers, who would be able to pick and choose those benefits that they feel would be most useful and beneficial to them.

It should also be noted that one provider representative cautioned the Commission about recommending the repeal of any mandated benefits, as they enjoy strong and broad-based support.

RESPONSE: The issue of mandated benefits was raised in the context of discussion about the proposed purchasing alliance. We believe that this occurred because of the Commission's reliance -- for modeling purposes only -- on the standard benefit package described in Chapter Two of the Draft Report as a foundation for discussing the alternative reform options. It is important to note, first of all, that the alliance model we proposed does not contemplate the offering of only one benefit plan. It was proposed, and still recommended, that the alliance offer

members the opportunity to enroll in a number of different plans. Members would have a range of choices, reflecting different benefit levels, different cost sharing arrangements and different premium prices.

Still, the benefit packages offered within the alliance would be subject to the current mandated benefit statutes. We recognize that it is possible that consideration of legislative proposals for mandates may not always occur in the most appropriate way. We know that the efficacy and effectiveness research regarding most types of health care services is lacking. However, we do recognize that new information regarding the efficacy and cost of services and provider types is continually coming to light. Upon review, this information might strengthen the case for maintaining a particular benefit as a mandate, or it might suggest that the mandate be lifted.

We are not in a position to conduct a competent review of the mandates that are currently codified in Maine law. However, we do believe that it is appropriate to recommend that the legislature direct that a study of current mandated benefits be carried out. This study would be conducted not by the Legislature itself, but by an independent task force, appointed by the Legislature and staffed by the Bureau of Insurance, which has experience in this area.

The task force would be charged with assessing each of the mandates with respect to the same review and evaluation criteria that the Bureau of Insurance must consider when preparing reports on mandated benefits proposals to the Legislature. These criteria include the social impact, the financial impact, the medical efficacy, and the effects of balancing the social, financial and medical efficacy considerations of the mandate.[7] This review should incorporate the most current information available regarding cost, social considerations and efficacy.

The task force would make recommendations to the Legislature, by the beginning of the next biennium, regarding the advisability of continuing each of the current mandated benefits. The Legislature would have the opportunity to either wholly accept or wholly reject the recommendations of the task force.[8] This process will allow an opportunity for a careful, thoughtful and deliberate review of each of the mandates without the pressure of the compressed timetable of a legislative session. While this process will undoubtedly be subject to political pressures, the process will not be as highly charged as a legislative session might be. These factors should contribute to a reasoned evaluative process.

COMMENT: We received a number of comments regarding our proposal to limit the benefit offerings in Maine's insurance market to a standardized set of packages. The commenters assert that this limitation would stifle the development of innovative package designs and would too severely limit consumer choice.

RESPONSE: The proposal to limit market offerings was predicated on recent actions by a number of other states (New Jersey, in particular) and by the Medicare supplemental coverage

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[7] 24-A M.R.S.A. §2752.

[8] This model is intended to parallel that of the federal base closings commission.

market construct, which limits the types of medigap coverage that may be sold, nationwide. The limitations are designed to allow consumers to more easily compare insurance products and evaluate price differences. Because the products are standardized, the consumer is assured that price variations are not due to "fine print" variations in the evidence of coverage that are difficult to discern. Instead, they will be able to compare products based on price, quality and other considerations, making the transaction more manageable, and making the market work better for them. Our objective in developing the proposal for standardized packages was to extend this same manageability and degree of market function improvement to the non-medigap segment of the market.

However, this provision is not a critical feature of our reform effort and it is not required to assure the viability of the proposed alliance. The alliance will be charged with assuring that members are fully informed of the benefit options available to them. That organization has every reason to want its members to be knowledgeable market participants. The benefit options within the alliance will be standardized and easy to understand. This will make "shopping" for insurance coverage within the alliance a potentially more manageable experience than it is outside of the alliance. Moreover, with the mandatory disclosure requirement discussed above, all consumers should be afforded a better explanation of exactly what each of their coverage options do and do not include, allowing all purchasers to make more informed choices. Therefore, we have decided to remove the draft recommendation for standardization of benefit packages from our Final Report.

COMMENT: The Health Insurance Association of America opposes the recommendations that appeared in the Draft Report regarding the extension of current small group market reforms to all groups of 99 or fewer employees. While the Association supports the extension of these reforms up to groups of size 50, they believe further expansion is unnecessary. They believe that the market works well for groups of 50 to 100. They are concerned that the introduction of these reforms to that market segment would cause a portion of these groups to fall back to self-insuring, even though self-insuring for groups of this size is a questionable proposition. The shrinking of the commercially insured population would result in increased premium prices for the remaining insured businesses, putting them at a competitive disadvantage.

RESPONSE: We continue to believe that it is important to extend the current continuity of coverage provisions to all groups up to that point where self-insurance really becomes a viable proposition. In our view, that viability becomes realistic when a group reaches the 100 employee size. While we are aware that groups smaller than this may decide to try to self-insure, this action by a fraction of businesses is not enough to dissuade us of the importance of expanding the scope of protections these reforms represent.

We do recognize that smaller companies sometimes do attempt to self-insure, removing their employee benefit plans out of the scope of State insurance regulations designed to protect beneficiaries of insurance policies. In many instances these companies purchase what amounts to a high deductible policy and purchase stop loss coverage, and claim that they are self-insuring when they really are not. The National Association of Insurance Commissioners has developed model statutory language that defines stop loss coverage as being coverage with a per person

attachment point of $20,000. The level was arrived at through a sophisticated actuarial analysis and represents that point at which the self-insured entity and the stop loss insurer bear equal levels of risk. Adoption of this language, which we recommend, should deter those companies that are not financially able to self-insure from doing so, providing an extra degree of protection to the beneficiaries of those benefit plans.

COMMENT: Current continuity of coverage provisions in Maine law prohibit medical underwriting as long as a person has not been without coverage for more than 3 months. The Maine People's Alliance suggested that the Commission recommend an extension of the 3 month time period to 6 months for those persons who are unemployed for a long period of time. They are interested in having this modification apply to those persons who lost coverage as a result of leaving their employment and who are eligible for and receiving unemployment benefits (therefore, they must actively be seeking employment). The basis for their recommendation is that such persons are ordinarily without adequate income to purchase insurance coverage and meet their living expenses.

RESPONSE: Representatives of the Bureau of Insurance have informed Commission staff that there is no actuarial basis for limiting this particular continuity of coverage provision to 3 months. The NAIC model language for continuity provision suggests 3 months, but Bureau of Insurance staff who are involved closely with the NAIC have said that this time period is merely suggestive and is not based on actuarial experience.[9] In light of this information, it seems consistent with our broader objective of making coverage accessible to all people of the State of Maine to recommend this extension. This new recommendation is reflected in the Incremental Reform chapter of the Final Report.

COMMENT: Healthsource Maine offered generally supportive comments about the proposed purchasing alliance. However, Healthsource expressed some concern about the proposed standardization of risk rates outlined in the draft recommendations. They suggested that efforts to standardize risk rates will be extremely difficult due to definition and accounting problems.

RESPONSE: Upon reflection and after consultation with Richard Curtis, an expert in the field of health insurance, alliances and health policy, we agree with this commenter. Our proposal to standardize risk rates was a reflection of our desire to standardize the market, forcing insurers to essentially compete on the basis of administrative costs alone. However, we have come to the conclusion that limiting competition to this narrow definition would not provide as much benefit to consumers as we had hoped. In fact, we believe that consumers will enjoy better premium prices without this standardization, because the competition between insurers will be broader and more vigorous. We have, therefore, withdrawn this recommendation.

COMMENT: An ad hoc committee of the State Employee Health Commission (SEHC) offered comments regarding the proposal for the development of a purchasing alliance using the

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[9] Personal communication with Glen Griswold, week of October 16, 1995 (relating comments of Rick Diamond) and with Brian Atchinson, October 20, 1995.

state employee health plan as a foundation. The committee stated that it agreed in principle with the concept of a purchasing alliance, but noted that it had strong objections to the details of the proposal. First and foremost, the committee objected to the mandatory inclusion of the state employee group in the Alliance; they insisted that if state employees' participation was to be mandated, then all public employees -- including teachers -- should also be required to purchase coverage through the Alliance. They feel it is fundamentally wrong dismantle the SEHC, a body that they believe to have proven its ability to carry out the very tasks proposed for the new alliance.

Because the proposal contemplated the merger of the state employee health insurance program into the Alliance, the committee viewed it as demanding that state employees cede their "hard won" health insurance benefit and familiar and effective governance structure for something unknown. They question the need to establish a new bureaucratic structure to administer what they view as simply an expanded state employee health program, and suggest, instead, that an expansion of the duties of the SEHC and the office and staff of the State Employee Health Insurance Program would serve the same ends more efficiently, economically and effectively.

In place of the alliance model described in our draft recommendations, the committee suggested a model predicated on an expanded State Employee Health Insurance Program, which would allow the participation of other groups or populations. In their model, the SEHC would continue to carry out all functions relating to plan development and oversight, including enhanced and expanded data collection and quality monitoring activities, thus obviating the need, in their view, for the health data organization proposed in Chapter Seven of the Draft Report and the Quality Improvement Foundation referred to in Chapter Nine. The SEHC would be responsible for carrying out these activities on behalf of all Alliance members, not only state employees and retirees but for other public employees enrolling in the alliance as well as any private sector enrollees. The committee also suggested that the composition of the SEHC remain the same with additional representation based on proportional membership of new groups joining the purchasing pool.

RESPONSE: We appreciate the thought and consideration given to our draft recommendations by the members of the ad hoc committee of the State Employee Health Commission and we understand the concerns raised in their comments. We have had a series of discussions with the SEHC, with representatives of the Maine State Employees' Union and with the Administration regarding the organizational structure. Based on those discussions and in a sincere effort to allay the concerns of the state employees and the ad hoc committee we have substantially revised our alliance proposal.

The modified proposal is designed to allow the State Employee Health Insurance Plan (SEHIP) and State Employee Health Commission to maintain relative autonomy while providing the opportunity to leverage that large group's negotiating clout on behalf of private sector businesses and individuals. We now envision a cooperative purchasing initiative, with the SEHC and the Board of Directors of a Community Alliance working together to obtain the optimal purchasing arrangements for each of the two groups. We believe that this alternative, which is

described in detail in Chapter Five of the Final Report, will accomplish substantially the same objectives as the draft model would have, allow all players to realize the potential for cost savings and accommodate the concerns of the state employee group. Not only will the SEHIP have the opportunity to realize cost savings, but its participation in the Alliance can offer much in the way of a public service, stimulating health system reform and assisting in the effort to extend affordable health coverage to a greater number of Maine citizens.

While the state employee group may still oppose the degree of "mandated cooperation" that this model represents for them, we believe that the involvement of the state employees plan is critical to the success of the initiative. We have tried to strike a balance between the concerns expressed by the SEHC, its ad hoc committee, the union and the Administration with the needs of the greater community. That balance is carefully reflected in our revised proposal.

COMMENT: Dr. David Hartley of the Maine Rural Health Research Center at the Muskie Institute, University of Southern Maine commented that a requirement of bidding insurers to offer statewide coverage might have a negative impact on rural health networks. He noted that these networks, by definition, serve a relatively small, but defined community. Such networks may help prevent the migration of health care dollars out of the area, positively impacting the local economy and the integrity of the local health delivery system. He suggested that a waiver of the statewide requirement be allowed for bidding plans that can demonstrate that they are based in and confined to rural communities.

Dr. Hartley also suggested that regional health plans may not be able to directly offer all of the services required under the contract specifications. Instead, he argued that these plans be allowed to arrange for the provision of those services they are unable to provide through contractual arrangements.

Finally, Dr. Hartley commented that the governance of the Board of the Alliance be reflective of geographic boundaries. Instead of having "at large" seats for businesses and consumers, five regions of the State should be identified and representatives from each of those regions should be selected for the Board.

RESPONSE: We agree that a requirement of statewide coverage potentially poses a hardship to many health plans, especially local integrated networks. The original proposal was rooted in a desire to encourage health plans to serve all parts of the State, not just the urban areas. It was also intended to avoid the potential for bidding plans to pick and choose those areas which they wished to serve, effectively avoiding poorer, and perhaps less healthy populations.

Aside from the limitations facing local networks, we are now aware that many plans in Maine are simply not licensed to conduct business on a statewide basis. Instead, they have regional licenses, covering areas where they are able to demonstrate to the satisfaction of the Superintendent of Insurance, that they have adequate provider participation. Many regional plans may also be able to offer more competitive rates on products than can a statewide plan; to preclude the participation of such plans would be shortsighted. We have therefore modified our proposal to require that bidding health plans agree to enroll Alliance members in those areas of

the State where the plan is authorized to do business. While the mandate of a statewide panel is gone, plans will still be precluded from explicitly "picking and choosing" their populations based on geography. If access to coverage on a geographic basis becomes a problem, the Alliance will have the ability to capitalize on its negotiating position to encourage insurers to expand to underserved areas.

We do not see a problem with the commenter's suggestion that local plans may have to arrange for the provision of certain services -- particularly specialty services -- through contractual arrangements with other providers. This is essentially how all health plans conduct business. However, the adequacy of the contractual arrangements will be an issue for the Cooperative Purchasing Committee and the Alliance to examine during negotiations.

Dr. Hartley's suggestion for a geographic distribution of Board seats is an interesting one. However, we believe that, over time, the composition of the Board will naturally come to be representative of the Alliance enrollees. Board members will eventually be elected by the membership of the Alliance. Therefore, if most enrollees reside in Aroostook County, it is likely that they will elect representatives to the Board from their area. If the governance of the Alliance becomes an issue due to geographic "non-representation," the Legislature can easily correct the situation by modifying the enabling legislation.

COMMENT: The Maine Chapter of the National Federation of Independent Businesses commented that small businesses want the ability to band together to purchase insurance. The NFIB is concerned that the "quasi-governmental" Alliance that the Commission has proposed will preclude the development of other, less costly options for purchasing coverage for small business owners.

RESPONSE: The commenter describes the alliance model that we have developed as being "quasi-governmental." We disagree with this characterization. In both the draft recommendations and in its final form, the Alliance is a private organization, despite the involvement of the state employees. Second, it is important to understand that participation in the Alliance is totally voluntary. Businesses that wish to do so may form other purchasing groups, just as they have always been free to do. The reason that this Alliance proposal is necessary, in our view, is that no significantly large purchasing initiative has evolved in Maine as of yet. If businesses were going to form such a coalition, we believe that it is likely that they already would have done so. Moreover, our alliance model contemplates the enrollment of entire associations of businesses, at the discretion of those associations and their members. Therefore, the associations may capitalize on the purchasing power of a larger cooperative purchasing initiative, while still offering other valuable services to members. We firmly believe that this proposal represents an opportunity to the business community, especially Maine's many small businesses, to efficiently purchase health coverage without imposing harsh mandates.

Comments Regarding Other Proposed Market Reforms

COMMENT: Representatives of the Maine People's Alliance submitted two proposals for additional insurance market reforms for our consideration. The first proposal called for the

development and administration of an "Unemployment Health Security Fund." This fund would be used to assist people who have lost employer-sponsored health care coverage due to a separation in employment in the purchase of a COBRA-option coverage policy to continue coverage for themselves and their children. Under federal law, people leaving employment must be provided the option of buying into an employer-sponsored, commercially insured health plan, if they had participated in that plan while employed. This coverage, however, can be very costly, especially for an unemployed person, often removing the purchase of extended coverage as a practical option.

The Maine People's Alliance suggested that employers with 5 or more employees be required to contribute to the Health Security Fund, as employers are required to do in Massachusetts. This contribution would be funded by a tax based on payroll. The amount of the tax might range from 0.1 percent to 0.9 percent, depending on the particular characteristics or structure of the assistance program.[10] Eligibility for assistance from the fund would be limited to those persons who are eligible for and who are collecting unemployment insurance. This limitation will assure that assistance is given only to those persons who are actively seeking employment.

RESPONSE: We have carefully considered this proposal for an Unemployment Health Security Fund. Our staff has reviewed the cost estimates provided by the Maine People's Alliance and has found them to be reasonable. The concept of providing increased access to coverage is one which we certainly agree with. Aside from the merits of the proposal, though, we have concluded that we are unable to endorse it. At this point in time, we view the imposition of an additional payroll tax on Maine businesses as politically unfeasible. The reform package that we are proposing reflects our assessment of priorities; these proposals demand a certain level of new revenue and we have identified funding sources for that revenue. To propose additional measures requiring even higher levels of funding would present significant problems, particularly in a climate where public revenues are down, other demands on those revenues are increasing and there is a general sentiment against the imposition of new taxes on business.

COMMENT: Several commenters including the Maine Osteopathic Association, the Maine Medical Association and the Maine People's Alliance urged the Commission to review the provisions of the pending legislative proposal that would establish certain protections to patients and providers in managed care plans, and to consider incorporating those provisions in the incremental reform proposal. The bill the commenters refer to, L.D. 1512, *An Act to Ensure Fairness and Choice to Patients and Providers under Managed Health Care,* has been held over from the first session and will be considered by the Banking and Insurance Committee during the course of the second session.

RESPONSE: We have reviewed each of the provisions of the "managed care bill" as the commenters suggested. After careful consideration we have decided to adopt certain of the

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[10] A detailed description of the proposal is available, upon request, from our offices. This description includes cost estimates.

provisions of the proposal; we have also included a number of provisions that are similar but not identical to other provisions of the legislative proposal the commenters refer to.

It is important to note that there are provisions of the bill that are not reflected in our proposal. Our failure to address these provisions does not imply our tacit agreement or disagreement with any one of them. We were opposed to some of those provisions. Others we agreed with but have already addressed the issues in other portions of our recommendations. On others we were unable to reach agreement or felt that we lacked the expertise on which to base an assessment.

Most importantly, we believe that these provisions should apply to all health care plans, not just managed care plans. In a highly competitive environment, any health care plan that maintains participating agreements with providers and/or engages in some type of utilization review presents a certain potential for risk to patients and providers. That is not to say that creative contracting with providers or careful review of service use are bad things, but only that there exists a possibility for a level of unfairness or harm that needs to be guarded against. It is difficult to balance the need to contain costs and maintain affordability with the sometimes competing demands of choice and quality assurance. We believe that the new provisions we have included in our final proposal will help to locate that balancing point.

COMMENT: The Maine Medical Association expressed its strong opposition to the proposal in the Draft Report that would have expanded the purview of the Certificate of Need (CON) program to include all providers, including physicians. The MMA argued that CON laws have not been proven to be cost-effective and that they make no sense in the context of a system where payment is not based on cost. Insofar as non-hospital providers are reimbursed under a range of payment methods, without specific recognition of capital expenses, the application of CON to such providers is, in the view of the Association, unfair.

The commenter stated that since non-hospital providers have no guarantee that their costs will be met, they will only make significant capital investments when there is a community need for the service that investment represents. To do otherwise, they argue, would expose the provider to potentially large financial losses since they can only "sell" what the market demands.

RESPONSE: We acknowledge that there is a great deal of disagreement about the cost effectiveness of Certificate of Need programs. This approach to regulation seems to move in and out of vogue; no one seems absolutely certain of its absolute utility. Still, the public does have an interest in having some degree of oversight of significant capital investments as they often do contribute to the increasing cost of care. Therefore, we conclude that some level of regulation may be desirable.

In the most recent legislative session, the Legislature signaled a strong desire to rely on the competitive market to control health care prices by repealing the rate setting system and the Maine Health Care Finance Commission. In light of this significant shift in policy direction, an expansion of Certificate of Need is inappropriate. We have therefore modified our draft

recommendations, removing our expansion proposal. Instead, we recommend no change in the current CON policy.

COMMENT: The Maine Medical Association disagreed with our conclusion that there is currently no need to reform the anti-trust statutes. The Association believes that changes are required that would allow physicians to better position themselves for effective negotiation *vis à vis* managed care plans. They suggested that physicians need to be able to meet, talk and negotiate as a group without being required to be a fully integrated entity. They recommended that the same right to cooperate that has been extended to hospitals and mental health centers should be extended to doctors.

RESPONSE: In drafting the proposed recommendations we carefully considered the issue of current anti-trust law. It is a difficult and controversial subject, especially in a time of great shifts within the industry toward managed care. We are not aware of any information, however, that would cause us to alter our original recommendation; that is, we do not see any reason to now recommend that the anti-trust statutes be altered in any way. We therefore decline to modify our proposal in response to this comment.

COMMENT: The Maine People's Alliance and Christopher St. John asked that the Commission consider including in its recommendations a proposal to expand the current hospital charity care statute to apply to affiliated interests of hospitals as well. The law currently requires that all hospitals make charity care available to people living at or below the poverty line. This statute was contained in the health care financing statute that was repealed last session; the Legislature, however, retained that provision of the law, transferring enforcement responsibility of the charity care statute to the Department of Human Services.

Mr. St. John pointed out in his comments that hospital corporations are engaging in vertical integration with increasing frequency, establishing related physician practices and ambulatory diagnostic/procedures facilities. The charity care statute does not apply to these related corporations, only to the hospital itself. The commenters suggested that the statute be expanded to include related corporations. By doing so, they believe that access to an appropriate level of care will be expanded for low income persons who now seek care in the most expensive setting -- the emergency department -- because of the limitations on charity care availability. This, in turn, should generate savings to the system because of a shift toward more appropriate sites of care.

RESPONSE: We were unable to come to any consensus regarding the proposal that these commenters have put forward. We are, however, aware that Senator Mills of the Maine Legislature has submitted a proposal that will be considered in the second session that would accomplish the expansion sought by Mr. St. John and the MPA. We concur with the observation that the Legislature, by allowing the charity care statute to "survive" the repeal of the rate setting system, has signaled an interest in maintaining a safety net for some of Maine's most vulnerable citizens.

Comments Relating to the Proposed Children's Program

COMMENT: Our recommendation for an expansion of Medicaid coverage to all children living at or below 250 percent of poverty received strong support in every public hearing that we held. We also received numerous written comments expressing support for the provision of coverage to this population. Many commenters also stated specific support for the proposed funding source for the children's expansion -- the elimination of the premium tax exemption for non-profit health insurers. However, some commenters opposed this recommendation, suggesting that the revenue required to implement this initiative be generated in some other manner.

RESPONSE: Some commenters believe that the removal of the exemption will generate increases in premium costs of the products offered by insurers who will become subject to the tax for the first time. First, it is not clear to us how much, if any, of the "new" cost must be extracted from rate payers as opposed to coming out of administrative costs. It is true that the corporations that currently enjoy the tax exemption are non-profit in nature, but that does not imply that there is no room for reducing administrative overhead. Second, and to the extent that any of this revenue must be derived from increases in premium rates, it is important to remember that the enrollees in health plans that currently have exemptions have been and continue to be subsidized by others who purchase coverage through those insurers who are subject to the tax. It is not clear to us why this favored treatment should be continued.

In our view, the provision of a tax exemption to a certain class of health plan/insurer contributes to basic inequities between competitors which works against efforts to achieve a healthy and efficient market for insurance coverage. The rationale upon which the tax exemption was granted in the first place is now largely gone; community rating and continuity of care provisions force all insurers to play by the same rules. Our proposal to eliminate this exemption follows from our interest in stimulating as competitive market for insurance as possible. It made sense to us to generate the revenue required for the children's expansion -- a piece of our incremental reform package -- through the closing of this "loophole." If, however, policymakers believe that this linking of the removal of the tax exemption and the children's program is inappropriate, we would not object to an alternative funding source, although we are not prepared to identify such a source.

COMMENT: Some commenters, while supportive of the notion of expanding coverage for children, suggested that Maine needed to do more with respect to increasing coverage for other vulnerable groups. These commenters urged the Commission to consider the need for and possibilities of including in the recommendations a proposal for the expansion of coverage to adults who are leaving welfare programs or who are at risk of relying on welfare. The commenters argued that this additional expansion of coverage is critical to efforts to successfully encourage people to leave the welfare rolls or to avert their entry onto welfare in the first place.

A range of fairly specific proposals which included cost estimates were submitted for the Commission's consideration by Pine Tree Legal Association on behalf of one of its clients, the Maine Association of Interdependent Neighborhoods. These proposals ranged from making

Medicaid coverage available to single parent families with incomes below either 200 percent or 185 percent of poverty, to extending coverage under the Transitional Medicaid Program until such time when the family's income reaches 200 percent of poverty (rather than limiting transitional benefits to 1 year, as they currently are). The cost estimates provided by the commenters suggest that the State share of such expansions would be just over $1 million in the third year of implementation, without taking into account cost offsets that could be realized through third-party liability payments and the net savings to the welfare program that would be generated by this type of initiative.

RESPONSE: We appreciate the time and thought that these commenters devoted to their remarks.[11] The proposals they have made were carefully thought out. Based on information provided to our staff by the Bureau of Medical Services, it appears that data upon which the commenters' cost estimates were derived is valid and appropriate. However, we decline to incorporate the proposals in our recommendations. This decision is based on a number of considerations.

First, it does not appear to us that the proposals advocated by these commenters meet a basic condition for the granting of a Medicaid waiver; that is, the proposals do not appear to be revenue-neutral with respect to Medicaid funds. Federal statutes require that §1115 waivers not cause any greater expenditure in federal Medicaid funds than would have otherwise been spent in the absence of the waiver. Even if these proposed expansions lead to substantial savings in the State's welfare program, Medicaid spending would rise. The federal government will not participate in paying those additional costs; the new costs would have to be underwritten solely out of additional state monies.[12]

The commenters also suggested that it was their understanding that savings under one Medicaid waiver initiative could be used to offset, in HCFA's eyes, cost increases under another waiver initiative. In other words, if the State realized savings under its managed care waiver (which is referred to as the §1915(b) waiver), the commenters believe that it could be used to offset new costs under a §1115 waiver. This view is contrary to our understanding of the federal Medicaid waiver process. We have consulted with the Department of Human Services, the National Academy for State Health Policy and the consulting firm of Enquist, Pelrine and Powell, experts in the area of Section 1115 waiver policy, about this issue. They each have expressed their understanding of the process to be similar to ours. In fact, it was brought to our attention that some states have attempted to apply savings from one waiver program to another waiver program, only to have that strategy disallowed by HCFA.

We also lack the expertise and resources necessary to draft a sound legislative proposal that would call for the submission of a Section 1115 waiver application. This waiver process is complex and requires actuarial analyses that exceed the level of sophistication that either appears in the commenters' proposals or that we are able to develop ourselves. The compressed time

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[11] The complete description of these proposals is on file in our offices.

[12] The additional state revenue required could conceivably be provided by savings in the State share of AFDC costs.

frame within which we have had to work and the relatively scant resources available to us simply preclude us from undertaking such a task.

Aside from the practical considerations cited above, we encountered a more fundamental dilemma when assessing the proposals. While we firmly believe that the first population that should be afforded expanded access to coverage is Maine's children, we are unable to come to a decision regarding other priority populations. While these commenters argue for covering single parent families under 200 percent of poverty as a priority, others have argued that the parents of the children targeted in our expansion should be covered even before the children are. Still others have stated that they believe that adults living below the poverty line may be more appropriately a priority population than are children living at 250 percent of poverty. We do not feel that we are able to adequately evaluate the competing priorities and arrive at a well-informed policy recommendation. Instead, we include in our Final Report a strongly worded statement urging the Department of Human Services to fully explore all opportunities for Medicaid expansions and to identify priority populations for coverage. We believe that it is Maine's interest to cover as many of its citizens as possible. We remain committed to the principle of universal access to coverage and believe that the State should make the best use possible of federal funds in working toward this goal.

COMMENT: The Maine Medical Association stated their support for the proposed children's program but cautioned the Commission to be careful in its cost estimation. The Association cited Vermont's experience with a similar Medicaid expansion effort, where participation in the initiative had been underestimated leading to an underfunding of the program. The MMA is concerned that if the same thing happens in Maine, the burden of an underfunded program will fall on the shoulders of Maine physicians.

RESPONSE: We appreciate the concerns raised by the Medical Association and can assure them that we are comfortable with our cost estimates. The estimates are predicated on cost figures developed by the Department of Human Services for its managed care waiver; these figures were developed with the assistance of a professional actuarial firm. The estimates of the eligible population are based on the total numbers of uninsured children in Maine residing in households with incomes below 250 percent of poverty, based on the March Current Population Survey conducted by the federal government. They also incorporate a liberal assumption regarding the number of currently insured children in this income group who would convert to Medicaid eligibility should it become available. We therefore believe that our estimates are likely to be high, avoiding the likelihood of underfunding the initiative.

Public Health

COMMENT: Many commenters expressed their enthusiasm and support fro the Commission's proposal to increase funding to improve public health in Maine. With only one exception -- the Administration -- these commenters also expressed their strong support for the proposed financing mechanism for the initiative -- a significant increase in taxes on cigarettes and tobacco products.

RESPONSE: The Commission appreciates the support and interest shown for this proposal. The improvement of public health in Maine is one incremental but very important step we can take to invest in a healthy future for Maine's residents.

We firmly believe that the use of the cigarette tax is, *in and of itself*, an extremely significant public health measure. The tax increase that we have proposed is designed to assure that the current revenue stream from tobacco sales realized by the State is maintained. At the same time, the proposed increase would generate the additional revenue required to adequately fund public health in Maine. Most importantly, such a tax has the proven ability to change smoking behavior, especially among young people. It is designed to encourage people -- especially young people -- to stop smoking or to avoid starting to smoke in the first place.

We acknowledge that the proposed tax is a regressive one. Still, we believe that it represents sound public policy. Although smoking rates have declined somewhat over the past decade, tobacco use continues to be the leading preventable cause of death in this State.[13] A recent study of chronic disease mortality in Maine found cigarette smoking to have contributed to over 17,600 deaths over the course of the ten year study period.[14] Maine youth continue to exhibit one of the highest smoking rates in the nation. Almost all adult smokers (96 percent of male smokers and 93 percent of female smokers) report having begun smoking when teenagers.[15] Smoking rates are higher among the poor. While this tax would represent a greater burden for children and for the poor, the high smoking rates among these groups and the concomitant health care cost to Maine, provides a counterpoint to the regressivity argument.

Some have argued to us that such a tax will encourage a black market for cigarettes or will cause people in Maine to travel to New Hampshire to purchase cigarettes and other tobacco products. However, the experience of other states implementing much higher cigarette taxes than neighboring states has not shown cross-border purchasing -- or smuggling -- to be a significant problem.

While we appreciate the Administration's position opposing the introduction of new taxes, we are disappointed that the value of the tax as a tool for encouraging healthy behaviors and improving the health of Maine's children, especially, has not been recognized. We continue to recommend this strategy (albeit in a slightly modified manner, as described below), and will include it in the proposals we forward to the Legislature this coming January.

COMMENT: Dr. Lani Graham informed the Commission that other states have taken measures similar to those recommended in the Draft Report to improve public health. However, some State Legislatures, faced with the increasingly difficult task of crafting workable budgets, have found it necessary to divert revenues intended for increased support of public health to other purposes, especially to fund the cost of "sick care" covered by state medical assistance programs.

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[13] DEPARTMENT OF HUMAN SERVICES, MEDIA ALERT (October 5, 1995).

[14] *Id.*

[15] DEPARTMENT OF HUMAN SERVICES, HEALTHY MAINE 2000: A HEALTH AGENDA FOR THE DECADE (1993).

Dr. Graham, while expressing her support for the initiative, cautioned the Commission about the prospect of a similar fate for new revenues here.

RESPONSE: We view the public health initiative described in our draft recommendations as an important and fundamental step in improving the health status of Maine's population and, in the longer term, in containing health care costs. Adequate funding for public health is a prerequisite for the success of the initiative. Therefore, we have modified our Draft Report to include a provision recommending that the new revenue generated by the proposed increases in the cigarette and tobacco taxes be dedicated to a new public health fund. This may help to assure that the monies will be directed to those activities for which it was intended.

COMMENT: A number of commenters asked for clarification regarding how new public health monies would be distributed. These comments came primarily from people at the local level, at health delivery sites. Dr. David Hartley, Maine Rural Health Research Center, noted that Maine lacks a well-developed local infrastructure for public health, with the State assuming most of the responsibility for public health functions. He suggested that rural communities will require assistance in directing new public health dollars toward effective use.

RESPONSE: Currently, public health dollars are primarily received through federal grant funding. The dollars flow into state government and into the Department of Human Services' Bureau of Health. Much of that money flows through the Bureau down to the community level. Communities submit proposals to the Bureau, and disburses funds to those "projects" which appear best able to meet the objectives of the grant initiative. The State now provides a great deal of technical assistance to localities to enable the successful implementation of grant initiatives.

The initiative proposed by the Commission in the Draft Report does not contemplate any significant departure from this approach to disbursing funding. We would continue to expect that much of the new monies would be directed to communities for local projects. The most significant change might come in the nature of the funding. Whereas federal funds are often categorical in nature -- that is, they are related to a particular grant initiative or narrow objective -- the new public health funding would more closely resemble a block grant for public health. In that sense, the funds may be more flexible that they now are.

The new Public Health Improvement Plan contemplated in the report would set out clear but likely, broad priority areas for public health in Maine. Funding should then be directed at these priority areas, with award preference being given to projects falling within the scope of the identified priorities. The Bureaus would continue to provide support to localities with respect to needs assessments, project development, implementation and so on, as described in the draft recommendations.

COMMENT: Dr. Lani Graham suggested that instead of targeting a specific dollar figure for the funding of public health as the Commission proposed, funding levels for these activities be set at a percentage of "sick care dollars." Therefore, as expenditures for sick care declined, so

would the funding level for public health. This follows from the assumption that as the population grows healthier, there will be a less intense need for public health activities.

RESPONSE: Dr. Graham is correct in noting that the Commission's proposal does, by default, sets a specific dollar funding target for public health. That target, though, was arrived at by a review of the literature and the practices of other localities, which suggest that the appropriate funding level for public health is approximately 3 percent of total health expenditures.

It is true that this level will not vary considerably from year to year, even as total health care costs vary (either up or down).[16] Until Maine has a better and more timely method of measuring health care expenditures, Dr. Graham's very reasonable suggestion would seem difficult to implement. Instead, we believe that the approach that we have recommended will provide Maine with the minimum funding now necessary to bring investment in public health to the level it should be. The level of funding will undoubtedly be an issue that will be revisited in the future by the Legislature and the Department, and so will be subject to ongoing scrutiny and tests for adequacy and reasonableness.

COMMENT: We received several comments supporting the notion of a Center for Public Health Practice, as described in the Draft Report. One comment received recommended that the Commission modify the model legislative language borrowed from Michigan for use in crafting an enabling statute for Maine's Center for Public Health Practice. The commenters had consulted with staff at the Michigan center and solicited suggestions for improvements in their statutory language. The recommendations made by these commenters would broaden the model statutory language used by the State of Michigan to allow the Center's Board to direct study and activities to any areas they deem appropriate; the Michigan language appears to be restrictive, identifying health services research as the primary agenda for the Center.

RESPONSE: We agree with the commenters suggestions and will modify the proposed statutory language to accordingly. It is important to note that our proposal contemplates the enactment of enabling legislation only. Such an action by the Legislature would facilitate the development of this important resource but would not commit the State to provide funds or other support for the Center.

Quality Assurance Programs

Summarized below are comments we received regarding our proposal for a statewide quality assurance program, as well as our responses to them. There is one modification to the draft recommendations on quality assurance that was not generated by any of the comments summarized below. This change is related to our consideration of a set of market reforms designed to provide a certain level of "protection" to providers and consumers from health care

[16] The estimated revenue stream from the proposed tax increase reflects the conservative assumption that the impact exercised by the tax increase on smoking behavior will be realized upon the introduction of the tax, rather than over time. In that sense, the revenue stream is underestimated.

plans that must operate in an ever-more competitive environment. Certain of these reforms relate to quality issues and so have been referenced in the final version of this Chapter.

COMMENT: We received a number of comments endorsing the concept of a Quality Improvement Foundation for Maine. Most of these commenters agreed that there is a great need to develop a framework for assessing quality that revolves around outcomes analyses that factor into consideration patient satisfaction, cost effectiveness, improvement in health status, and recovery duration. Some of the commenters cautioned that an effort should be made to assure that the data required for the quality assessment effort not pose an undue burden for providers. Quality studies in Maine should strive to make use of the same data set as is currently being collected or demanded by other entities such as the National Committee on Quality Assurance through its HEDIS requirements.

RESPONSE: We appreciate the support shown for this concept. In presenting our recommendations at hearings around the State, we encountered almost universal approval for our focusing of quality assurance efforts around outcomes assessments. The information provided by such studies will provide invaluable guidance to policymakers, providers and consumers alike.

We recognize the need to minimize disruption to providers practices as well as to assure that the provision of the data required to carry out these quality assurance studies is not unduly burdensome. Our draft recommendations make mention of the fact that these studies will be constructed in such a way as to accomplish these two objectives, and we see no reason that this cannot be done.

COMMENT: The Maine Medical Association commented that any Quality Improvement Foundation should be operated by physicians to assure that the practice of medicine is accurately reflected in studies. The goal of the Foundation should be the improvement of quality, without a negative or punitive focus.

RESPONSE: We agree that the goal of any Quality Improvement Foundation should be to further improve quality of care. We further agree that these efforts should not be punitive in nature; the intent of such efforts is to educate and encourage change in practice that will improve the quality of services delivered. The most significant quality improvement projects that we are aware of are under physician direction. However, this is not to say that there is not a role for a broader cross-section of stakeholders in the study process. Restriction of these projects to physician researchers can conceivably result in the imposition of a purely medical model of viewing care that may not be appropriate in every instance. For this reason, it may be desirable to broaden study groups and organizational governance structures to include input from a variety of provider types. In this way, the concerns and interests from all of the stakeholders may be appropriately represented.

We do agree with our Advisory Committee on Quality that research and education on issues relating to professional activities in these domains should be the responsibility of the health professions. This would occur under the QIF model. There should, however, be careful

oversight of the work of QIFs. this can occur through public participation in the governance of these organizations.

COMMENT: The Maine Medical Association commented that every effort must be made, when studying quality of care, to assure that the data which is collected is standardized, uniform and allows for meaningful comparisons, including adjustments for differences in case mix/severity of each practitioners patient population. The study process and analyses must be objective and accurate. Moreover, the MMA believes that physicians should have an opportunity to provide input in to the process of designing studies and standards, to assure that they reflect the current practice of medicine, and to allow the physician community to become familiar with the standards upon which they will be judged.

RESPONSE: The comments presented by the Medical Association are valid and important ones. It is important to note that the existing QIF in Maine adheres to the qualifications laid out by the MMA. We believe that in order for any such organization to build and maintain credibility it would have to conduct itself in the manner suggested.

More broadly, quality assessment and improvement efforts must also take into account input from a variety of provider types; as mentioned above, the use of the medical model in evaluating every type of service or care may be of limited utility.

COMMENT: The Maine Medical Association noted that it prefers the term "assessment reports" rather than "report cards" as it finds the latter term too pejorative.

RESPONSE: The use of the term "report cards" was not intended to be pejorative. Instead, it was used to convey what might some might find a difficult concept, in language that may easily be understood by an audience that ranges widely with respect to its sophistication in the area of quality assessment. Additionally, it has become a part of the lexicon of quality reporting. In the interest of simplicity and readability, we will continue to use it in our reports.

COMMENT: One commenter noted that while the proposed Quality Improvement Foundation would provide feedback to providers about the quality of care being delivered, it would not provide needed technical assistance to providers in implementing the data systems required for monitoring of the selected quality indicators. The commenter was especially concerned about the provision of assistance to rural providers who might have a greater need for technical help with the new technology than do urban-based providers.

RESPONSE: We are aware that the implementation of the technology that would ease the task of generating the data required to operate the quality improvement effort may pose a challenge to some providers. This recognition is reflected in our discussion of a statewide health information system for Maine and the opportunities presented by the Community Health Information Network -- CHIN -- project currently underway in the State. The CHIN project, and other similar initiatives, are specifically designed to assist physician practices in the implementation of the technology required to allow a computerized exchange of data to occur.

This technology would facilitate the collection of quality indicators that might be needed by the QIF.

However, we would point out that the Maine Medical Assessment Foundation, a model of a QIF, has been operating in the State for a number of years. While a greater diffusion of technology might have facilitated its efforts, it has, nonetheless, been able to successfully carry out studies of practice patterns and outcomes. While we believe that computerization is desirable and would be of assistance to practitioners, we do not view it as an absolute prerequisite to quality improvement efforts. Nor do we believe that a lack of technology will place a provider in an untenable position *vis à vis* the QIF, imposing an undue burden on the practice.

COMMENT: An *ad hoc* sub-committee of the State Employee Health Commission expressed in written comments its support for the concept of a Quality Improvement Foundation but questioned whether a new organization had to be created to serve that function.

RESPONSE: The proposal for a Quality Improvement Foundation contemplates the recognition of a QIF for Maine. It does not dictate or require the development of a new entity to carry out this function. In fact, there are existing organizations that are already engaged in activities similar to that described in the report; still, we believe that it is critical that the importance of quality improvement efforts be formally recognized and sanctioned. In that way, quality assessment and improvement will become a centerpiece of the reform effort, because while the cost of care is important, it is the quality of care that should serve as the focus of any health care system.

Medical Liability Reform

COMMENTS: With respect to its medical liability reform proposal, the Commission received a number of comments ranging from the cautiously approving to the strongly disapproving. Medical Mutual Insurance Company believes that the proposal has potential because it is designed to get economic damages to the injured patient more quickly without the cost of litigation. The Maine Medical Association agreed that the proposal has promise but, because it is untested, believes that it should first be implemented on a small scale, pilot project basis. Dean Donald Zillman, of the University of Maine School of Law, believes that a proposal based on the work of Professor of Jeffrey O'Connell begins with a solid intellectual base. He believes that its success depends upon the cooperation of the medical community. Others believe that the early-offer proposal is unfair, unworkable and unable to achieve the goals that the Commission has endorsed. They objected to the limitation on noneconomic damages, the continuation of the pre-litigation screening panels, the different treatment of victims of medical malpractice relative to those injured by other torts, the practicalities associated with ongoing payment of damages, the constitutionality of denying patients the right to a jury trial, and the probability that the provider would only make offers in the most obvious cases of liability. The Governor's administration noted that no other state had implemented this model and that Maine's medical malpractice premiums were stable. In addition to comments addressing the specifics of the early-offer proposal, there were a number of comments addressing the liability system as a

whole. One commenter also submitted an alternative reform proposal that would eliminate the screening panels and make mediation mandatory.

RESPONSE: The Commission welcomes all comments on its proposal for an alternative to the current fault-based liability system. The Commission has carefully considered the extensive written and verbal comments that were submitted. In making its recommendations, the Commission hoped that there might be broad public interest in a liability system which had the potential to provide compensation to injured persons without the long delay, high transaction costs and uncertainty of the current tort system. However, given that our proposal did not generate the broad-based support we hoped, we have concluded that the proposal will not contribute to the ongoing debate over medical liability in any useful way. We will therefore withdraw the "early offer" proposal from our Final Report. Although we have withdrawn our proposal, we do respond to those comments relevant to the ongoing debate on medical liability reform. In addition, as discussed below, the Commission will recommend that the Bureau of Insurance plan and commission a study of the effectiveness of the pre-litigation screening panels.

COMMENTS: The Maine Medical Association and the Maine People's Alliance both agreed that the current liability system is in need of reform. The Maine People's Alliance agreed that the appropriate goal of reform should be to reduce the incidence of medical malpractice and to efficiently and fairly compensate the victim.

RESPONSE: The Commission believes that reaching consensus on the goals of the liability system is an essential first step to any reform effort. The Commission hopes that it is not alone in believing that the primary objectives of a liability system are, first, to deter events of malpractice and, second, the fair and efficient compensation of victims of malpractice. The Commission believes a disinterested assessment of whether or not the current system satisfies those goals would necessarily lead to a discussion of how to eliminate its shortcomings.

COMMENTS: One commenter stated his belief that the jury system works well at determining which claims are meritorious and which are not. This commenter noted that Maine juries tend to be conservative in the amount awarded and are often protective of the local doctor or hospital. This commenter noted that because of these concerns and the cost of litigating a medical malpractice case, attorneys are very careful in assessing the merit and economic value of bringing a medical malpractice lawsuit.

RESPONSE: The Commission does not have adequate data to evaluate the quality of jury decisions in Maine. However, in focusing on the accuracy of the jury, this commenter misunderstands the Commission's primary complaints against the jury system. One of the Commission's main goals is to provide a mechanism by which those injured by malpractice can promptly and predictably recover their loss. The jury system is a flawed mechanism for serving this end: its cost imposes a barrier to recovery and those that recover often do so only after years of protracted litigation.

As the commenter notes, attorneys are forced to weigh the economic value of claims in deciding whether to accept a case. As noted in the Commission's report, one Maine lawyer has

warned his colleagues to accept no cases worth less than $100,000. That means that a malpractice injury of up to $100,000 falls solely on the victim--a significant loss for anyone but the very wealthy.

The cost of proving malpractice before a jury is one of the reasons lawyers are reluctant to take small cases. Most of the money devoted to medical malpractice premiums is spent proving or denying a claim rather than compensating the victim. When a claimant is successful in winning a verdict from a jury, usually after years of litigation, the claimant only keeps a portion of that amount. A significant sum must pay attorneys' fees, experts' fees and other costs.

In summary, the Commission believes the jury system falls far short of the ideal system for compensating victims of medical malpractice.

COMMENTS: The Maine People's Alliance believes that the effectiveness of the current liability system at deterring malpractice is greater than suggested in the Commission's Draft Report and the Harvard Medical Practice Study cited in the report. The MPA has supplied the Commission with a copy of an article by Michelle J. White, *The Value of Liability in Medical Malpractice*, HEALTH AFFAIRS, Fall 1994. Based on a series of studies comparing the rate of negligence with the rate of recovery and the amount recovered, Professor White concludes that the current liability system imposes a significant cost upon negligent providers and its removal would result in an increase in negligent behavior.

RESPONSE: In its Draft Report the Commission recognized that the current liability system has a deterrent impact on medical negligence. Consistent with that belief, the Commission recommended that the threat of liability be preserved. The Commission believes that it is very difficult to measure how effectively the current system deters negligence. However, as demonstrated in the Harvard Medical Practice Study and in the studies discussed in Professor White's paper, untoward medical events continue to occur, and at a significant rate. No liability system can prevent simple forgetfulness, momentary lapses in attention, or other mishaps to which all people are susceptible. The Commission believes however that we can add to the deterrent effect of a liability system by implementing quality improvement measures that would work to reduce medical errors.

COMMENTS: Medical Mutual Insurance Company offered another critique of the Harvard Medical Practice Study in the form of an article written by Richard E. Anderson, M.D., FCAP, Chairman, Board of Governors, The Doctors' Company. According to Dr. Anderson the Harvard Medical Practice Study had several flaws that limit the usefulness of the study's results. Of particular relevance, Dr. Anderson calls into question the study's measure of negligence. Dr. Anderson also notes that the Harvard study is often misused to conclude that physicians are responsible for deaths and injuries measured in the study.

RESPONSE: The Commission recognizes that if the Harvard study inaccurately measured the incidence of negligence, then the study cannot be relied upon to conclude that many persons injured by medical negligence do not recover for their injuries. The Commission is not qualified to independently assess the quality of the Harvard Medical Practice Study. The Commission

notes, however, that an earlier study jointly sponsored by the California Medical Association and the California Hospital Association, using California data, corroborates the finding of the Harvard study.[17] That study estimated that only one in ten persons injured by negligence filed a claim and only one in 25 injuries resulted in compensation through the malpractice system.[18]

The Commission agrees that the Harvard study did not attempt to limit the measure of adverse events to only those that were caused by a physician.

COMMENTS: The Commission received many comments regarding the proposal to limit recovery of noneconomic damages. These comments were both in support and in opposition. Those in opposition had several reasons for opposing any limitation on noneconomic damages. Several parties expressed concern that limiting noneconomic damages would have a discriminatory impact because recovery based on lost earnings necessarily means lower recovery for those who typically earn less, such as the poor, the elderly, the young, women, and rural residents. Some commenters expressed concern that placing value on only economic damages rather than nonmonetary loss sends the message that the only loss worth compensating is monetary loss. In the words of one commentator: "Since nothing can restore a lost leg or correct a permanent spinal injury, it is axiomatic in Tort Law that only money recovery can even begin to compensate for...non-economic losses including greatly reduced quality of life, for persons of any age." The Maine People's Alliance commented that a victim of malpractice should receive "full compensation" for noneconomic loss.

RESPONSE: The Commission acknowledges that limiting the recovery of noneconomic damages raises a number of difficult issues. The Commission recognizes that noneconomic loss is real loss, however difficult it may be to measure in terms of money. The Commission also recognizes that, given systematic differences in earnings for various population groups, those who earn less necessarily recover less when only economic damages are recoverable.

At the same time, the Commission notes the contradiction of requiring a jury to mete out in dollars "full compensation" for that which cannot, by definition, be compensated in dollars. We ask the jury to express the value society places on a loss that defies measurement. There are many possible rationales for this approach to noneconomic damages, ranging from the emotional desire to recompense unlooked-for suffering, albeit, in an inaccurate and inadequate fashion, to the practical desire to impose a greater penalty on the person inflicting the injury, in the hope of deterring future similar injuries. The Commission does not explore these rationales further. It is sufficient to conclude that as a society we have expressed a need for placing a value on noneconomic damages. Similarly, as a society, we can place parameters on what that value may be. With respect to the early-offer proposal, the Commission believes society might perceive that limiting the value placed on noneconomic damages in return for speedier recovery for more injured persons is a worthwhile trade-off. At present, the majority of those injured by malpractice, be they the poor, the elderly, young people, women, rural residents, or any other category of citizen, recover nothing for malpractice injuries or, if they do recover, only a fraction

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[17] DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY (1985) at 22-25.
[18] *Id.* at 19, 24.

of their loss after years of protracted litigation. The Commission believes that a liability system that improves the distribution of economic damages, even with a limitation on noneconomic damages, would be an improvement over the current system.

COMMENTS: Several commenters had opposing viewpoints on the pre-litigation screening panels currently in place. Some believed that eliminating the screening panels altogether would greatly improve the current liability system. The Maine People's Alliance believes that in many cases the screening panels force consumers to go through two full scale trials before recovering for their loss. MPA says that means the consumer is subjected to double the cost and additional delay. Others, including the Maine Medical Association and the Medical Mutual Insurance Company, believe that the screening panels appropriately screened out nonmeritorious claims while accurately identifying meritorious claims. Dean Zillman noted that the case for screening panels had not been proven yet.

RESPONSE: In its Draft Report, the Commission took no position regarding the current mandatory screening panel process. We do not believe that there is sufficient evidence to draw a definitive conclusion about the efficacy of the screening panels. In our Final Report we recommend that the screening panels continue to function. In addition, we will recommend that the Bureau of Insurance develop a research methodology for collecting detailed information about the process and outcomes of the panel method. At the point that the Bureau has collected sufficient information, we recommend that the Superintendent commission (through an RFP process) an unbiased, external analysis of the success or failure of the screening panel process.

COMMENTS: The Maine People's Alliance cites the Office of Technology Assessment for the conclusion that "it is impossible in the final analysis to draw any conclusions about the overall extent or cost of defensive medicine."

RESPONSE: The Commission agrees that a meaningful measurement of the cost of defensive medicine is elusive. As stated in its Draft Report: "Depending on the measure, estimates range from the insignificant to as much as 15 to 30 percent of the nation's annual health care expenditures."

COMMENTS: The Maine People's Alliance urged the Commission to focus its attention on the Board of Registration in Medicine. MPA believes that the Board of Registration in Medicine needs to be reformed. MPA reports that a 1993 report found that Maine ranked 46th in the nation among state medical licensing boards for the number of serious disciplinary actions per 1000 doctors taken in 1991 and third to last in the same year for total number of disciplinary actions. MPA reports that it has heard many complaints that the Board of Registration in Medicine is disproportionately comprised of physicians. The MPA recommends expanding the membership of the board from 10 to 11 members and increasing the consumer representation from 3 to 6. MPA cites recent legislation in California as an example of this type of reform. Another problem cited is the complaint investigation process. MPA reports that, while a complainant has a right to be present during informal meetings or hearings, that person has no right to pose questions, present witnesses or challenge the evidence presented to the board. MPA proposed changes to the Board's complaint review process.

RESPONSE: The Commission has not conducted any analyses of the performance of the Board of Registration of Medicine. The fact that the State has relatively fewer disciplinary actions might be viewed as a positive rather than a negative; it could as well reflect a high level of quality and appropriate care as it might an inadequate performance by the Board. A regular analysis of the disciplinary actions of all health care provider boards could be considered. However, the Commission did not receive or have sufficient information to make such a recommendation.

COMMENTS: The Maine People's Alliance supports the Commission's proposal to create the Office of the Health Consumer Ombudsman. MPA recommends a different role for the Ombudsman. MPA believes the Ombudsman should serve as a strong consumer advocate to help guide the complainant, especially one unable to afford an attorney, through the Board of Registration of Medicine's complaint hearing process to ensure that the complainant is dealt with as fairly and as efficiently as possible. MPA provided proposed legislative language that would implement these changes.

RESPONSE: The Commission has withdrawn its original recommendation for medical liability reform, including its recommendation for the creation of the Office of the Health Consumer Ombudsman. As a result, the Commission will not comment on an appropriate role for an ombudsman.

COMMENTS: The Maine People's Alliance objected to the Commission's use of medical malpractice insurance premium data covering the period between 1984-1993. The MPA argued that more recent data suggested that the increase in cost of malpractice premiums had slowed since that period. In support, MPA reported that according to A.M. Best, there was a 26 percent decrease in malpractice premiums for the period from 1989 to 1993.

RESPONSE: Based on documentation provided by the Medical Mutual Insurance Company, the Commission agrees that malpractice premiums have declined or stabilized in recent years.

COMMENTS: John Kelly, Esq., an attorney practicing in Portland, offered an alternative reform proposal. (Mr. Kelly did not comment on behalf of any interest group or association.) Mr. Kelly proposes that the medical malpractice screening panel be eliminated to be replaced by a mandatory mediation process. Mr. Kelly models his proposal after the mandatory mediation pilot program in Androscoggin, Aroostook, Kennebec and Sagadahoc Counties.

Under Mr. Kelly's proposal a medical liability claim would be initiated with the service of a notice of claim. Upon service, the parties would be directed by court order to immediately arrange mediation within three months, unless the court extends the time period for "good cause." The parties would select a mediator from a list of qualified mediators provided by the court. The expense of the mediation would be borne equally by both sides. The judicial administrative costs would be offset by the elimination of the screening panel system.

Mr. Kelly proposes two procedural safeguards. First, the statute of limitations would be suspended for 30 days following written confirmation by the mediator that mediation had failed. Second, the fact of a claim and the contents of any filing related to the claim would be confidential. If a claim is settled, the fact of settlement would remain confidential.

As part of the mediation process, limited discovery would be allowed. Mr. Kelly would limit discovery to the claimant's pertinent medical records and the written reports of the parties' experts. Where good cause is shown, the deposition of the parties and an independent medical examination would be permitted. Mr. Kelly proposes that the claimant's medical records and medical expert's reports be provided to the health care provider at the time notice of claim. The parties would then be required to determine within 30 days whether additional information is required and the timing of the report of a defense expert.

To encourage an open mediation process, no information except the medical records and deposition transcripts would be admissible in court if mediation failed.

The Maine People's Alliance also supports a mediation scheme, similar to that described by Mr. Kelly. However, the MPA believes that mediation must be voluntary. The MPA also believes that a mediation process should require that the practitioner, and not just the practitioner's insurance company, be at the table.

Another commenter also expressed his approval for mediation but only if voluntary.

The Medical Mutual Insurance Company expressed opposition to Mr. Kelly's mandatory mediation proposal. It states that mediation is unworkable in the context of the National Practitioners Data Bank, which requires a practitioner to report a paid claim. MMIC also believes that adverse results would be used by HMOs, managed care entities, health insurers and others to decredential physicians. MMIC argues that, because a paid claim has such a negative potential impact on a doctor's ability to conduct his or her practice, mediation is likely to be ineffectual in the context of medical malpractice. MMIC also believes that three months is not enough time to resolve a malpractice claim. Also, MMIC argues that any qualified mediation panel would need to have sufficient medical knowledge or legal experience related to medical malpractice cases. The mediation panels in the current pilot project lists only volunteer lawyers as qualified mediators. MMIC believes that there are currently only about ten or so lawyers with sufficient expertise to serve as mediators for medical malpractice cases. MMIC objects that three months is insufficient time for appropriate discovery. MMIC also objects that relying on an expert's written report without an opportunity to cross examine the expert is an inadequate mechanism for determining the strengths and weaknesses of a case. Limiting discovery to pertinent medical records and the written report would prevent any meaningful evaluation of damages. MMIC suspects that proponents of such a proposal have the hidden agenda of dismantling the screening panels, paying only lip service to the mediation process and proceeding to a trial before a lay jury without medical training.

The Maine Medical Association also voiced objection to Mr. Kelly's proposal. First MMA expressed its support for the continuation of the screening panels. MMA believes that the

screening panels have been effective at resolving disputes before they go to court. By avoiding the court system, MMA believes the screening panels have saved the State considerable money. In addition, the screening panels generate money for the general fund: while almost all of the cost of the screening panels are borne by the participants, the parties pay substantial filing fees. For that reason the MMA concludes that the marginal judicial administrative costs associated with mediation would not be offset by eliminating the screening panels. MMA also questioned Mr. Kelly's complaint that the screening panel process was costly and time-consuming, given that Mr. Kelly's mediation proposal involved a three month discovery panel and depositions of experts for "good cause." MMA concluded that mediation would look a lot like screening panels, in terms of the time and money consumed. MMA also noted that the screening panel statute requires the panel chair to attempt to mediate differences between the parties before proceeding to findings.

RESPONSE: The Commission has considered the suggestion for a mandatory mediation process. We have not had the opportunity to carefully research this proposal but note that, like the "early offer" recommendation, there was considerable objection to the mandatory mediation concept. In the absence of more complete information and without evidence of broad support, the Commission will not make a recommendation regarding mandatory mediation in its Final Report.

Workforce Planning and Health Professionals Education

COMMENT: Most commenters expressed their support for the formation of a Healthcare Workforce Forum, as recommended by the Commission. These commenters believe that broad-ranging discussions of workforce and health education issues among a wide range of stakeholders will present an opportunity for enhancing communication and exchanging information. This process, in turn, is seen as a foundation for the careful development of effective policy initiatives. Many of the commenters expressed their support for the proposal that the Commissioner of the Department of Human Services be given the responsibility of convening the Forum. Only one commenter suggested that it would be appropriate for a federation of state licensing boards to convene the Forum, stating that the purpose of licensing boards is to represent and protect the public's interest relative to health professionals.

RESPONSE: We appreciate the many supportive comments received regarding our recommendation for the development of a Healthcare Workforce Forum. Our draft recommendations suggested that the Forum be convened by the Commissioner of Human Services, and we continue to believe that proposal to be appropriate. The Department of Human Services is the location of health planning within Maine; as such, it is both reasonable and important that DHS "host" this effort to stimulate workforce/health professionals education planning.

COMMENT: We received several comments that expressed concern over a statement in our draft recommendations that endorsed a particular finding of the Maine Health Professions Regulation Project. That finding pertained to the formation of a federation of health professions

licensing boards. We received several comments expressing strenuous opposition to this recommendation. The commenters stated their belief that such a federation would create an additional and unnecessary bureaucratic layer. They further stated that it appeared that a federation would be created to facilitate what is already happening among licensing boards, and therefore would not add any value.

Another commenter, representing the Maine Health Professions Regulation Project, expressed support for the draft recommendation, for all of the reasons articulated in that project's final report.

RESPONSE: When we issued our draft recommendations for workforce and health professions education planning, we were under the impression that the notion of the development of a federation of licensing boards was not a controversial issue. We now recognize that that assessment was incorrect. Many important stakeholders, including representatives of professional licensing boards and several of the larger professional associations, are outspoken in their opposition to this proposal.

Controversy, in and of itself, is not sufficient reason to modify a recommendation. However, it is clear to us that the level of disagreement regarding this proposal would, perhaps, work to make further communication and an exchange of information and ideas among stakeholders a more difficult proposition than it currently is. In the interest of fostering an environment within which people may effectively and collaboratively exchange ideas and information, we have amended our draft recommendation to withdraw an explicit endorsement of the federation concept. Instead, we recommend that the Healthcare Workforce Forum consider, among other things, the recommendations of the Maine Health Professions Regulation Project, including its recommendation for a federation of licensing boards. By putting this on the Forum's agenda, all interested parties will have the opportunity to further consider the development of a federation model.

COMMENT: Several commenters stated their support for the development of a comprehensive database on the health professions workforce in Maine, as recommended by the Commission.

RESPONSE: The Draft Report released in July, 1995 outlined in some detail our proposal for a statewide health information system. As the commenters point out, that system calls for the collection of data on Maine's health workforce. These data will be an important resource for those responsible for developing a policies designed to create a health workforce that assures that the needs of Maine residents are able to be met in a cost-effective and high quality manner. We urge all those who recognize the value of this data to continue to support the development and implementation of a comprehensive health data system for our State.

COMMENT: We received several comments about the inclusion in the draft recommendations of preliminary findings of an unpublished study. This study, done by the Maine Medical Assessment Foundation, focused on an assessment of the adequacy of Maine's physician workforce. The study is not yet available for general review. Because of this

limitation, the commenters suggested that the Commission eliminate reference to the study in its chapter on workforce planning.

RESPONSE: We recognize the difficulty presented to those reading our recommendation in our reference to an unpublished study. Although the study will be available for review in the future, it currently is unavailable for general circulation. Therefore, we have eliminated references to that study. Instead, we have incorporated reference to a study done by the Center for the Evaluative Clinical Sciences in the Dartmouth Medical School which has developed a report entitled *The Dartmouth Atlas of Health Care.* This study arrives at conclusions similar to those found in the Maine Medical Assessment Foundation study. While it is not yet published, the report is available for review. Those interested in reviewing at the paper should contact the Maine Medical Assessment Foundation.

It is important to note that while it appears that Maine has a sufficient number of specialist and generalist physicians (with the exception of cardiology and perhaps obstetrics/gynecology), the distribution of those practitioners across all areas of the State is not optimal. Residents in rural areas may have to travel considerable distances to access care. Clearly, this is not desirable, and we endorse an objective of working toward appropriate access to care for all Maine residents. By the same token, we also recognize that it is likely not possible, nor may it be appropriate (in terms of cost, efficiency, or quality of care), to assure that no Maine resident has to travel more than 30 miles to access a provider. Maine should work toward improving appropriate access, especially to primary care, for Maine's residents.

COMMENT: One commenter commended the Commission's recommendation for the convening of a Healthcare Workforce Forum, but suggested that the proposal did not go far enough. This commenter stated that the recommendation should include a more explicit description of the desired outcomes of the Forum process, to include some form of state-supervised oversight of the numbers of health workforce personnel.

RESPONSE: In drafting the workforce proposal, we considered an option similar to that raised by the commenter. The State might be able to determine an appropriate workforce size and distribution and enforce "compliance" with that plan, through licensing functions. We decided, however, that this type of regulatory approach was likely to present considerable political problems that could lead to the failure of making any progress in the area of workforce planning. We decided, instead, to propose a framework that allows for improved communication and an exchange of information -- necessary first steps to improve the process of policymaking in this issue area.

We note that the Forum structure does not contemplate collaborative decisionmaking on the part of participants with regard to the development and/or implementation of a coordinated strategy for workforce/education development. Such coordination could violate anti-trust laws. Instead, we hope that by exchanging information, stakeholders will be able to arrive at their own decisions in a more informed, reasoned manner that takes into account a comprehensive view of the context within which those decisions are made and executed.