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Health Care: Provision and Administration

SPECIAL SECTION

Network Governance and Health Care Policy

Nathan Myers, M. Ernita Joaquin

As a paradigm, network governance is trumping “public administration” or traditional models of government. Policies taking a network governance approach seem to have a greater chance of goal attainment. Is network governance in health care policy a means of bridging the ideological divide, what with national health policy initiatives tripping on partisan hurdles? One example of network governance (as expounded by Stephen Goldsmith and William Eggers in their 2004 book) at the state level is high-risk health insurance programs (HRPs).

HRPs are state-created, nonprofit organizations offering comprehensive health insurance benefits to individuals with pre-existing health problems. Features of network governance, both its advantages and weaknesses, can be observed in HRPs. (This article uses facts from the “Comprehensive Health Insurance for High-Risk Individuals” reports published by the National Association of Comprehensive Health Insurance Programs). First, we note that facilitative or non-hierarchical governance is modeled in HRPs’ utilization of non-profits and private insurance firms. State governments create a pool which

contracts with various vendors to administer the plan (determine eligibility, pay claims, bill clients, etc.) and provide services (actuarial, accounting, legal, etc.).

For instance, in California, Illinois and Texas, Blue Cross Blue Shield administers the program but actual health care and pharmaceutical services may be provided by different carriers, whose plans vary. A board of directors oversees the program with state legislators or executive officials sitting on or appointing those boards. Board members may include insurers, doctors, other health providers, and citizens. In network governance, the more points of contact among the players, the more likely that HRP boards can generate trust and communication among stakeholders.

Innovation in HRPs is made possible by another advantage of network governance, specialization. In California, the legislature proposed that a questionnaire be administered to anyone seeking individual coverage on the private market, based on which the 3 to 5 percent deemed most uninsurable would be sent directly to the risk pool, while the remaining 95 to 97 percent would be guaranteed coverage. Relying on the boards’ expertise to systematically determine if an individual is high-risk and then if that individual

should be served by the pool or the private market can alleviate inefficiency in the system and reduce instances of unfairly disqualifying people who deserve to be in the pool.

Speed and flexibility in governance are shown when HRPs work with vendors to help prevent harmful drug interactions by more closely monitoring what prescriptions clients take. A private entity like Walgreens has experience and technology available to accomplish this task and many states take advantage of it within the high-risk pool system.

As a case of network governance, HRPs today show that success owes less to political ideology and more to pragmatism.

In terms of network design and integration, Goldsmith and Eggers note that determining which form is appropriate to the particular service can be essential to success. HRPs can be described as a channel partnership, often with the board acting as integrator to coordinate activities, deal with problems, and ensure the provision of quality services. It acts as a conduit of information to the governor and the legislature on the financial health of the program, including its enrollment and premium levels.

The integrator may vary as states pattern the pool to their needs. Some are more comfortable with the insurance commissioner creating pool policy, while others desire more direct legislative involvement. As risk pools have been surviving in many states and in many forms for decades, one could surmise that risk pools are sustainable under a number of different integrating authorities.

Visibility is important to network success. “Coordinating activities among disparate organizations cannot occur without shared visibility into each partner’s processes,” wrote Goldsmith and Eggers. The board is the platform for state officials and other parties to stay current on the status and activities of the pool.

What about pitfalls? Networks often bring together actors whose goals simultaneously overlap and differ. In HRPs tensions arise between the government’s goal to expand access to health coverage and the network members’ aim to maximize their own interest, including profitability.

HRPs in Illinois and Texas must charge premiums considerably above the average cost of those charged by private insurers so that HRPs would not compete with the private market. Critics charge that this goal incongruence between seeking to provide a public good while behaving like a private sector entity limits the program’s effectiveness. A survey from the 1990’s by Sally Stearns and Thomas Mroz found that inability to pay forced some to disenroll from HRPs. In Iowa and North Dakota pools drove up the operating costs of small employers due to a health

insurance premium tax used to fund it. Some argue that pools serve to defray Medicaid costs; others argue the opposite. Yet another group argues that the populations do not really overlap.

HRPs are created by the legislature but it is unclear from research how much legislative oversight or other mechanisms ensure its accountability. Most are subject to regulation by the state agency that regulates the insurance industry. Minnesota has the highest current enrollment level, with almost 30,000 people, which is still relatively meager compared to the total population.

As HRPs cover small numbers who bear much of the cost for their coverage, HRPs might be expected to receive significantly less regulation and oversight than either private insurance firms or larger government programs like Medicaid. But the pools were created because the state realized that high-risk citizens must be given coverage or it would increase the cost of care for everyone. Therefore, oversight of the high-risk pool network is critical to insure that its mission is obtained.

Today’s revival of heated debates on health system reform requires an exhaustive look at all potential means to achieve this policy goal. The other question this article posed at the beginning concerns the capacity of network governance to diffuse the excessive influence of ideology on policy. As a compromise between increased government regulation/mandate and extending coverage to these individuals through Medicaid or Medicare, HRPs carry cross-ideological appeal. The pools do not require an extensive bureaucracy, significant public funding, or strong government intervention in the market. HRPs do not force companies to accept undue financial risk, yet still represent a government effort to help those in dire need.

So, as the traditional barriers between the public, private, and non-profit sectors break down, has this neutralized partisan barriers in health care policy as well? The weakness of the liberal/conservative dichotomy is evident in Nathan Myers’ 2009 study of the factors relating to state adoption of market-based health programs and Myers and Christopher Stream’s 2009 study of the effectiveness of market-based programs.

These programs exist in the different political cultures that scholar Daniel Elazar originally conceived of, including traditionalist Texas, moralist California, and individualistic Illinois. At first glance, looking at the different characteristics of states that have adopted and implemented market-based programs like HRPs, the statistical significance of small businesses positively influencing the adoption of market-based programs like HRPs seems to hint at the programs’ conservative bent.

At the same time, however, more liberal-leaning states are found to be less likely, statistically speaking, to enact certain market-based health expansion programs. Nevertheless, market-based programs are successfully managed in more liberal states like California.



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Health Care: Provision and Administration

SPECIAL SECTION

Health Care Reform: An Administrator's Viewpoint

Arthur Greenwood

As health care reform legislation looms on the horizon, there is a strong likelihood that President Obama and the Congress will soon be proudly introducing a new health care plan. The devil, though, is in the details and the regulators and administrators will be the one's tagged with responsibility to implement these wide ranging and far reaching programs. Health care reform is long overdue in the United States. At last count, an estimated 100 million citizens are without health coverage or seriously underinsured. United States families are being bankrupted daily by the outrageously high increases in the cost of medicines, medical procedures, and insurance premiums that have far outpaced inflation for many years.

Health care programs have been in need of reforms and controls for the past 20 years or longer. With multibillion dollar concessions now being offered from the nation's hospitals, health insurers and pharmaceuticals, one thing is clear: the stakeholders in health care are quickly realizing that the gravy train is nearing an end.

From the viewpoint of an administrator, what will happen when the new legislation rolls out? Will programs be broad in scope but limited in details, requiring state

lawmakers and third party agencies to have flexibility in implementation? Will the Obama Administration provide a detailed roadmap for administrators to follow? History suggests that when plans are light on detail, they tend to fail. So far, the Administration seems well positioned to insure that the plans do not fail but state and local administrators will ultimately play a major role.

As plans are handed over for implementation, grass roots administrators from across the country will have the power to make or break health care reform measures...

In Massachusetts, when health care reform was implemented, very little was known about the outcome. Former Governor Mitt Romney and his staff touted that the entire state would have health coverage and an alternative public plan would be made available to those not insured through other commercial and government programs. According to Diane Archer of the Institute for America's Future, the plan

is still leaving many people underinsured or uninsured and does not promote cost control. Massachusetts' Treasurer, Timothy Cahill, recently announced plans for significant cost reductions and benefit cuts in the program, stating that the Massachusetts plan can serve as "a warning for the federal government as it looks to do something similar."

Many of Massachusetts problems can be traced to the recent recession with thousands more residents applying for the state subsidized Commonwealth Care. Even before the recession arrived however, the plan did not adequately project significantly higher enrollments than anticipated and the recessionary period exacerbated this dilemma for the state. Many other problems exist in the way the plan was implemented. The Commonwealth Care plan was designed as a fall back for those who could not afford insurance from commercial insurers and not as a competing plan with means testing. As a result, the plan does not promote competition. The plan also does not work with health care providers to control costs, although that is finally happening now as costs have risen 42 percent since 2006 according to Kevin Sack of *Boston.com*.

All of the turmoil that Massachusetts is experiencing should not take away from the fact that the State now has only 2-3 percent of its citizens without some level of insurance benefit. The Massachusetts plan points to the simple adage that proper prior planning prevents poor performance. Administrators were left to interpret and implement the plan and, in many ways, failed to achieve the objectives set out by the authors of the legislation.

The federal government appears to be well positioned to direct massive changes in health care. The plan is to have a government sponsored health insurance alternative to the commercial insurers. Unlike the Massachusetts plan, the federal alternative will not be only for those without access to other programs or without a means to pay. The plan will offer a more cost effective way for those without health care to afford it and the government intends to use the massive buying power of the program's enrollment to negotiate lower costs. As Senator Jay Rockefeller (D. W.VA) observed recently, "Back in 1993, all our Veterans Administration hospitals got together and

agreed to buy prescription drugs as a group. The next week, the costs of those drugs went down by 50 percent. Today, the insurance industry runs this whole deal, spending \$1.4 million every day to fight health-insurance reform. The government has a lot of power to lower prices."

And the fed's big picture plans to reform health care don't stop there, as U.S. citizens are about to gain the ability to purchase less expensive prescriptions from Canadian pharmaceutical companies; a newly appointed health care IT czar is working to modernize an IT infrastructure system that is woefully behind and costing billions more than necessary and the government is discussing remodeling health care delivery after world class programs such as the Mayo and Cleveland Clinics. Known as one of the finest integrated health care providers in the world, the Mayo Clinic is able to offer its programs efficiently and effectively.

Clearly, the government has big plans and soon administrators at the federal, state and local levels will be called to task to implement many of the programs and initiatives being designed. Administrators in government offices, health care providers, insurers and elsewhere will need to carefully and thoughtfully implement the plans being designed.

As plans are handed over for implementation, grass roots administrators from across the country will have the power to make or break health care reform measures and determine the success or failure of the program. As with Massachusetts, the plan will likely be high on expectations but limited on the detailed blueprint needed to carry out the plan. Consider the Mayo Clinic example. How does this plan become a reality in every state? Many hospitals, clinics and other providers will resist or refuse to implement this type of change.

As administrators, we will need to work diligently not only to implement reforms passed on by the legislators but also take steps to insure that the savings anticipated is realized. As with the Mayo example, many stakeholders are likely to be resistant to change because it impacts not only their autonomy and their approach to health care but also their wallet.

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Network Governance Needs More Study

From **NETWORK GOVERNANCE**, pg. 5

Overall the picture suggests that we have to move away from using an ideological lens when searching for fruitful avenues in the complex arena of health policy reform. Network governance as an approach can help overcome contentious points of equitability and fiscal discipline, the staple of partisan debates. The approach seems at least neutral and avoids exacerbating some ideological tendencies.

As a case of network governance, HRPs today show that success owes less to political ideology and more to pragmatism. A political realignment may occur the more

we realize that political support from particular groups is not as critical to policy effectiveness as being able to harness the advantages and avoid the weaknesses of governance by network.

Continuous study is needed on the link between state market-based programs and small businesses even as we see more established and giant firms dominate HRP networks. Finally, we should be careful to see that networks do not banish the public service ethos as decision and action points multiply.

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