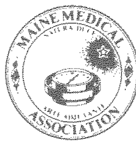

MAINE MEDICAL ASSOCIATION

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TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

IN OPPOSITION TO

L.R. 2678, GOVERNOR LePAGE'S PROPOSED SFY 2012-2013 SUPPLEMENTAL BUDGET FOR THE DEPARTMENT OF HEALTH & HUMAN SERVICES

Joint Standing Committee on Appropriations & Financial Affairs
Joint Standing Committee on Health & Human Services
Room 228, State House, Augusta, Maine
Friday, December 16, 2011

Good day Senators Rosen and McCormick, Representatives Flood and Strang Burgess, and Members of the Joint Standing Committee on Appropriations & Financial Affairs and the Joint Standing Committee on Health & Human Services. My name is Andrew MacLean and I am Deputy Executive Vice President of the Maine Medical Association, a professional organization of more than 3500 Maine physicians, residents, and medical students whose mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens.

The MMA strongly opposes the LePage Administration's substantive and procedural approach to this supplemental budget. The proposed reductions in MaineCare eligibility, elimination of optional services and arbitrary limits on others, cuts in reimbursement, particularly for our hospitals, and diversion from the *Fund for a Healthy Maine* will have a devastating impact on the health and well being of thousands of the most vulnerable Mainers. It also will threaten the financial viability of many of the

medical professionals and health care institutions that care for Maine people, undoubtedly increasing the pressure on our fragile economy.

First, I will address our procedural concerns with this budget proposal. We fundamentally disagree with the Governor's decision to pursue a major policy initiative, the restructuring of the MaineCare program, through a supplemental budget, a bill that absolutely must do nothing beyond ensuring the state budget is balanced for the first year of the biennium ending June 30, 2012. The legislature has managed similar DHHS budget gaps in the past. We urge you to approach the budget problems in a serial manner, thinking about bridging the relatively short time period until the implementation of the *Affordable Care Act* picks up momentum in 2014. Furthermore, we ask you not to isolate DHHS from the rest of state government in this supplemental budget, an unprecedented step. We acknowledge that you will be challenged to set priorities for the services state government can provide for the people of Maine, but we believe that your budget analysis should be comprehensive and involve a prioritization among all services the state provides. Because health care and other social services are basic necessities for us all, and because a lack of these basic necessities will produce a ripple effect throughout our economy, we do not believe it is appropriate to presume that this budget problem must be solved within DHHS.

Second, we share the substantive concerns about this budget proposal expressed by many others during these last three days. These proposals are contrary to our sense of humanity and the role of government in protecting those among us who are less fortunate, yes. But, they neither are based on rational health care, public health, or economic policy. We all know that our health and social service system is a "balloon." Poke your

finger in the balloon in one place and it will pop out in another. The real human needs will not go away. Costs simply will be shifted elsewhere in state government and in our economy. Some care will be shifted to higher cost settings, such as hospital emergency rooms; in other cases the burden will increase on our law enforcement and corrections agencies and on municipalities. Cutting MaineCare has an exponential negative impact on our health care delivery system and our economy because we lose not only the General Fund component, but also the federal match that, even with the downward adjustment we currently face, still is nearly 2 federal dollars for every state dollar. I cannot speak about the problems with each line of this budget, but let me comment specifically on a few:

- Elimination of so-called "non-categorical" coverage. During the past decade, the Maine legislature endorsed pursuit of this waiver from the federal government with bipartisan support and for sound reasons. This population with very high medical needs was a substantial financial burden on our hospitals. Elimination of this coverage will directly and significantly impact Maine hospitals' bad debt and charity care costs. Likewise, the Maine legislature has otherwise expanded Medicaid eligibility during the past decade for rational financial reasons as a part of an incremental approach to universal health care coverage and as an alternative to a single payer health care system. I have attached a 2002 resolution of our membership and a 2003 White Paper on health care reform both of which emphasize the need to achieve health care coverage for all in order to address the real problems with our health care system. The result of these policy initiatives is

that Maine is one of only a handful of states that has a rate of uninsured under 10%.

- Elimination of coverage for physical therapy services (among various arbitrary service limits). The arbitrary elimination of classes of service or visit limits take tools away from the medical professionals caring for Mainers. The opioid and other prescription drug diversion and abuse problem in our state has been on the front page of our newspapers and the subject of debate among legislators and other policymakers for at least a decade. Some expect physicians to fix this problem. Well, upon review of this budget, John Garofalo, M.D., a primary care physician in North Anson, pointed out that elimination of PT services takes away one of his primary alternatives to opioids for chronic pain. Eliminating coverage for dental services will mean simply that emergency physicians will provide even more dental care than they do now. As you have heard earlier this week, the limits on suboxone and mental health crisis services are very concerning to psychiatrists and other behavioral health practitioners.
- Hospital rate reductions, particularly the reduction from 109% to 105% of costs for Critical Access Hospitals. Though being asked to provide more care and improve quality, Maine hospitals have faced the financial pressure of overdue state settlements and reimbursement cuts in most, if not all, state budgets of the past decade. The proposed cut to Critical Access Hospitals, which bore a substantial cut in the SFY 2010-2011 biennial budget (P.L. 2009, Chapter 213) in the 124th Legislature, is particularly disturbing because these rural hospitals

provide the primary care base and the health care safety net in many parts of Maine.

The MMA acknowledges the need for increased cost savings and efficiency in the health care delivery system and the medical community is fully engaged in this effort, through numerous quality improvement initiatives and payment reform efforts such as those in the *Affordable Care Act* and DHHS' value-based purchasing initiative in MaineCare. These will take time to produce savings. In the meantime, if you cannot find sufficient savings across state government to bring the budget into balance, rather than radically restructure the MaineCare program, the MMA urges you to consider new revenue sources, including but not limited to:

- Taxes having a positive impact on public health, such as an increase in our cigarette tax, equalizing the tax on tobacco products, a tax specifically on sugar-sweetened beverages, and/or an increase in the tax on beer, wine, or liquor;
- A short-term increase in the sales tax to 6%; or
- A deferral or elimination of the tax breaks enacted as part of the biennial budget last session.

Thank you for considering the views of the Maine Medical Association on this proposed DHHS supplemental budget. I know that you face a difficult task in balancing the state budget, but the MMA believes very strongly that the proposed restructuring of MaineCare may produce a short-term fix, but it will harm thousands of Maine's most vulnerable citizens, will permanently damage parts of our health care delivery system, and will degrade the public health of all of us. I would be happy to respond to any questions you may have.

RESOLUTIONS 2002 – ACTION TAKEN BY HOUSE OF DELEGATES 9/14/2002

Resolution #8 re "Health Insurance Coverage," presented by the MMA Public Health Committee, was amended and approved as follows:

WHEREAS, one out of sixteen Maine children do not have health insurance, and

WHEREAS, one out of five non-elderly Mainers do not have health insurance, and

WHEREAS, only 49% of all Maine businesses offer health insurance to their employees, and

WHEREAS, the uninsured rarely get checkups and often don't seek treatment when sick, and

WHEREAS, full participation in the insurance market would spread the risk and thus lower the cost of health insurance coverage, and

NOW THEREFORE BE IT RESOLVED, that the MMA advocate, publicly and legislatively, for a pluralistic system of universal coverage for all Maine citizens, and also advocate for the same at a national level, working through our congressional delegation; and

BE IT FURTHER RESOLVED, that the MMA advocate for and work in support of a system of universal health care coverage that builds upon the current system of public and private insurance, including existing employer-based and government programs; and

BE IT FURTHER RESOLVED THAT the issue be referred to the Executive Committee to study and report to a special session of the membership in six months.

May 1, 2003
Reaffirmed July 15, 2009

"PROVIDING COVERAGE TO ALL"

MMA'S WHITE PAPER ON HEALTHCARE REFORM IN MAINE

Background

At its 2002 Annual Session, the Maine Medical Association considered a Resolution prepared by its Public Health Committee, which called for the Association to endorse the concept of universal healthcare coverage for all Mainers (See Resolution attached). During the discussion at the Annual Session, members referred the Resolution to the Executive Committee to consider more fully some of the more novel and complex issues noted in the Resolution. The Executive Committee appointed an Ad Hoc Committee on Health System Reform and charged it with writing a White Paper detailing the steps to be taken to achieve universal coverage in a manner consistent with the charge of building upon the existing system of public and private payors.

The Ad Hoc Committee (members are listed in appendix B) met on four occasions to devise a set of Guiding Principles and to develop a list of features of a universal coverage plan. This paper adds discussion and detail to the Committee's work.

We hope that this plan from Maine's largest physician professional organization will add to the very substantial dialogue taking place in Maine on health system reform. The Association acknowledges the substantial efforts by several other groups to offer similar plans, from which this Paper has drawn inspiration.

1. "Closing the Gap", Maine Hospital Association;
2. "Creating a Healthy Maine"; Anthem Blue Cross Blue Shield;
3. "White Paper on Principles for a Universal Health Care System for the State of Maine"; Portland Universal Health Care Work Group,
4. "The Health Care Challenge", Maine Health and other participating organizations.

In the preparation of this paper, the Ad Hoc Committee has also drawn upon several papers prepared by the American Medical Association, the American College of Physicians – American Society of Internal Medicine, and Governor Baldacci's Office of Health Policy & Finance and Health Action Team. Appendix C contains the agendas and minutes of the Ad Hoc Committee meetings, which contain a fuller description of the many resources considered by the Committee.

The Principles upon which a system of universal coverage should be built are as follows:

Guiding Principles

- Universal coverage, which ensures access. Mandate participation
- Emphasize prevention eg: recommendations of US Preventative Task Force
- Systematic support for healthier lifestyles, through incentives for identified health risk avoidance.
- Individual responsibility, including responsibilities for one's own behaviors affecting health and well-being.
- Eliminate cost shifting,
- Educate patients and providers as to the price of services, products, and valid quality outcome data.
- Hold all stakeholders accountable for working together to make our health care system better and health insurance more affordable.
- Maximize the percent of health care dollars that support direct provision of patient care.
- Provide patients with choice in the selection of physicians.
- Improve quality and minimize errors by relying upon evidence-based medicine, benchmarking, and outcome measures.
- Build organizational structure that provides ongoing quality improvement and support of quality initiatives.
- Provide ongoing stakeholder monitoring of governmental initiatives in universal coverage program.

Achieving Universal Access

More than 140,000 Maine people, approximately 12% of the state's population, are without health insurance.

While Maine's uninsured percentage is lower than the national average of 14%, the goal of achieving coverage for all Mainers is essential for the following reasons:

1. There is cogent evidence that persons without insurance wait too long to access necessary medical services and are less likely to avail themselves of preventive services.

2. When the uninsured do access services, they frequently are unable to pay the cost of those services which is then shifted to others. This notion of "cost-shifting" has become a major policy issue.

The Maine Hospital Association annually estimates the cost-shift represented by bad debt and charity care to be $145 million and that figure does not include the cost-shift that also affects physicians and other providers. Governor King's Blue

Ribbon Commission on Health Care Costs (2000) estimated the total cost–shift to be approximately $163 million in 1999.

While achieving universal access in a single state, without the full participation of the federal government, will be difficult, it is not impossible.

Any plan to cover the uninsured must take into consideration the diversity of the uninsured population. More than one-half of uninsured individuals are employed. A substantial number are eligible for public programs but have not enrolled. Still others are individuals who wish to purchase coverage but cannot afford, on their low salaries, to do so. A very small group of people make more than 300% of the federal poverty level, but choose not to obtain coverage.

We believe that universal coverage can only be achieved through a variety of diverse initiatives. Briefly stated, they are as follows:

1. Develop incentives for small businesses to offer health insurance to their employees. The former Maine Health Program, a pilot project in the late 1980's was a very good model, but the Legislature eliminated the Program during the budget crisis of the early 1990's.

   It may be possible to draw down federal Medicaid funds to assist in covering those employees currently eligible for Medicaid coverage. This approach has been discussed in the Governor's Health Action Team and may find its way into the Governor's package.

2. Raise income eligibility levels to the maximum permitted in Medicaid, as drawing down the additional federal dollars will always be a positive strategy for Maine, so long as Medicaid payments to physicians and other providers are increased to cover the cost of providing the care. Gradually, Medicaid reimbursement rates for individual practitioners should be increased to the level of Medicare. To expand access by increasing eligibility in the public programs will only exacerbate the cost-shift if the programs continue to inadequately reimburse physicians and other providers.

3. Continue efforts to reach out to and enroll those individuals who qualify for public plans, but have not enrolled. While DHS, hospitals, and consumer groups have initiated such outreach programs, thousands of eligible persons still are not enrolled. This problem becomes particularly unfortunate when children are involved, as they are dependent upon others to enroll them.

4. Private insurance must be reformed in order to lower premium costs and to offer products that are attractive to uninsured. For young,

healthy adults it is important to offer a product emphasizing preventive care and catastrophic coverage.

While the notion of a Basic Health Plan has been criticized by many, we believe that it is one option that should be included in our effort to pursue universal coverage. In Washington State, a Basic Health Plan exists for about 125,000 low-income residents who are ineligible for Medicaid. We envision a similar Plan with the following coverages:

- Two physician visits annually with co-pays of $10-$20. For pediatrics, coverage for well-child visits in accordance with the recommendations of the American Academy of Pediatrics.
- Up to $300 in preventive care costs per year
- Up to $500 for lab or imaging services
- Cap total out-of-pocket costs at $2,500
- Annual deductible of $1,000

As a rule, the current system could be stronger and more viable and certainly would be more equitable, if more people were covered for fewer services. The full tax deductibility of employer-paid health insurance encourages purchasing more health insurance than some people need. This over-insurance also impacts utilization, as people are not as discerning in their use of the health care system when they are insulated from its cost.

Bottom line. Less expensive policies must be developed if the "young immortals" are going to be motivated to purchase health insurance.

5. MMA supports the concept of Association Health Plans and other group purchasing collaboratives. While we are mindful of the problem of "cherry-picking" whereby such plans insure only the healthy leaving the chronically ill or disabled for high risk pools, this problem will be lessened in a system where all persons are insured.

Individual Mandate

Despite the five approaches endorsed above, it is the Association's considered opinion that universal coverage cannot be achieved without requiring everyone to maintain some basic coverage. For the same reason Maine requires motorists to buy auto insurance, the state should require the purchase of health insurance. This approach will not seem radical if several types of plans are accessible, some of which are basic plans with low cost. Some system of public subsidy will

be necessary for those individuals who do not qualify for a government health program and cannot afford individual or employer-sponsored coverage. Administratively, the individual mandate need not be difficult. At least one commentator has suggested requiring people to indicate on their annual tax form whether they are insured for health care. If they do not so indicate, they would be enrolled by default in a plan or either billed or subsidized accordingly. (Ted Halstead, New York Times article 1/31/03)

Such an approach would have several salutary effects, including:

1. People would be likely to have more opportunity than they do currently to select a policy and the level of insurance appropriate for them and their families. Continuity of coverage and of care would be more likely to be maintained.

2. A more vigorous and competitive market for health insurance would develop as the result of more customers. More choices of carriers and products would be available than the very limited choices available in Maine today.

3. People would be likely to seek preventive care earlier, thus improving the quality of their care.

4. Insurers would be more likely to invest in disease prevention because more people would stay with a single insurer for a longer period ensuring the carrier a better return on its investment.

State Subsidized Non-Profit Insurer

If the types of affordable insurance products contemplated by this Plan are not forthcoming, MMA is not opposed to the state chartering its own non-profit insurance company. In fact, at the time MMA opposed the sale of Blue Cross Blue Shield of Maine to Anthem, we noted that it might become necessary to "re-create" a similar company in the future, as a hedge against a lack of competition in the insurance market. This may be even more necessary today now that the three major health insurance companies are all for-profit, stock-based companies. In a relatively poor state such as Maine, we are skeptical about the ability of our patients to pay enough premium to pay for all the legitimate health care needs of the members, the administrative costs associated with those needs, and still have money left over to pay shareholders. The truly huge premium increases of the past 24 months are further evidence of this problem. Our MMA Group Health Plan has increased 67% in the past two years for our retired group and nearly 30% for our active members. It is a bit ironic when the physicians responsible for providing the hands-on care cannot afford coverage themselves!

Cost

Any plan to achieve universal coverage cannot ignore the fact that the high cost of health insurance is the greatest barrier to access. We cannot achieve universal coverage if premium costs continue their unrestrained increase. In addition, we acknowledge that health insurance premium increases are primarily the result of increasing health care costs. While many of the cost drivers are beyond the ability of government or society to control (aging population, new technology, patient demands, etc.), there are several concrete steps that can be taken to positively impact health care costs and premiums in Maine, including the following:

1. Eliminate geographical inequities in the Medicare funding formula. Maine's healthcare providers and institutions should not receive less pay for the same services that warrant up to 40% higher reimbursement in other states.

2. Provide incentives for electronic claims submission, electronic medical records, and other technological advances likely to make the delivery and finance system more efficient and to promote quality health care. Capitalize on new technology to develop care management systems to support the care of patients with chronic disease.

3. Establish a state health planning process that is independent, objective, and designed to ensure a rational building of additional capacity. Such a planning process should avoid duplication but should also encourage patient choice, including incentives for patients to receive care in the lowest cost setting where safe and appropriate. Ample data supports the case for allowing patients a choice of outpatient facilities rather than expanding existing monopolies. It may be possible to have different Certificate of Need rules apply in those areas where there is competition among providers versus those more rural areas where protection of the existing facilities may be a priority.

   Any state planning process should include specific goals for access, quality, and affordability.

4. Educate patients and providers as to the price of all health services and products, particularly the cost of prescription drugs. Encourage co-insurance rather than fixed co-payments to ensure that patients have a substantial personal investment in the medical care they seek.

5. Accept limits. No health care system can hope to cover all the services that patients want. Universal coverage cannot mean

unlimited care. Appropriate services based on evidence-based medicine, outcomes research and appropriate patient education should be covered. Appropriate end-of-life-care presents a unique opportunity to set limits, based on clear patient preference and appropriate ethical guidelines.

6. Professional Liability. Increasing medical liability premiums are a cost driver in the system and encourage the practice of defensive medicine. While Maine has an existing system of reforms, such as the pre-litigation screening panels, a reasonable cap on non-economic damages is necessary to reduce potential unlimited liability. We recommend $250,000.

Quality.

Most observers of our healthcare system now understand that good quality care saves costs. Medical errors and other examples of poor quality not only hurt patients physically, but also hurt all of us in the pocketbook. The MMA offers the following recommendations for improving quality.

1. Give physicians and other providers incentives to adopt new technologies such as electronic medical records and automated order entry and pharmacy monitoring in order to reduce medical errors.

2. Encourage conformance with professionally developed practice guidelines and protocols. Support establishment of a successor organization to the Maine Medical Assessment Foundation. Such a statewide quality improvement foundation could engage in a number of activities ultimately designed to improve quality such as small area variation analysis and standardized data analysis.

   Currently, many quality improvement initiatives exist throughout the state and all are well intentioned, but there is an acute need to coordinate and perhaps centralize these disparate and sometimes duplicative efforts.

   Both the Maine Hospital Association and the Maine Medical Association have quality committees working on these issues, but a state role may be necessary in order to assure broad-based funding and broad participation. We clearly need to build organizational structures that provide ongoing quality improvement and support of quality initiatives.

3. Quality can be enhanced by empowering patients to partner with their physicians in their health maintenance and care. The healthcare system needs to provide systemic support for healthier lifestyles through incentives for identified health risk avoidance.

Conclusion

Our final principle for reform provides that all stakeholders are accountable for working together to make our health care system better and health insurance more affordable. The Maine Medical Association stands ready and willing to work collaboratively with all other stakeholders, including state government, in order to address the very real crisis in health insurance coverage in our state.

Inclusion Statement July 15, 2009

In an effort to provide coverage to all persons, that MMA supports a public option in the health insurance market so long as the plan meets the principles of the MMA White Paper on Health System Reform dated May 2003.