



## MAINE MEDICAL ASSOCIATION

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### ***MEMORANDUM***

**To:** The Honorable Dawn Hill, Senate Chair  
The Honorable Margaret R. Rotundo, House Chair  
Members, Joint Standing Committee on Appropriations &  
Financial Affairs

**From:** Gordon H. Smith, Executive Vice President

**Date:** March 5, 2013

**RE:** **THE AFFORDABLE CARE ACT'S OPPORTUNITY FOR  
FEDERALLY FUNDED HEALTH CARE FOR THE UNINSURED  
IN MAINE AND OTHER STATES**

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Thank you for the opportunity to address you on this important health policy matter this afternoon. As background for our discussion, I have attached the following documents:

1. Federally Funded Health Care for Maine's Uninsured: Good Health Policy - - Good for Maine's Economy;
2. COVER MAINE NOW COALITION membership list;
3. "Providing Coverage to All," MMA's White Paper on Healthcare Reform in Maine (approved 2003; reaffirmed 2009); and
4. Resolution #8 re: *Health Insurance Coverage* approved at the 2002 Maine Medical Association Annual Session.

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## **Federally Funded Health Care for Maine's Uninsured: Good Health Policy -- Good for Maine's Economy**

The Affordable Care Act (ACA) has set aside federal dollars for Maine to provide Medicaid coverage to approximately 69,500 people who would be uninsured otherwise. Adults with income up to 138% FPL (\$15,856/year for an individual; \$26,951/year for a family of three) would be covered, starting January 1, 2014.

**Full implementation of the ACA's Medicaid option is a good deal for the State of Maine.** The federal government will pay 100% of the cost of covering "newly eligible" individuals in Maine for three years, through December 31, 2016. After that, the federal contribution will be adjusted gradually until it reaches the permanent rate of 90% in 2020, far greater than the 64-cent rate it pays for current Medicaid members.

**Most working low-income adults with income below 138% of the federal poverty level can't afford health insurance.** They have little to no discretionary income and cannot afford the out-of-pocket expenses that people in health care Exchanges will have to pay, even with available subsidies.

**Accepting federal dollars already set aside to cover Maine's uninsured will benefit all Maine people AND boost Maine's economy.**

- ✓ **More Mainers Will Have Health Insurance:** Forty percent of the uninsured in this state have incomes at or below 133% of the poverty level.
- ✓ **Health Care Costs Will Go Down:** With insurance, people will be less likely to delay the care they need; their overall health will improve; and their need for more costly care will be reduced.
- ✓ **Coverage Saves Lives and Improves Health:** A recent Harvard study found that expansions of Medicaid coverage were associated with an improvement in overall health status and a significant reduction in death rates.
- ✓ **Charity Care Will Decrease and People with Insurance Will See Rate Relief:** This coverage will keep people out of emergency rooms and dramatically reduce rates of charity care for all hospitals in Maine. The decrease in the cost of hospitals' charity care means there will be less shifting of costs private payers.
- ✓ **Workers Will Be Healthier:** Health coverage helps to prevent and treat illness and helps people with chronic conditions to better manage their health.
- ✓ **Maine's Economy Will Grow:** Millions of new federal dollars will be invested in our health care system, creating thousands of new jobs for our State.
- ✓ **Thousands of Uninsured Maine Veterans Will Gain Coverage:** Approximately 7,000 uninsured Maine veterans who do not have health insurance today could be covered in 2014 if Maine accepts these federal funds.

**This is an opportunity Maine can't afford to pass up.** If we don't accept these federal dollars, they will simply go to other states.

## COVER MAINE NOW COALITION

AARP	Maine Dental Access Coalition
Acadia Family Center	Maine Equal Justice Partners
Advocacy Initiative Network of Maine	Maine Labor Group on Health
Alzheimer's Association	Maine Medical Association
American Cancer Society Cancer Action Network	Maine Parent Federation
American Diabetes Association	Maine People's Alliance
American Heart Association	Maine Primary Care Association
American Lung Association in Maine	Maine Public Health Association
American Nurses Association-Maine	Maine Small Business Coalition
Behavioral Health Community Collaborative	Maine Speech Language Hearing Association
Catholic Charities of Maine	Maine Unitarian Universalist State Advocacy Network
Center for Creative Healing	Maine Women's Health Campaign
Consumers for Affordable Health Care	Maine Women's Lobby
Crisis and Counseling Centers	Mainely Girls
Dirigo Counseling Clinic	MooseRidge Associates
Disability Rights Center	MSEA SEIU
Family Planning Association of Maine	NAACP Portland Branch
Home Care for Maine	NAMI Maine
Homeless Voices for Justice	National Association of Social Workers, Maine Chapter
Kidspace Inc.	National Multiple Sclerosis Society, Greater New England Chapter
Maine Affiliate of Susan G. Komen	Opportunity Alliance
Maine Association of Area Agencies on Aging	Oxford County Mental Health Services
Maine Association of Mental Health Services	Planned Parenthood of NNE
Maine Association of Psychiatric Physicians	Preble Street
Maine Association of Substance Abuse Programs	Religious Coalition Against Discrimination
Maine Center for Economic Policy	Roman Catholic Diocese of Portland
Maine Children's Alliance	Somali Culture and Development Association
Maine Community Action Association	Sweetser
Maine Council of Churches	

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.

