MAINE MEDICAL ASSOCIATION

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MEMORANDUM

To: The Honorable Geoffrey M. Gratwick, M.D., Senate Chair
The Honorable Sharon Anglin Treat, House Chair
Members, Joint Standing Committee on Insurance & Financial Services

From: Andrew B. MacLean, Deputy Executive Vice President

Date: January 9, 2014

RE: L.D. 1037, AN ACT TO PROVIDE ACCESS TO AFFORDABLE HEALTH CARE FOR ALL MAINE RESIDENTS BY 2020

AND

L.D. 1345, AN ACT TO ESTABLISH A SINGLE-PAYOR HEALTH CARE SYSTEM TO BE EFFECTIVE IN 2017

Good afternoon Senator Gratwick, Representative Treat, and Members of the Joint Standing Committee on Insurance & Financial Services. Gordon and I are at meetings out of state today and we have asked Jessa to cover a number of events in our absence, so I wanted to offer this memorandum with attachments as the Maine Medical Association's (MMA's) contribution to the Committee's discussion of these two bills and their goal of providing access to affordable, quality health care for all Maine people. Please consider the MMA's position to be "neither for nor against" the bills.

I would like to thank Representative McGowan and Representative Priest for sponsoring these bills and drawing attention to our health care coverage goal. I note in particular Representative Priest's consistent advocacy in support of a single-payer approach to health care reform as sponsor of such legislation in each of his recent terms in the House. I also acknowledge the passion and commitment of the physicians of Maine AllCare who will participate in today's hearing.

I have attached for your reference, the following two documents which constitute the MMA's standing policy on health care reform and our health care coverage goal.

- Resolution #8, *Health Insurance Coverage* adopted at the 2002 Annual Session of the MMA; and
- *Providing Coverage to All, MMA's White Paper on Healthcare Reform in Maine* dated May 1, 2003 and reaffirmed July 15, 2009.

Based upon the principles outlined in these documents, the MMA supported the Dirigo Health Program legislation in 2003 and the *Patient Protection and Affordable Care Act* (PPACA or ACA) in 2010. Since 2010, the MMA has consistently advocated the implementation of the ACA in Maine, including the acceptance of the additional federal funds available under the ACA to expand health insurance coverage for approximately 70,000 low-income Mainers (L.D. 1066 and L.D. 1578).

Regarding the views of Maine physicians on a single-payer approach to health care reform, I think that physicians' views are evolving with more physicians leaning towards a single-payer approach the more they witness the deficits and frustrations of our current system in their daily work. The 2002 Resolution #8 was a clear statement in opposition to a single-payer approach to health care reform. Just six years later in 2008, the MMA surveyed its members on the topic as follows:

- ***When considering the topic of health care reform, would you prefer:***
  - ***To make improvements to the current public/private system (47.7% of all respondents)***
  - ***A single-payer system such as a "Medicare for all" approach (52.3%)***

The MMA intends to ask this question of its members again in the near future, but the 2008 polling results suggest that the physician community in Maine is closely divided on the topic of health care reform and approach to our health care coverage goal.

Lastly, I caution the Committee about the challenges of a single-payer approach to health care reform at the state level, particularly a small state, because of the dominant influence of federal law (the *Social Security Act* establishing the Medicaid and Medicare programs and the *Employee Retirement & Income Security Act* [ERISA] as two principal examples) on our health care system. To give you a sense of the physician perspective on Vermont's recent experience, I have attached an article entitled, *Administration Releases Single-Payer Financing Plan: All Savings Based on Reduced Payments to Providers* from the May/June 2013 edition of **The Green Mountain Physician**, the newsletter of the Vermont Medical Society.

Thank you for considering the MMA's perspective on these bills and the topic of health care reform.

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.

Administration Releases Single-Payer Financing Plan: All Savings Based on Reduced Payments to Providers

Earlier this year the Shumlin administration released its long-awaited financing plan for Green Mountain Care (GMC) – the proposed publicly financed single-payer health care system. The study projects that under GMC Vermont would save $34 million in 2017 in funding the state's $6.0 billion health care system. The report's savings appear to be achieved solely by reducing provider payment rates by $155 million.

The University of Massachusetts Medical School and Wakely Consulting Group were paid $300,000 to provide the cost estimates and to draw up two financing plans for the state. One plan was for the state's single-payer system scheduled for 2017, and the other was for funding the state's new health insurance exchange, which will go into effect in 2014, as required by the federal Affordable Care Act (ACA). The consultants worked directly with members of the administration to develop the report and the plan's cost components.

A federal waiver from the requirements of the ACA is necessary for implementation of the single-payer health care system in 2017. An ACA Section 1332 waiver from the federal Secretary of Department of Health and Human Services would allow Vermont to opt out of specific exchange-related provisions of ACA beginning on Jan. 1, 2017, if it ensures that the state's residents would have access to high quality affordable health insurance by alternative means. The plan indicates that the State of Vermont would receive $267 million in federal funds to support the single-plan as a result of the waiver.

The plan estimates $1.61 billion in new tax revenue would be required to replace the insurance premium portion of the $6.0 billion in total system costs in 2017. And while $1.61 billion may seem like a very large amount, it would have been a much greater sum if the plan did not propose setting provider reimbursement at a low level.

Unexpectedly, the Act 48-mandated financing plan lacked any specific proposals for how the state would generate the $1.61 billion in publicly financed revenue for the new single-payer system. However, it is important to note that the 2017 ACA single-payer waiver from DHHS is not dependent on the enactment by the Vermont Legislature of new taxes in order to move to a single-payer system, but does require a 10-year budget.

It will be extremely difficult for the legislature to enact broad-based taxes in 2015 sufficient to generate $1.6 billion in new revenue due to the potential impact on the state's economy. The Vermont Medical Society believes it is entirely plausible that the state's single-payer plan in 2017 will continue to rely on a combination of existing Medicaid revenues and subsidized premiums from beneficiaries to fund the state's single-payer plan. It is clear from the report that a major focus of GMC beginning in 2017 will be the implementation of a state-established uniform reimbursement methodology for the health care services provided to the vast majority of Vermonters who are under 65.

Of great concern to VMS is that the report's $34 million in savings for the 2017 plan appear to be achieved solely by reducing provider payment rates by $155 million. The plan states "[A]nd health care providers will receive the same and adequate rates for all their patients, calculated at 105 percent of Medicare payments." The financing plan further indicates that private insurance reimburses providers at 155 percent of Medicare and that the number of individuals covered by private insurance will be reduced in 2017 from 343,085 to 39,499. The plan therefore anticipates a 32-percent cut in provider reimbursement in providing care for the 303,585 Vermonters who were formerly covered by private insurance.

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SINGLE-PAYER FINANCING PLAN

(Cont'd from pg. 3) As devastating as a $155 million cut in payments would be, VMS believes the plan underestimates the reduction in payments to providers in 2017. The plan indicates the total reduction in payments from private insurance companies would actually be $469 million and that this amount would be offset by an increase in Medicaid payments in 2017 of $314 million -- with a net reduction of $155 million. However, the plan fails to acknowledge the increase in 2013 and 2014 of Medicaid payments to primary care physicians to 100 percent of Medicare that was mandated by the ACA and overstates the savings of any hypothetical increased Medicaid payments in 2017. There is also no guarantee that the legislature would approve such an increase in Medicaid reimbursement.

More importantly, by setting the single-payer reimbursement at 105 percent of Medicare, the single-payer plan would permanently tie its physician and hospital reimbursement to any future increases (or decreases) in Medicare reimbursement. Over the next 20 years, the federal government will continue its efforts to constrain the cost of Medicare in order to ensure its sustainability with the enrollment of the Baby Boomer generation. For example, since 2001, due to Congress' inability to address the Sustainable Growth Rate (SGR), Medicare payments for physician services have only increased by four percent, while the cost of caring for patients as measured by the Medicare Economic Index (MEI) has increased by more than 20 percent.

Correspondence dated Jan. 21, 2013, between the administration and their consultants makes it clear that the single-payer plan's "ongoing savings comes from keeping provider rates at the rate of increase of Medicare rates which is lower than the current growth in health care costs."

The UMass study's estimates are based on the assumption that all Vermont residents would be automatically enrolled in the single-payer plan in 2017. Using the plan's mid-level estimates, 437,500 Vermonters would have GMC as their primary insurance, and provider reimbursement would be at 105 percent of Medicare; 70,000 individuals would continue to receive their insurance from their employers, and provider reimbursement would be at 155 percent of Medicare, and 129,000 seniors would be covered under Medicare, and provider reimbursement would be at 100 percent of Medicare.

Using the plan's estimates, on a population basis, the average reimbursement in Vermont for the entire population would be 109 percent of Medicare. However, due to the higher utilization rates in the Medicare population and the GMC population, the average state-wide reimbursement would be lower. By way of contrast, DVHA currently reimburses federally qualified health centers (FQHCs) on a cost basis at 125 percent of Medicare – a cost-based reimbursement rate that is 19 percent higher than the 105 percent of Medicare rate established in the financing plan.

In response to these concerns, the Vermont Medical Society, the Vermont Business Roundtable, Blue Cross and Blue Shield of Vermont, Fletcher Allen Health Care, the Vermont Chamber of Commerce, Vermont Assembly of Home Health and Hospice Agencies and the Vermont Association of Hospitals and Health Systems have jointly contracted with Avalere Health, LLC, to provide an assessment and health delivery system impact of the Health Care Reform Financing Plan. Avalere will provide an expert assessment of the Financing Plan, its assumptions and models, and its impact on health care provider economics, businesses and consumers of health care and service delivery.

Each of these organizations shares a commitment to the goals of universal access and coverage; to providing the highest-quality care; and, to delivering this with the greatest cost efficiency in a way that is financially sustainable for the state and its citizens. The group believes these health care reform goals can only be achieved through a collaborative, transparent and meaningful public/private relationship that builds on our state's existing strengths and assets and achieves mutual accountability for their outcomes.

The period of time between today and 2017 will be critical for the future of Vermont's health care system. VMS will strive to keep its members informed of the various health care initiatives as they become available and it will continue its advocacy on behalf of all physicians and their patients.