LESSONS LEARNED: MAINE LEGISLATORS WEIGH IN ON HEALTH CARE NEEDS AND BEST PRACTICES TO BE ADDRESSED IN CONGRESS AND THE ADMINISTRATION'S HEALTH CARE PROPOSAL[1]

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PUBLIC OPTION:

We are strong proponents of a single payer approach to providing access to health care because it is less wasteful administratively and likely to cost-effectively provide affordable coverage to all, with streamlined administration, and a guarantee that everyone is in the same pool. We are concerned that alternative proposals won't be able to provide quality health care to everyone without bankrupting the country. We note the meager attempts of health insurance companies to work together to lower health care costs were branded as a violation of the Sherman Antitrust Act, and the difficulty states have had in controlling costs through the private insurance system.

That said, the insurance exchange proposed by President Obama can achieve many benefits -- if and only if it includes a robust public option combined with significant health system reforms, cost controls, consumer protections, and is seamlessly wrapped around Medicaid and Medicare.

A public option will help insure there is full transparency, accountability and competition. Our perspective on this is informed by Mainers' experience with the Medicare Part D prescription drug benefit. Part D has no public option. The prices are inflated, it is an incredibly confusing program with multiple insurers offering many different products (which change constantly), and consumers don't have good information. Basically, consumers don't get good value for their money under Part D, and the cost is so great there is no coverage at all once they reach the infamous "donut hole."

Our views are further influenced by our experience with Maine's DirigoChoice, which has led us to be strong proponents of a true publicly-run option: to the extent possible everyone should be in the same pool so that we can drive costs down and capture savings as fewer people rely on hospital emergency rooms, and "uncompensated care" costs no longer are added to everyone's health insurance bill. We have had mixed experience in Maine with private insurance carriers as partners, with DirigoChoice suffering initially because the insurance carrier did not market the public option, favoring its own competing plan.

OTHER PREREQUISITES FOR AN EFFECTIVE INSURANCE EXCHANGE MODEL:

In addition to requiring a public option, an insurance exchange will assure quality, affordable care to everyone only if:

(1) true affordability is a priority, including caps on out of pocket costs and subsidies for those who are ineligible for Medicaid and below 500% of the Federal Poverty Level;
(2) there are rules as in Maine requiring guaranteed issue and community rating, and prohibiting discrimination based on health status and other factors including age, gender and immigration status;
(3) there is complete transparency of insurance options with uniform terms (as required by Maine LD 1205);
(4) there are significant cost controls; and
(5) there is a strong emphasis on prevention, wellness and primary care, with best practices rewarded and financial sanctions for those who do not measure up.

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[1] *Compiled and drafted by Rep. Sharon Treat, House Chair, Insurance & Financial Services Committee (IFS), with input from House Speaker Hannah Pingree; Rep. Anne Perry, NP, House Chair, Health & Human Services Committee (HHS); Rep. Adam Goode (IFS); Rep. Lisa Miller (Appropriations); Rep. Charles Priest (IFS); Rep. Linda Sanborn, MD (HHS); Rep. Peter Stuckey (HHS); Rep. David Webster (Appropriations).*

LESSONS LEARNED & BEST PRACTICES:

- **Insure fair funding.** Health care based on ability to pay is key – for both businesses and individuals.
    - A LESSON LEARNED from Maine: had sufficient funding for Maine's DirigoChoice subsidies been available, allowing us to make the product cheaper, many more people would have coverage. So the subsidy is key – for a public plan or private plans – to expand coverage to all. We recommend subsidies up to 500% of the federal poverty level.
    - A BEST PRACTICE: Wellness incentives could play a role in the subsidy programs, as in Maine's recently adopted biennial budget which allows state employees to "buy back" premium increases by participating in wellness initiatives.

- **Develop and encourage comprehensive primary care.**
    - Move health care systems away from fragmented, quantity-driven care models toward BEST PRACTICE Mayo Clinic models, where providers band together in accountable-care organizations in which doctors collaborate to increase prevention and quality of care.
    - Discourage overtreatment, over-testing, and profiteering by eliminating current incentives for extra testing and procedures. Too often, medical practices discover they can add dollars to their bottom line by getting a person trained (minimally) to provide a new service in-house; medical care suffers and costs go up.
    - Reduce the economic burden on starting physicians and pay primary care providers more relative to specialists. Provide incentives to practice primary care and make enough per patient so that physicians can give the time and quality care required.

- **Control costs.** We need to rein in health care costs in a comprehensive manner. One of the most salient LESSONS LEARNED in Maine was when we discontinued our Maine Health Care Finance Commission in the 1990s, which featured global budgets for hospitals, and we have watched our health care costs skyrocket ever since.
    - Establish a mechanism for global budgeting, and consider regulation of the health care business to standardize rates and justify the changes in any cost, as we do for utilities.
    - Require reporting of all profits, fund balance and incomes of all management staff if hospital takes any government dollars.
    - Encourage patient centered medical homes through financial and other incentives to develop infrastructure, information systems and coordinated care.
    - Change the incentives to discourage physicians from developing their medical practices as a business model that maximizes profits.
    - Create clinics that are open until late in the evening. 80% of emergency room visits take place in the evening until about 11 p.m. Although some hospitals do not have the staffing to create a clinic, others do, and providing evening clinics helps develop a primary care relationship with patients which will reduce costs in the long run.

- **Make it easier and less expensive to administer practices.** We are now spending as much time on paperwork and reimbursement hoops as on providing care, spending an ever-larger percentage of the medical dollar on administration at the local practice level. An insurance exchange could lead to even more paperwork. Instead, it must be designed with one set of rules, harmonizing insurance and public payment forms and billing, prior authorization and other administrative provisions.

- **Pay for quality, not quantity of care.** This will require measurement of outcomes and coordinated care. Maine BEST PRACTICES include the Maine Quality Forum and public reporting through the Maine Health Data Organization.
    - Create disincentives for care that doesn't measure up to consensus standards; a BEST PRACTICE in Maine is the Maine Health Management Coalition's sanctions of hospitals that don't measure up. It is quite damaging financially for them.

- One approach would be a fixed payment to the insurer for the care of a patient, the same payment for each citizen. The insurers/providers then compete for those patients, who are free to choose where they get their care, by offering the best quality care with measurable outcomes that are transparent to consumers. If the providers offer patient education, preventative care, and good chronic disease management, it will cost them less to care for those they cover and keep health care costs down. They will not be paid more for doing more tests and procedures.

- **Make sure Medicaid is supported and integrated into federal health reforms and that states receive sufficient funding. Incorporate incentives for quality, cost-effectiveness and a focus on primary care and wellness are into Medicaid as in the health care system as a whole.**

  - **BEST PRACTICE:** Placing income eligible populations directly into Medicaid is the most effective and efficient method to provide coverage for these families. **LESSON LEARNED:** Our experience enrolling Medicaid dual eligibles into Medicare Part D has shown that the private insurance model doesn't work for everyone. Maine established a simplified system that automatically enrolled eligible patients in the best Part D plan, and recommends a similar model to enroll certain populations in the public health care option or Medicaid. Otherwise, placing certain populations, including adults without children, into private plans through the exchange would establish a burdensome process that could diminish access to critical coverage for people who often have high health care needs.

  - **Create simple, streamlined ways for people to enroll in and renew Medicaid coverage. Eliminate existing categories in Medicaid and establish a simple, universal federal floor for all low-income children and adults**, **including adults without children,** at 150 percent of the poverty line with state option to cover all adults up to 200% FPL and children at higher levels.
    - Improve enrollment and retention for all enrollees by eliminating face-to-face interviews and asset tests and requiring 12-month continuous eligibility. Create standardized, family-friendly application forms, and fund community-based outreach.
    - Since Maine and many other states have already committed to covering families above 150% of the federal poverty level, they should be permitted to continue to provide this coverage and receive federal financial participation to do so. It is important to give states this flexibility since the extent to which private insurance options exist varies widely from state to state.

  - **Encourage greater provider participation in the Medicaid program by increasing payments to providers.** Some states have difficulty recruiting necessary primary care providers and specialists to Medicaid, especially for underserved areas and minority and immigrant populations, because of low reimbursement rates.

  - **Develop quality measures in Medicaid that ensure high-quality, cost-effective services and coordinated care across health settings.** As a starting point, apply Medicare quality standards to Medicaid where appropriate, and extend the CHIPRA quality provisions to Medicaid as proposed by the Senate Finance Committee. Medicaid should transition to a stronger medical home model that coordinates care across settings for all services for every Medicaid enrollee. Additional quality measures must focus on children, who have markedly different care needs than adults, and on reducing ethnic disparities.

  - **Fully fund Medicaid and automatically increase federal matching funds in periods of economic downturn.** Because Medicaid is a countercyclical program, the federal government needs to help states respond to increased Medicaid costs when unemployment rises and state revenues decline. Increased federal support for home-based care could reduce Medicare and Medicaid costs.