



Task Force on Health Care Coverage

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January 22, 2018

Eastern Maine Healthcare Systems

- Nine Member Hospitals
- Monthly Encounters: 160,000 – 180,000
- Monthly Self Pay Encounters: 9,000 -11,000 (5.7%)
- Financial Counselors: 30
 - Certified Application Counselor: 20
- Charity Care Adjustments 2017 - \$60.9 million *\$ 83 million bad debt*

Coverage Availability: Self-pay & Underinsured

- 100% Free Care: ME Residents below 150% FPL
- 50-55% Free Care: ME Residents 151-250% FPL
- Special Programs:
 - Prescription discount programs
 - Community grant programs
- Affordable Care Act (ACA) Plans: EMHS employed Certified Application Counselors (CAC) available to help patients enroll in available ACA plans.
- Payment Plans: tiered plans available at zero cost to patient.
- Balance Forgiveness: Periodically patients are offered discounted settlement of outstanding balances.

501r Compliance

- 501r regulates the provision of financial assistance for patients at not for profit hospitals. It requires the clear communication of the availability of Financial Assistance, and governs the timeline and methodology of sending uncollected accounts to collections.
- EMHS undergoes continual internal audit to ensure we meet all requirements of 501r.
- Patient facing website with all required Financial Assistance Policy (FAP) documents. <http://emhs.org/billing-help.aspx>
- Posters and FAP documents available at patient facing locations and community locations.
- Billing statements offer access to FAP documents and financial counseling services.

Self-Pay Outreach

- All Self Pay registrations are reviewed for existing MaineCare coverage.
- Financial Counselors (FCs) throughout the system are assigned worklists to reach out to SP patients.
- Referrals for FC services come from hospital departments, physician practices, and patients.
- FCs offer help in identifying coverage and alternative payment sources for those in need. Many are CACs and can enroll patients in ACA plans.
- Patients are offered 25% discount for payment at Point of Service (POS) or in first three billing cycles.

Underinsured Patient Outreach

- EMHS strives to provide assistance to patients who have questions about potential financial impact of their medical care.
- All Medicare patients without secondary insurance are checked for MaineCare coverage.
- EMHS supports Pricing Transparency with web links to MHDO site and member price lists available via web, phone or in person.
- Patient estimates are offered for a growing number of services throughout EMHS i.e. Imaging, Surgery and ED.
- Providing estimates leads to referrals to FCs for patients concerned about ability to pay.
- EMHS complies with ME 128- “Patient’s Right to Shop.”

ME 128- Patient Right to Shop

- Patient is notified in writing of their Right to Shop either on Discharge/Visit Summary document or on printed form if summary not automatically generated.
- Provides patient with description of ordered services and summary of their rights and responsibilities.
- *If your healthcare provider has recommended that you receive one or more of the following non-emergency outpatient healthcare services: physical therapy, occupational therapy, radiology, imaging, laboratory services and/or infusion therapy, you have the right to compare prices for these services between different healthcare providers. If you have health insurance, you can contact your healthcare insurance carrier directly at their toll free number for information. Your healthcare insurance carrier may also have a healthcare price transparency tool that you can review. If you or your healthcare insurance carrier needs additional information in order to compare prices, please contact your healthcare provider. If you choose to receive these services from a different healthcare provider, you must tell us so that we can give that healthcare provider a copy of your referral and any other paperwork that may be needed.*

Future Enhancements

As EMHS rolls out changes to EHR and Revenue Cycle systems we anticipate several enhancements to aid identification of payment sources and Financial Counseling service expansion.

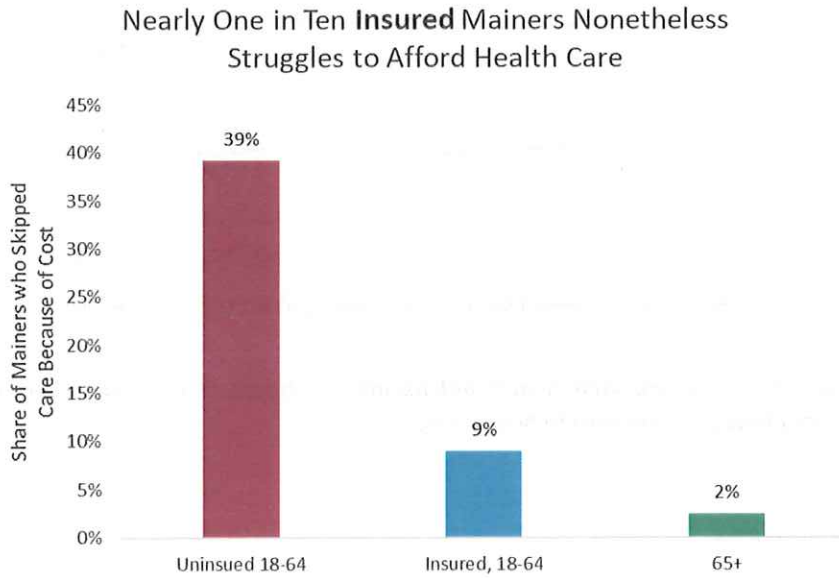
- Expanded insurance eligibility review for SP and underinsured patients.
- Enhanced estimation functionality.
- Integrated FC workload.
- Enhanced identification of patients in need of assistance.

Testimony Before the Task Force on Health Care Coverage for All of Maine

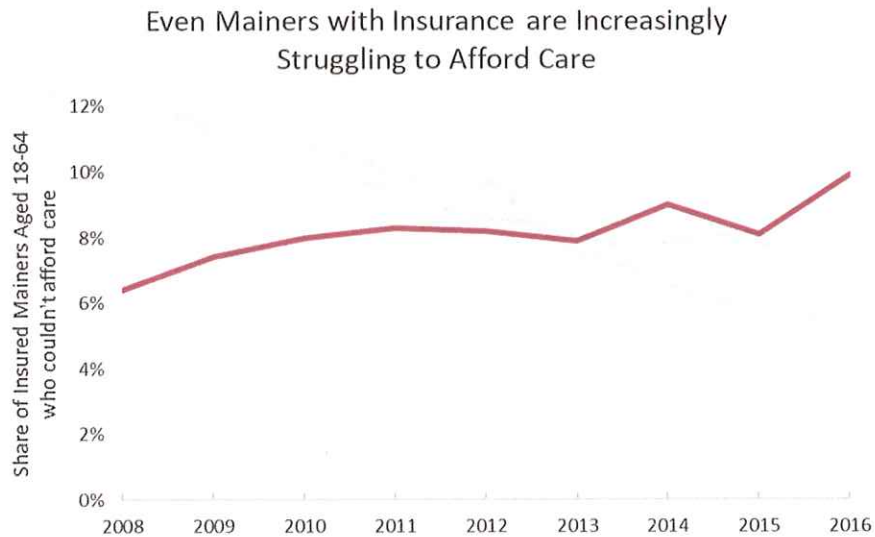
January 22, 2018

James Myall, Policy Analyst

Insurance Coverage is Not the Same as Access to Care

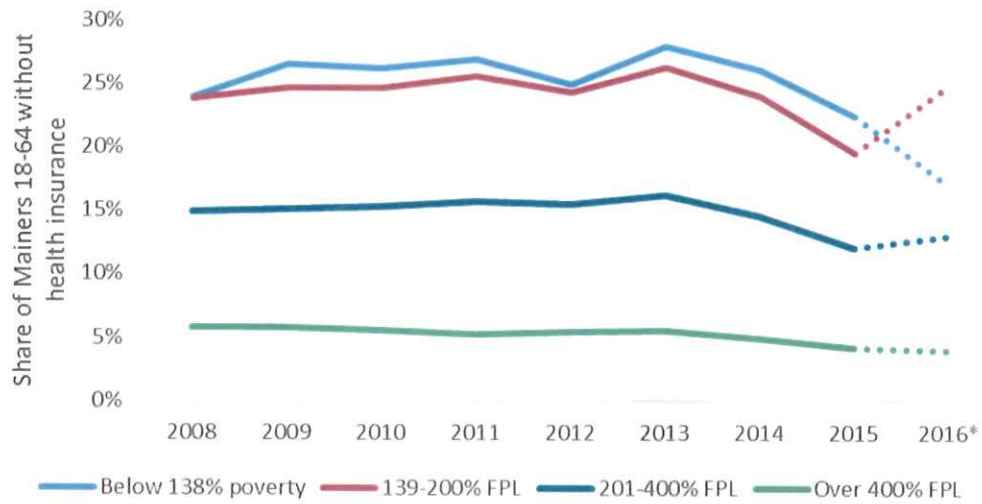


Source: MECEP analysis of US Centers for Disease Control and Prevention, Behavioral Risk Factors Surveillance System, 2014-16 data. An individual who skipped care because of cost is defined as someone who forewent or delayed a visit to a health care provider because of cost at least once in a year.



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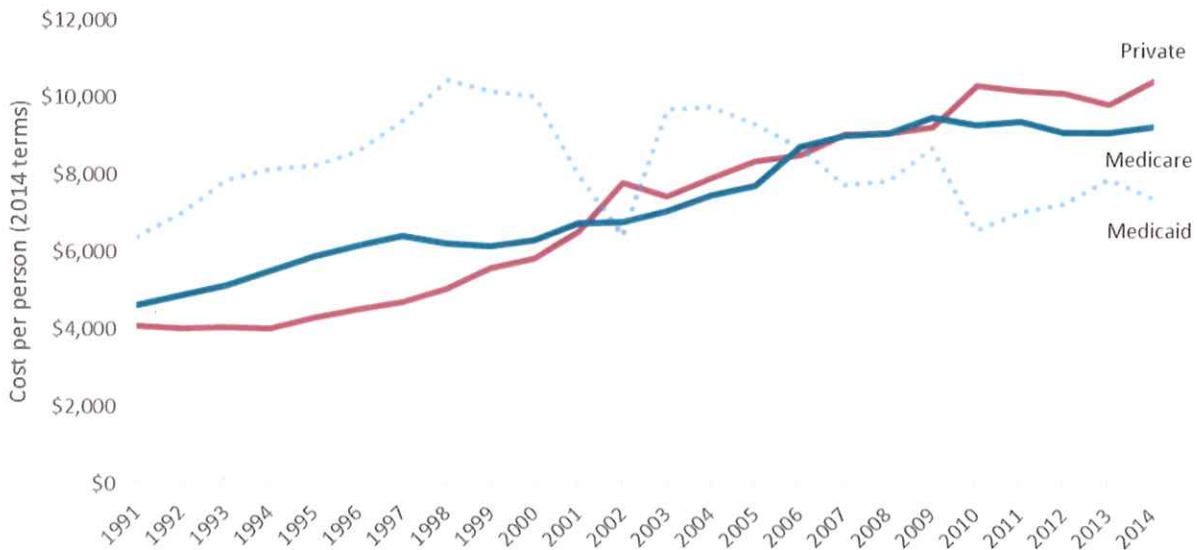
Mainers Just Above the Poverty Line Still Struggle to Afford Insurance



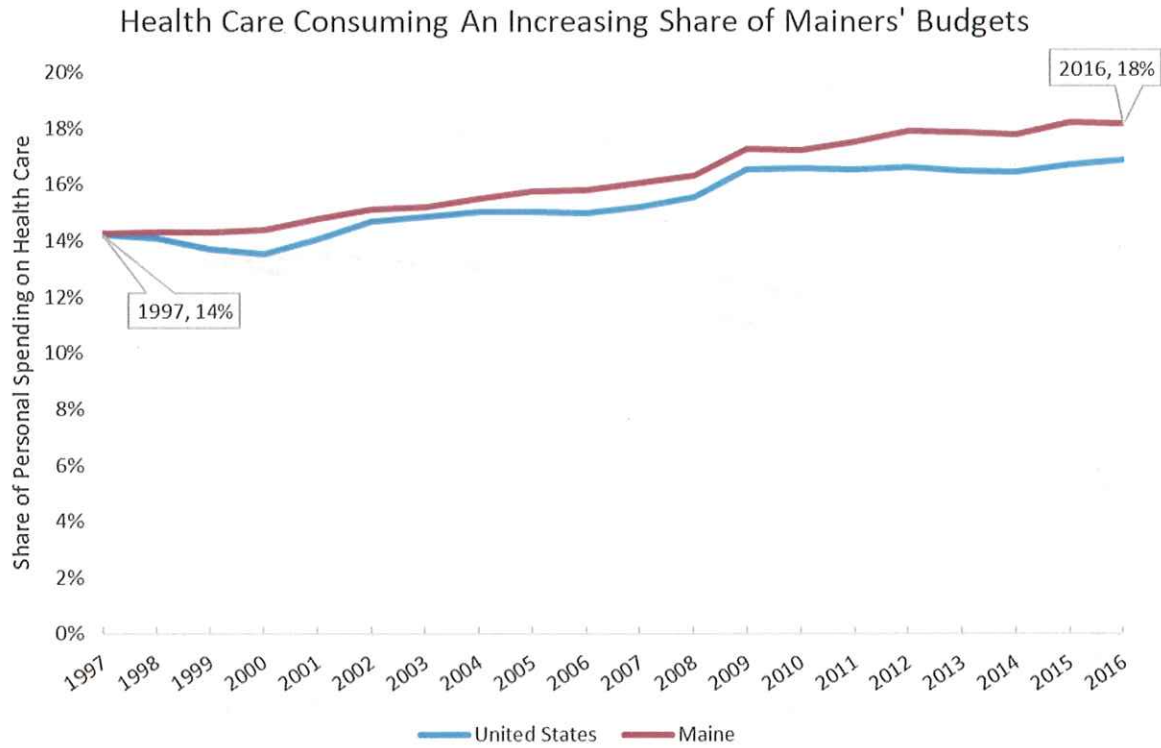
Sources: MECEP analysis of US Census Bureau, Small Area Health Insurance Estimates (2008-15) and American Community Survey data (2016). 2016 data are not directly comparable to prior years.

Health Care Costs Continue to Rise

The Real Cost of Private-Sector Health Care has Doubled Since 1998

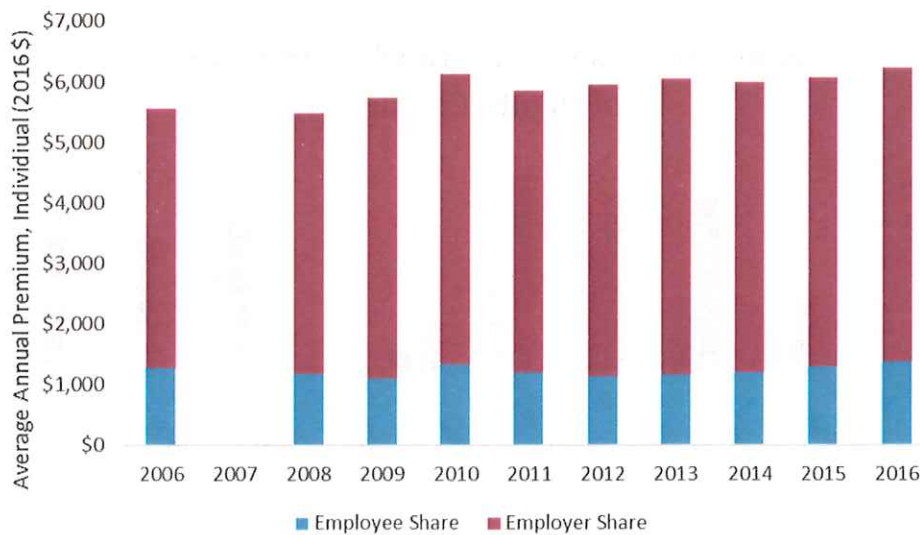


Source: MECEP analysis of US Centers for Medicare and Medicaid Services, National Health Expenditure Survey data for Maine. Data for private expenditures include those paid by private insurance providers and out-of-pocket expenses by individuals.



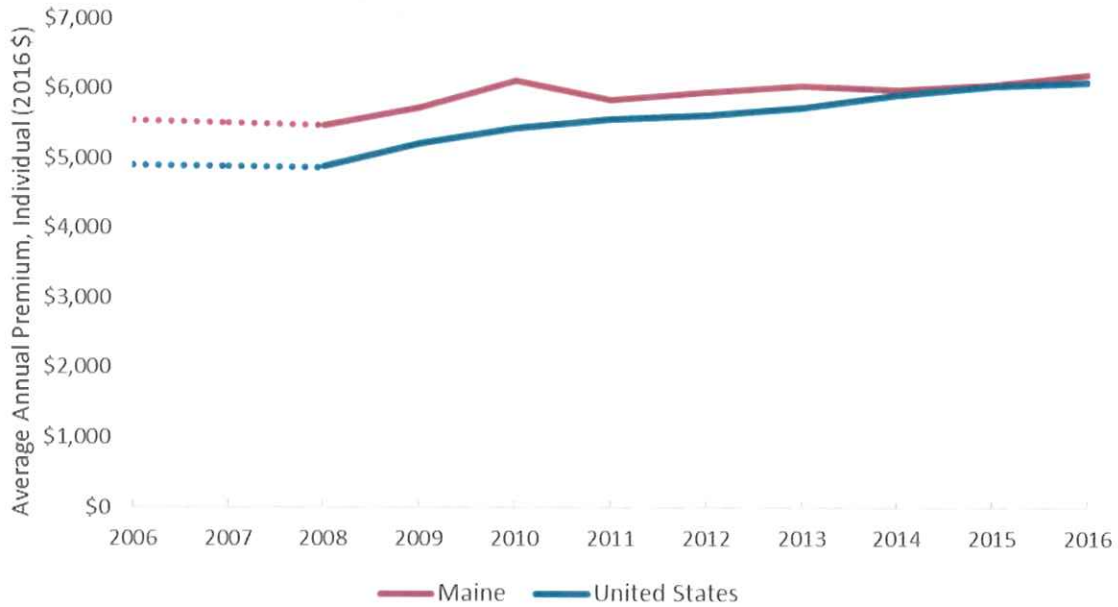
Source: MECEP analysis of US Bureau of Labor Statistics, Personal Consumption Expenditures data.

Affordable Care Act Had Some Impact on Slowing Rising Health Insurance Costs



Source: MECEP analysis of US Department of Health and Human Services, Medical Expenditures Panel Survey data. No data were collected in 2007.

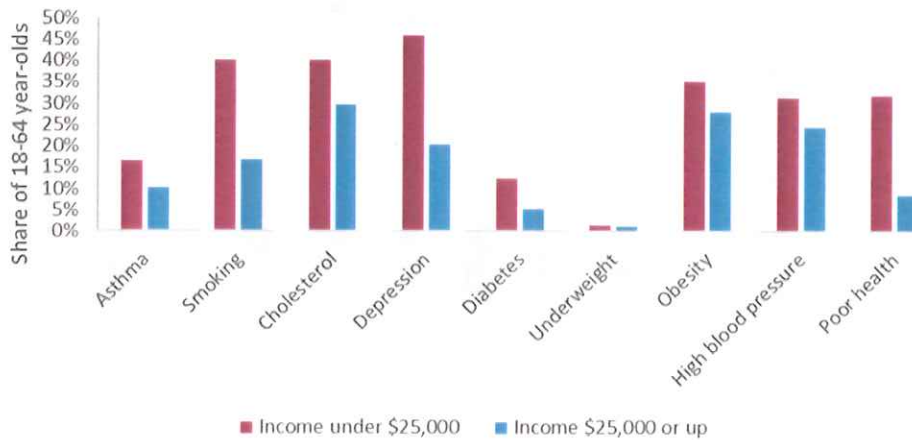
Affordable Care Act Made Maine Businesses More Competitive Nationally



Source: MECEP analysis of US Department of Health and Human Services, Medical Expenditures Panel Survey data. No data were collected in 2007.

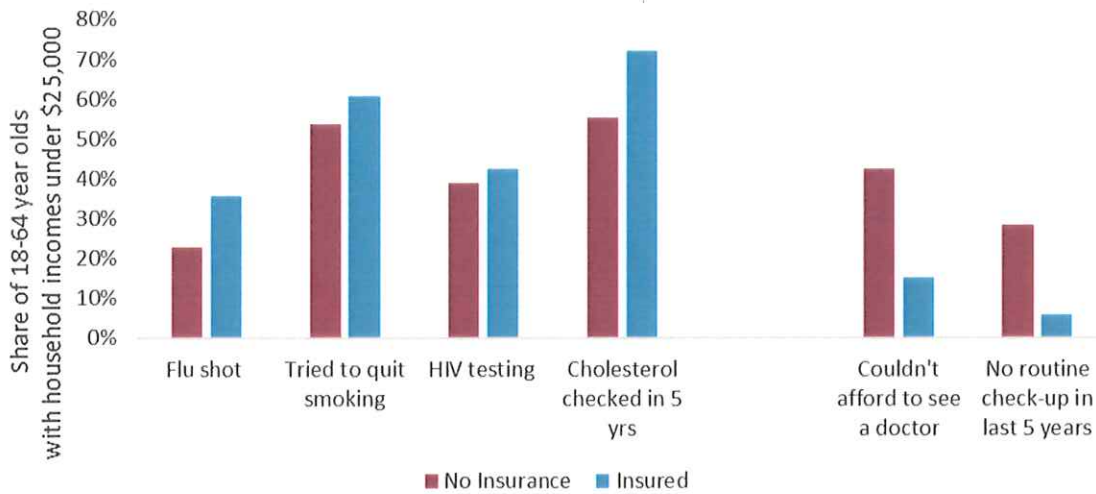
Unaffordability of Care Impacts Lives, Economy

Low-Income Mainers More Likely to Have a Host of Health Conditions



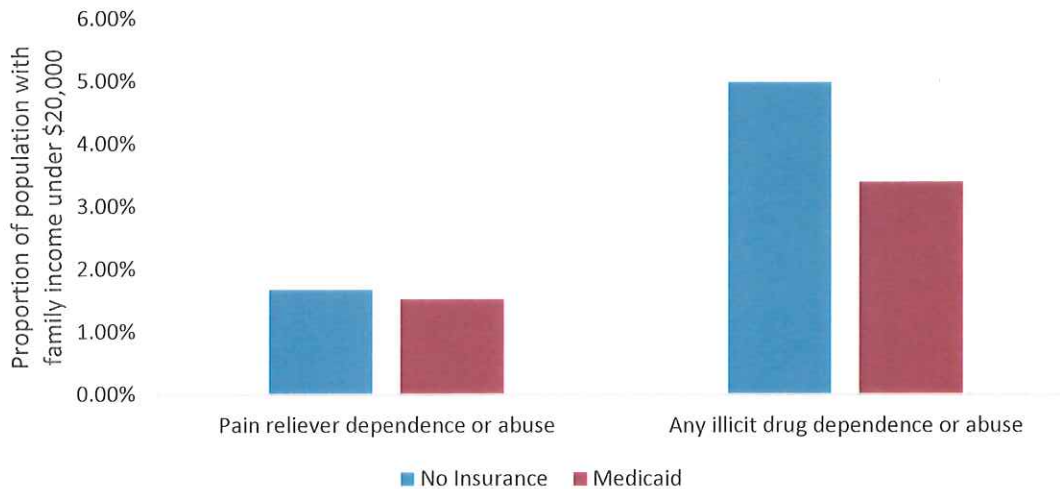
Source: MECEP analysis of US Centers for Disease Control and Prevention, Behavioral Risk Factors Surveillance Survey, 2015

Uninsured Low-Income Mainers Are Less Likely to be Receive Primary Care, Preventative Medicine



Source: MECEP analysis of US Centers for Disease Control and Prevention, Behavioral Risk Factors Surveillance Survey, 2015

Low-Income Individuals on Medicaid Have Lower Rates of Drug Addiction



Source: MECEP analysis of US Substance Abuse and Mental Health Administration, National Survey of Drug Use and Health, 2015

We the people of Maine...

THE MAINE HERITAGE POLICY CENTER

Good morning, and thank you for inviting The Maine Heritage Policy Center to participate in this discussion. We believe it is important for all Mainers to have access to health care services, however we have fundamentally different views on how to get there.

The solution for providing access to affordable health care services cannot be found by taxing and spending. You cannot rob from Peter to pay Paul and expect to maintain an affordable system that works for everyone. This has been the solution offered by our counterparts for far too long, and we are now in a state of health care where it seems the only way out of debt and high costs is to spend more money. This simply isn't true. There are free market solutions, like Direct Primary Care (DPC), that give Mainers access to affordable, quality, preventative health care, and a move toward this model would improve health outcomes for all Mainers while cutting costs significantly.

To give you some Maine-specific background information, the Kaiser Family Foundation estimates health care spending per capita in Maine is \$9,531, or approximately \$1,046 above the national average. Personal spending on healthcare amounts to more than 22 percent of our total state product, the highest in the nation. In 2014, personal health care spending in Maine totaled \$12.3 billion, and 41.5 percent of our state health care expenditures went to hospital care. Not only are we the oldest state, people over 65 with chronic illnesses are responsible for nearly one-third of health care costs in Maine. Today, our state depends on the health care sector for 18 percent of total state employment. Health care is also the greatest cost pressure on Maine businesses, accounting for upwards of 40 percent of business expenditures.¹

To combat the constant increase in health care spending, it is often suggested that we must reduce the uninsured rate. We contend that this is not the answer for Maine, and that health insurance should be used only for catastrophic incidents – not as your everyday vehicle to consume health care services.

The current third-party fee-for-service (insurance) system is not working nationally, nor does it work in Maine. When covered by insurance, you must use providers within your network and are often forced to receive care from the most expensive providers. This is not cost-effective. Further, we've learned from ObamaCare that having coverage means nothing if you cannot afford to use it. Premiums in Maine and across the country continue to rise, and it is due to our dependency on a broken, inefficient system that only benefits big insurance companies and the providers within their network.

Others will agree the insurance-based system is broken, but will also recommend a move toward

¹ <https://www.kff.org/statedata/?state=ME>

a single-payer system. This type of health care system would be even more devastating for taxpayers and businesses than the one we currently employ.

One of our New England neighbors, Vermont, attempted to move toward a single-payer system in 2011. The state has approximately half of Maine's total population, and the single-payer system it attempted to construct folded on itself once lawmakers fully realized the price tag. The program collapsed because its enactment would have resulted in economically devastating taxation on individuals and small businesses. Then Governor Peter Shumlin, the state's champion of single-payer health care, acknowledged that 11.5 percent payroll assessments on businesses and sliding premiums up to 9.5 percent of an individuals' income "might hurt the economy." What an understatement.

There are ways to reduce current spending and enhance quality of care without imposing new taxes or expanding insurance coverage. The real solution to health care in Maine is a complete restoration of the doctor-patient relationship, which will help put Mainers back in charge of their health care. The best way to make this happen is for the state to actively promote direct primary care services for all Maine people.

The direct primary care model abandons third-party insurance payments and emphasizes coordinated, comprehensive, and personalized care. With direct primary care, consumers pay a simple, flat monthly fee for coverage of all primary care services. There are no insurance companies, and intuitively, the quality of care is much higher and comes at a price that all Mainers can actually afford.

The DPC model offers patients:

- One hour annual wellness visits
- Office visits for acute illnesses, usually the same day or within one business day
- Management of chronic medical issues
- Medications and vaccines at wholesale costs
- Direct email and telephone access to your physician
- No co-payments or scheduling fees
- Visits with their personal physician, not a physician's assistant or nurse practitioner who did not attend medical school, and;
- Enhanced patient privacy

The rates for DPC services run as low as²:

- \$50/month for an individual
- \$95/month for a couple, and;
- \$140/month for a family (average monthly premium per person in individual market is \$335.61)

The Direct Primary Care model has been proven to:

- Reduce preventable hospitalizations and emergency services by providing better preventative care and chronic disease management
- Reduce patients' out-of-pocket expenses, and;
- Help mitigate the primary care physician shortage.

² <http://ciampifamilypractice.com/our-prices/>

Though the idea of direct doctor-patient financial arrangements may seem radical in light of the insurance-based system prevalent today, the DPC model was the conventional payment mechanism for much of our history. Before the rapid growth of employer-based health insurance coverage in the 1940s, Americans paid directly for virtually all of their medical needs. As insurance-based health care emerged, the underlying financing mechanisms and cost structures became opaque, leaving patients unable to determine the true cost of their health care and enabling insurance companies and medical providers to exploit this lack of transparency. Exorbitant health insurance premiums and deductibles are now the norm, with patients shouldering an ever-increasing share of the cost of their health care. Direct primary care, by simplifying the payment arrangement, promotes cost transparency and empowers patients to have a more active role in controlling their health care spending.³

DPC patients save up to \$679 annually compared to people with commercial insurance, primarily as a result of reduced hospital stays and emergency room visits. Another major benefit to DPC is the lack of administrative positions within DPC practices, which are unnecessary given the service excludes insurance entirely. The average primary care practice in the U.S. has 2.05 administrative staff members for every doctor. Not one single DPC practitioner in Maine has reported having more than one full-time administrator, and 40 percent of DPC practices in Maine only employ a single part-time administrator. This helps reduce cost within our health care system and for the Mainers currently utilizing these services.

To improve our health care system, we must employ a strategy that gets us ahead of illness and injury. Mainers need reliable, accessible, and affordable primary care services that keep health problems from developing into situations where insurance is truly needed. They do not, and should not, need insurance for a simple visit to the doctor. DPC is the best way to ensure all Mainers receive preventative care, and is proven to be the most cost-effective way to manage chronic medical conditions.

We strongly urge this Task Force to consider direct primary care in its solution for ensuring all Maine citizens have access to affordable health care services. A recommendation from this Task Force that does not include the enhanced use of and access to DPC services would be, in our view, a terrible mistake. The third-party fee-for-service model does not work and is not practical for the health care needs of Maine citizens. Neither is a single-payer system that would devastate Maine's economy.

Health care should be about providing the quality care we all need to stay healthy, not about lining the pockets of hospital administrators and insurance companies. What good is insurance when you cannot afford to use it, and how can expanding insurance coverage be the answer when people utilizing DPC services get higher-quality care and spend less money to receive it? We implore members of this task force to think outside of the box and formulate solutions that get the government out of our health care. Thank you again for inviting us to participate in this discussion. We would be happy to answer any questions you may have about the free-market reforms we believe would measurably and significantly enhance access to quality, affordable health care services in Maine.

³ <http://mainepolicy.org/restoring-the-doctor-patient-relationship/>



**Statement of Steve Butterfield, Policy Director
Consumers for Affordable Health Care**

To the Task Force on Health Care Coverage for All of Maine

Monday, January 22, 2018

Senator Whittemore, Representative Sanborn, and members of the Task Force, I'd like to thank you all for this opportunity to present to you today.

My name is Steve Butterfield, and I am the policy director at Consumers for Affordable Health Care – or “CAHC” – a nonpartisan nonprofit organization based here in Augusta. Since 1988, CAHC has advocated the right to quality, affordable health care for every person in Maine.

I was asked to be here today to speak about the “economics” of health care. I'd like to focus my remarks on the ways in which the cost of health care and health coverage can impact individual consumers and their families, and the decisions people make about when and how they access the care they need.

To begin, let me lay out a simple truth: costs are a barrier to care. People cannot get the care they need if they cannot afford that care. That is true if they cannot afford insurance premiums or deductibles, or cannot afford to see a doctor or go to the hospital, or cannot afford to fill a prescription. I have provided links and citations in my statement today that will lead you to high-quality, comprehensive, unbiased research that shows the following:

- cost is a barrier that impacts consumer behavior;
- costs are rising faster than consumers can keep up with;
- consumers cannot “shop” their way to saving the overall trend in our health system, nor should they be expected to;
- and that is because Americans do not “use” or even try to use more health care than consumers in other, comparable countries.

In other words, while it is undeniable that health care costs are rising and that American families are feeling the strain, this is not a situation that they have caused, or even heavily contributed to. America's health care system already has a tendency to overburden consumers with excessive demands¹: to serve as their own diagnosticians, care coordinators, social workers, attorneys, medical coders, and billing experts. Asking them to also fix a cost problem that they are in no position to influence is as cruel as it will be unproductive.

¹ <https://www.vox.com/2016/6/1/11712776/healthcare-footprint>

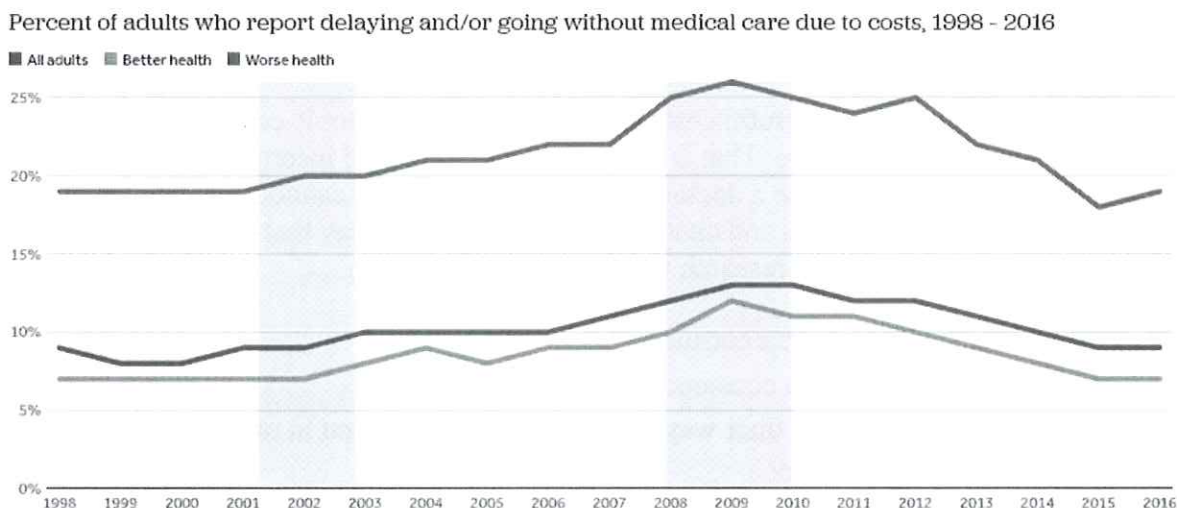


Cost is a barrier

According to survey data published last week by the Kaiser Family Foundation, approximately 1 in 10 Americans reports avoiding or forgoing necessary medical care because of the cost of receiving that care.² Another survey of 2016 data shows that 33% of Americans avoided care because of cost.³ The cost barrier is particularly burdensome for uninsured individuals, individuals who report worse overall health, and those with higher deductibles.

This situation is, in some ways, improving. The Affordable Care Act (ACA) is responsible not only for significant coverage gains, but also has been credited with being responsible for cutting personal bankruptcy filings in half by driving down the number of individuals facing bankruptcy as a result of medical costs.⁴ The implementation of the ACA consequently correlates with a decline in the number of Americans who reported difficulty accessing care due to costs, as this chart shows:

Adults in worse health are more likely than others to have difficulty accessing medical care due to costs, but rates have declined in recent years



Shading represents years when a recession took place in the U.S.

Source: Kaiser Family Foundation analysis of National Health Interview Survey • Get the data • PNG

Peterson-Kaiser
Health System Tracker

One point of concern I'd raise is that, even as coverage rates are increasing – and, with the recent expansion of Medicaid in Maine, I'd expect our state-level data to improve dramatically over the

² https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#item-1-10-adults-report-delayed-not-get-care-cost_2016

³ <http://www.commonwealthfund.org/publications/blog/2016/nov/americans-cost-barrier-decreasing-more-improvement-needed>

⁴ <https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/>

next year or two – many consumers with insurance are facing new cost barriers through increases in their out-of-pocket cost sharing amounts, such as deductibles.

While the ACA limits deductibles and annual out-of-pocket maximums for many plans, the cost share amounts are still significantly higher than most Americans can afford. One estimate by the Federal Reserve showed that 44% of Americans would not be able to cover a \$400 emergency from their savings.⁵ With the maximum deductible for a bronze plan set at over \$7,000, deductibles rising in the employer sector as well⁶, and with insurance plan designs increasingly relying on consumers meeting significant amounts of their deductibles or out-of-pocket maximums before the plan assists in paying for many services, it is clear that even insured consumers are going to be put in positions where the cost of care will once again become a major burden.

And in fact, we are already seeing some evidence of this. Hospitals have reported increases in the number of *insured* consumers who are unable to pay their bills.⁷

"It's the prices, stupid."

The trajectory of increase in health care spending has been driven far more by increases in the *cost* of health care than by *utilization* of health care. In other words, even when they avoid or delay care, avoid treatments, and avoid filling prescriptions – which they do, in response to cost concerns – Americans are getting slammed by the unstoppable march of health care costs.

The title of this section refers to a landmark 2003 study by four health economists which compared the U.S. health sector to other Organization for Economic Cooperation and Development (OECD) countries – nations comparable to the U.S. in terms of overall development and economic status – and found that “the difference in spending [on health care between the U.S. and other countries] is caused mostly by higher prices for health care goods and services in the United States.”⁸

While that study is from 2003, newer research shows the same problem. In fact, in an article published in November in the Journal of the American Medical Association, researchers investigated how five factors – population growth, population aging, disease prevalence or incidence, service utilization, and service price and intensity – impacted health care spending increases in the U.S. between 1996 and 2013. They found that more than 50% of the increase was due to service price *alone*.⁹ In other words, our problem is not that we *buy* too much: rather, it is that we *pay* too much.

Rising health care costs have continued¹⁰ to dramatically outpace overall economic growth, or inflation, or wages. While there has been some slowing in recent years, it's important to note that

⁵ <https://www.federalreserve.gov/newsevents/pressreleases/other20170519a.htm>

⁶ <http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2016/sep/september-19-2016/deductibles-rise-in-employer-sponsored-health-plans>

⁷ <https://www.reuters.com/article/us-usa-healthcare-hospital-payments/ballooning-bills-more-u-s-hospitals-pushing-patients-to-pay-before-care-idUSKBN17F1CM>

⁸ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.3.89>

⁹ <https://jamanetwork.com/journals/jama/fullarticle/2661579>

¹⁰ <https://www.healthsystemtracker.org/brief/how-u-s-utilization-and-price-of-healthcare-compare-to-other-countries/#item-start>

we're talking about a decrease from, say, 9% in 2011 to "only" 6% in 2016 (according to data from PriceWaterhouseCooper¹¹). That's particularly alarming when compared against overall wage growth, which is statistically more or less stagnant – rising only 10% in inflation-adjusted terms since 1973.¹²

Consumers can't shop us to safety

In a well-functioning market, it would be reasonable to expect competition to lead to market-driven control of price growth. However, there are limitations to the applicability of that approach in the health care market.

Research has shown that the percentage of health care services that are both "shoppable" and in which consumers bear a significant enough percentage of out-of-pocket costs to have an incentive to comparison-price accounts for only 7% of overall health spending.¹³ While that's not insignificant, and while we certainly advocate that transparent and valid price data must be available to consumers to help inform their decision-making, it is also not enough for interventions in this component alone to significantly impact the overall cost curve.

In other words, increasing price transparency is an important piece of the puzzle, but we need more focus on the actual drivers of health care spending growth – prices – and less on blaming consumers for a problem they aren't causing.

American consumers are not over-utilizers

To synthesize all of the data I've presented above, I'll close with this.

If I could permanently eliminate one pernicious, persistent, and fallacious idea from the conversation around America's health care costs, it would be the idea that American consumers are unhealthy profligate spendthrifts who go to the doctor so much that the system cannot bear the strain.

Let me be absolutely clear: this is wrong, wrong, wrong, wrong, wrong.

Not only is there no *actual* evidence that this is systemically true, the *opposite* is actually the case¹⁴. We are not over-utilizers. Study¹⁵ after study¹⁶ after study¹⁷ shows that the problem is prices, not service delivery or utilization.

¹¹ <https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html>

¹² <https://www.brookings.edu/research/thirteen-facts-about-wage-growth/>

¹³ <http://www.healthcarevaluehub.org/improving-value/who-target/>

¹⁴ <https://www.nytimes.com/2018/01/02/upshot/us-health-care-expensive-country-comparison.html>

¹⁵ <http://www.nber.org/papers/w23117>

¹⁶ http://www.oecd-ilibrary.org/social-issues-migration-health/comparing-price-levels-of-hospital-services-across-countries_5km91p4f3rzw-en

¹⁷ <https://www.ncbi.nlm.nih.gov/pubmed/24219951>