Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

In Opposition To

LD 1196 - *An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health*

April 15, 2021

Senator Sanborn, Representative Tepler and members of the Health Coverage and Insurance and Financial Services Committee, my name is Jeffrey Austin and I am with the Maine Hospital Association. I am offering this testimony in opposition to LD 1196.

The Maine Hospital Association (MHA) represents all 36 community-governed hospitals including 33 non-profit general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital.

Bill is Structurally Flawed. We believe this bill is structured incorrectly and should be rejected as a result.

The bill regulates payers and what they do. The fundamental flaw in the bill is that the carriers could satisfy the requirements of the bill, and yet the goal of the bill is still not achieved. When all of a bill's regulatory controls can be met, and yet none of the promised outcomes occur, you have a poorly designed bill. That is the problem with LD 1196.

The goal of the bill appears to be increased primary care utilization. Increased utilization of primary care services is a widely promoted public policy goal. There is much belief, that increased utilization of primary care services -- more health screenings, more chronic condition management etc. – can lead to better health. There is also some association, but no clear causal connection, between increased primary care and lower spending elsewhere in the system.

MHA can support proposals that seek to increase primary care utilization, but this bill doesn't do that.

TABOR for Healthcare. The regulatory control in this bill is a math formula. And it's a formula that does not require increased primary care utilization.

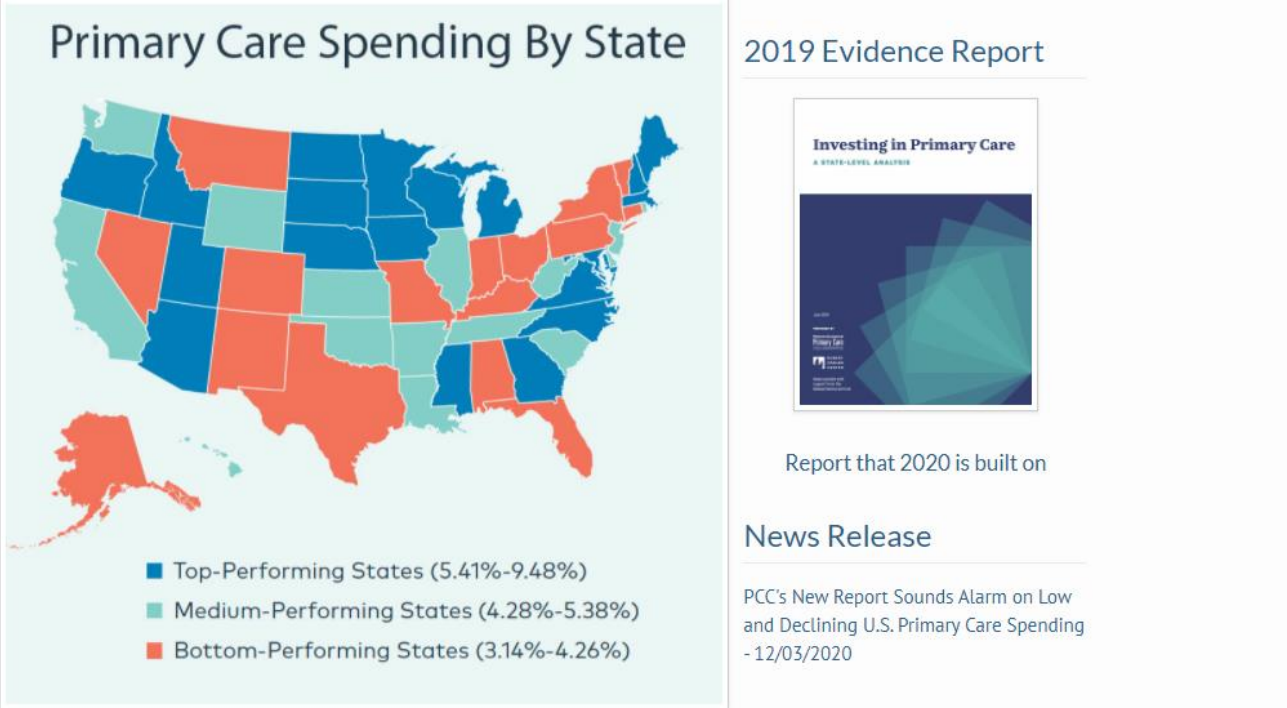
The regulatory outcome will most likely be accomplished by cutting rates to non-primary care providers and increasing rates to primary care providers. Not one additional breast cancer screening; not one additional blood test, not one smoking cessation session has to occur to satisfy the math formula. Not one. Just like TABOR attempted to artificially regulate government spending, this is an artificial regulation of healthcare spending. Its doomed to fail.

Cut rates over there and spend more over here and the math formula is satisfied. But, not the policy goal of more preventative care. This is little more than state rate making and we oppose that.

No Growth? The bill also has an unrealistic goal – a global cap of 0% growth on total healthcare spending for each carrier regulated by Maine, MaineCare and the State Employee Health Plan for four years. No growth in spending for four years. Really? Plus, for non-primary care spending, it's four consecutive years of cuts. Even TABOR allowed some growth. The bill wisely doesn't spell out a mechanism for how four years of 0% growth would be enforced – because it could get ugly.

Is this a Maine Issue?. Furthermore, Maine is already a top performer in primary care spending nationally. The leading publication on this topic "*Investing in Primary Care*" by the Patient-Centered Primary Care Collaborative identifies Maine as a "top-performing state" on primary care.

Proponents tell you that Rhode Island is the model…Rhode Island is not a top performer on primary care spending, Maine is.



MHDO also studied this issue and found that five other states are looking at publishing primary care benchmark reports (VT, WA, OR, CT, DE) none of whom are top performers. Maybe this is an issue that other states need to work on more acutely than does Maine.

Look at Utilization. Finally, we could support primary care promotion efforts if they were actually focused on primary care utilization.

Maybe providers should be required to have after-hours appointments, same day appointments, and/or weekend appointments.

Maybe carriers should be required to waive cost sharing for certain preventative efforts beyond annual wellness visits.

Maybe we should explore a transformation of telehealth and primary care.

There are lots of ideas out there that look at actual utilization instead of math formulas and global spending caps.

The basic idea of LD 1196 is that increased spending on primary care will lead to good things. Maybe it will. In fact, Maine already did this, and maybe what we should do is just study it to see if it worked.

A few years ago, the Medicaid program increased reimbursement rates for some primary care doctors. The Medicaid program should have data that could be studied to see if there was any positive outcome as a result of increasing spending on primary care doctors. Did these doctors see more patients? Did they do more screenings? Did their patients quit smoking and lose weight? We have data from Medicaid, let's look at it.

The policy underlying the bill is widely accepted – that regular primary care utilization is a good thing.

Belt and Suspenders. I see that an amendment may be proposed to delay "cost containment" for four years. It begs the question, why is it necessary at all. If the suspenders (primary care) work as the proponents tell you, then good things will follow investments in primary care. Why are they also calling for the belt of a government-imposed cap? Either you believe the suspenders will work (in which case you don't need a belt of cost containment) or you don't. If you don't, then why would you support this bill?

Conclusion. Let's not adopt a TABOR-like math formula for healthcare and then hope for good things to happen. A direct route is better than this very, very indirect route.

Please vote LD 1196 'ought not to pass.'

Thank you.