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April 15, 2021

Testimony of Rep. Sam Zager introducing

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

Before the Joint Standing Committee on Health Coverage, Insurance, and Financial Services

Senator Sanborn, Representative Tepler, and other honorable members of the Health Coverage, Insurance, and Financial Services Committee, thank you for your service and holding this hearing. I'm Sam Zager, and I am honored to represent House District 41 in Portland, and pleased to present to you LD 1196. I thank the bipartisan, bicameral, rural-to-urban set of co-sponsors, including some members of this committee.

This bill is designed to make primary care and behavioral health more available; by doing so we can decrease costs.

Everywhere I look, I see we're collectively going in the wrong direction, even though good people are working hard in healthcare. As a family physician who trained in Maine, I've sat and listened to thousands of people one-on-one tell me about their health concerns and worries. As I do my best to help each person with individual concerns, I also look upstream at the big-picture things that dictate so much of people's health.

For instance, I have a patient I'll call Mike, who is around 60 years old, and unfortunately suffered a life threatening cardiac event a few years ago. He received excellent care at a nearby Portland hospital -- Maine does have excellent hospitals -- which was the difference between survival or not. I'm so glad he is doing as well as he did, but he's not so sure. He told me he's going to be paying over $200,000 in medical debt for the rest of his life. The hospital worked out a payment plan with him, but he doesn't relish the financial cost to his family.

Many others are not as fortunate to have fared well medically. This is especially true for Black, Indigenous, and other People of Color -- a shameful reality before COVID, and I think we're all familiar with how suffering in the pandemic has been unfairly distributed.

Too many Mainers in Presque Isle and Hodgdon and other rural communities have terribly hard time accessing behavioral health services and primary care.

This bill is a proposal to address a big-picture paradox. Even though there are good Mainers working very hard, and even though we are among the most advanced economies in the world, our way of providing healthcare is both unsustainable and, in important ways, unsatisfactory.

I'm going to briefly convey (1) how our status quo is unsustainable and unsatisfactory. (2) Evidence basis for this bill's strategy for addressing that failing status quo. (3) mechanics of the bill with some proposed amendments.

Unsustainable and Unsatisfactory Status Quo

If you take one thing from this hearing, I hope it'll be the graphs in the appendix of my testimony**.** It used to be thought that our Fee-for-Service approach eventually would yield ever-increasing efficiency; we would achieve the best outcomes at the lowest cost over time.

The paradox is that we're actually getting the opposite. For instance, **Graph 1** looks at overall life expectancy, compared to expenditure per capita.We also must recognize there are very important factors that this doesn't include, such as equity, which I'll get back to.

We get 3-5 years shorter lives than our economic peer nations. To put that into perspective, think of the damage the opioid epidemic is wreaking upon our state and nation. All that carnage has diminished overall life expectancy by a *fraction* of a year, so 3-5 years *improvement* could bring incredible benefits in how much Mainers live to their fullest potential, how enriched their family and social relationships are, and how productive our economy is. Prevention works.

Moreover, we are paying $2000-$5000 *more* per person in Maine and the rest of the United States to live shorter lives, and I would argue sicker and less equitable, lives. In other words, we're getting far from the best outcomes for 2-3 times the cost. Think of my patient, Mike. We are behind the pack on both outcomes and costs. By a lot.

Indeed, there have been some system improvements at the state and federal levels. But we can do so much more as a state, and LD 1196 aims to move us more in a favorable direction. How?

Evidence Basis for Primary Care and Behavioral Health

The common thread among systems that are outperforming us and spending less is an orientation toward **Primary Care**. I'll say that again, the common thread among systems that are outperforming us and spending less is an orientation toward **Primary Care**. This has been known for at least a couple decades, and has been a feature of both market-based systems such as Japan, and single-payer systems such as Great Britain, Canada, and the Scandanavian countries.

Graphs 2 through 4 in my submitted testimony show that this association between Primary Care and good outcomes is also evident when we look at a state-by-state analysis. We know Maine is only average in this regard, from the Maine Quality Forum's Primary Care Spending reports to this committee last year and this year pursuant to Senator Linda Sanborn's "Primary Care Transparency" law from the 129th Maine Legislature. Approximately 5-10% of our health dollars go toward Primary Care, depending on using a narrow or broad definition. That's true for commercial payers *and* for MaineCare.

This orientation towards Primary Care matters because "**Every 10 additional primary care physicians per 100,000 population was associated with a 51.5-day increase in life expectancy**. However, from 2005 to 2015, the density of primary care physicians decreased from 46.6 to 41.4 per 100,000 population."

I submit that this self-harming decrease in PCPs is to be expected in a system that is not oriented sufficiently toward Primary Care. We can do better in Maine.

Investing in Primary Care would likely improve **equity** and reduce health disparities. The Association of State and Territorial Health Officials favors this approach to improve health, and reduce downstream costs.

There is broad consensus that **behavioral or mental health** -- whether delivered in a primary care practice or other setting -- is crucial. This is reflected in state-level bipartisan proposals, such as one being worked on as we speak in Massachusetts. The opioid crisis, COVID-19 pandemic, and this Legislature's budget deliberations have all driven home the importance of behavioral health.

Part of our challenge is applying the evidence basis to Maine's circumstances. We are largely rural with many important safety net hospitals. We have the oldest population in the country. We don't have many private insurers. We have an oligopoly with two large hospital systems that are indeed providing top-notch care safely. The opioid epidemic is hitting us particularly hard. We are the 43rd state in GDP per capita. And, of course, any decisions we make in Maine are constrained by federal laws like ERISA [Employee Retirement Income Security Act of 1974].

Even though there will be naysayers who say, "It's too hard in Maine," I respectfully disagree.

Bill Mechanics

Let's look under the hood of LD 1196. LD 1196 would require that the percent of overall health care costs spent on Primary Care and Behavioral Health (PCBH%) incrementally increase four times by at least 1-2%. The printed bill envisions annual increases, but I propose an amendment in which that interval is **increased to *two years***. This is a technical fix, for a one-year cycle is simply impossible [based on discussions with Maine Health Data Organization, MaineCare, private insurers, hospitals, and policy experts.]

For example, the PCBH% for Private Insurer X may be 6% at baseline (2019). In the first cycle, Insurer X would need to increase that by 1% to 7% if it's ahead of its peers, or to 8% if it's at or behind the median PCBH%. Two years, later, the median for the private insurers would be recalculated, and Insurer X would have a new one- or two-percent increase.

The Superintendent of Insurance would ensure these goals are met, but only for the plans that the office regulates. In other words, the bill doesn't intend to obligate the superintendent to regulate large group rates.

This has been done in New England, and it worked. Rhode Island implemented a similar plan approximately a decade ago, it found total healthcare costs fell by 14% in a handful of years. That's huge.

Public insurers, Mainecare and the State Employees Health plan, would have the same requirements.

Rhode Island also implemented price controls for hospitals. I've discussed this extensively with hospital groups here in Maine, and am mindful of the excellent care Maine hospitals have provided before and certainly during this pandemic. And I agree that we must ensure rural access to hospital care.

Therefore, a **second amendment** I propose is that the cost controls be softened from the "overnight" change in the printed bill, and to allow for inflation through the consumer price index. A period of four years might be considered before the cost containment measures go into effect. This amendment would permit providers and provider groups in Maine to work with payers (e.g. private insurers, MaineCare) on ways to implement a *further transition from Fee-for-Service to value-based-care.* And allow for things like coordination of care and population health. It also would permit planning for investments in psychiatric and behavioral health infrastructure.

This would help us avoid two hazards of continuing to rely predominantly on a Fee-for-Service model. Even if we achieve better health outcomes, it could have significant negative impacts:

- Total costs can go up further. (Remember Graph 1 showing us as an overspending outlier.) Some say we therefore need to force a spending or price cap on healthcare.

- However, if we apply a rigid price cap, then Maine's two large hospital groups -- who again are providing, on average, excellent and safe care as best as they can throughout Maine -- will feel compelled to protect their bottom line in order to keep hospitals open. (The Maine Hospital Association points out that Medicare reimbursements are 46% of costs, and MaineCare pays 15% of costs. "Hospital Issues for State Office Candidates," Sept 2020). Historically, this has led to heightened "productivity" requirements in which PCPs have to cram as many visits into a day as possible. I've seen it, and I've heard countless stories from unsatisfied patients and burned out healthcare providers. Recall the 2019 JAMA study that found PCP supply is dwindling even as we gain more evidence that having more of them is associated with significant health improvement. I'll also add that physicians have a burnout rate higher than the general population.

Their suicide rate twice that of the general population. It's worth noting that Rhode Island saw an *improvement* in the density of PCPs in the population after their 2010 Primary Care investment shift.

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A **third amendment** I propose is to stagger action on Primary Care and Behavioral Health. We simply know more about Primary Care in Maine based on reporting pursuant to the 2019 "Primary Care Transparency" law than we do about Behavioral Health. We clearly need more investment in behavioral and mental health, but I propose making part of this bill a Behavioral Health version; we should calibrate future action on Behavioral Health based on what we could learn in the next couple years, even as we commit in this bill to act on Behavioral health. In effect, it would be a two-phase implementation.

Conclusion

At the end of this hearing, there will be no easy answer. There are "known unknowns," such as how exactly new technology such as genomic medicine will affect healthcare. We also don't know exactly how Health Information Technology such as telehealth and truly integrated Electronic Medical Records will affect things. We don't know the rest of the story with the current pandemic or future health crises. And we don't know what other events or phenomena will compete with health issues for resources and airtime. But we will *never* know all the unknowns. *Let us not let lack of perfect knowledge freeze us into inaction. The status quo is not acceptable.*

Systems change is hard. The status quo is more comfortable. But it hurts hard-working Mainers like my patient Mike with his $200,000 medical debt; and it hurts the State due to unsustainability. Ask anyone on Appropriations, or your own mayor or school board members how reducing healthcare costs would free up so many other priorities that are important to people across the political spectrum in Lewiston, Scarborough, Buxton, Brunswick, Kittery, Portland, Topsham, Dover-Foxcroft, Auburn, or Turner.

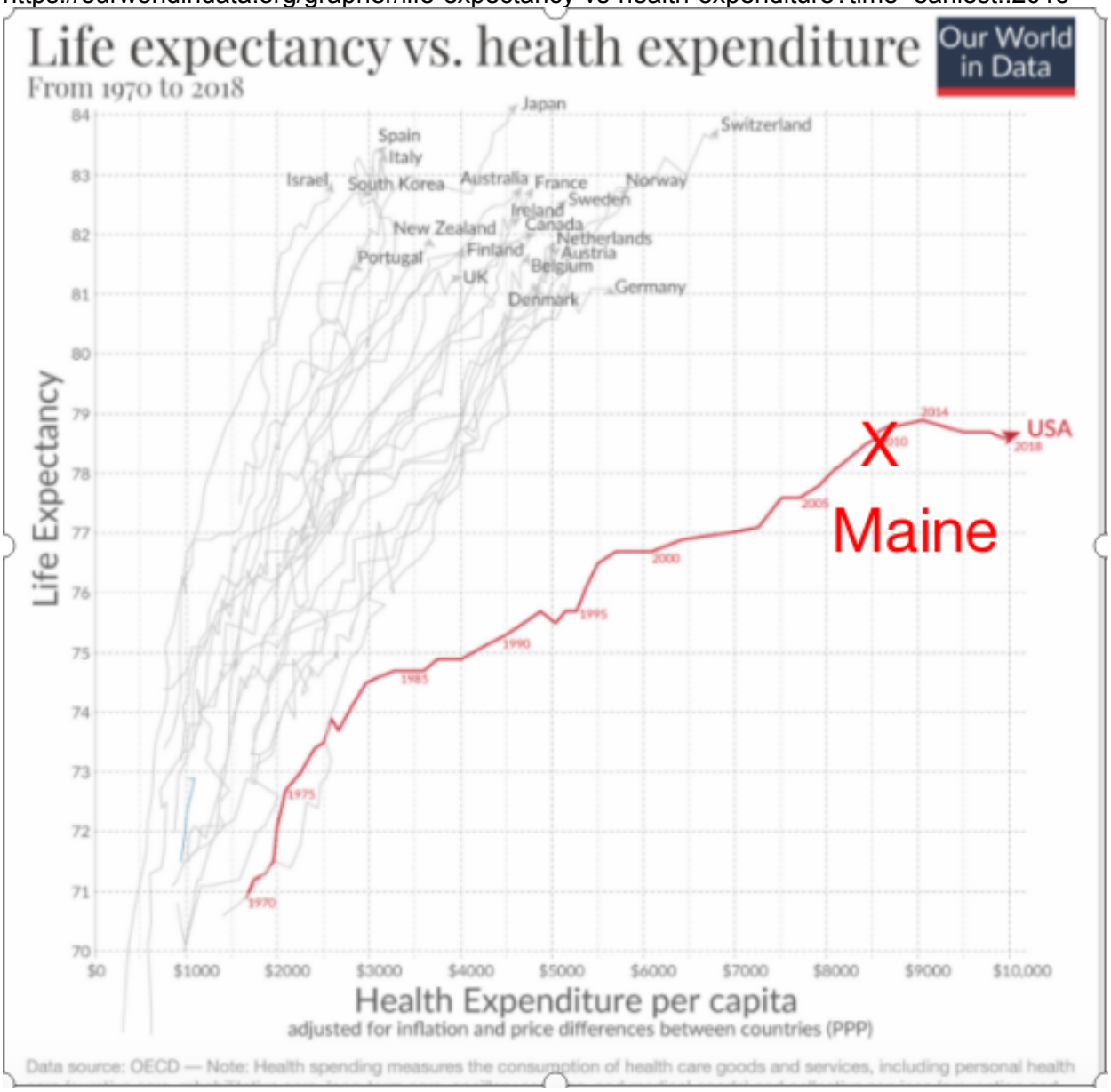
There is no panacea. If anything, the process of drafting and refining this bill over many months has been a bruising lesson in the complexity of the challenge.

Still, I believe we can get there. Many will *say* that they support primary care and behavioral health; this bill offers an evidence-based, proven way forward. I look forward to working with this thoughtful and dedicated committee, stakeholders, and experts to further refine it. The goal isn't simply to pass a bill; it's to achieve the mid-to-long run better health outcomes for Mainers, more equitably, at lower overall costs.

Thank you for today's hearing, Madam Chair. I'd be happy to take questions now and/or at the work session.

Appendix

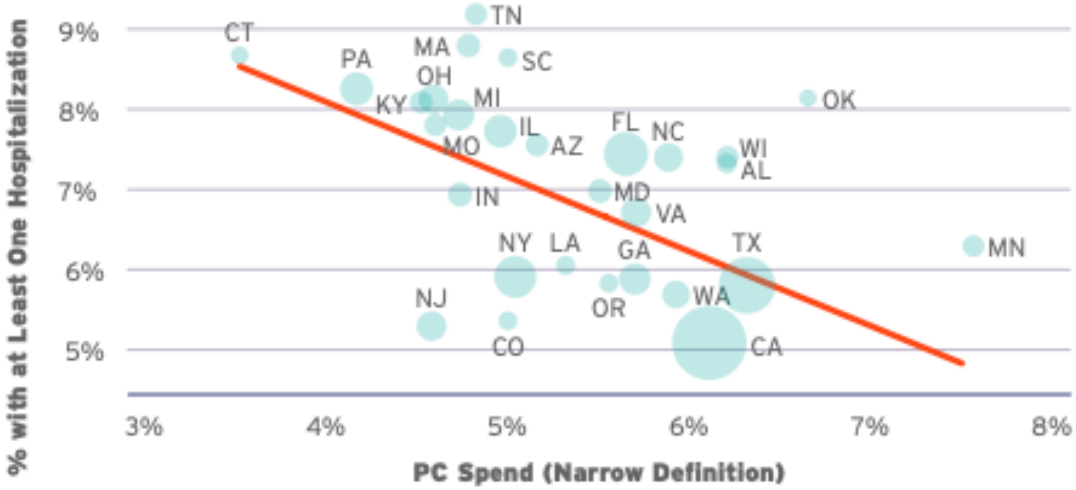
Graph 1. Life Expectancy vs. Health Expenditure. This graph shows how Maine (and the rest of the US) is a poor-performing, expensive outlier.
https://ourworldindata.org/grapher/life-expectancy-vs-health-expenditure?time=earliest..2015



Graphs 2, 3, 4. These show how unfavorable outcomes from poor chronic disease management (e.g. Emergency Department visits and hospitalizations) tend to be much less common in states that are more oriented toward Primary Care. PC Spend = money spent on Primary Care as a percent of total health dollars.) https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf

FIGURE 2.4

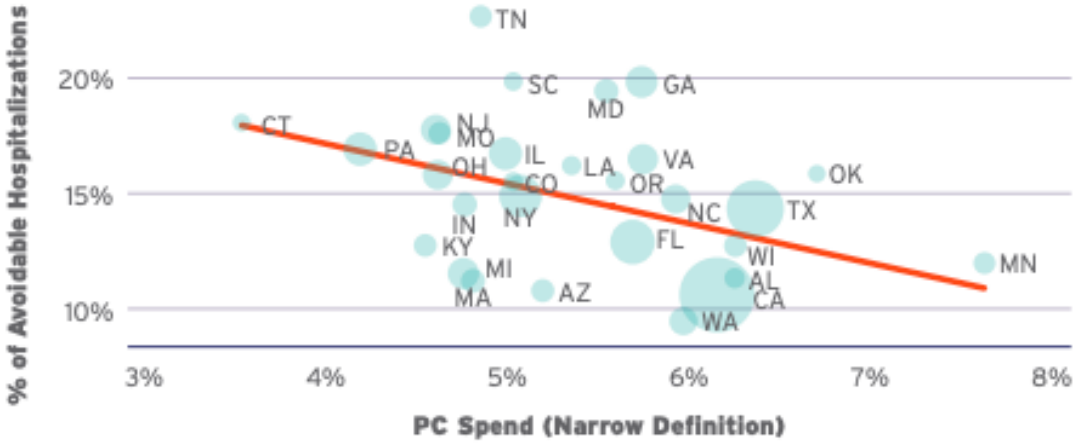
PC Spend-Narrow Vs. Percent with at Least One Hospitalization in Last 12 months



R = -0.58. Note: Size of circles represents the population size of the state.

FIGURE 2.5

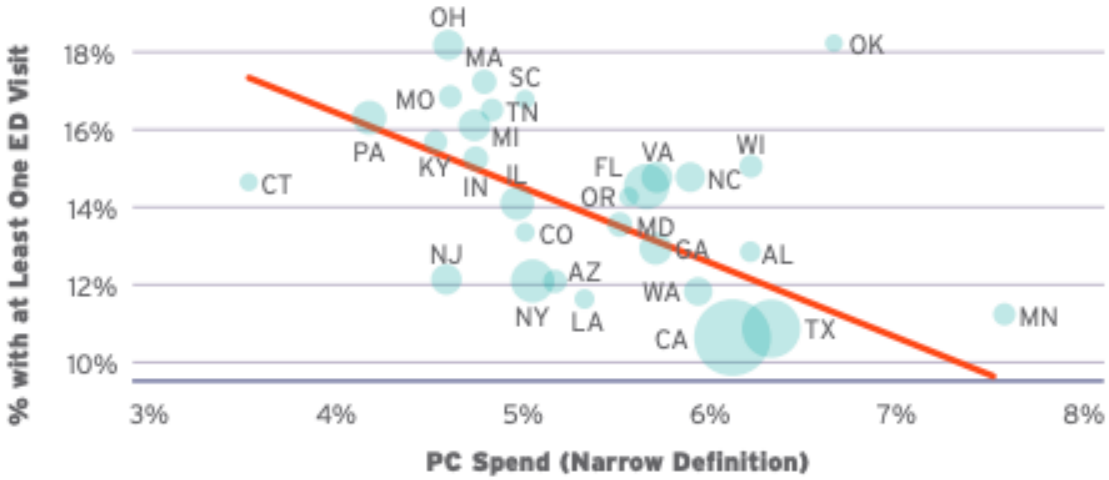
PC Spend-Narrow Vs. Percent Avoidable Hospitalization



R = -0.44. Note: Size of circles represents the population size of the state.

FIGURE 2.3

PC Spend-Narrow vs. Percent with at Least One ED Visit in Last 12 Months



R = -0.58. Note: Size of circles represents the population size of the state.