BLUE RIBBON COMMISSION TO STUDY THE
REGULATION OF HEALTH CARE EXPENDITURES
(1987 P.L., ch 440)

MEMBERSHIP

Appointed by the President of the Senate

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(Will attend)
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Appointed by the Speaker of the House

Rep. Margaret P. Clark
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Appointed Jointly by President and Speaker

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Appointed by the Maine Health Care Finance Commission

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Executive Director
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BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

PROPOSED MEETING SCHEDULE-WORKPLAN

July 13	Discussion of Report Outline (Excluding CON)	(Consultant)
August 1	Discussion of Report Outline (Excluding CON)	(Consultant)
August 10	Deadline to sign off on draft report (No meeting - notify staff by phone)	

REPORT DISTRIBUTED TO INTERESTED PARTIES

August 31	Public Hearing - Bangor	
September 1	Public Hearing - Portland	
September 14	Discussion of Public Input Con Presentation - LD 2500	
October 12	Public Input on LD 2500 - Con Discussion	
November 9	Revisions to Draft Report - Legislation	(Consultant)
December 14	Discussion of Final Draft and Legislation (Consultant)	
January	Meeting with Legislature	(Consultant)

5621*

approved 2/24/88

February 17, 1988

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES
SUMMARY OF FEBRUARY 11 MEETING

1. Questions For Soliciting Testimony:

Commission members agreed to adopt the list of questions proposed by Graham Atkinson and added one question to address the issue of how to respond to health care insurance premiums rising at a yearly rate of 25%. The question asks for input on what services, if any should be decreased, and what alternative funding mechanisms are appropriate if revenues should be raised to pay for these cost increases.

2. Scope of Work:

The scope of work proposed by Graham Atkinson was adopted, with an amendment indicating that general professional shortages in Maine's health care industry would be discussed.

3. Data:

Discussion of Atkinson's issue paper "Costs, Revenue and Utilization Data, Maine and the U.S.", showed that in recent years the rate of increase in hospital costs and revenues im Maine has been below the national average.

In absolute terms, costs per case and revenue per case have been below the national average. However, this may be partly due to lower wage rates in Maine.

According to Maine Health Care Finance Commission data, Maine's per capita hospital expenditures between 1980 and 1986 were slightly less than those of the U.S., and greater than those of Vermont and New Hampshire.

Hospital expenditures as a percent of total disposable income were higher in Maine than in the U.S., New Hampshire and. Vermont during those years, despite the fact that hospital costs went up less than the national average.

4. General Discussion:

Commission members entered into a fairly detailed discussion of issues related to medicare and medicaid cost shifting. Some members expressed concern that if hospitals are seriously shortchanged by medicare and medicaid programs and face financial hardships as a result, they may have to cut back certain services, such as charity care. This could have a major impact on access to care for the poor. This led to a discussion of alternative funding mechanisms such as a payroll tax.

3915m

8a

3/1/88

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

SUMMARY OF FEBRUARY 24 MEETING

The focus of the meeting was Atkinson's paper entitled "Discussion of Major Issues". The following notes summarize some points of consensus, as well as issues raised during discussion.

1. **CON:** (Atkinson's comments) A major issue concerning CON is the inconsistency of its application. The concept of broadening CON requirements to physicians has been raised in the past, without much success and has caused a great deal of controversy. This Commission needs to decide whether or not to raise the issue again or decide that the outcome is sufficiently predetermined so that the prospect of applying CON to physicians is not even worth discussing.

Possible options for amending the CON program are:

1. Apply CON review to physicians
2. Eliminate CON review for equipment
3. Increase the thresholds for review to reduce the problem
4. A blended system with review for some hospitals but not for others, depending on the payment system.

However, a final decision on this issue should be delayed pending discussion of the payment system for hospitals.

Commission discussion centered on CON review for equipment. Consensus was reached that: High priced, high technology equipment should be subjected to public review, but the "playing field" should be leveled. The mechanism for providing that leveling is setting some kind of threshold for review, which is yet to be determined. Anything below that threshold is not subject to review, anything above is subject to review, independent of the setting.

NOTE: This appears to deal with the application of CON requirements to other health care providers not currently subject to review when purchasing high priced, high technology equipment.

c). Some discussion ensued of the current Robert Wood Johnson Foundation Project, which is run by DHS with assistance from USM. It is a demonstration project to provide managed care to poor people. It involves AFDC recipients, Medicaid beneficiaries, people looking for work, and people employed by small businesses that don't have health insurance.

Health insurance premiums are funded by medicaid for the medicaid beneficiaries. Funding for non-medicaid people is a combination of payments from individuals receiving coverage, from employers, with some absorption of charity care and bad debts from individual hospitals. The amount of funding from employers and individuals is subject to a means test.

The project is small, involving 3,000 medicaid beneficiaries, and 2,100 non-medicaid. Results will not be known for several years. The Commission agreed to refer to the project in the report, but not to devote time to studying the project in any detail.

2. **Medicare Profits:**

In a Boston federal court, several hospitals are challenging the offsetting of medicare profits. The MHA is entering the dispute as "Amicus Curiae" (friend of the court), on the part of the objectors. This issue may need to be revisited by the Commission as events unfold.

3. **Data Collection and Dissemination**

MHCFC is planning some expansion of its current data collection system to include plural charges and ambulatory surgery data.

In response to the discussion of this topic, Graham Atkinson has submitted a short paper on the subject of data collection and its use, which will be discussed at the next meeting.

4. **Viability of Hospitals**

The current regulatory system does not guarantee solvency for all hospitals in the State. There was some discussion that whatever regulatory system is recommended, it should be clear that solvency for all hospitals would not be guaranteed.

March 18, 1988

Cathance Lake
Cooper, ME 04638

Annika Lane, Legislative Analyst
Office of Policy & Legal Analysis
Room 101/107 State House Station 13
Augusta, ME 04333

Dear Ms. Lane:

I only received your questionnaire today - the day it is due. Therefore, I am completing it in a rather hurried manner and as an individual rather than in my professional role as there is no time for my standard feedback/review loop.

I believe I've covered most of the major areas of need that I'm aware of. I am certain that others could provide additional data, if they were asked.

I would be interested in knowing how the commission solicited input, both on this survey and in general, from people in the northern five counties of the state. If there are additional avenues for participation, I would like to be informed.

I am enclosing F.Y. I some materials on the Katahdin A.H.E.C., which I was actively involved in developing as a partial response to health manpower education, recruitment and retention problems in northeastern Maine.

Please feel free to call me if I can provide more information or otherwise assist you.

Sincerely,

Bo Yerxa

Bo Yerxa

Enclosures

3/15/88

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

SUMMARY OF MARCH 9 MEETING

Continued discussion of paper entitled "Discussion of Major Issues".

1. Assuring Solvency of Effective and Efficient Hospitals.

a). (Atkinson's comments) In summary, the Medicare program underpays hospitals which Medicare classifies as rural. The payment rate difference between urban and rural hospitals is substantial - 25-30%.

Currently AHA is in the process of lobbying to eliminate the distinction between urban and rural hospitals. The Prospective Payment Advisory Commission (ProPAC) is required to report to Congress on what should be done. It appears that it will recommend elimination of the distinction, but given this is an election year, there is no way of knowing how Congress will react.

Eliminating the distinction would lower reimbursement rates for urban hospitals a little, while substantially increasing rates for rural hospitals.

The possibility of this change, and how it may affect Maine's regulatory system should be taken into account as the Commission drafts its final report.

NOTE: Information on Maine's urban/rural hospital mix based on Medicare definitions will be provided to the Commission as soon as possible.

b). The Commission is going to have to deal with Medicare and Medicaid shortfalls, but also has to discuss the issue of charity care and bad debts. Some options for dealing with this problem are:

Increasing the Medicaid payments to cover full financial requirements.

Increasing Medicaid eligibility levels

Pooling of hospital funds to cover these requirements

Use of general or other revenues

Absorption of some of the shortfalls by the hospitals.

c). Some discussion ensued of the current Robert Wood Johnson Foundation Project, which is run by DHS with assistance from USM. It is a demonstration project to provide managed care to poor people. It involves AFDC recipients, Medicaid beneficiaries, people looking for work, and people employed by small businesses that don't have health insurance.

Health insurance premiums are funded by medicaid for the medicaid beneficiaries. Funding for non-medicaid people is a combination of payments from individuals receiving coverage, from employers, with some absorption of charity care and bad debts from individual hospitals. The amount of funding from employers and individuals is subject to a means test.

The project is small, involving 3,000 medicaid beneficiaries, and 2,100 non-medicaid. Results will not be known for several years. The Commission agreed to refer to the project in the report, but not to devote time to studying the project in any detail.

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In response to the discussion of this topic, Graham Atkinson has submitted a short paper on the subject of data collection and its use, which will be discussed at the next meeting.

4. Viability of Hospitals

The current regulatory system does not guarantee solvency for all hospitals in the State. There was some discussion that whatever regulatory system is recommended, it should be clear that solvency for all hospitals would not be guaranteed.

approved 4/13/88

3-28-88

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

SUMMARY OF MARCH 23 MEETING

1. DATA COLLECTION AND DISSEMINATION:

Graham Atkinson's paper on this topic generated most of the initial discussion. It was agreed that two questions must be answered when addressing this issue.

1. What is the data to be used for?
2. Is the data going to be any good for that purpose?

Three types of data normally collected by hospital regulatory agencies are already collected in Maine. These are:

1. Cost and Utilization data
2. Financial data
3. Medical Record and Abstract data

MHCFC is planning to collect total charge data in the near future.

INSURANCE DATA:

The Joint Standing Committee on Banking and Insurance is concerned with lack of information and analysis on the rising cost of health insurance - particularly with regard to procedures in the non-regulated, non-hospital side of the industry. This generated a discussion of the feasibility of collecting certain kinds of data.

Graham Atkinson recommended expanding Maine's current data collection beyond hospitals to free-standing facilities such as ambulatory surgery centers. Reliable data on these types of facilities could be obtained. However, he argued that obtaining data from sources such as physicians offices and insurers is much more difficult and less cost-effective.

Atkinson also commented that inpatient data is cost effective as cost of collection is small compared with charges associated with inpatient services. The same is true for free-standing facilities like ambulatory surgery centers. But charges associated with services such as doctors' visits and diagnostic visits involve small charge levels, so even relatively low-cost data collection can end up as a substantial percentage of the billed cost. Also, data bases already exist which could be used for one-time studies - e.g. Medicare-Caid, Blue Cross-Shield data bases.

Commission members agreed that more data on diagnostic procedures outside hospitals is desirable. However, there is a need to define those procedures that could be targeted and to determine the usefulness and feasibility of collecting data on those procedures. Graham was asked to expand on this, responding to such questions as:

Defining what could be done with data
Who would collect it and how?
Cost-effectiveness?
Format for data collection?
What data to collect?

Committee members also expressed interest in finding out about what is being done in Pennsylvania with regard to data collection.

2. NURSING HOMES

According to DHS, there are currently approximately 9,000 beds in Maine, with 450 new beds under review. DHS in in the process of developing a case-mix payment system for nursing home patients.

Commission members discussed problems associated with patient screening before admittance to nursing homes.
Staff was directed to look into this. The following is a summary of information received from DHS Bureau of Medical Services and Bureau of Maine's Elderly:

The State has a screening process for medicaid patients. However, there is concern about private payor patients. A 1986 study by the Human Resources Committee recommended screening for all patients before admittance to a nursing home. In response to the Committee's recommendations, the Bureau of Medical Services did a study on what other states are doing in this area, and considered the possibility of doing a demonstration project in Maine for voluntary screening. The possibility of using community agencies for implementing such a project was also considered. The issue has not gone any further.

3. HOSPICES:

There was some discussion about the need for a hospice facility for AIDS patients in Portland. This issue may need to be revisited.

5/12/88

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

SUMMARY OF MAY 11 MEETING

Presentation by David Landes, Health Consultant, National Conference of State Legislatures. Summary of his comments.

1. Health Insurance for the Uninsured

In dealing with this issue states generally adopt one or a combination of three different approaches.

a) Medicaid Expansions - more services, adding more eligible groups.
b) Charity/Bad Debt Pools
c) Health Insurance Programs

Charity/Bad Debt Pools:

Notion is to spread the burden so that hospitals should not be soley responsible for picking up the shortfalls.

Where to get funds for a pool?

Currently, the most common method among states is to use hospital assessment system - e.g. Florida, South Carolina, New York, West Virginia. Florida uses direct hospital assessment system. A percentage of net hospital yearly income goes into a pool. Advantages of a hospital assessment system are that it is easily administered, fewer payors (less than 100 hospitals in Maine), fairly easy to determine how much is to be paid in, and it is politically more easily imposed than a tax. The disadvantage is that it doesn't spread the burden of paying for indigent care.

Money can also be raised from general revenue, payroll, excise taxes etc. Advantage is that the burden is spread more equally, disadvantages are that funds are more difficult to collect and taxes are always a harder route politically.

N.B. No states currently use a payroll tax to fund bad debt/charity care pool.

How to distribute those funds?

- In Florida, each hospital submits a bill based on unpaid charges.
- Some states set a yearly percentage reimbursement
- Some states use a formulated reimbursement system based on historical bad debt/charity care shortfalls, adjusted yearly for inflation.

N.B. David Landes agrees with Graham Atkinson's recommendation to use a formula-driven system with appeal mechanisms built in. Provides incentives for hospitals to take indigent patients plus collect bad debt and charity care shortfalls.

Florida's hospital assessment system drew a lot of negative publicity when it was first implemented (1980), because at first there was a huge surplus in the pool. It appears, however, that the surplus was more due to poor planning than with the fundamental concept of a pool system. The eligibility process was slow, and it took some time to build up enrollment, so in the beginning expenditures from the pool were small compared with the revenues.

Health Insurance Programs.

Massachussetts Health Security Act: .(Information about the Act is included in articles 6,7 and 8 of the packet distributed by Landes). Landes noted that most of the opposition to the Act came from small business organizations. He suggested that it might be easier to approach hospital assessment issues and employer assessment issues separately - in separate bills for example.

Washington State: (Articles 9 and 10). Established Washington Basic Health Plan as an independent agency, with a Basic Health Plan Trust Account in the State Treasury as a depository for plan funds. The agency is to design a schedule of basic health care benefits, and market those to individuals. Premiums are based on a sliding scale system, depending on family income. Copayment deductibles are included. Funds are provided by general revenues.

Wisconsin: (Article 12) At first 5 pilot programs were proposed - sparking political controversy.

1) Voucher program for individuals to subsidize premiums.
2) Group plan subsidy for those who have access to insurance but can't afford premiums.
3) Epanding small business programs - e.g. high risk pools.
4) Loan system to individuals for paying premiums.
5) Allow individuals to buy into state-funded program similar to medicaid.

After controversy, Wisconsin is now looking at a scaled down set of proposals.

1) Group plan subsidy
2) Individual access to state funded program similar to medicaid.
3) Subsidy to workers for purchasing health care (new component)

2. Multi-Faceted Systems: - Some general comments:

Some possible results of a multi-faceted system such as the one recommended by Graham Atkinson:

- Smaller, rural hospitals are more likely to opt for a more regulated structure to ensure their own solvency, while larger hospitals in a more competitive environment will opt for a less regulated structure.
- Allowing solvency for rural hospitals through more rugulated structure ensures preservation of access to health care in rural areas.
- In more competitive environment, less regulated hospitals may buy more equipment, provide more services and compete more aggressively, prehaps driving down prices in the long run.

3. Rural Hospitals

Rural Health Problems:

a) Population decline
b) Lower Medicare reimbursement rates
c) Utilization decline (DRG system provides incentives to decrease utilization.)

Potential Solutions:

a) Increasing services
b) New types of facilities - e.g. North Carolina has funded growth of community clinics.
c) Improved EMS services
d) Physician recruitment programs

5343m

18 April, 1988

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

SUMMARY OF APRIL 13 MEETING

1. ISSUES REFERRED TO THE COMMISSION:

The Commission received letters from the Joint Standing Committees on Human Resources and Business Legislation concerning bills considered during this legislative session. Both committees have referred the issues addressed by the bills to the Commission.

a) L.D. 2324, An Act Establishing a Medicare Assignment Program. This bill, which was considered by the Committee on Business Legislation, would require physicians who agree to treat Medicare patients to accept Medicare assignments as a condition of licensure and practice. It would also impose a financial penalty on Medicare providers who fail to post their policy regarding Medicare assignment.

The Committee on Business Legislation did not act on the bill, referring the issue to the Commission for consideration.

The Commission decided to postpone discussion of this issue until a meeting with members of the Commission on Access to Health Care could be arranged, to avoid any possibility of the two commissions working at cross purposes.

b) L.D. 2500, An Act to Revise the Certificate of Need Process Dealing with the Purchasing and Delivery of New Medical Services. This bill, considered by the Committee on Human Resources, proposed establishment of a 7-member committee of experts which would examine medical technologies and treatments not yet offered in Maine and make recommendations regarding their introduction into Maine.

The Commission agreed to postpone discussion of this proposal until the time when the overall CON issue is discussed.

2. DATA COLLECTION AND DISSEMINATION:

During discussion of the Pennsylvania statute it was concluded that Pennsylvania is not really doing anything very different from what Maine is already doing. It was also noted that the Banking and Insurance Committee has proposed to study the issue during the interim and report to the Blue Ribbon Commission by September 1988.

Commission members agreed to defer further discussion of this issue until they discuss issues relating to hospital regulatory systems.

3. OPTIONS PAPER: - Pooling Mechanisms

Graham outlined some questions/issues in his paper that need to be adressed in discussing this topic. I have summarized points of consensus as reached during the discussion.

a)Are Pools Necessary? There was general consensus on the goals and objectives of a pooling system to spread the load of bad debts, charity care and governmental shortfalls more evenly - either across hospitals or to a broader population base.

b) Administration? Consensus was reached that a public entity with public accountability should administer a pooling mechanism. The entity should be semi-independent and has political, public and executive support. The same entity could also administer the regulatory system.

c)Building Public and Political Support. Some ways of soliciting support were discussed.

Taking the "package deal" approach. Offer taxpayers a number of ways to deal with various bad debt and charity care issues. For example, taxing businesses that do not provide insurance to their employees.

Argue that current financing methods are no longer appropriate in today's health care environment, and that the legislature and public need to look to the future.

Insurance premiums have been greatly affected by the bad debt and charity care shortfalls. Blue Cross and Blue Shield premiums, for example, would decline by 15% if this problem was resolved.

d) Options For Determining Payments. Graham listed five options in his paper.

Actual Bad Debts and Charity Care
A Formula-Determined Predicted Amount
Actual, But Subject To A Review
Lesser Of Actual And Predicted Amounts
Lesser Of Actual And Predicted, But With Appeals

Graham noted that separating bad debts from charity care can be difficult. This causes complications as hospitals should be provided with incentives to collect as effectively as possible, so the incentive should be to minimize bad debts. However, hospitals should not be discouraged from providing charity care.

The problem of separating bad debts from charity care may be may be resolved, however, as the MHCFC may soon be requiring hospitals to distinguish between bad debts and charity care. Graham will follow this up with MHCFC staff and revisit options for determination of payments.

e) **Governmental Shortfalls.**

The Medicare program is placing cost containment pressures on hospitals. One suggestion raised during the meeting was the possibility of setting up a state medicare subsidy. It was agreed to revisit this option in the future.

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5/3/88

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

Summary of April 27 Meeting

1. Evaluating Current System:

After some discussion concerning the Commission's charge with regard to evaluating the current system, it was agreed that the Commission's final report should include some statements about the current system's performance since implementation. Graham agreed to summarize and review technical information received to date so that Commission members can devote some time to assessing the current system before discussing future options (Revisit at May retreat).

2. Paper on Regulatory Systems:

Graham summarized his written work, with some additional comments and recommendations. I have documented some of those additional comments as follows:

a)Maryland System:

General Characteristics: Mixed system, partly customized to needs of hospitals.

Three basic types of rate regulation:

- -Total patient revenue system (some rural)
- -Approved charge per case (most hospitals)
- -Rates set per unit of service (some small and specialty hospitals)

Generally, regulation choice varies by size of hospital. For example, large teaching hospitals tend to choose a case-mix adjustment system, which is more DRG-based. Other hospitals either use a DRG system, ICD9 coding system, major diagnostic categories, or a mixed system.

The majority of hospitals receive an automatic formula adjustment to adjust rates from one year to the next, which accounts for inflation, volume change and other factors such as direct and indirect teaching costs. Every year, hospitals are screened and ranked by cost per admission. The top 10 hospitals are denied inflation adjustments.

A detailed review process exists for those hospitals that are low cost and need additional revenue.

A separate commission reviews CON

There is some regulation of outpatient costs. Regulatory commission collects statistics on units of service. A hospital may charge what it wants for particular tests, but over a year it has to meet an approved average rate per unit.

Maryland has a medicare/caid waiver so that medicare/caid pay rates set by the Commission. This has an impact on accessibility, as 94% of charges are paid by medicare/caid. Some contained cost shifting occurs, as the remaining 6% is distributed amongst other payors.

NOTE: On average Medicare pays 70-80% of Maine's charges, Medicaid pays 80-90%.

Non-hospital activites are hardly regulated at all.

System performance: Before this regulatory system was implemented, Maryland ranked in the nation's top 10 states in terms of high cost per case. It is now below the national average.

In general, there is broad-based support for the system. An annual poll is taken, which continues to indicate hospital support for the system and existing commission.

b)General Comments, Recommendations (Atkinson's)

Medicare waivers: Popular with many states under the cost-based reimbursement system. However, there are less advantages to such waivers under the prospective payment system. Also, the current administration does not favor waivers.

Types of waivers vary. For example, to keep the waiver since medicare went on the prospective payment system, Maryland has to demonstrate that the rate of increase in medicare payments per case in the state has been less than or equal to the rate of increase per case nationally. Maryland's goal is to keep the rate of increase at 1% below the national average. States already with waivers, such as Maryland and New Jersey, tend to stay with system because it is stable and predictable despite the hassle involved.

Atkinson recommends using a pooling mechanism to deal with bad debts, charity care and government shortfalls instead of waiver system.

DRG pricing VS DRG for revenue control: Graham made the point that DRG pricing systems tend to be very clumsy, but using DRGs as a mechanism for controlling revenue is a reasonable approach.

Under a DRG pricing system, patients would have to be charged based on DRG categories, which is complicated and difficult to administer. However, DRGs could be used to control inpatient revenues without using them to control prices. Under a revenue constraint system, a hospital adds up charges and bills for those charges, but over a year's time, the hospital has to meet the average revenue it would have received under a DRG pricing system.

The key to a successful, multi-level regulatory system is to get broad-based support from health care industry

Volume adjustments should be generous, with an 80-90% variable cost factor.

It is important to establish evaluation criteria to be used when discussing changes to regulatory system.

C)Other States - further comments, observations:

Connecticut
- Sets a rate per case for hospitals, with a DRG weight of 1
- Psychiatric and rehabilitation hospitals have per diem rate system.
- Medicare/caid shortfalls are capped at the level incurred during 1986.
- System lacks broad-based support.
- Annual attempts to abolish system.
- Huge revenue fluctuations from year to year

New Jersey
- DRG pricing system for all payors, with weight of 1.
- Medicare/caid waiver system - hidden cost shift.
- Large revenue fluctuations from year to year.
- Lacks industry support

New York
- DRG based system - blend of DRG pricing and DRG revenue limits (began January 1988).
- No recognition of Medicare payment shortfalls
- Too early to tell how effective system is.

Finger Lakes
- Total regional revenue system with annual adjustments for inflation, new technology and population growth.

5262m

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BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

TO: Commission Members

FROM: Annika

RE: Next Meeting

DATE: May 4, 1988

The next meeting will be from 10:00 a.m. until 3:00 p.m., Wednesday, May 11, room 427 State House (Banking and Insurance). David Landes, Rebecca Craig, and Tracey Hooker from the National Conference of State Legislatures will give a presentation and answer questions about other states' regulatory systems. Part of the discussion will evolve around the Massachesetts bill.

I have enclosed a summary of the last meeting, a copy of the Massachusetts Bill, and a wayward survey response from HIAA.

Mail often gets lost in the confusion of the session. If you are aware of a survey response that was sent but not received, please let me know and I will try to get another copy from its authors.

Have a nice weekend.

5271m

John R. McKernan, Jr.
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

June 30, 1988

TO: Interested Parties

FROM: Deborah Curtis, Staff, Special Select Commission on Access to Health Care

SUBJECT: Symposiums on Access to Health Care

The Special Select Commission on Access to Health Care has contracted with Lewin/ICF, a health policy consulting firm in Washington, D.C. to assist the Commission in developing a plan for addressing problems of access to care in Maine. Lewin/ICF will be conducting several symposiums over the next several months as part of its contract. Interested parties are welcome to attend.

The schedule for the remaining symposiums is the following:

Tuesday, July, 19, 1988:	Insurance Mechanisms to Address Access to Care
Wednesday, September 7, 1988:	Financing Strategies for Addressing Access to Care
Thursday, September 29, 1988:	Design of a Basic Plan to Address Access to Health Care in Maine
Tuesday, November 29, 1988:	Discussion of the Components of the Commission's Plan

All seminars will be held in Room 427 of the State House, from 9:30 a.m. to 4:00 p.m.

bb

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BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

To: Commission Members

From: Annika Lane

RE: Next Meeting

Date: July 5, 1988

The next meeting is scheduled for Wednesday, July 13, 9:30 a.m., Room 334 State House (Legislative Council Chambers).

I have enclosed a proposed meeting schedule through January 1988, and a draft introduction and background section to the Commission's report.

I have also enclosed a schedule for Symposiums on Access to Health Care, conducted by Lewin-ICF for the Special Select Commission on Access to Health Care.

5736m

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BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

TO: Commission Members

FROM: Annika Lane

RE: Testimony, next meetings etc

DATE: September 9, 1988

I hope you have recovered from the public hearings. I apologise for the Portland hearing room - unfortunately I had little control over which room was assigned to us by the USM Conference Center!.

The good news is that the Bangor hearing went smoothly.

I have enclosed a complete packet of testimony from the two days. Most people submitted written testimony and I am requesting written comments from people who spoke but did not provide me with a written document.

I am in the process of preparing a summary of comments/recommendations/criticisms with regard to the actual report.

By the end of the month therefore, you should receive the following documents:

1. Summary of testimony relevant to the report (staff)

2. Summary/analysis of the New Hampshire CoN system, L.D. 2500 and Maine's CoN system (staff).

3. A list of issues that need to be resolved (prepared by Graham).

The next meeting will be on October 12.

At the last meeting, the possibility of an additional meeting in October was discussed. Members expressed willingness to attend a meeting without reimbursement for expenses. I have explored our budget possibilities and am pleased to announce that we have funds enough to reimburse you and bring in Graham for that additional meeting, which is scheduled for October 26.

6251m