BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

PUBLIC HEARINGS

Portland September 6, 1988

Speaker	Representing
David Crowley Director, Hospital Payments	Blue Cross and Blue Shield of Maine
Brian Rines, Ph.D Chairman	Maine Hospital Association Trustee Advisory Group
Edward David, M.D., J.D. President	Maine Medical Association
Bill Spolyar Chairman elect	Maine Hospital Association
Jack S. Dexter, Jr. Chairman	Coalition for Responsible Health Care
John DiMatteo Trustee	Maine Medical Center Finance Committee Chairman
Stuart Ferguson	Maine Committee on Aging
Richard Morrell Chairman of the Board	Mid Coast Health Services
Clifford H. West Chairman	The Maine State Legislative Committee of the American Association of Retired Persons
Janet Corbett Director	Miles Memorial Hospital Nursing & Asst. Administrator
Joe Ditre	Maine People's Alliance
Howard Buckley Chief Executive Officer and President	Mercy Hospital
Dale McCormick	A member of the State AIDS Advisory Committee and Consumers for Affordable Healthcare

Speaker	Representing
Jud Knox President	York Hospital
Pamela Prodan Secretary	Maine National Organization for Women (NOW)
Burt Wilner	Stevens Memorial
Dr. Harris J. Bixler Trustee and Treasurer	Northeast Health
Michael Cavanagh	AFL-CIO
Beth Kilbreth	Human Services Development Institute - HSDI
Gloria Leach President	Adolescent Pregnancy Coalition
Rev. Lewis Beckford	Southern Maine Area Agency on Aging
Kay Mishkin	Family day provider
Elizabeth Rothberg Assistant Director	HIAA
Charles Landry	York Chamber of Commerce
Mike Poulin	Counsel for Central Maine Medical Center
Rep. Peter Manning	D - Cumberland
Jill Fargo Vice President of Nursing	York Hospital
Stephen Pelletier Director of Human Resources	York Hospital
Russell A. Peterson Vice President of Financial Services	York Hospital

6249*

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

PUBLIC HEARINGS

Bangor September 7, 1988

Speaker	Representing
Bonnie Brooks	Opportunity Housing
Brian Rines, Ph.D Chairman	Maine Hospital Association Trustee Advisory Group
Lisa Miller President Elect	Maine Public Health Assoc.
Richard Fredericks Chief Executive Officer	Maine Coast Memorial Hospital
Dave Crowley	Blue Cross & Blue Shield
George James Trustee	Aroostook Medical Center
Mary Bennett Williams, R.N.,Ph.D. Vice President for Patient Care	Eastern Maine Medical Center
Kenneth P. Trevett President	Project Hancock
Roger Mallar	Coalition for Responsible Health Care
Clifton Eames Chairman of the board of trustees	Eastern Maine Medical Center
Madelaine Freeman Executive Director	Eastern Area Agency on Aging
Harold Gerrish, M.D. Trustee	Mayo Regional Hospital
Judie Burke President	Maine Medical Records Assoc.
Jill Goldthwait	Private nurse
Elizabeth Whitehouse	Consumer
Grace Summner	Maine People's Alliance

Speaker	Representing
Michael Carey	Planned Approach to Community Health & Mount Deset Island Hospital
Lucy Pullman	Lives and works in shelters for the homeless
Bonnie Post	Access to Health Care Commission
Ken Schmidt	Regional Medical Center - Lubec
Craig Bean	Houlton

6249*

WRITTEN TESTIMONY IN LIEU OF VERBAL TESTIMONY

Rep. Neil Rolde	D - York
Anne Pezzullo Director of Physical Therapy	York Hospital
Barbara A. Desrochers Employee	York Hospital
Janice Fawcett	Concerned citizen
Eleanor Apgar	Concerned citizen
Laura M. Childs	Concerned citizen
Paul H. Apgar	Concerned citizen
June H. Curtis	Concerned citizen
Pauline G. Hall	Concerned citizen
Jud Knox President	York Hospital
Sally Rollins	Concerned citizen

Northern Cumberland Memorial Hospital (NCHM)

6249*

TESTIMONY

William Spolyar
Maine Hospital Association
Blue Ribbon Study Commission Hearing

September 6, 1988
Portland, Maine

Good afternoon Chairman Gauvreau and members of the Commission. My name is William Spolyar and I am the President of the Mid-Maine Medical Center in Waterville, Maine. I am here today to speak to you as Chairman-Elect for the Maine Hospital Association.

First, I would like to express our appreciation to the Commission for the hard work dedicated to this task. We all recognize that the task is formidable because the issues are difficult and interrelated to other issues not directly the responsibility of the Commission. We are pleased to see a report outlining, in conceptual framework, a new system for regulating hospitals which reflects the Commission's recognition that significant change is necessary.

Second, I want the Commission to know that the Maine Hospital Association is working to build consensus among the hospitals, other providers and other parties who have significant interest in health care policy. Health care policy is obviously too important an issue to approach without as much consensus as possible.

To achieve consensus, however, is a long educational process for all of us -- not just hospitals -- and we as hospitals are committed to that process with all people and groups with whom we work and for whom we serve.

We compliment the Commission for recognizing that this education process is an essential ingredient to a successful end result by issuing a draft report which is conceptual in nature and begins to stake out the parameters of the new system. We recognize that much more work needs to be done and we are committed to work with you to bring more focus to these concepts.

Before discussing these concepts, however, I would like to leave the Commission with two important messages:

1. Unless significant change is made, there will be many unintended consequences resulting from the current regulatory system which will begin to negatively affect access to care and quality of care. I will follow up later in my testimony with information on this point.

2. The Commission and the state must decide if it chooses to regulate hospitals what appropriate rate of growth is consistent with the health care needs of the people in the state of Maine.

   It is our strong belief that unless you allow health care

services and capacity to grow consistent with up-to-date costs and standards, you must understand that the health care system in Maine will begin to erode and affect access and quality in very meaningful ways.

I would like to step back and provide the Commission with some historic facts:

1. In the years 1980 through 1982, preceding the creation of the current regulatory system, Maine hospitals spent 4.8% less per capita than the national average, and 16.4% less than the New England average.

   In the years 1984 through 1986, under the current regulatory system, Maine hospitals spent 6.2% less per capita than the national average, and more than 18% less than the New England average.

2. In the years 1980 through 1982, preceding the creation of the current regulatory system, an admission in a Maine hospital cost 3% less than the national average, and over 22% less than the New England average.

   In the years 1984 through 1986, under the current regulatory system, an admission in a Maine hospital cost 4.2% less than the national average, and over 20% less than the New England average.

These trends are disturbing, in that it would appear that regulation has only constrained, and maybe inappropriately so, a system which appeared to be operating responsibly to begin with.

3. The Maine hospital industry as a whole has never enjoyed large operating margins. Maine hospital margins peaked at an average of 1.8% in 1982, and have since declined to an average of only one half of one percent in 1987.

4. In 1982, preceding the creation of the current regulatory system, 20 hospitals lost money from operations, and only about half of them were able to cover those losses with income from gifts and investments; income that would otherwise have been used to replace equipment and keep up facilities. Small hospitals made up nearly half of that group of losing hospitals, and their operating losses totaled just over $1,000,000.

   In 1987, the most recent year for which data are available, under the current regulatory system, there were still 20 hospitals that lost money from operations. Small hospitals still make up half of the group, but their losses now total more than $3,300,000. And small hospitals as a group did not generate enough non-operating revenue to cover those operating losses.

I believe any reasonable person would conclude from the above discussion that Maine hospitals are behaving responsibly and appropriately to meet community needs for health care services. I also believe that any reasonable person should conclude that hospitals are beginning down the slippery slope of financial jeopardy.

It is our opinion that the primary reason for this erosion is a basic philosophy of the Maine Health Care Finance Commission and its statutory authority that growth for health care costs in the state of Maine need not relate to national norms or standards, but that the Maine hospital system can somehow function significantly below such norms or standards.

When this philosophy is translated into the financial needs of hospitals by the Commission, what this really means is that hospitals have great difficulty hiring or retaining employees across the board because the wages and compensation allowed by the Commission are formula driven and do not relate in any meaningful way to the marketplace. Let me state right now that for the most part we are competing in a national market for our people and to argue that hospitals should not be allowed to compete in that national marketplace because for some reason Maine is different is, I believe, foolish at best and fundamentally wrong at worst.

I would like to now address the balance of my remarks to the draft report.

1. We endorse the recommendation that there be multiple options available to regulate hospital inpatient costs and charges. We believe this acknowledges the reality that all of our hospitals must be sensitive to their diversity, size and geographic location.

As the Commission further deliberates, we ask them to consider the following questions in these options:

1. Assure that the options for special regulation or deregulation are made readily available to those hospitals seeking different treatment under one of those two approaches.

2. There should be an opportunity for realistic demonstration projects and for special treatment of special and/or unique hospitals.

If these options are implemented fairly and appropriately, there should be broader acceptance of regulation since it will be more sensitive to particular needs of hospitals.

We would ask the Commission to give some thought to needs of certain hospitals in the state, particularly rural hospitals that

are having a difficult time attracting or retaining primary care physicians for their communities. A mechanism should be made available to those hospitals to help them absorb the costs of providing these services.

There will also be a need for protection of hospitals for circumstances that occur that are outside their control and allow for hospitals to seek relief in the event of emergent needs. Current experience under the "unforeseen circumstances rule" has not been positive for the most part.

Finally, we would ask that productivity measures be applied with sensitivity to all hospitals, especially smaller hospitals that may have rational reason for higher costs than a similar hospital in a less rural area. We endorse productivity and efficiency measures as a keystone to any new system, but would ask that such measures be carefully employed to avoid unintended consequences.

2. Outpatient rates and revenues -- You should know that hospitals remain ambiguous about the implications of deregulating outpatient services. On the one hand, much of health care is being delivered in outpatient settings for cost effective and efficiency reasons.

   Further, as Dr. Atkinson has stated, the growing costs in the outpatient service area is primarily a function of utilization and not, therefore, a problem that rate control

can deal with. Therefore, hospitals understand the wisdom and philosophical reasons for deregulating outpatient services. On the other hand, hospitals are concerned about unknown and unintended consequences with respect to access and financial viability of deregulating certain outpatient services.

We do believe the system should provide for deregulation of outpatient rates under certain conditions, but we acknowledge that we do not have any clear view what those conditions ought to be at the present time.

We also believe that cross-subsidization of outpatient services should be permitted to continue at the current level and that some adjustment ought to be available, though not necessarily identical to the inpatient adjustment factor and be incorporated into the rate of growth for outpatient revenues.

3. Standard Component (rebasing)

We support the use of a standard component for rebasing, but believe that that standard should be from outside the state of Maine and be chosen from a system which represents a level of quality of care equal to the state of Maine.

We believe that requirements of any rebasing mechanism are

that it be based on efficiency and productivity, that it be as equitable as possible and not be artificially constrained by budget neutrality. Many of us have been harmed by the current system and need to be rebased before any new system is imposed.

4. Discounts -- We would oppose the regulatory system allowing discounts at the present time and would recommend that no discounting on the part of the provider or the payer be permitted at least under the total revenue system or rate per case system. We believe by prohibiting discounts, except for prompt payment, providers and payers are protected from the inability to negotiate or accept a discount due to their particular circumstance.

5. Appeal Mechanism -- We oppose the draft recommendation that would limit appeal based on the percentage of the hospital's cost base. We do not believe that legal rights should be determined based on any hospital specific percentage formula because there may be instances in which an appeal is sought which does not directly relate to revenue needs.

6. Governmental Shortfalls, Pools for Bad Debt and Charity Care -- We agreed with the concept of a pooling strategy or other similar mechanism to reasonably distribute the burden of bad debt, charity care and governmental shortfalls among hospitals and as a means of augmenting the funds available to

pay for these responsibilities. Such a mechanism, however, must distribute the burden among hospitals in an equitable manner, taking into consideration efficiency and productivity of the hospitals. In addition, the current system for reimbursing hospitals for shortfalls must be retained until public funding for the pool is appropriated.

7. Rate Setting Body -- We support the concept of an accountable body located in the Executive Branch of government. It is important that the rate setting body be publicly accountable in a more immediate way, not for having its decisions overruled, but for purposes of assuring that it is managing the system consistent with the purposes for which it was set up.

8. Shortages of Health Care Professionals -- We believe that any regulatory system must recognize the actual labor costs occurred by hospitals, including wages and benefits. We believe the current formula-based system has clearly proven itself to be inadequate and inappropriate for purposes of responding to this very major issue all hospitals are experiencing today. Of equal importance, the Commission should recommend major tort reform efforts for purposes of health care providers if we are to continue to be able to offer services, especially in our rural areas, at any cost.

9. Mandated Benefits -- We would urge the Commission to recommend approaches which allow maximum flexibility to

enrollees in the choice of benefits purchased with their health care premiums as opposed to a continuation of philosophy based on mandated benefits.

We see no reason why an employer should not be able to offer a health care benefit to its employees with the employee having the opportunity to choose certain benefits above baseline basic health care package.

We look forward to working with the Commission as it continues its deliberations as we all work toward a new system appropriate for the people of the state of Maine which is more sensitive and realistic based on the realities of providing health care today.

Thank you for your attention.

HELEN T. GINDER, DIRECTOR
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BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

TO: Committee Members

FROM: Annika Lane

RE: More Written Testimony

DATE: 9/15/88

I have enclosed some more written testimony and a letter from George Wright that was sent to Sen. Gauvreau on September 7, 1988.

6351m

Anne Pezzullo
43 Pine Road
North Hampton, NH 03862
September 6, 1988

The Honorable N. Paul Gauvreau
Office of Policy and Legal Analysis
Room 101/107
State House Station 13
Augusta, ME 04333

Dear Mr. Gauvreau:

My name is Anne Pezzullo, I live at 43 Pine Road in North Hampton, New Hampshire, and have been employed at York Hospital for two and one-half years as the Director of Physical Therapy. I would like to speak to you today on several perspectives, as an employee and as a manager. The positions will demonstrate issues that show why York Hospital has unique circumstances that warrant special consideration from the Maine Health Care Finance Commission.

As a manager, there are many challenges I encounter. When I first came to York Hospital, there were vacancies in the Physical Therapy Department. I was fortunate in that I was able to hire two therapists that I had worked with at my previous job in Portsmouth, New Hampshire. Since then, staffing has become a more difficult issue. There is presently a shortage of physical therapists, in Maine, as well as nationwide, and qualified Physical Therapists have their choice of job/location/salary because of the shortage. When I interview, I am forced to compete with the high pay rate that is being offered by our neighboring New Hampshire hospitals. Thus far, York Hospital has been able to compete with these high salaries, which has enabled me to continue to staff my department with excellent personnel; but the hospital is stretched to the limit at this point and I fear I will either be unable to staff my department at all or will only be able to hire mediocre therapists. Either option would negatively affect the high quality of patient care that we work so hard to provide.

Another issue that I have been struggling with the past two and one-half years as a manager is not being able to serve all the patients that we should because of our present staffing levels. The quality of care we provide is very high but with our present system we do not have the manpower to serve all the patients we want to, including those who are already at our hospital. Patients are being forced to go to competing New Hampshire hospitals, where costs are higher, for their treatment. The York community wants to receive therapy in York and it is sad that they often need to seek treatment out of our state. We know that we provide quality care, but I have to wonder what the people of the York community think when they call my department for treatment and are informed that there will be a seven to ten day wait and then they call a New Hampshire hospital and are seen in two to three days. I would doubt it if they feel that our quality of care is high. What would you think about the quality if you called for service and had to wait that long?

As a resident of the State of New Hampshire, I have to pay an unfair Maine state tax. This is an issue that I have as an employee and as a manager and is another circumstance why York Hospital, as the only border hospital, deserves special consideration. With 1% unemployment in the area, we often seek New Hampshire residents to work at York Hospital. There is a severe shortage of health care workers and this tax issue only worsens the problem. It is extremely difficult to recruit New Hampshire residents with this unfair tax law. Good employees have not come to work at York Hospital because they would be in my situation. You may ask me why I bring this issue up to you as you do not make the tax laws. I realize that you cannot make a change with the tax law, but you are in the position to make a recommendation to the

appropriate state agency that would influence a change to correct this tax law that is so unfair to border employees. This is an issue that York Hospital, a border hospital, deals with that no other hospital deals with. It deserves appropriate recommendations to state agencies and my hospital deserves special consideration based on this issue.

In closing, I strongly feel that York Hospital is unique and deserves special consideration based on its unique circumstances, some of which I have addressed, as well as others you are hearing today. These unique circumstances are making it increasingly difficult for us to continue to provide the high quality of care that the people of York want and deserve. We are the only border hospital and we are dealing with non-regulated New Hampshire hospitals with their high salaries, an extremely low unemployment rate in our community, Maine tax laws which negatively affect border employees, high costs of housing and living. These are issues that no other hospitals are dealing with and I trust that you will give us the special consideration that York Hospital deserves.

Thank you!

Anne Pezzullo
Director
Physical Therapy
York Hospital

Barbara A. Desrochers
RFD #2 6 Creation Rd
York, Me. 03909

Sept 6, 1988

Dear Commission Members,

As a resident of the town of York and an employee of York Hospital I would ask that Special Consideration be given to York Hospital by the Commission.

York Hospital is a unique hospital and very much committed to quality care. The regulations imposed on the hospital make it very difficult to give quality care. Being a border hospital which has to compete with New Hampshire's unregulated hospitals is almost impossible. If the Commission continues to regulate York Hospital with out giving it Special Consideration it will be impossible to compete and give the quality care the people in this community want and deserve.

I am the parent of a 20 year old handicapped and retarded daughter. Medicare requires I bring my daughter to Maine doctors and Maine hospitals. If York Hospital has to curtail it's services or close because of the Commissions unFair regulations I will be forced to either go to New Hamshire or drive 50 mile to Portland to get the excellent Services I am receiving here in York for my daughter

I ask that you give Special Consideration to York Hospital and keep Maine patients in Maine

Barbara A. Desrochers

Remarks to the Blue Ribbon Commission

on Health Care Expeditures

September 6 and 7, 1988

Prepared by the Coalition for

Responsible Health Care

For more information, please contact:

The Coalition for Responsible Health Care
John S. Dexter, Jr., Chairman
C/O Maine Chamber of Commerce & Industry
126 Sewall Street
Augusta, ME 04330

Chairman Gauvreau and members of the Blue Ribbon Commission on Health Care Expenditures, my name is John Dexter, Jr., I'm President of the Maine Chamber of Commerce and Industry, but I appear before you today as Chairman for the newly formed Coalition for Responsible Health Care. I appreciate the opportunity to speak to you.

Let me begin by telling you something about our Coalition. As you are aware, the burden of cost of our health care system falls predominately on the members of the business community and their employees. Since the beginning of this year, employers and employees have seen dramatic increases in the cost of their health care insurance. While the norm appears to be about 40%, many have seen increases of 60% or more. To say that these increases have been viewed with alarm would be an understatement. Recognizing that they had a right and an obligation to participate in the health care cost containment dialog, a number of business organizations have banded together to ensure that their concerns are made clear. In addition to the Maine Chamber of Commerce and Industry, organizations who have already become part of the Coalition include the Maine Merchants Association, the Associated General Contractors of Maine, the Maine Motor Transport Association, and the Paper Industry Information Office. At least three other major associations and many other payor/related groups are expected to join the Coalition.

Let me begin by noting that the Coalition appreciates the difficulty of the Blue Ribbon Commission's charge. Over the past few months, we have all come to recognize that the problem of containing health care costs is a far more serious and compelling issue than originally understood when the Commission was formed. It is much more than merely assuring a reasonable financial base for our hospitals. We believe that the impending health care crisis coupled with the expectations created by the very existance of this Commission require that the Commission take a broad view of the need to contain health care costs. We believe that the Commission should aim its recommendations at addressing the overall problem of the potential for the collapse of our health care system, not just at finding a more acceptable method of hospital regulation, although we agree that a sound hospital financial environment is an essential element to successful health care in our state.

Of the dozen of so causes for health care cost increases, the most significant by far is the so called cost shifting to private payors of Medicare and Medicaid shortfalls and bad debt and charity care. This is estimated currently to exceed 100 million dollars annually for hospitals alone. There is little question that the combined impact of the burden of this cost shifting threatens to collapse the entire medical delivery system as

we know it. In early 1988, the typical Mainer and his employer who purchased a family medical insurance package of hospital, medical, and major medical coverage paid about $250 per month or about $3,000 per year. We estimate that by 1990 or 1991, unless a dramatic reversal of current trends occurs, that same package will cost about $6,000. That is $2.90 per hour for every hour that the average employee works! Who will pay this increase? Clearly, business can not and should not. Nor can or should employees. To perserve the system it will be essential that the Governor and the Legislature develop an approach that will provide sufficient support from a broad-based source to assume the Medicaid shortfall and the cost of bad debt and charity care and to cap the Medicare shortfall at its present level. If such dramatic steps are not taken, we believe that access to health care for Maine citizens is seriously at risk.

It should be noted that Maine is practically unique in requiring private payors to pick up these shortfalls. Maine's employers and their employees have paid enough. Purchasers of health care insurance should not be required to pay for unfunded governmental programs.

In the interest of time, I will keep my comments on the rest of the report very brief.

The coalition believes strongly that outpatient services should continue to be regulated in all types of hospitals regardless of whether they are under a per-case payment system or a total revenue system. We know of no way under either type of regulation that cross subsidization can be identified or avoided. We believe that it is totally unreasonable for payors to be forced to continue massive subsidies under a system which makes massive cross subsidization possible. Continuated outpatient regulation must be a condition of revenue guarantees.

We strongly endorse the Commission's recommendation that the regulatory system establish a standard component in the rate to be phased in over a five year period. We agree that such a system would encourage and reward productivity.

The Coalition agrees with the Commission's recommendation with respect to discounts and with respect to appeals.

We concur that hospital payment demonstrations should be encouraged. However, we are concerned with the broad authority given to the rate setting body to waive "any and all regulatory and statutory requirements" and suggest that some alternate definition may be appropriate in this situation.

We believe the idea of letting some general hospitals receive licenses to operate as lower level facilities makes enormous sense. This is particularly true in areas where no medical facility may exist if current hi-tech trends force increased centralization of hospital services. We hope that this goal is aggressively pursued.

We believe the concept of pooling may be a necessary mechanism to assure a means of fairly distributing government support for its mandated programs. Considerable effort will be required to develop the concept into a workable system and we stand ready to assist in this and other areas.

We urge the Commission to take an aggressive position with respect to tort reform in the medical area. It is our understanding that Maine providers pay an estimated $18,000,000 a year in insurance premiums. This number is expected to grow dramatically in the years to come. Of even greater concern is the fact that, according to national sources, practitioners generate 5 to 7 times premium costs in additional tests and procedures to be in a better position to defend themselves from malpractice suits. We believe that an aggressive, private utilitization review system outside of the government arena must accompany tort reform if this change is to have the desired affect.

We are pleased that the Commission has endorsed a review of the cost of mandated benefits. Blue Cross and Blue Shield and others estimate the cost of mandated benefits to be millions of dollars per year. Some health program administrators tell us that they delete other services from their medical packages in order to minimize the impact of the cost of mandated benefits.

We suggest that one approach might be making so called mandated benefits an option which must be made available to employees in so called flex-benefit plans but that the decision as to whether or not to elect them be left to the employee.

In conclusion, we would like to congratulate Senator Gauvreau and all of the members of the Blue Ribbon Commission for an outstanding job to date. We believe the ground work exists for the next Legislature to take enormous steps to address the health care crisis. However, much is yet to be done. We must approach the remaining task in a spirit of cooperation recognizing that no one will get everything he or she wants. We must recognize that employers and employees can not stand to bear any more of the health care burden. We must recognize that if we are to encourage employers who do not now provide health insurance to do so, that we can not continue to layer on not only the burden of their own workers but of bad debt and charity patients and Medicare and Medicaid shortfalls. We must recognize that we can not deal with questions of

expanding access until we have broadened the base of those paying the medical bills.

The members of the Coalition for Responsible Health Care look forward to working with you constructively on these and other issues.

Thank you for your time.

Adolescent Pregnancy Coalition

TEENS ARE OUR FUTURE

74 Winthrop Street
Augusta, Maine 04330 207-622-5188

Senator Gauvreau and members of the Blue Ribbon Commission, I am Gloria Leach from Brunswick. I am President of the Board of the Adolescent Pregnancy Coalition, a coalition of over fifty service providers whose clients are teens seeking to avoid pregnancy, or who are already pregnant or parenting. The Coalition members represent diverse philosophical perspectives but we are united in our commitment to advocating for this group of teens. We appreciate the opportuniuty to tell you about our concerns for our clients.

For most of them access is their biggest problem. Our clients needs preventative services; family planning information, prenatal care, and/or well baby clinics. As a general rule, these services have not been hospital based. Our clients have several reasons for not accessing care including transportation and psychological barriers but their biggest problem is financial.

Under the Sobra Amendment embrased by the 113th Legislature, more of our clients are eligible for care earlier in their pregnancies than they have been previously. However, we are still finding it very difficult to find physicians or other practitioners who will see these young women for prenatal care. Even when families have health insurance, it does not always cover the pregnancy of a minor daughter. These clients are often difficult to treat. They are risk takers who do not follow directions well. Compared to older clinets, they take a large amount of practioner time. Physicians tell us that they are particularly concerned about liability when treating this population.

We are concerned about a Commission recommendation to put large amounts of general fund money into hospital based crisis services at the further expense of outpatient and preventative services. We believe that the state has an obligation to suppliment the Medicaid account so that no provider goes into debt to care for this population. Shortfalls and cost shifting has occurred not just in hospitals but in physicians offices, rural health clinics and home health agencies as well. We believe that cost shifting and further shortfalls cannot continue in any setting. The system cannot continue to absorb those shifts.

Funded in part by:
The Division of Maternal and Child Health, Bureau of Health
Maine Department of Human Services

Eastern Area
Agency on Aging
Twin City Plaza, P. O. Box 70, Brewer, Maine 04412-0070
(207) 941-2865 or 1-800-432-7812

September 7, 1988

TESTIMONY BEFORE BLUE RIBBON
COMMISSION ON HEALTH CARE EXPENDITURES

My name is Madeleine Freeman, Executive Director of the Eastern Area Agency on Aging, a private non-profit agency serving Penobscot, Piscataquis, Hancock and Washington Counties - an area in which approximately 39,000 individuals over the age of 60 reside. An important part of our responsibilities, under the Older Americans Act which created the Area Agencies on Aging, is to participate in the development and coordination of comprehensive service delivery systems for older persons.

Since the elderly as a group are, in fact, the largest consumers of health care, we are participating in the recently formed coalition of Consumers for Affordable Health Care. And, since, in Maine, individuals over the age of 65 represent 46% of hospital days, we are pleased with the opportunity to comment on the Draft Report of the Blue Ribbon Commission on Health Care Expenditures. We commend the Commission for inviting public comment and discussion before firm recommendations are made.

Our comments are in two parts. General comments about the Report will be followed by commentary on those portions of special significance to the elderly.

GENERAL COMMENTS

1. We agree with the Commission that the whole issue of health care expenditures is much more complex than has been addressed in this Draft Report. Actually, the Report uncovers only the tip of the iceberg - the tip that encompasses expenditures for acute care in the hospital setting - NOT addressed is the whole continuum of health care which begins with access to the health care system and also includes primary and long-term care.

2. Although it is true, as the Commission points out, that other Committees and Commissions have been charged with the study of other components of the health care system, it is imperative that somebody, somewhere, somehow put together all of the information gathered into a comprehensive health care system that is no longer fragmented, make-shift and filled with gaps through which many of our citizens, including the elderly, continue to fall.
3. For all the reasons presented by the Commission, especially those of conflicts of interest, we believe the Rate Setting Body should be an independent executive agency with a review of its performance at periodic intervals.
4. Considering the varying types of hospitals serving Maine's large geographic area and the regional differences that exist in availability of total health care resources, it seems appropriate that alternative systems be available for the regulation of inpatient hospital rates or revenues. The experience of Maine's five Area Agencies on Aging, as regional administrative agencies for the State's Home Based Care and Elderly Medicaid Waiver programs, corroborates the fact that regional differentials are a significant factor in the cost of health care delivery.

SPECIFIC COMMENTS

1. Medicare/Medicaid Shortfall

The Commission must be aware that the so-called Medicare shortfall impacts, not only on hospitals and third party payors, but also on the elderly. As Medicare pays less and less of the cost of health care, the elderly pay for an ever increasing proportion of their own care in the form of higher Medicare cost-sharing deductibles, escalating premiums for supplemental policies, and the direct charges to elderly patients when physicians do not accept Medicare assignment.

Maine hospitals, unlike hospitals in most states, are fortunate that in 1985 the state adopted an all-payor reimbursement system which tends to shield hospitals from financial losses under Medicare. However, there is no comparable system to shield individual elderly persons from the widening gap between the actual charges for health care services and the amount that

Medicare will pay. The elderly may not be uninsured, but they are becoming increasingly under-insured.

The Commission is recommending that an undetermined amount be sought from the General Fund to cover the projected increase in the total shortfalls in Medicare and Medicaid payments in the next year. This raises the following questions:

a. Is this to be a one-time payment only or is there danger that it will become an annual payment?

b. If it is not to become an annual payment, what basic reforms to the total health care system will make future payments unnecessary?

c. What will be the impact of such a payment, even if it is one-time only, on other health and social service programs that must compete for limited General Revenue funds?

d. Could, and should, these same dollars be used to effect basic changes in the health care delivery system to make health care more accessible and affordable for all Maine citizens?

2. Outpatient Services

We support continuing regulation of outpatient services. There is evidence that the less severely ill elderly are being treated more frequently on an out-patient basis. The elderly are concerned about the potential for additional shifting of diagnostic testing and medical procedures to the out-patient setting if out-patient services were deregulated. The reasons for this concern are two-fold:

a. The long distances individuals often have to travel, especially in Northern and Eastern Maine, to see a physician often make it easier, especially for the elderly and the poor, to be hospitalized where the physician can frequently observe the person's condition rather than treatment in an out-patient setting which often requires additional travel if the person returns home and then has to come back to the physician or hospital.

b. The elderly, especially those more frail and alone, have learned that there is often unanticipated need for attendant care at home after out-patient procedures. The need is often more than expected and is not easily available, especially if an emergency arises.

3. Length of Stay

After a steady decline between 1980 and 1984, mean length of hospital stay for persons aged 65 and over in Maine, increased from 8.6 days in 1984 to 9.4 days in 1986. One reason for the increasing length of stay is attributable to the hospital's inability to discharge Medicare beneficiaries due to a lack of post-acute services in the community, either home-based or institutional care. As you undoubtedly know, there are only 400 skilled nursing beds state-wide. In the Eastern Area which we serve there are 95 SNFs located in Penobscot and Piscataquis Counties. There are none in Hancock and Washington Counties. Intermediate care beds are also in short supply and there are waiting lists, especially for elderly dependent on Medicaid.

The State's Home Based Care and Elderly Medicaid Waiver programs have not been able to meet the demand for in-home care for individuals at risk of nursing home placement. The total state budget for these in-home programs currently is only $7 million.

All of these long-term care services, both institutional and community based, are an integral part of health care in Maine. They cannot be separated from a consideration of health care expenditures. Each component of the system impacts on the other. Gaps are recognized but continue to persist.

The elderly have consistently supported additional state and federal funds to close the ever-widening gaps that exist. They continue to advocate for additional funding for a comprehensive long-term care system. They are concerned that, if the Blue Ribbon Commission seeks General Revenue funds for acute care shortfalls, there will be less money available for the expansion of long-term care facilities and community programs which, in turn, impact on hospital costs.

4. Hospital Demonstrations

   Legislation should, as recommended by the Commission, provide for demonstrations for utilization of hospitals that are unlikely to be able to remain viable as acute care general hospitals because of low patient volume. The elderly have a stake in maintaining some of these hospitals as a lower level health care facility within a reasonable travel distance.

In summary, we want to again commend the Blue Ribbon Commission for its efforts to date and for involving the public in the dialogue on health care expenditures - a dialogue that we believe has only begun and which must encompass more than expenditures for acute care.

SENATOR N. PAUL GAUVREAU
DISTRICT 23

State of Maine
Senate Chamber
Augusta, Maine 04333

September 12, 1988

Anika Lane
Staff Assistant
Office of Policy & Legal Analysis
State House, Station 13
Augusta, Maine 04333

RE: Blue Ribbon Commission

Dear Anika:

I am enclosing a copy of correspondence dated 9/7/88 addressed to me from George Wright which is in response to certain questions Rep. Pines raised at the August 31, 1988 Commission meeting dealing with Certificate of Need issues. Would you kindly distribute this correspondence to members of the Commission.

Please give me a call should you have any questions in this regard.

With best regards,

N. Paul Gauvreau

NPG/jd
Enc.

MediMaine Health Associates

498 Essex Street
Bangor, Maine 04401
(207) 947-0529

September 7, 1988

Senator Paul Gavreau
Chairman
Blue Ribbon Commission on
Health Care Expenditures

Dear Senator Gavreau:

Dr. David has requested that I write to you explaining the normal procedure for the performance of MRI scans at our facility in Bangor. Currently, we are performing approximately 240 studies a month. Patient referrals come from central, eastern, and northern Maine; including Waterville to the west, north into Aroostook County, and downeast to Calais. There are occasional patients who are referred from Atlantic Canada, as well. The physicians referring patients include neurologists, neurosurgeons, orthopedic surgeons, oral surgeons, internists, and oncologists.

These cases are all reviewed once a week by our Chief MRI Technologist, who is a Certified Registered X-Ray Technologist specifically trained and qualified in MRI, prior to the time they are to be performed. Requested studies that do not seem to be clearly indicated or are possibly inappropriate are discussed by the Technologist with a physician at the MRI facility. He contacts the physician(s) who has requested the study and discusses the reasons for the MRI request I make sure that the appropriate study has been ordered and that the MRI examination is, in fact, indicated on all the head and spine studies. Dr. Mark Piccirillo, a Radiologist with special expertise in body MRI, performs this function for all other body parts. Additionally, all Workers' Compensation cases have pre-authorization by the insurance company involved in the case. Some other third party payors also have pre-test authorization.

The head and spine MRI studies are read by one of four neurologists with specific training and experience in MRI, or by one of seven radiologists with specific training and experience in MRI. The radiologists are also responsible for reading all MRI examinations of other body parts.

There is also a weekly conference to review studies which have been performed. This conference is attended by radiologists, neurologists, neurosurgeons, and internists. Cases reviewed are chosen both

on a random basis, and because of special interest. At these conferences, a number of issues are discussed, including the appropriateness and usefulness of the MRI examination in the particular clinical setting.

I hope this information has been helpful to you in understanding the normal operations of our MRI facility. If you have any other questions, I would be happy to try to answer them for you.

Sincerely,

George J. Wright, III, M.D.
Medical Director

GJW/lr

maine public health association
P.O. Box 5004, Augusta, ME 04330

TESTIMONY BEFORE THE BLUE RIBBON COMMISSION
ON HEALTH CARE EXPENDITURES
LISA MILLER, M.P.H., PRESIDENT-ELECT
September 9, 1988

I currently serve as President-Elect of the Maine Public Health Association, a voluntary organization of 280 members from all areas of the health care system: administrators, dentists, dieticians, educators, nurses, physicians, planners, psychologists, researchers, toxicologists, and local health officers. Our organization is particularly interested in disease prevention and health promotion, as well as access to care for all Maine citizens, including the uninsured and the indigent.

I would like to comment on four areas in the Commission's report: the Medicare/Medicaid shortfall, proposed demonstrations, payment mechanisms, and physician recruitment.

Conceptually, the general fund approach for making up the Medicare/Medicaid shortfall is appealing in its attempt to spread the responsibility for such care over the entire taxpaying population. However, such an approach represents an even larger contribution of state funds to acute, tertiary care. We cannot continue to escalate funding for these services and ignore the roots of those medical problems. Disease prevention activities receive comparatively few funds in this state. Consider smoking:

* One in three adults smoke in Maine
* Smoking is a major risk factor in heart disease and stroke--the two major causes of death in Maine
* Smokers suffer from more acute and chronic disease, more bed disability, and more lost work days than nonsmokers
* Smoking is a major public health problem in Maine, yet there is no line in the state budget, no staff, and no specific program devoted to smoking, even though we collect millions of dollars in tobacco taxes annually.

Maine is already rationing preventive health services with insufficient funds; perhaps we must now ration tertiary care services as well. We would support the idea of requiring that any general funds used for the shortfall be matched with funds for preventive health services and health care for the uninsured OR a proposal to direct a given percent of total annual acute care expenditures into such services.

With regard to the hospital payment demonstrations and demonstrations on changes to a lower level of care suggested in the report, we would add that cost-effective preventive health service demonstrations should also be encouraged. We are not proposing revolutionary new services here -- there is ample documentation in the medical literature of the value of early detection and control of disease through use of hypertension and cholesterol screening, routine pap smears, and appropriately spaced mammography. We simply need to get services such as these out to the public in more effective ways.

We would like to express one concern about the per case payment system. As far as we can tell, the proposed system makes no provision for bad debt or charity care. We suggest that you build in a margin in the per case rate for bad debt and charity care.

My final comment pertains to physician recruitment. I work part-time as a physician recruiter for rural health centers in central Maine. Health centers, which are required to be placed in medically underserved areas, are finding it increasingly difficult to recruit family physicians to small town Maine. Residents are routinely emerging from medical school and residency with $50,000 to $100,000 of debt. Alluring as Maine is, rural communities cannot compete with urgi-care centers, hospitals, HMO's, and group practices that offer residency graduates $70,000 and up for their first year of practice. Our association therefore supports creative mechanisms to attract physicians to our rural areas, such as loan forgiveness or assistance setting up a practice. Incidentally, the nursing shortage will probably necessitate similar measures to assure adequate recruitment of nurses to rural areas.

To conclude, the Maine Public Health Association believes that the Blue Ribbon Commission on Health Care Expenditures must view health care expenditures in the broadest terms -- your decisions affect not only hospital budgets, but the funding of preventive and primary care services as well. Prevention must receive its piece of the health care financing pie.

Delivered at Bangor 4-1-88

A RESPONSE TO THE BLUE RIBBON HEALTH CARE EXPENDITURE REPORT

by Elizabeth Whitehouse
201 Husson Ave., Noble 8
Bangor, ME 04401-3240
945-6715

After looking over the draft report on Health Care Expenditures, my great fear is that the frustrating pattern of regulation now in use is going to be continued--perhaps magnified in scope. The present measures of cost containment and shutting off of funds have led to overwhelming stress, stroke-generating frustration, and even to downright heartbreaking situations for elderly patients and for young handicapped people as well. Medical ignorance on the part of bureau employees in many situations compounds the difficulties generated by rules which are also dreamed up without adequate medical knowledge. Patients are often put at risk, and in some cases, the final result has been greater expense rather than cost containment.

One major cause of the frustration is the rule that sounds reasonable but in practise is far from it. The rule is that home care of any kind can only be provided for those who are completely home bound. It is referred to as the "going out the door regulation." It tries to push live human beings into niches with the result of much senseless pain and suffering. A whole separate hearing could be filled with the nightmarish results of the regulation. Here are samples from my experience

I was recently released from the hospital following shoulder surgery which made it necessary to completely avoid using my right hand. I am a right handed person. I was ambulatory, but having some minimal home personal care was advisable--for having a bath; help in preparing meals, and cutting my food. There is a shortage of such help--if it had been availab it was denied on the strength of the "can go through the door" regulation. Oh, yes, I also had to have home physical therapy to qualify for personal

home care. I had physical therapy at the hospital and it has been continued, but was denied at home. Why home physical therapy and home personal care are related, I don't know. It didn't matter that I couldn't get my shoes on and tie them with one hand, or that I couldn't put my back brace on and fasten all the straps. It didn't matter that I wouldn't go through the street door to take a shower or that I wouldn't go barefoot to EMMC for physical therapy. No one bothered to explore that there might be extenuating circumstances to put the regulation aside. Tragedy nearly occurred when I tried to take a shower to overcome nine days of hospital sponge baths. I was very fatigued and in considerabl pain from my total multiple medical problems. I had my eyes closed against the cascading water. Probably because I was using my left hand, I became disoriented and turned the faucet toward scalding hot water rather than toward off. In my scramble to get out of the tub and away from the scalding danger, I could have ripped out over $2500 worth of delicate surgery and probably would have completely ruined my chances for returning to active performance with the piano. Having a personal home care service for the bath could have prevented such a frightening experience. The requested care wasn't for 24 hours a day, but for short periods for just a few days.

A year ago in April, I experienced the heartbreak of lying on a cot in Emergency for over four hours while the cost containment argument raged over whether or not I should be admitted, since I was experiencing excruciating pain when I tried to walk; lived alone in the second floor apartment, and knew from personal experience that I would not be able to manage alone under the circumstances. Two Emergency Room doctors said they could find no cause for the excruciating pain. X-ray showed a ruptured ankle tendon, but that was not sufficient cause for hospitalization. After entering Emergency, I began to experience even more excru-

ciating muscle spasms in the affected leg. Not one person asked me any questions or gave me a chance to explain that I had a severely degenerated spine with pinched nerves which a neurosurgeon had warned could lead to just such an experience. The admitting staff would not allow me to contact my personal doctor because it was during his office hours. He could have shed light on the subject and given a character reference that I wasn't out for a hospital holiday at taxpayer's expense. My orthopedist was out of town. I felt like I was considered a worthless and troublesome human being, and when I thought of the over 50 years of intensive volunteer work I have done for community and church while serving as the best wife I could be and raising three children, and when it was the truth that I had experienced severe spinal pain since I was in my mid-thirties, and, at the time this happened I was 72 years old and working long hours to serve other people through the beauty of my original music and poetry, photography, and art, it was as though my heart was broken. I cried and cried, and that seemed to make one of the doctors angry--both that I cried and that I wouldn't quietly go home where I belonged. The saving grace in all this was the compassionate attitude of another doctor, whose name I believe was Clement, and the nurse who was in charge of Medicare admissions and had done every thing she could think of to see that I would be given proper care. My orthopedist's associate came in after his office hours, the first opportunity I had to discuss the pinched spinal nerves. Very soon after that I was in a hospital bed receiving the tender loving care that I surely had merited from the beginning. The fear that Medicare might not pay had done something to ordinarily very caring people that made concern for the patient take a subservient place below the dollar sign.

The hospital's patient relations representative to whom I later talked apologized for what had happened. The very wonderful and loving care I received at this same hospital with my shoulder surgery did much to help erase the memory of that nightmare. Nevertheless, there is much wrong with the cost containment mechanism to set such a nightmare in motion in the first place.

Another situation which has led to great stress and frustration is that there is no medical priority for ambulatory handicapped people in the regulations governing homemaker's care. I have had a discouraging three year struggle to try to get just three hours a week of homemaker's help on a long term basis because my condition is chronic; help to do the portions of home care that are helping destroy my already badly damaged spinal joints and other inflamed joints when I try to do such work--such movements as grasping and bearing down with arthritis damaged hands and wrists; bending repeatedly, and piston movements of arms and the bending to run a vacuum cleaner; these will all too rapidly destroy the joints that otherwise could suffice to keep me independently living for some time to come. The alternative is a boarding home for the elderly or, of course, living in filth. I could be evicted from my apartment for accumulated filth. The boarding homes cost from $750 to $900 a month, which neither I nor my family could afford to pay. There are other complications that could send me to the next step, the $2000 and up a month expense of a nursing home. There are waiting lists for both types of homes. I could become a criminal and the taxpayers would pay $1000 a month and up to keep me incarcerated. Somehow, paying $75.00 a month for 15 hours of homemaker's care seems a better bargain all the way around.

Every day the media proclaims that legislators are proclaiming that the nation just cannot afford adequate health care, eye glasses, dental

care; hearing aids. Every day the media services urge the buying of every luxury item one can possibly imagine, as well as absolutely unnecessary snacks, alcoholic and non-alcoholic beverages; personal $3000 spas to relax in after a hard day's work. Sales reports confirm that people are buying all these things, totalling in the billions. It isn't that we can't afford such important things--the truth is that there is a desire for Christmas every day, and who wants dental work or eye glasses for Christmas? The elderly do, that's who!--and just once a year would be fine. Legislators and taxpayers would do well to remember that old saying, "There, but for the grace of God, go I."

I am speaking at the request of many people who have had bad experiences and say they cannot speak for themselves. I've also been encouraged to speak by several doctors, nurses, social workers, and the personnel of health agency staffs and homemaker and home nursing-care-providing agencies. An analogy should help make graphically clear the way cost containment looks to a multitude of people. This is what the management of an auto manufacturing company would say to their customers under the cost containment scenario. "Because manufacturing costs are getting out of hand, this car you are purchasing will have only three wheels--new regulations, you understand. These wheels may have tires that leak, but testing is an expense we are avoiding to keep costs down. Oh,yes, we hope you will get by all right on your own out on the highway without a steering-wheel assembly, but costs must be kept down, remember. What happens to you after you leave here is, of course, not our responsibility. Dont' rock the boat by protesting these cost containment measures--that's liberal; unAmerican. it isn't our fault the taxpayer-stockholders are demanding that these stringent measures be applied to the elderly, the poor, and the handicapped."

In all seriousness, the present system seems to take the cost containment scissors and begin snipping without adequate proof that the

parts snipped are really the cause of excessive medical expense. I find it impossible to believe that the reasons for the mounting costs can reliably be determined without the legislative Blue Ribbon Commission sitting down with appointed representatives of hospital administrators, physicians and surgeons, and other health care providers to conduct non-confrontational; non-adversarial, mutual-aid dialogues which will get at the truth. It will be made clear where the points of waste and inefficiency are if the medical people are guilty as inferred, or it will reveal other levels where there is waste. Or it may be made clear that these health care providers are doing a remarkable job under very difficult circumstances, and taking undeserved blame. The answer may lie somewhere in between, but it is an answer that has not been, but must be, explored.

(Mrs.) Elizabeth Whitehouse

I was very impressed with the courtesy and efficiency with which details of the hearing in Bangor were handled - also the considerate determination to have meetings there for the evening session even though I was originally the only speaker scheduled for the evening session. It was of great advantage to me to be included in the afternoon session. I was again impressed with the courteous and considerate help given to me to have transcripts arranged for me as quickly as possible when I arrived near the end of the hearing at 5 p.m. Long distance telephone calls to Augusta were handled as quickly as possible so that reading the pre-pre-pre-recorded transcripts helped stayed in one's memory rather than frustrating periods of wait at daytime long distance rates.

Thank you and Congratulations

Sincerely,

(Mrs. Elizabeth Whitehouse

From Mrs. Elizabeth Whitehouse
who spoke at Bangor 9/7/88

ADDITIONAL HELPFUL INFORMATION FOR BLUE RIBBON COMMISSION

Another example of the "can go out the door" or homebound rule being applied inflexibly concerns a man who is virtually confined to his home with medical problems, yet has been benefitting from being transported to the Adult Day Care Center where he has companionship with other people in the same condition, to help end the terrible isolation and loneliness of people who have difficulty in being normally ambulatory and having social contact with others. Now he is in a situation requiring that a home nurse come and change his catheter daily. He was told (my information is from an agency providing assistance to the elderly and a home health care bureau) that he could not go out to the Adult Day Care Center because "going through the door" made him ineligible for the nurse to come to his home for the brief catheter changing service. Changing the catheter has to have priority, if a choice must be made, but by all the rules of compassion and common sense, it surely could be arranged that the man could have both and not break the taxpayer's bank.

An example of the "cost saving" of omitting medical tests when a doctor feels the diagnosis is so obvious that no test is necessary, and the reality of what may result in expense is shown by my own experience. The first test omitted was over forty years ago, and was not under current cost containment regulations, but forty years of situations of error related to testing gives a good idea that the matter of testing is far more complicated than is now being recognized. The omitted test was to identify a supposed case of hyperthyroidism. The doctor felt the signs were so obvious that the expense of a metabolism test was not necessary. He treated me with potassium iodide, which apparently did not harm and the "obvious" signs dissipated. Later a

more cautious practitioner performed the metabolism test and declared that he did not believe that the thyroid had ever been over-active. Again, just a couple of years ago, the signs were so "clearly obvious" in the words of an endocrinologist that he was sure that the new diagnostic blood test would confirm his suspicion. He was quite baffled that no hyperthyroidism existed. The measures taken to correct hyperthyroidism are quite drastic at times. Therefore, testing even when the diagnosis seems obvious is the better part of wisdom.

That situation resulted in little harm to me, but in another situation of failure to test spread over a period of years, the result had the potential for tragedy. I have a medical condition of my left leg called lymphedema. The lymph nodes do not fulfill their normal function. Fluid accumulates and infectious bacteria are not protectively filtered, which is one function of lymph nodes. The excess fluid makes the leg very uncomfortable, sometimes painful, and the sudden onset of the subcutaneous infection (usually staph) called cellulitis in some cases is mild, but in my case sweeps through my body and makes me very ill. Great effort is made to monitor the leg to prevent this happening, because I usually have to be hospitalized. The need for prevention has grown even more urgent since I have developed allerigc reation to almost every antibiotic that has been administered to me. A recent episode with antibiotic therapy caused such severe asthmatic bronchitis that surgery had to be postponed and when hemoptisis grew worse and there were other contributing signs, a bronchoscopy was done. The symptoms are different, but the lymphedema-cellulitis combination and phlebitis have been confused in my case repeatedly. In 1979, I was hospitalized for excruciating spinal pain; a bladder infection, and what was first termed cellulitis and then was rediagnosed as phlebitis.

Partly, I believe, because previous doctors had diagnosed the fluid filled and erythematic condition as phlebitis, no test was done and the condition was assumed to be phlebitis. Coumadin was prescribed to thin the blood and supposedly to help reduce the blood clottinng blockage. After I was released from the hospital, a laboratory nurse came to draw blood--twice a week at first and then once a week--to make sure that the blood thinning was not out of contol. There was considerable expense involved in this. Next there was some intestinal bleeding and a banding process was performed to stop it. The doctor had somehow overlooked the fact coumadin was being administered. The banding process led to excessive bleeding which required out-patient surgical fulgeration to halt. The hemorrhaging became very great when I returned home. My doctor was out of town and the covering doctor told me to stay in bed and wait until my appointment with my own doctor on the following Tuesday. I tried my best to do as he said, but the bleeding was so great that I finally collected evidence in a pint measuring cup and called the covering doctor to ask if a pint of blood was enough of an emergengy to have me admitted to the hospital. Admission was arranged immediately. Several more fulgerations were necessary and six blood packs were administered. I have bad reactions to transfusions which was bad enough, but all this led to the fact that after the news surfaced of AIDS on occasion passing on the virus to innocent people, at age 72, I was faced with the degrading necessity of going to the Sexually Transmitted Disease Clinic to be tested for AIDS exposure. This had happened to me within the nine to ten year period when it was realized that the sleeping virus might become evident. The expense of omitting a test that would have confirmed or ruled out phlebitis led to a horrendous amount of expense, to say nothing of what I was personally put through as a result of the ommission. Fortunately, the blood test proved negative.

SOME THOUGHTS FOR THE BLUE RIBBON COMMISSION

Presented By

George A. James, Trustee

The Aroostook Medical Center

INTRODUCTION

I am not an expert in either health care policy or administration. I am not a member of the medical delivery fraternity and I do not even know all the acronyms associated with the health care business. At one point not too long ago I thought a PRO was something you took when you were over forty!

I am a University Administrator in Presque Isle and I have served on the Board of our local hospital for approximately three years. I serve as the chairperson of our strategic planning committee and on the executive committee. Perhaps I have attended a few more meetings than some of our board members but I am basically just another citizen attempting to serve our community as a volunteer on the board.

I will attempt to share with you my observations and experience with the operation of our hospital under the MHCFC. Our official position as a board has been to support the Maine Hospital Association position - a recommendation made to us by our CEO Mr David Peterson.

OBSERVATIONS AND COMMENTS

1. As volunteer, lay persons in the field of hospital administration we find the regulations of MHCFC incomprehensible, unfathomable and removes us from a feeling of control and direction over our institution and the vital care it provides to our neighbors and friends in the community. Some states require insurance policies to be written so that the "common man or woman" can understand what the policy says. If we are going to continue with some form of regulation as Dr. Atkinson recommends, require that the rules and regulations be written so that we can clearly understand the meaning.

2. We have a meaningless budget process as the result of MHCFC. Our 20 million plus dollar budget is routinely presented by our administration as the best we can do under the circumstances. We have little or no opportunity to change any of the items and we really know little about what it is that we are buying with the budget. More importantly, we do not know whether we are cost effective with our proposed expenditures. Our budget is routinely out of balance as it is executed but we are told not to worry because, thanks to MHCFC, it will eventually balance. We have gone from a sizeable deficit to a position where it appears our bills are being paid fairly promptly. There is little room for us

to adopt new programs, take new initiatives, or measure quality and productivity. A reconstituted MHCFC must allow for improved budget - making at the local level.

3. We have a serious problem providing some basic medical services to the Central Aroostook area because of MHCFC. We need surgeons, OBYN personnel and pediatricians. We are limited as to what we can offer because of what our policies were in regard to these positions in 1983. The "new model" of MHCFC must not tie our hands in the recruiting of critically needed medical staff. If we need to pay these professionals salaries and/or handle their billing, we must be allowed to do it.

4. We have engaged in a very comprehensive strategic planning process. The involvement of every facet of the hospital organization was encouraged. A number of excellent recommendations emerged but we find in trying to implement these new programs that we are very limited by the constraints imposed by MHCFC. Recruitment of new physicians, for example, appears to be stymied by MHCFC.

5. As a Board, we are very concerned about the salaries for our nursing staff. If it were not for MHCFC, we would raise the salaries not only where they are competitive but where they reflect comparable worth as we define it in our organization. Although it is important to consider what the rates are in Portland or Bangor, we want to establish our own remuneration policies. We do not have that flexibility under the heavy hand of MHCFC.

6. It is not clear to those of us on the board that one can cut too many costs without cutting quality. We are told that MHCFC has little concern for quality. For example, I have been told that we could not get approval to add staff to reflect the increased workload caused by the new regulations regarding precautions for diseases like aids. As a recent patient at the hospital I noticed that the health care workers did not always have time to put on and take off gloves when they were dealing with my body fluids. I assume there were the same constraints when they were dealing with others. My care was jeopardized, I am told, because the hospital was not allowed to increase costs to support the personnel necessary to provide for my care and the safety of the health care workers.

7. THE MAJOR PROBLEM I FIND WITH MHCFC and the Blue Ribbon Commission is that you are not looking at the big picture. Let me illustrate by relating a story as follows:

Some years ago, as a new town manager, I was making an inspection tour of the city garage on a very rainy day. The street crew was in the garage and they were busy carrying buckets to a number of serious leaks in the roof. One of the crew, as he watched the pails slowly fill with water, scratched his head and said to me as he looked up at the dripping water , "I think I am starting on

the wrong end of this business."

It seems to be a parable of our times in health care in Maine when you think about it. We spend our scarce resources supporting a "Blue Ribbon Commission" which deals with symptoms such as I have described when we ought to be dealing with the causes. We are dealing with "the leaking roof" syndrome when we just look at health care costs in the hospital setting. It seems that many of the cost containment problems in our hospitals are due to the fact that we are busy carrying pails to catch the leaks rather than fixing the roof. We often appear to be depending on additional MHCFC regulations, appeal procedures or even court cases for the solution rather than instituting basic reforms and dealing with causes. It almost appears that we are using the best brains on our Blue Ribbon Commission to devise bigger pails to catch the leaks rather than repairing the proverbial roof. Both my own organization, the MHA, and the Commission appear to be concerned with issues which might be compared to the decision of where to place the pail to catch the leak. Others who may be appearing here today judging by their remarks, are praying for sunshine so that the problem will go away! Clearly, it would appear that we need an infusion of new, more broadly based ideas which will deal with the problems in the roof.

We might look at some more basic issues such as the level of health care we are willing to support in Maine. Certainly, we must be equally concerned with the quality of medical care provided to all our citizens and its accessibility. My challenge to you is that you become committed to the process of finding solutions to the root causes of the many complex health care issues you have examined. I do not really see much more than a tinkering with the status quo. There are some excellent adjustments being recommended such as the deregulation of outpatient care but that is not enough. Why are we not looking at bold steps like the state of Oregon has implemented in limiting the expensive procedures which really add to cost?

Would it not be better to let the sun set so to speak and rebuild the roof by dealing with not just the shingles but the pitch, the rafters and the very foundation of the structure? Our marvelous consultant Dr. Atkinson, whom I have now listen to with admiration on two ocassions, is a professional tinkerer! He appears to be able to sell us pails to catch the water in many different shapes and sizes. I assume he was hired because he is a world class expert on "buckets." I for one, however, am not at all satisfied that we need any more buckets!

I would be glad to respond to any "non technical" questions you might raise.

Stephens Memorial Hospital

80 Main Street Norway, Maine 04268 207-743-5933

Testimony offered to the "Gauvreau" Blue Ribbon Commission at Public Hearing, Portland, September 6, 1988.

by Burton L. Wilner, Trustee, Stephens Memorial Hospital, Norway

Mr. Chairman, Members of the Commission:

Thank you very much for the opportunity to testify at this hearing. I am Burton Wilner, a Trustee of Stephens Memorial Hospital, Chairman of the Board of Directors of Western Maine Health Care Corporation, the Parent Company of which Stephens is a subsidiary. I am a member of the Trustee Advisory Committee of the Maine Hospital Association, a consumer of health care services, an employer of consumers in my business and a payor of their health care insurance premiums. I am a dedicated representative of the consumers of our community who built and support our Hospital and I bow to no one as a qualified representative of consumer and patient concerns.

Trustees employ professionals to conduct the affairs of our institutions, and to represent us in the councils of our Maine Hospital Association. They stay in our employ so long as they do their jobs as well. Most of them do their jobs very well, so that here in Maine we are fortunate to have CEO's with proven long-term track records, and demonstrated commitment to the well being of Maine citizens, so that, as Trustees, we feel ourselves well represented.

But, by definition, it is Trustees who have fiduciary responsibilities. We are charged with exercising fiscal common sense to safeguard the assets of our community-owned not-for-profit hospitals, to see that quality service is available

and delivered to those who present themselves at our door. No one at our Hospital, or others in this State, is turned away for lack of funds to pay for Hospital care - so we maintain a healthy level - I use the word healthy advisedly - of charity care and bad debts to write off. We are further constrained by Maine Hospital Licensing Law, decisions of Law Courts throughout the country, and by a sense of moral duty to deliver our services in a modern state-of-the-art system of technology, so that patients in our Hospital are offered diagnostic and treatment procedures that are generally available everywhere. Our duty as Trustees is to be responsible for everything.

I am a Trustee, not a technician, so that I will not address specific issues of the Draft Report of the Commission in detail. But in more general terms, I can discuss the issues that concern us as we struggle to meet our responsibilities.

The combative and hostile relationship with the present Health Care Finance Commission is atrocious, unnecessary, and unproductive. Our time, energy, and money are being poorly consumed. In all my years of service to the Board of Stephens, I have never known any Trustee who wanted to do anything other than to deliver our services at the lowest possible cost, and to ask for operating margins any higher than the minimum needed to keep our doors open, and to provide for normal and necessary replacement and growth, as our community demonstrated its needs. And, as a former chairman of the State Hospital Licensing Advisory Committee - where I worked pleasantly and fruitfully with the very able Frank McGinty - and as a member of the MHA Trustee Advisory Committee, I've had an opportunity to meet with many of the 1000 or so Trustees of Hospitals throughout Maine, so I know that this attitude is not unique to my Hospital.

Under the existing regulatory system, our Hospital is forced to operate at a loss. This year the loss would appear to be about $500,000 on a volume of about 10 million Dollars. Our operations actually show an operating profit of perhaps 3% or so, but the loss picture is generated because we have been forced to exceed the revenue cap imposed unfairly by regulation, and will be required to "pay back". Yet, look at a few important statistics:

First, understand that the "Degree of Complexity" reflecting the severity and acute nature of cases treated in our institution place us in the 5th or 6th or so highest position of all hospitals in the State. Then compare us with other Hospitals of 100 beds or less in the state for the 3 month period prior to June, 1988.

SMH % of Occupancy	85 %	Average of Others 57 %
Length of stay	5.6%	6.2%
Expense/Adjusted Pt. Day	$431.00	$472.00
Revenue/Pt. Day	544.00	650.00
Intensive Care Revenue/Pt. Day	447.00	608.00
Full Time Employees/Occupied Bed	3.7%	4.2%
Patient Medicare Component	50 %	44 %

Every indicator points to a well managed, efficient operation, charging far less than the average of our group, offering high standards of care to a highly complex mix of patients and, may I add, with accolades from the Hospital Licensing Survey Team (who use our Hospital as an example to others) and from the Joint Commission on the Accreditation of Hospitals. And, if only we were permitted to charge

enough more to wipe out our deficit, or to keep what we do charge, we would still be lower in costs and charges than the average of our grouping, lower than the average of all Hospitals in the State - and for that matter, lower than the Northeast and National averages as well.

So our Board looks at this data and at our history of successful low cost operation, and wonders how such a state of affairs has been permitted to come to pass. We are being forced to spend about $75,000 annually in direct payroll costs and Commission assessment to work with the present system, financing, as it were, our own demise. Untold hours of our CEO, staff members, and Trustees are being used to function within the hostile environment forced upon us, diverting us from our primary tasks, and large legal and accounting fees are required to help us obtain what is only right and proper - all told, a crushing burden.

We recommend that your proposed Legislation correct these problems by addressing appropriately the following issues:

1. That Hospitals that have historically demonstrated, and who continue to demonstrate a lower than average cost to the consumer - tied to their "degree of complexity" in a rational manner - be deregulated. The intent of all Legislative action is to control the rising costs of Hospital care. We suggest that regulatory time be spent in problem areas, and not with those institutions which are already meeting the goal.

2. That the intent of the Legislature to reward hospitals for low cost, efficient, quality care - as expressed in the current statute, but which has been ignored by the present Commission - be made mandatory in any new Legislation.

3. That - barring deregulation as I have suggested - your draft proposals regarding demonstration projects, and any new Commission's right to abrogate any or all of its rules and regulations, be expanded to require trials, when requested, of a deregulated status for Hospitals who have historically demonstrated the ability to meet low cost, high quality operational standards.

4. That, in the establishment of any new system, a rational base-year determination be made, with the opportunity to recoup or to forgive the unfair and ill-advised losses that have been thrust upon us.

5. That the choice of revenue cap or per-case rates be expanded to permit choice by hospital, under reasonable guidelines, in the absence of the option of deregulated status.

6. Finally, that all rules and regulations set forth by any new Commission ordered by new Legislation be required to be reviewed by an appropriate Legistative Committee, to guarantee that the intent of the Legislature is being met.

The State did not build our Hospital, provide our equipment, nor does it met our payroll. Neither did nor does the Federal Government. The State and Federal Government do grant us tax-free status, and a lower than average mortgage rate.

In return, we supply the citizens of our community with high quality health care, accessible to all, at the lowest possible cost - and free as necessary. We accept, and have always accepted Medicare and Medicaid payments at lower-than-cost, meet all requirements of the Certificate-of-Need Law, reach out to our community with education and preventive Health measures, foster an ambulance and pre-hospital emergency care system, and reach out constantly in any way needed.

Our only vested interests as Trustees is to do what is right, decent, and moral. No one in the State Hierarchy can do this better, and to the extent that we can prove that <u>have</u> done this and that we <u>can</u> do this, your proposal for new Legislation should recognize this effort, reward it, and let us get on with doing our job.

Thank you for you time and concern.

MAINE COMMITTEE ON AGING
State House Station 127
Augusta, Maine 04333

LOCAL 289-3658
TOLL FREE 1-800-452-1912
(for Ombudsman Program)

September 6, 1988

To: Blue Ribbon Commission on Health Care Expenditures

From: E.Stuart Fergusson, Member
Maine Committee on Aging

Good afternoon, I am E. Stuart Fergusson, a member of the Maine Committee on Aging. I am presenting the Committee's comments on the Blue Ribbon Commission's Draft Report on Health Care Expenditures. While the Committee recognizes the significant work done by the Blue Ribbon Commission and its consultant, the draft report falls short of the study description. While the draft might provide ample information for individual hospitals to begin assessing how they might benefit or not from the proposed regulatory systems, the draft barely touches on the larger public policy issues of how we are to achieve the basic goals of health care which must include the provision of quality, accessible, and affordable health care. The Commission was specifically requested to evaluate the current and anticipated market for health care services, the current methods and trends in the financing and delivery of health care, the current and anticipated environment for health care delivery systems and the various methods of regulating health care and health care expenditures. As far as we can determine from this draft report, all of these pertinent and relevant issues will still be as plaguing and pressing once this report is finalized, unless substantial further work is done.

During this dynamic period of rapidly changing delivery of health care, when hospitals are buying nursing homes and developing home care operations, when advanced medical procedures are more commonly being done outside of hospitals, when large corporations are increasingly controlling the health care field, all of which affect quality, accessibility and affordability of health care. It is unfortunate that these issues were pushed aside to look at the minutiae of how "hospital X" should be regulated. We can no longer look at hospitals in isolation from the rest of the continuum of health care delivery.

The approximate 205,000 elderly in Maine are heavy users of the health care system and are approaching half of all hospital care days in the state. It is from this context that we make the following comments specific to your draft report.

1. **Regulation of Out Patient Rates**
It is our understanding that little or no standardized data exists to show outpatient use or costs to compare across hospitals. We know older people share in the trend toward more outpatient care. In a report done for us by Richard Fortinsky, Ph.D., Director of the Aging Research Policy Unit at the University of Maine, Human Services Development Institute, it shows that in Maine, since the implementation of the Medicare prospective payment system (DRG's), hospital discharge rates (and thus admissions) have fallen sharply, 15% as compared to the national rate of 10.9%. At the same time, case mix or degree of illness has increased noticeably in Maine since implementation of DRG's. Fewer and sicker hospital patients suggests that less severely ill older persons are now treated more often on an outpatient basis rather than in hospitals.

In contrast to the proposed recommendation, we believe these facts suggest it is more important to collect data, review trends and regulate costs of this increasing area of care provision. An additional issue not totally unrelated, is the fact that older people who leave the out patient setting to go home, frequently are frail and have no discharge plan or care plan set up, as is a requirement if they had been an inpatient. This clearly is not in the best interest of older people.

2. **Government Shortfalls**
The Commission is recommending that an amount be sought from the General Fund to cover the projected increase in the total governmental shortfalls over the next year. Some have cited this figure at $20 million. This gratuitously casts on the shoulders of the legislature the unwarranted burden of making funding decisions of a very large magnitude without the staff or resources to undertake such activity. This is a dangerous precedent to set. In addition, such action could never be supported by elderly advocates given that almost every hospital in this state is experiencing government shortfalls or bad debt charity care problems because of the "Days Awaiting Placement" problem when older patients who no longer need acute hospital care are backed up in hospitals because nursing home or home based care is not available. This draft report does nothing to address this problem. Our state funded, highly successful, home care program still is funded with approximately $6 million of state funds which pales in comparison to this potential $20 million request. We must devise a more rational allocation of resources based on needs in the health care continuum, and we could not, in any case, support this $20 million proposal to cover shortfalls at this time given this

back-up in hospitals and the tremendous unmet needs in long term care, and the failure of this report to address this problem.

3. **Demonstrations**
We support the flexibility of hospitals to develop demonstrations if it done with the approval of the rate setting body, or for hospitals to convert to lower level facilities. Throughout this section, and draft report, there are recommendations that unresolved issues be referred to a "task force" to explore remedies. Consistently, recommended composition excludes consumer representation. Why is this? We have got to engage consumers more fully and more meaningfully in these discussions if we are serious about improving our health care system.

4. **Rate Setting Body**
The Maine Committee on Aging believes the rate setting body must remain a fully independent agency. We have observed the nursing home field where the Department of Human Services acts at the major buyer, rate setting body, as well as the licensor, that is in effect a monopsony resulting in a completely irreconcilable conflict of interest caused by these functions being situated within an executive department. This same situation exists regarding Medicaid in the hospital field.

While it would be inadvisable to classify hospitals as public utilities in the classic, historical sense, they are "affected by the public interest" to use the language of the U.S. Supreme Court in Munn VS. Illinois. It has been the practice in the U.S. to regulate industries "affected by the public interest" in a similar manner, that is by a fully independent body, concerned only with the welfare of the State's entire citizenry. An example in Maine being the Maine Milk Commission.

Finally, in the study cited earlier, conducted by Dr. Fortinsky for the Maine Committee on Aging, he found the length of hospital stay for older people in Maine is increasing which is a trend counter to the national pattern. In Maine, the mean length of hospital stay for a person 65+ increased 8.6 days in 1984 to 9.4 days in 1986, as compared to the U.S. where the length of stay declined from 8.9 days in 1984 to 8.5 days in 1986. Maine seems to be escaping the national trend of hospitals discharging the elderly quicker. Possible reasons are:

1.) The regulation of hospitals by the Health Care Finance Commission which shields hospitals from financial losses under Medicare,

2.) A rise in acuity levels or sicker patients, and

3.) Difficulty discharging older patients due to lack of long term care services in Maine.

We believe the existing regulatory system may have in fact benefitted older citizens in this state. We would hope that this type of analysis which studies the effect of the hospital system on the people served, would be done by a Blue Ribbon Commission before it recommends changes to the regulatory system. Unfortunately, it appears the draft report focuses only on detailed hospital regulation without regard to the effect on individuals served in the hospital setting and without regard to impact on the rest of the health care continuum.

Thank you.

lo

To Whom It May Concern:

I would like to voice my opinion on this hearing today and hope that every consideration will be taken to listen to the people from the town of York.

I have always used York Hospital and consider it to be a valuable asset to the Town and I am fully convinced that it should be allowed to make its own decisions.

It is a border town and should be given special consideration, the same as our Discount Liquor Store in Kittery.

Laura M. Childs

I as a person with Angina would feel very unsafe to have our Emergency Room closed down during the evening hours as this is My difficult time.

I also have a deceased husband who, used this very capable & well staffed Room very frequently also during P.M hrs.

Eleanor Eggar
Yrs R Maine

Blue Ribbon Commission on Health Care Expenses

We have lived in the York area for 35 years and have watched the York Hospital grow from year to year. This is a special hospital that has always provided, not only the best of services, but in a very kind, caring, unique way. I have been a patient in this hospital and, if convenient, would never choose to go anywhere else. The people of York & surrounding areas are lucky & proud to have such a special place to go when ill, injured or even just to ask questions! We are most grateful to all who have kept it going through the changes & through the struggles created by regulations from people unfamiliar with our special needs. As a town bordering another state where no regulations determine their health care, we do find the lack of understanding on the Commission's part most disconcerting. I am also aghast at what appears to have happened to the program today. As a public hearing & the first a list was given to the Commission last week, it is rather strange that the original number of speakers (15) was reduced to one. It would appear that "the rules were changed" with no way to help ourselves. What is going on here?

9T.

Why is it, that when a Hospital is doing well, serving its' people and caring for them (in more ways than one), a group of people who are unfamiliar with the uniqueness of the York Hospital decide what is necessary or not. No hospital can operate on the schedule suggested - emergencies do not occur "on time". To keep up the necessary and appreciated services, we must be able to ~~1) make~~ make our decisions ~~2) operate as the special hospital we~~ always have.

I am sad & angry that we have to struggle so hard to get permission for things that should rightfully be ours to begin with.

Sincerely,

Janice W. Jewett
P.O. Box 634
York Harbor, ME 03911

EDWARD DAVID, M.D., J.D.
PRESIDENT
MAINE MEDICAL ASSOCIATION
SEPTEMBER 6, 1988

TESTIMONY BEFORE THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

I APPRECIATE THE OPPORTUNITY TO PRESENT THE MAINE MEDICAL ASSOCIATION'S POSITION RELATIVE TO YOUR DRAFT REPORT, DATED AUGUST 5, 1988. THERE ARE SEVERAL ISSUES THAT I WOULD LIKE TO ADDRESS, SOME OF WHICH RELATE DIRECTLY TO YOUR RECOMMENDATIONS AND OTHERS WHICH PERTAIN TO OTHER AREAS RELATED TO YOUR WORK, SUCH AS PROFESSIONAL LIABILITY ISSUES. INASMUCH AS I PRESENTED THE ASSOCIATION'S POSITION TO YOU LAST WEEK REGARDING CERTIFICATE OF NEED, I WILL NOT REPEAT THAT TESTIMONY HERE THIS AFTERNOON.

REGULATORY ENVIRONMENT

THE MEDICAL ASSOCIATION APPLAUDS THE COMMISSION'S ATTEMPT AT GIVING MORE OPTIONS TO MAINE HOSPITALS THAN ARE CURRENTLY AVAILABLE TO THEM UNDER THE HEALTH CARE FINANCE COMMISSION. AS AN ORGANIZATION WHICH OPPOSED THE CREATION OF THE SYSTEM, IT IS NOT SURPRISING THAT THE ASSOCIATION CONTINUES TO BE OPPOSED TO THE EXISTING LEVEL OF REGULATION OF MAINE HOSPITALS. THE EXCESSIVE REGULATORY STRUCTURE IN MAINE DOES NOT RECOGNIZE THE REMARKABLE CHANGES IN THE FINANCING AND DELIVERY OF MEDICAL CARE WHICH HAVE TAKEN PLACE IN THIS STATE IN THE PAST TEN YEARS. WHILE THE EXISTING REGULATORY APPROACH MAY HAVE BEEN APPROPRIATE IN A TIME OF UNRESTRAINED COST-BASED REIMBURSEMENT, CLEARLY, THE EXISTING ENVIRONMENT DOES NOT SUPPORT SUCH AN APPROACH. WE NOW HAVE A SYSTEM WHERE HOSPITALS COMPETE WITH OTHER HOSPITALS AND WHERE OTHER HEALTH CARE PROVIDERS, SUCH AS PHYSICIANS COMPETE WITH HOSPITALS, WHERE HMO'S AND IPA'S COMPETE WITH BLUE CROSS AND COMMERCIAL CARRIERS, AND

WHERE EMPLOYERS ON BEHALF OF EMPLOYEES ARE INCREASINGLY EXERCISING THEIR INFLUENCE. WHILE WE WOULD BE INCLINED TO DEREGULATE COMPLETELY AND TO LET MARKET FORCES WORK, WE APPLAUD THE GENERAL DIRECTION THAT THE COMMISSION IS GOING IN AND HOPE THAT IN YOUR FINAL REPORT EVEN MORE DRAMATIC RECOMMENDATIONS WILL BE MADE IN THE DIRECTION OF DEREGULATION.

PROFESSIONAL LIABILITY

YOUR DRAFT REPORT NOTES THAT MALPRACTICE INSURANCE RATES WERE CONSIDERED BY THE COMMISSION TO BE OUTSIDE ITS SCOPE OF WORK WHICH COULD BE ACCOMPLISHED IN ITS AVAILABLE TIME BUT THAT THIS TOPIC WOULD WARRANT STUDY IN THE FUTURE. WE WOULD ENCOURAGE THE COMMISSION TO MAKE A STRONGER RECOMMENDATION REGARDING MEDICAL LIABILITY REFORM AND ENCOURAGE THE COMMISSION TO RECOGNIZE EXPLICITLY THAT MEDICAL MALPRACTICE COSTS ARE AN IMPORTANT FACTOR IN RISING HEALTH CARE COSTS AND A SIGNIFICANT FACTOR IN THE GROWING ACCESS PROBLEM IN THE STATE. ALTHOUGH MAINE PHYSICIANS ARE REIMBURSED AT VIRTUALLY THE LOWEST RATES IN THE COUNTRY BY MEDICAID AND MEDICARE AND BY MANY INSURANCE COMPANIES, THEY PAY THE SECOND HIGHEST RATE IN NEW ENGLAND AND RATES HIGHER THAN PHYSICIANS EVEN IN CALIFORNIA, INDIANA AND MANY, MANY OTHER STATES FOR THEIR MALPRACTICE INSURANCE. OVER 200 CLAIMS PER YEAR ARE FILED AGAINST MAINE'S PHYSICIANS AND DATA FROM THE ST. PAUL INSURANCE COMPANY INDICATES THAT THE SEVERITY OF CLAIMS, THAT IS, THE AMOUNT PAID PER CLAIM DOUBLED BETWEEN 1985 AND 1986 AND INCREASED BY ANOTHER ONE-THIRD BETWEEN 1986 AND 1987. COMPARED WITH 40 OTHER STATES IN WHICH ST. PAUL WRITES INSURANCE, THE SEVERITY OF CLAIMS IN MAINE IN 1987 WAS 143% OF SEVERITY NATIONWIDE. AN OBSTETRICIAN IN MAINE WHO PURCHASES A MODEST $1 MILLION WORTH OF INSURANCE WILL PAY OVER $45,000 FOR THAT INSURANCE POLICY THIS YEAR. NEUROSURGEONS WILL PAY NEARLY $60,000.

PREMIUMS OF THIS MAGNITUDE ARE CREATING SERIOUS ACCESS PROBLEMS IN SOME SPECIALTIES. IN OBSTETRICS, THE PROBLEM IS PARTICULARLY ACUTE BECAUSE OF THE HIGH RISKS INVOLVED AND BECAUSE OF THE THE RELATIVELY LOW LEVEL OF REIMBURSEMENT HISTORICALLY PAID FOR OBSTETRICAL CARE IN THE STATE OF MAINE. OBSTETRICIANS ARE RETIRING EARLY, LIMITING THEIR PRACTICES TO GYNECOLOGY OR BAILING OUT ALTOGETHER. FAMILY PRACTICE PHYSICIANS, THE MAJORITY OF WHOM ALSO PERFORMED OBSTETRICAL SERVICES, ARE LEAVING OBSTETRICAL PRACTICE AT THE RATE OF 10% A YEAR IN MAINE. THERE ARE 200 FAMILY PRACTITIONERS IN MAINE WHICH MEANS THAT 20 FAMILY PRACTICE DOCTORS A YEAR ARE GIVING UP OBSTETRICS. FEWER THAN HALF NOW PERFORM OBSTETRICS AND WE ARE LOOKING SERIOUSLY AT A PROSPECTIVE SITUATION IN ONLY TWO TO THREE MORE YEARS WHERE THERE MAY BE NO FAMILY PRACTICE PHYSICIANS PERFORMING OBSTETRICAL SERVICES IN MAINE. YET, IN MAINE, SOME HOSPITALS RELY WHOLLY UPON FAMILY PRACTITIONERS FOR THEIR DELIVERY SERVICES. UNLESS STATE GOVERNMENT IS WILLING TO TELL THE FUTURE MOTHERS OF THIS STATE THAT BABIES WILL BE BORN ONLY IN BANGOR, AUGUSTA, LEWISTON AND PORTLAND, THEN SOMETHING CONSTRUCTIVE MUST BE DONE ABOUT THIS PROBLEM. WHILE WE IN THE PAST HAVE PROPOSED SOME MODEST LIABILITY REFORMS TO THE LEGISLATURE, THE REFORMS THAT ARE MOST MEANINGFUL HAVE BEEN REJECTED. THESE REFORMS MUST CONTINUE TO BE EXAMINED. OTHER APPROACHES MAY BE TO SIMPLY SUBSIDIZE THE AMOUNTS THAT PHYSICIANS PAY FOR THEIR INSURANCE OR TO HAVE THE STATE PICK UP THE MEDICAID PORTION OF THEIR LIABILITY RISK. WHATEVER THE SOLUTIONS, WE MUST CONTINUE TO WORK TOGETHER TO EXAMINE THE PROBLEM AND TO PUT INTO EFFECT SOLUTIONS APPROPRIATE TO THE NATURE OF THE PROBLEM IN MAINE. BECAUSE YOUR COMMISSION HAS A BROAD SCOPE OF AUTHORITY TO EXAMINE HEALTH CARE EXPENDITURES, I WOULD URGE YOU TO TAKE A CLOSER LOOK AT THIS ISSUE AND ITS IMPACT UPON HEALTH CARE EXPENDITURES AND ACCESS IN MAINE.

Utilization of Medical Services

The regulatory model recommended in your Draft Report will do little to affect the largest, single factor in increasing health care costs - that is, the demand for and utilization of medical services. I would urge you to examine the work of our Maine Medical Assessment Program and other utilization/outcome approaches and would be glad to make more information available to the Commission. The Medical Association firmly believes that health care cost increases can be moderated through effective utilization review and approaches like the Maine Medical Assessment Program. The Medical Assessment Program's concept of data feedback and study group review allows Maine physicians to review regional incidence of surgery and medical practice patterns within their own specialty. It is clear from the work of the study groups that this activity has a major impact on specific rates of medical and surgical hospitalizations. Even now, the data shows that the statewide hospital use in Maine for all conditions has decreased for several years in a row. In addition to the Medical Assessment Program, there are many other approaches that the profession is pursuing in Maine to review professional competence and utilization and I am enclosing with my presentation a two-page summary of some of the work being done, including extensive peer review, the Impaired Physician Program of the Association and Risk Management Programs initiated by the malpractice insurance companies.

We believe that any regulatory approach that does not deal with the volume of services is doomed to failure. Conversely, we believe that if effective utilization review is achieved, then significant savings can be found.

IN THE 10 MINUTES ALLOTTED, IT IS NOT POSSIBLE TO TOUCH UPON ALL OF THE POINTS IN THE DRAFT REPORT IN WHICH THE ASSOCIATION IS INTERESTED IN SUCH AS AIDS, THE PHYSICIAN SHORTAGE, THE SHORTAGE OF OTHER HEALTH CARE PERSONNEL AND MANDATED BENEFITS. HOWEVER, I HAVE APPRECIATED THE OPPORTUNITY TO PRESENT THIS INFORMATION TO YOU AND WE LOOK FORWARD TO CONTINUING TO FOLLOW THE WORK OF YOUR COMMISSION WITH GREAT INTEREST. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

Anne Pezzullo
43 Pine Road
North Hampton, NH 03862
September 6, 1988

The Honorable N. Paul Gauvreau
Office of Policy and Legal Analysis
Room 101/107
State House Station 13
Augusta, ME 04333

Dear Mr. Gauvreau:

My name is Anne Pezzullo, I live at 43 Pine Road in North Hampton, New Hampshire, and have been employed at York Hospital for two and one-half years as the Director of Physical Therapy. I would like to speak to you today on several perspectives, as an employee and as a manager. The positions will demonstrate issues that show why York Hospital has unique circumstances that warrant special consideration from the Maine Health Care Finance Commission.

As a manager, there are many challenges I encounter. When I first came to York Hospital, there were vacancies in the Physical Therapy Department. I was fortunate in that I was able to hire two therapists that I had worked with at my previous job in Portsmouth, New Hampshire. Since then, staffing has become a more difficult issue. There is presently a shortage of physical therapists, in Maine, as well as nationwide, and qualified Physical Therapists have their choice of job/location/salary because of the shortage. When I interview, I am forced to compete with the high pay rate that is being offered by our neighboring New Hampshire hospitals. Thus far, York Hospital has been able to compete with these high salaries, which has enabled me to continue to staff my department with excellent personnel; but the hospital is stretched to the limit at this point and I fear I will either be unable to staff my department at all or will only be able to hire mediocre therapists. Either option would negatively affect the high quality of patient care that we work so hard to provide.

Another issue that I have been struggling with the past two and one-half years as a manager is not being able to serve all the patients that we should because of our present staffing levels. The quality of care we provide is very high but with our present system we do not have the manpower to serve all the patients we want to, including those who are already at our hospital. Patients are being forced to go to competing New Hampshire hospitals, where costs are higher, for their treatment. The York community wants to receive therapy in York and it is sad that they often need to seek treatment out of our state. We know that we provide quality care, but I have to wonder what the people of the York community think when they call my department for treatment and are informed that there will be a seven to ten day wait and then they call a New Hampshire hospital and are seen in two to three days. I would doubt it if they feel that our quality of care is high. What would you think about the quality if you called for service and had to wait that long?

As a resident of the State of New Hampshire, I have to pay an unfair Maine state tax. This is an issue that I have as an employee and as a manager and is another circumstance why York Hospital, as the only border hospital, deserves special consideration. With 1% unemployment in the area, we often seek New Hampshire residents to work at York Hospital. There is a severe shortage of health care workers and this tax issue only worsens the problem. It is extremely difficult to recruit New Hampshire residents with this unfair tax law. Good employees have not come to work at York Hospital because they would be in my situation. You may ask me why I bring this issue up to you as you do not make the tax laws. I realize that you cannot make a change with the tax law, but you are in the position to make a recommendation to the

appropriate state agency that would influence a change to correct this tax law that is so unfair to border employees. This is an issue that York Hospital, a border hospital, deals with that no other hospital deals with. It deserves appropriate recommendations to state agencies and my hospital deserves special consideration based on this issue.

In closing, I strongly feel that York Hospital is unique and deserves special consideration based on its unique circumstances, some of which I have addressed, as well as others you are hearing today. These unique circumstances are making it increasingly difficult for us to continue to provide the high quality of care that the people of York want and deserve. We are the only border hospital and we are dealing with non-regulated New Hampshire hospitals with their high salaries, an extremely low unemployment rate in our community, Maine tax laws which negatively affect border employees, high costs of housing and living. These are issues that no other hospitals are dealing with and I trust that you will give us the special consideration that York Hospital deserves.

Thank you!

Anne Pezzullo
Director
Physical Therapy
York Hospital

Barbara A. Desrochers
RFD #2 6 Creation Ln
York, Me. 03909

Sept 6, 1988

Dear Commission Members,

As a resident of the town of York and an employee of York Hospital I would ask that Special Consideration be given to York Hospital by the Commission.

York Hospital is a unique hospital and very much committed to quality care. The regulations imposed on the hospital make it very difficult to give quality care. Being a border hospital which has to compete with New Hampshire's unregulated hospitals is almost impossible. If the Commission continues to regulate York Hospital with out giving it Special Consideration it will be impossible to compete and give the quality care the people in this community want and deserve.

I am the parent of a 20 year old handicapped and retarded daughter. Medicaid requires I bring my daughter to Maine doctors and Maine hospitals. If York Hospital has to curtail it's services or close because of the Commissions unfair regulations I will be forced to either go to New Hamshire or drive 50 mile to Portland to get the excellent Services I am receiving here in York for my daughter

I ask that you give Special Consideration to York Hospital and Keep Maine patients in Maine

Barbara A. Desrochers

263 Brackett Street
Portland, Maine 04102

August 29, 1988

Dear Senator Hathaway,

It has come to my attention that you are chairing a Blue Ribbon Commission on hospital regulation; particularly as re. hospital income.

It seemed ridiculous to me several years ago when I heard that hospitals were to be put on a 'fixed income'. I have several friends on such and then how inflation has eroded their fiscal solvency. They have had to 'cut back' to the point of bare survival. Government 'help's' are all that have kept them going (housing, food stamps, med. help).

I work at Maine Med. Center in housekeeping. The Sat. Evening Express ran an article (Aug 27/88) on the 'working poor'. The working ones who now need food stamps to eat. Some need help getting housing. The family mentioned made $6 /hr. We

start at $4.75. The turnover rate is increasing in our dept. Most go to jobs starting at $6-8 per hr. They have to. Rents are way up. Food for part following. Welfare for the working is an absurdity & should be.

To be sure, hospital costs were skyrocketing. But, so was the cost of running a hospital (equip., supplies, insurance.) One item: even we are a bit more disposable gloves. They cost.

I'm not sure how much would get down to 'pay' for housekeeping. But, I'd like to think we had a chance to earn enough to live on. If the ceiling were raised or controls (esp. rent salaries) removed.

Housekeeping effects the patients. Mom appreciated her friendly 'maid' when she was ill. Infections must be kept down. And, appearances must (should) be kept up.

Thank you. Sincerely,
Sally Ahlers

York Hospital 15 HOSPITAL DRIVE • YORK, MAINE 03909-1099 • TEL. 363-4321

TESTIMONY PROVIDED TO THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES, BY JUD KNOX, PRESIDENT, YORK HOSPITAL, SEPTEMBER 6, 1988

Members of the Blue Ribbon Commission:

Good afternoon. I am Jud Knox from York Hospital. Although we are considered to be in the southern part of the state this afternoon, I would point out that those of us from York live about half way between here and Logan International Airport. We are in the southern extreme. We are proud to be in Maine and we are proud to be in York, but we do recognize the reality of the Seacoast region of Massachusetts, New Hampshire and Maine. We recognize that reality because we belong to the Seacoast YMCA in Portsmouth, New Hampshire; because our back-to-school shopping is done in Newington, New Hampshire; because our children's "home" ice for hockey is in Dover, New Hampshire; because the Kittery Trading Post enjoys the patronage from New Hampshire and Massachusetts residents.

We are in a special place on the border and we are a special hospital. Our location has led us to some very unique achievements:

- We were one of the first hospitals in the country to develop primary nursing practice and collaborative care.

- We have moved to nursing participation on our Board of Trustees and a new Nursing Shared Governance Program.

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We have accomplished this in spite of the Commission. We have responded to our ultimate judge, not the Commission, our community. We have fought, clawed, hammered, pounded every step of the way. Our community is not average. Our hospital is not average. We do not fit any of the formulas.

But now we have been stretched beyond all reasonable limits. Our people are stretched. We cannot continue. We do not have the financial wherewithall to maintain the high quality, affordable, accessible care that we are now providing if the Commission, or a similar system, continues.

Why is York so different?

- We are one of the fastest growing areas of the state. The community has exploded from a sleepy retirement community to one of burgeoning neighborhoods of young families.

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- We are the Maine hospital most affected by the Boston wage and salary market.

- We are the only hospital with a significant number of employees residing in New Hampshire and, therefore, subject to double taxation of spouse's incomes.

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We don't fit the formulas, we never will fit the averages. You must consider that York is as different from Portland as Portland is from Fort Kent. Our location, our environment, our character require special consideration that we have never received under the Commission.

The border issue is not a new one. I think we are as important as liquor stores; border liquor stores have special price considerations. I think we are as important as law enforcement and border police have special provision to pursue offenders across state lines. Even the

Certificate of Need law provides special provision for border applicants.

Therefore, we offer a special proposal for consideration of our unique border characteristics. The proposal is entirely consistent with our discussions with you as members of the Blue Ribbon Commission, Mr. Atkinson and Maine Health Care Finance Commission members. It is also consistent with the draft report which suggests flexible alternative systems. It is a simple statement to be incorporated into your draft report and final recommendations: "Hospitals that are located in identifiable economic/trade regions that ignore state borders and that are also situated within ten miles of that border will be allowed to design and utilize alternative systems commensurate with the goals of accessibility, quality and affordability that will enable those hospitals to competitively provide services in that economic area. Such systems will be designed to provide care for Maine citizens who would otherwise obtain care out out state, and also attract consumers from across the border."

More generally, you must sunset the Commission. Don't continue the erosion of quality of health care in this state. Act before the Emergency Room doors are closed at 9:00 p.m. Don't be found with a child in your arms looking for service when there is none to be had. Don't witness your neighbor with a heart attack, the nearest hospital no

longer available. We are talking about people and patients, not widgets. Act before qualified physicians flee communities because adequate diagnostic tools are no longer available. It is happening today. Ask nurses, physicians and trustees working in today's community hospitals.

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Are you listening to those folks who are now making the decisions for our community hospitals? Those representatives of the Commission staff? They are saying that hospitals, generally, are showing their financial projections in the worst possible light to secure political points. Do you think that I want to project York Hospital's financial position in the worst possible light? In a community of competing hospitals, do I want us to look as the weak health provider?

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The entire system has lost touch with reality. We have a philosophically incestuous bureaucracy that is carelessly and callously ruining the high level of medical care in Maine. Sunset the Maine Health Care Finance Comission and don't give us another.

To Whom It May Concern:

I would like to see the Finance Committee done away with at this time.

If unable to or unadvisable to at this time, I would definitely like to see some consideration given to York Hospital, a unique hospital in every way.

I am a 76 yr. old native of York and know the history of our York Hospital.

It has always been and always will be a unique small town hospital.

They have always been able to function on its own and I hope that as long as I live and depend on our hospital that it will continue to be the unique hospital that it is.

I have given a great many volunteer hours to our hospital because I do believe in it and every day I come in contact with someone of our patients that say it is the best hospital they have ever been in. I even hear this comment from some of the nurses that have come from other areas.

Having been in other areas of politics I am firmly convinced that no one else can know and do what is best for a small town like York.

I truly hope and trust that the members of the Committee will listen to the people of York.

Thank-you.

Sallie G. Hall

Blue Ribbon Commission on Health Care Expenses:

York Hospital is a very special and unique hospital to the town of York and all the surrounding towns. It has been in operation for 80 years and has added many special services in order to handle the communities' ~~health~~ health care needs. If some of the regulations suggested by the Commission go through, York Hospital will have to curtail some of their services and since we are a borderline hospital, many of their patients will be going to New Hampshire. Is this what the State of Maine wants?

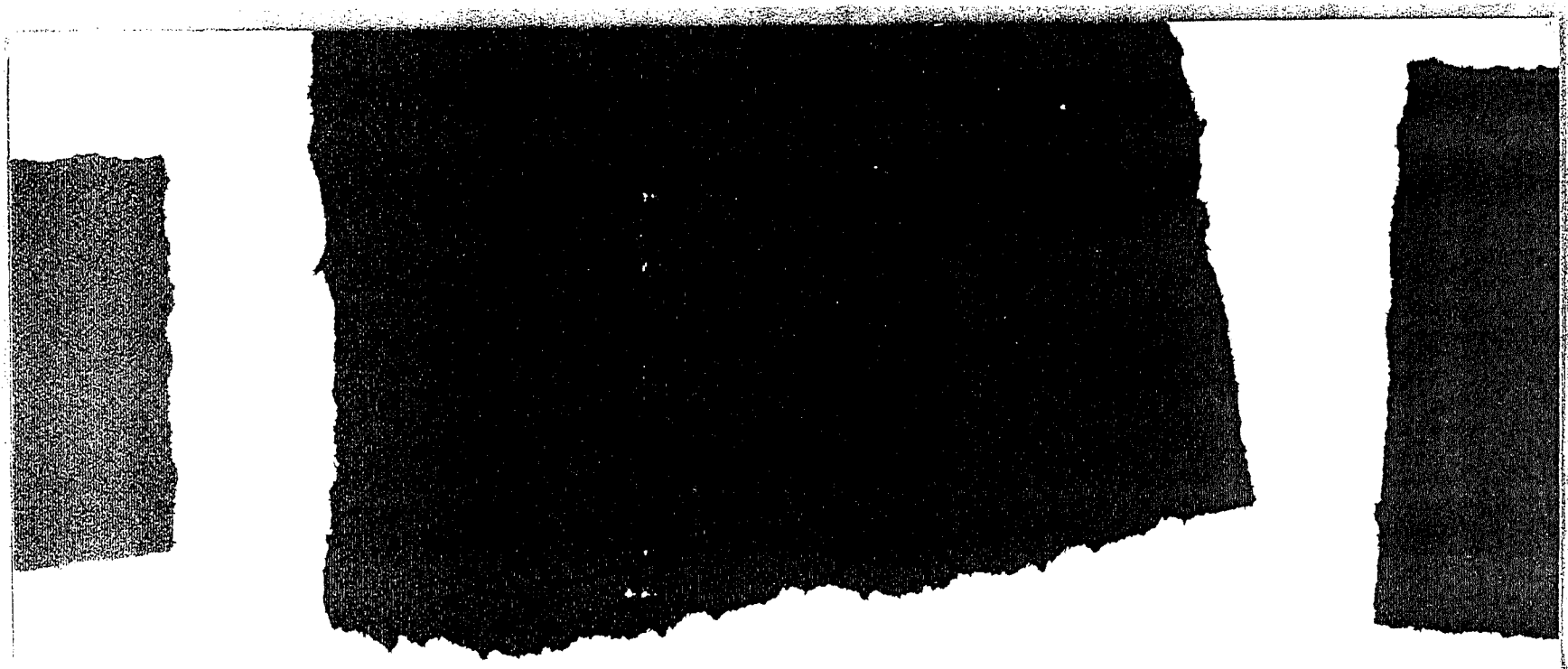
According to the rules of this hearing, we sent a list of 15 people who wanted to be heard and then a few days before the hearing we were limited to 1! As a former patient and volunteer since 1972, I can't help but feel that York Hospital is being discriminated against.

Sincerely,

Joyce H. Curtis

I am a stroke victim - also a heart by-pass surgery - I would feel far more concerned if we still had our emergency room functioning 24 hours per day. I live alone now. My calls have come in the early morning.

Paul H. Agger
York, Me.



Adolescent Pregnancy Coalition
74 Winthrop Street
Augusta, Maine 04330

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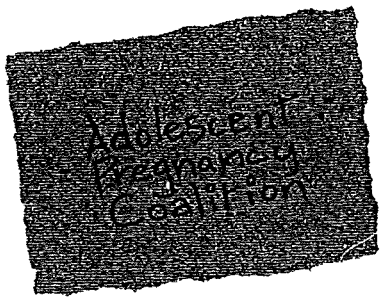
Member Agencies
Aroostook County Action Program
Bangor-Brewer Y.W.C.A.
Brunswick Parenting Center
Central Maine Medical Center
Community Counseling Center
Community Health and Nursing Services
Community Health Services
Cooperative Extension
Crossroads for Women
Department of Educational & Cultural Services
Department of Human Services:
Division of Welfare Employment;
Family Services Program
Diocesan Human Relations Services
Downeast Health Services
Family Planning Association of Maine, Inc.
Franklin County Community Action Council
Genesis
Good Samaritan Agency
Kennebec Valley Community Action Program
Kennebec Valley Regional Health Agency
Lewiston-Auburn Y.W.C.A.
Lewiston Y Teen Intervention
Maine Ambulatory Care Coalition
Maine Chapter of the American Academy of Pediatrics
Maine Children's Home for Little Wanderers
Maine Medical Center
Maine Young Fathers Project
March of Dimes — State of Maine Chapter
Medical Care Development
Mid-Maine Medical Center
Miles Memorial Hospital
National Council of Jewish Women
Parent Resource Center
Penobscot Bay Medical Center
Penquis Community Action Program
Portland Y.W.C.A.
Rural Community Action Ministry
St. Andre's Group Homes
St. Mary's General Hospital
Servants of Immaculate Heart of Mary
Southern Coastal Family Planning, Inc.
Tri-County Mental Health Services
York County Health Services

The Problems Of Teen Pregnancy and Teen Parenting Touch Everyone . . .



TEENS ARE OUR FUTURE

Funded in part by:

The Division of Maternal and Child Health, Bureau of Health
Maine Department of Human Services
Statewide Service Providers' Coalition on Adolescent Pregnancy & Parenting, Inc., (Maine)

HE FUTURE.

Public Awareness

A commitment to the problems of teenage pregnancy and parenting requires a commitment of dollars and a commitment of caring. One volunteer, one teacher, one concerned parent can turn a teenager's life around. It can turn a whole community around. Likewise a single program or a single service can have a wide-ranging impact. Keeping the issue in the public eye, creating grassroots support, mobilizing for unique and innovative programs for teens and involving the entire state of Maine in this issue requires persistence. Eventually, with all our help, it will become clear that Maine teenagers are Maine's future...that their future is ours . . . and that the future is now . . .

The Coalition Statement

Because the Adolescent Pregnancy Coalition respects a diversity of philosophical viewpoints, it does not as a group advocate for contraception and abortion, but leaves these positions up to each member organization. As a group, the Coalition works together in those areas of group agreement.

- We support families in expanding their capacity to nurture and guide their children.
- We support teens learning and choosing responsible behavior.
- We strive to prevent premature sexual activity in our primary prevention efforts aimed at 11-13 year olds.
- We promote healthy outcomes for those teens already pregnant or parenting.

Add Your Name to the Coalition Solution

Name _____

Organization _____
(if applicable)

Profession _____

Address _____

_____

City _____ Zip _____

_____ I would like to become a member. Enclosed is my annual membership fee.
($35.00 Agency, $25.00 Individual)

_____ I wish to support the efforts of the Coalition through my tax-deductible contribution of $ _____ which is enclosed.

Please make checks payable to the Adolescent Pregnancy Coalition and mail to:

74 Winthrop Street
Augusta, Maine 04330
(207) 622-5188

. . . . RIGHT NOW AND IN T

The Coalition - What Is It?

The Adolescent Pregnancy Coalition's mission is to impact on the problem of adolescent pregnancy and parenting in Maine by mobilizing the resources and support of members around common objectives not vulnerable to philosophical differences. We represent over 40 agencies and individuals concerned with improving the quality of life for Maine teens. Our approach is three-fold, focusing on pregnant teens, parenting teens and prevention of teen pregnancy. In that framework there are worthwhile goals to aspire to and abundant tasks to be performed.

The Statewide Organization

Members meet on alternate months for educational presentations and forums. Committees meet more frequently to define policy, explore issues, advocate for teens, and carry out specific Coalition agendas. Coalition headquarters in Augusta provides technical assistance to members, advocates for teens in the legislature, supports media campaigns, seeks out funding sources and provides an environment for members to share resources and information.

Six Regional Coalitions

Six Regional Coalitions explore the issues, learn from and support one another and develop services and programs at the local level. The Regions are an important source of input to the Statewide Coalition, and marshall grassroots support and advocacy for teens to access needed services. Anyone interested in helping teenagers can become a part of the Statewide and Regional Coalitions.

Regions by Name

Region 1	York and Cumberland Counties
Region 2	Androscoggin, Franklin, and Oxford Counties
Region 3	Kennebec, Knox, Lincoln, Sagadahoc, Somerset and Waldo Counties
Region 4	Penobscot, Piscataquis, and Washington Counties
Region 4-A	Hancock County
Region 5	Aroostook County

Why Coalitions Work

The problems of teen pregnancy and parenting touch everyone...now and in the future. The problems are real and costly. There is no one single solution. Parents, peers, schools, media, finances, health, personal and religious values all impact on the incidence and outcomes of teenage pregnancy. The Coalition provides a broad base of support and diverse solutions. Coalition-building provides the framework for meaningful social change. Compassion and concern for the teenage pregnancy problem in Maine enable the Adolescent Pregnancy Coalition to seek common ground and stand firm.

The Coalition as a Clearing House

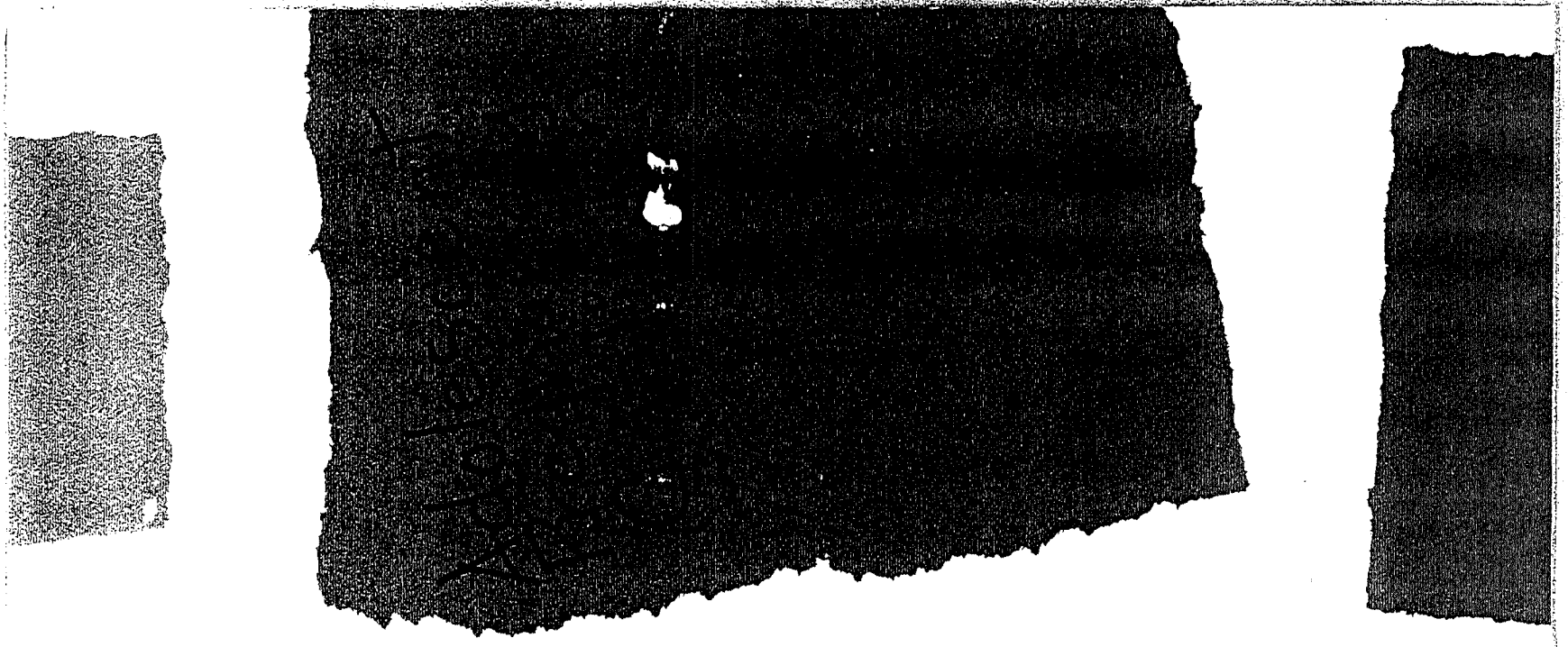
The Coalition serves as a clearinghouse for educational resources. Statistics, articles, newsletters, audiovisual media are available to members. The Coalition's library of information about teen pregnancy and parenting is continually updated and expanded. Several Statewide and Regional Conferences are offered each year on a variety of topics. The Coalition's staff and members have the expertise to provide training, consultation and presentations to interested groups.

Pregnant and Parenting Teens

Coalition members provide a wide array of services to pregnant and parenting teens. These young people need support, need to know there are people who care, places to go for help, a chance to complete their education and the opportunity to make a future for themselves. The Statewide Coalition has a prime commitment to helping all pregnant and parenting teens make choices consistent with their own value systems.

Primary Prevention

Reaching adolescents before they become sexually active; giving them good reasons to delay sexual activity through self-esteem building, decision making skills, adequate health and educational opportunities, and enhancement of parent-child communication are all ways to prevent pregnancy in young people. The Coalition supports and is engaged in primary prevention efforts aimed at pre-adolescents.



Adolescent Pregnancy Coalition
74 Winthrop Street
Augusta, Maine 04330

STATE OF MAINE
HOUSE OF REPRESENTATIVES
AUGUSTA, MAINE 04333

Statement by Rep. Neil Rolde

Because family responsibilities have kept me out of State and unable to attend the hearing on September 6 before the Blue Ribbon Commission, I would simply like to add to the record some brief thoughts on the problems of health care cost containment in Maine.

It seems to me that there is glaring evidence that our approach in Maine to this problem hasn't worked.

Historically, when we first looked at the problem, the first scapegoat became new (and expensive) technology and so a program of Certificate of Need was instituted. This approach clearly didn't solve the problem and so the Maine Health Care Finance Commission was added to it - probably the most stringent hospital control mechanism in the country. Yet since then, the problem of rising health care costs in Maine has become significantly worse.

Logically, then, two directions can be followed. One school of thought says: make the control even more totalitarian. Go beyond the hospitals for a scapegoat and take all health care providers under your dragnet. Another school of thought says: Loosen up. If these draconian measures haven't worked, let there be flexibility enough for institutions to find new ways of coping with the problems of providing quality health care at prices people can afford. There is some evidence that in States where this happens, the increase in costs and insurance rates is far lower than in Maine. Obviously, I am a partisan of this second school of thought.

I have been speaking generally up until now. Let me be more specific as regards the hospital in my district. Our special problems as a border hospital have never been clearly recognized by the Commission, although they have been by the Legislature in the matter of Certificate of Need. The Legislature has recognized, in law, that it is important to keep Maine people from going out of State for their health care and that there is even an advantage in attracting persons from out of State to our border hospitals.

There are some indications - at least in press reports - that the Blue Ribbon Commission is considering a two-tiered system of hospital cost control in Maine, separating smaller hospitals from larger hospitals and not trying to treat every hospital the same.

I doubt, however, that within that two-tiered system, if it is recommended, will be a provision for hospitals that are both small and

STATE OF MAINE
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on a border, facing competition from out of State, as is the case with the York Hospital. I earnestly ask the Commission to take such a combination of conditions into account, following the legislative intent as expressed in the Certificate of Need law.

Furthermore, it is my intention, if I am re-elected, to introduce legislation to this effect, should the appropriate resolution of the problems of hospitals both small and on the border not be reached through the Blue Ribbon Commission's deliberations.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL
P.O. Box 230 • South High Street • Bridgton, Maine 04009-0230 • Tel. (207) 647-8841

September 6, 1988

William F. Julavits, Esq.
Maine Hospital Association
160 Capitol Street
Augusta, ME 04330

Dear Mr. Julavits:

Townsend F. Southard has informed me that you would be kind enough to forward our written testimony to the Blue Ribbon Commission on Health Care Expenditures.

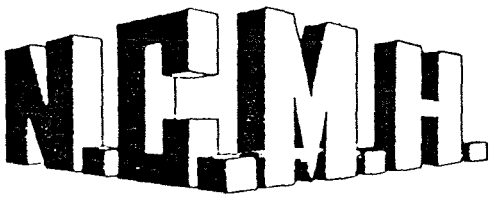
Enclosed is our written testimony for you to forward to the Commission.

Thank you for expediting this matter.

Sincerely,

Michael J. Numrich
Chief Executive Officer

Enclosure



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P.O. Box 230 • South High Street • Bridgton, Maine 04009-0230 • Tel. (207) 647-8841

MEMBERS OF THE BLUE RIBBON COMMISSION
ON HEALTH CARE EXPENDITURES

I present to you the feelings of the Board of Directors and the administration of Northern Cumberland Memorial Hospital located in Bridgton, Maine. The hospital is a 40-bed acute care facility serving the health care needs of 16 communities in western Maine. We submit our position to you on the draft report in hopes that they will be helpful in your deliberations in reaching an equitable decision to alleviate the hospital health care crisis that exists in this state.

OPTION # 1 - HOSPITAL INPATIENT SERVICES

We favor the approach that there should be a variety of options available for the regulation of inpatient hospital rates or revenues. Hospitals should have the flexibility though, to choose the various options available. For this hospital, for the present time, we favor Option #1 as long as there are adequate adjustments for volume changes. For small hospitals, volume increases have a larger impact on operating costs. On the other hand, volume decreases, in reality, do not impact costs in the same manner -- in fact, longer periods of time should be allowable for smaller institutions to adjust their operations.

OPTION # 2

We are in agreement with your proposed Option #2.

OPTION # 3

We were very happy to see this option included in your draft recommendations. We feel that this will encourage hospitals to increase their preventative health care programs and, furthermore, will give incentive to hospitals to look at new approaches in health care delivery.

OPTION # 4

This option specifically does not effect N.C.M.H. but we feel that your proposal would probably suit the needs of specialty institutions.

We strongly disagree that hospitals should only be permitted discounts which are approved by a rate-fixing body. We feel that hospitals should be free to contract with payors for discounts or payment methods provided that the discounts do not increase the charges to other payors. We believe there should be a threshold below which no discounts should be allowed. This threshold should include at least operating costs plus bad debts and charity care, plus a minimum return on equity.

APPEAL PROCESS

We also strongly disagree with the mechanics of the proposed appeal process. We feel that a hospital should have the right to appeal any regulatory amount imposed on it. There should be **NO** restrictions to hospitals making a legitimate appeal.

While we agree with the recommendations that it would be a good idea for the rate-setting body to be located within the Executive branch of the government, we feel that the appeals process should be a separate entity from the rate-setting body. We would suggest that the rate-setting body, as aforementioned, be set up within the Executive branch but would strongly suggest that the approval body be set up and appointed by the legislature. As it is presently proposed, the rate-setting body also acts as judge and jury which is not an equitable situation.

DISCOUNTS

We oppose the Commission's recommendations as written. The system would allow no flexibility. We would instead favor allowing discounting privileges as long as there was zero impact on the provider or other payors.

OUTPATIENT RATES AND REVENUES

We would strongly favor unregulated outpatient rates. The system though, should allow for continued cross subsidiation of outpatient services from inpatient services. If outpatient services are to be regulated, then there should be an adjustment to prevent regulatory cost shifting in an effort to control other rates under their jurisdiction.

GOVERNMENT SHORTFALLS

We concur with the Commission's recommendations that an amount be sought from a general fund to cover projected increases in the total shortfalls over the next

year. Where we differ is that we feel that an amount should be distributed among all hospitals who have had shortfalls.

DEMONSTRATIONS

We concur with the Commission's findings in this area.

POOL FOR BAD DEBT, CHARITY CARE & GOVERNMENTAL SHORTFALL

We support a pool for bad debt, charity care and governmental shortfalls but this pool should be derived from the general fund and the general fund should be derived from the state income tax. Once an equitable pool has been implemented, cost shifting could be decreased. It would be folly to tax hospitals for the shortfalls because, in reality, this would add cost to the system and to the citizens of Maine.

PHYSICIAN SHORTAGES

We feel that existing physician shortages are basically due to a need for tort reform.

SHORTAGES OF OTHER HEALTH PROFESSIONALS

While we generally agree with the Commission that the state should encourage students to enter health care professions, we realistically feel the best incentive is monetary reimbursement -- in other words, scholarships. In addition, any new regulatory system must again face reality and recognize actual labor costs, including wages and benefits.

In conclusion, we hope that the Commission will take into consideration that more restraints on hospitals will cause a decline in availability of health care services in the state of Maine and would encourage the philosophy of flexibility in drafting your final recommendations.

We thank you for this opportunity to submit our feelings to you.

York Hospital 15 HOSPITAL DRIVE • YORK, MAINE 03909-1099 • TEL. 363-4321

TESTIMONY PROVIDED TO THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES, BY JUD KNOX, PRESIDENT, YORK HOSPITAL, SEPTEMBER 6, 1988

Members of the Blue Ribbon Commission:

Good afternoon. I am Jud Knox from York Hospital. Although we are considered to be in the southern part of the state this afternoon, I would point out that those of us from York live about half way between here and Logan International Airport. We are in the southern extreme. We are proud to be in Maine and we are proud to be in York, but we do recognize the reality of the Seacoast region of Massachusetts, New Hampshire and Maine. We recognize that reality because we belong to the Seacoast YMCA in Portsmouth, New Hampshire; because our back-to-school shopping is done in Newington, New Hampshire; because our children's "home" ice for hockey is in Dover, New Hampshire; because the Kittery Trading Post enjoys the patronage from New Hampshire and Massachusetts residents.

We are in a special place on the border and we are a special hospital. Our location has led us to some very unique achievements:

- We were one of the first hospitals in the country to develop primary nursing practice and collaborative care.

- We have moved to nursing participation on our Board of Trustees and a new Nursing Shared Governance Program.

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The entire system has lost touch with reality. We have a philosophically incestuous bureaucracy that is carelessly and callously ruining the high level of medical care in Maine. Sunset the Maine Health Care Finance Comission and don't give us another.

PROPOSAL TO THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

Public Hearing, September 6, 1988, provided by Jud Knox, President, York Hospital, 15 Hospital Drive, York, Maine.

Consistent with our discussions with members of the Blue Ribbon Commission, Mr. Graham Atkinson, and Commissioners serving on the Maine Health Care Finance Commission, York Hospital urges the adoption of the following recommendation. It is entirely consistent with the draft report of the Blue Ribbon Commission which suggests flexible alternative systems. The recommendation adds specificity to the "different systems for specialty and unique hospitals" to encompass unique border situations. We recommend that the following be added to the paragraphs numbered 4 on pages 3 and 6 of the Commission's draft and that the same provision be applied to outpatient rates or revenues as well as inpatient.

"Hospitals that are located in identifiable economic/trade regions that ignore state borders and that are also situated within ten miles of that border, will be allowed to design and utilize alternative systems, commensurate with the goals of accessibility, quality and affordability, that will enable those hospitals to competitively provide services in that economic area. Such systems will be designed to provide care for Maine citizens who would otherwise obtain care out of state and to also attract health consumers from across the border."

Testimony

before the

Blue Ribbon Commission

September 6, 1988

Miles Memorial Hospital
Damariscotta, Maine

Senator Gauvreau, Members of the Commission: My name is Janet Corbett; I am Director of Nursing and Assistant Administrator at Miles Memorial Hospital in Damariscotta.

We are a 27-bed acute care hospital in an area of rapid population growth - with much of our population being in an age group which utilizes health services at a rate higher than the state or national average.

The current reimbursement system has caused our financial situation to deteriorate to the point where our services and quality are now deteriorating as well.

Attached to your handout are three exhibits. Exhibit A shows the increase in our Hospital out-patient visits. Exhibit B shows the increase in our acute care hospital occupancy. (Please note, the line labeled SHP standard (approxiately 69%) - this is the State Health Plan's recommended occupancy rate for a facility of our size) As you can see, our volumes have increased dramatically.

Also attached is Exhibit C which shows the Hospital's deteriorating financial status, with last year's loss at $751,379.

During the period from 1985-1988, when our combined in-patient and out-patient volume increased by 98%, our Hospital work force increased by approximately 18%. May 1 of this year, we were forced to further reduce that work force due to even higher projected financial losses for the current fiscal year.

This has all resulted in services being lost or cut back. It has been our own belief that the quality of all care has begun to suffer. Unfortunately, this was verified two weeks ago, when we were surveyed by the Joint Commission on Accreditation of Health Care Organizations. We were informed that we will be considered deficient in several areas - due to understaffing.

In your consideration of recommendation for changes in the reimbursement system, we are hopeful that a new system will include the following elements:

A more timely and flexible response to a Hospital's changing needs.

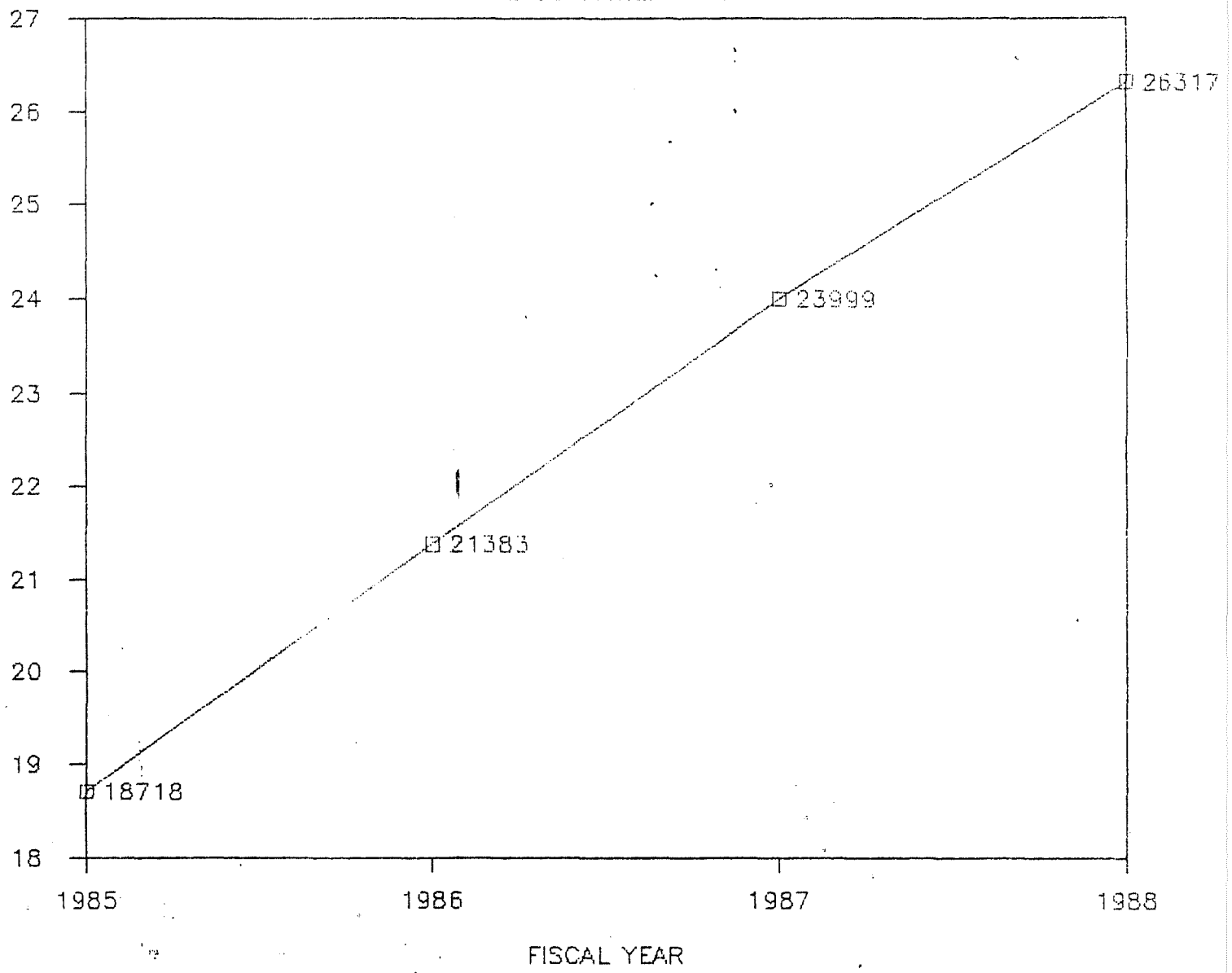
A mechanism for allowing Hospitals to respond to serious labor shortages in both professional and non-professional positions.

A method for allowing a Hospital in a growing population area or with other unique circumstances, to respond to the needs of its own individual community

EXHIBIT A

MILES MEMORIAL HOSPITAL

TOTAL OUTPATIENT VISITS



Includes -
- Laboratory
- Radiology
- Physical Therapy
- Respiratory Therapy
- Emergency Room

EXHIBIT B

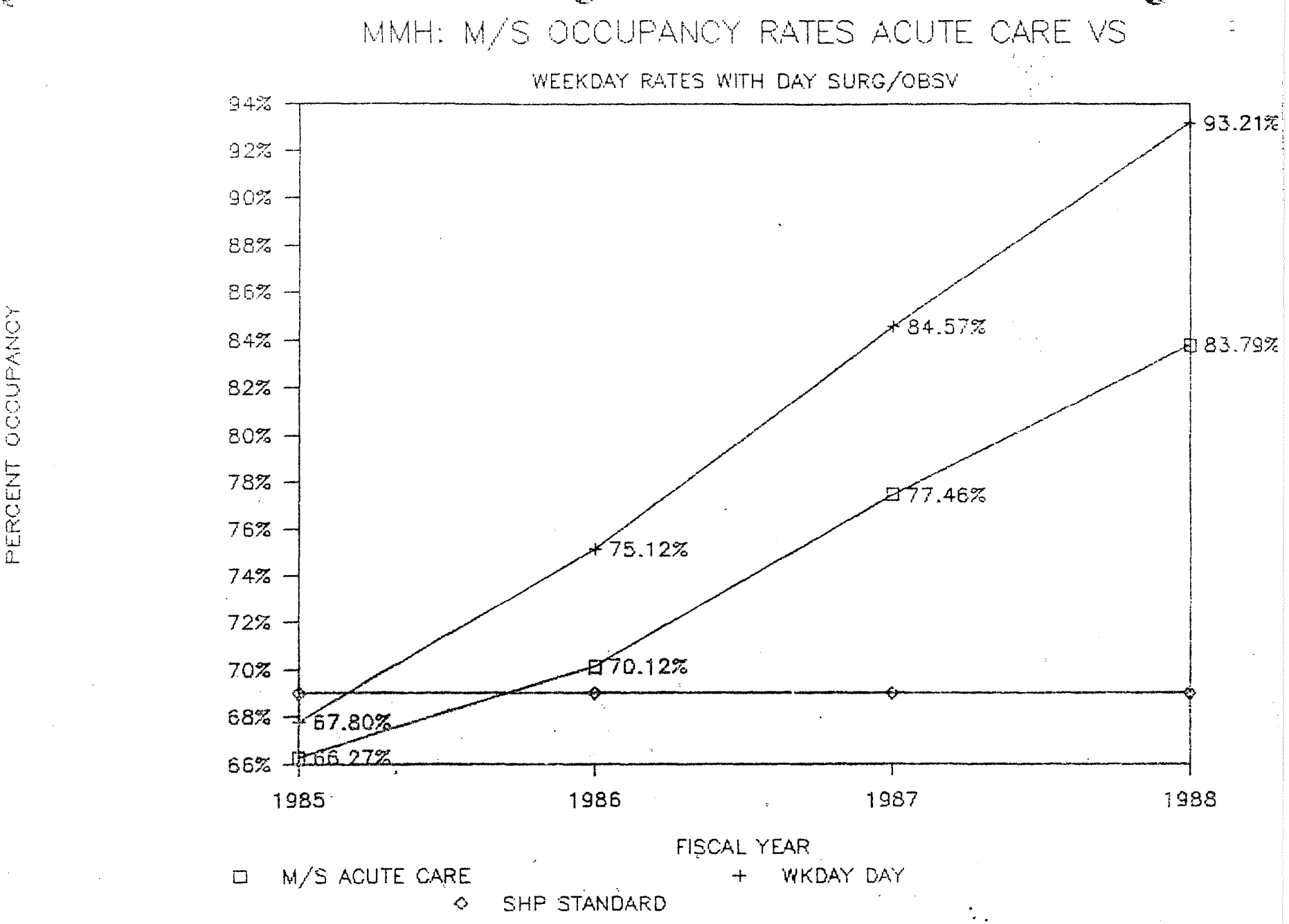
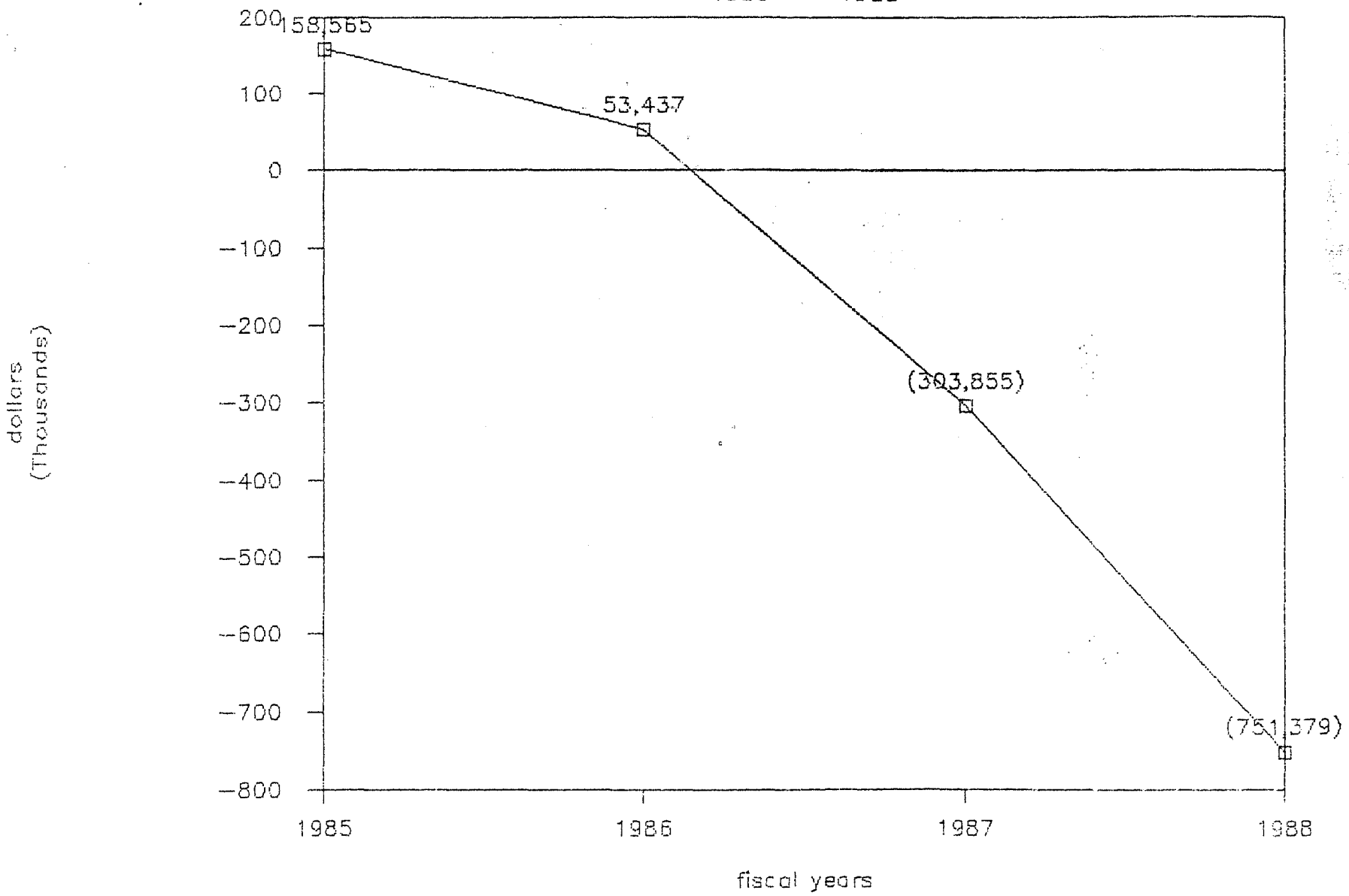

MMH: M/S OCCUPANCY RATES ACUTE CARE VS
WEEKDAY RATES WITH DAY SURG/OBSV
PERCENT OCCUPANCY
94%
92%
90%
88%
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
66%
93.21%
84.57%
83.79%
77.46%
75.12%
70.12%
67.80%
66.27%
1985
1986
1987
1988
FISCAL YEAR
M/S ACUTE CARE
WKDAY DAY
SHP STANDARD

EXHIBIT C

Miles Memorial Hospital

Hospital Profit/Loss on Operations

1985 – 1988



MERCY HOSPITAL

TESTIMONY BEFORE THE BLUE RIBBON COMMISSION

SEPTEMBER 6, 1988

Chairman Gauvreau, members of the commission, my name is Howard Buckley and I am Chief Executive Officer and President of Mercy Hospital.

I would like to begin by expressing my appreciation for the enormous challenge that you have accepted in reviewing Maine's Health Care Financing System; and for the opportunity to comment on the broad recommendations outlined in the Blue Ribbon Commission Report.

In testifying before you today, I am wearing two hats: that of the president of a health care organization struggling under stringent regulation, and that of a CEO finding it increasingly difficult to provide health care benefits for nearly 1,000 employes. I am sure that there are those who would argue that this first hat, that of a hospital administrator seeking deregulation, is a "black hat", and that of the employer, victimized by increasingly costly health care is a "white hat".

business and providers that must join forces to solve the health care cost crisis. In Maine, relationships among regulators, insurers, hospitals and business have become untrusting, defensive and counterproductive instead of successful in creating effective public sector/private sector partnerships. This deterioration in working relationships has become painfully obvious to those who watch our battles in the lobby of the State House - conflicts which serve to confuse, instead of assist, the legislative process.

I do not proclaim to have the answers which will balance the State's need for health care with it costs. But I do believe that collectively, by working together, the people in this room may. As former Governor Kenneth Curtis once said, "Maine people have a history of working out problems, of seeking solutions in finding common sense answers". I would like to share with you this afternoon why I believe that Managed Care is one such "common sense" solution which represents a better alternative than the current beauracratic approach to cost containment. I support the Blue Ribbon Commission's recommendations to reduce the scope of regulation in Maine because I believe that managed care is a more effective vehicle around which to align the interests of patients, providers, and payors in affordable health care.

I offer two final thoughts.

Maine's health care environment is in a state of constant change. The cost containment target is moving too quickly for that one accurate regulatory shot that will solve our problems in the days ahead. We need solutions that are flexible enough to meet the ongoing needs of a changing market and must avoid creating the type of rigid and unbending legislation that has brought us to the impasse we face today. Any new system must be free to react to changes in the Medicare program, new technologies, the needs of our aging population and the continuous changing availability of healthcare workers.

We have had 5 years of stringent regulation. We have had 5 years of rhetoric on the legislative floor, 5 years of expense to our judicial system and 5 years of breeding a divisive environment; far too great an investment for what little gains there may have been.

Now is the time to abandon the futile effort to fix a system that is incapable of addressing the total challenge facing us and to focus our energy on seeking new directions.

TESTIMONY BEFORE THE BLUE RIBBON COMMISSION ON HEALTH CARE

September 5, 1988

My name is Dale McCormick. I am a member of the State AIDS Advisory Committee and Consumers for Affordable Healthcare. I have also been ridered out for a whole category of diseases and am currently uninsured. I want To focus on Three issues

THE UNINSURED AND RIDERED OUT

Studies have shown that 15% of Maine citizens are without health insurance. In addition many more citizens have been "ridered out" of health insurance in the area where they most need it. Health insurers have increasingly made use of the rider. Each new medical discovery yields another test, genetic marker, or propensity for disease. Applicants for health insurance are screened for more and more statistical factors. Insurance companies are ridering out people who 10 years ago would have been completely covered.

The playing field is not level. Your draft report does not adequately address the problem of why a growing number of people are uninsured. It is a public policy question that you and the legislature MUST address.

FACT: People are not able to get health insurance for what they need it for. People with lower back pain can get insurance for everything but their backs. People with diabetes can get coverage fore everything but diabetes. Gay men can get coverage for everything but HIV related infections.

FACT: For the University of New Mexico Hospital, all AIDS patients who had private insurance on their first admission were on Medicaid for subsequent admissions. (Study by Hull) REPORT

FACT: Persons without insurance who have a bout with a catistrophic illness are forced to spend down into poverty to qualify for Medicaid.

The taxpayers are subsidizing the insurance companies. The government is allowing the practice of "creaming" and then picking up the consequent medical bill.

Our current system of health insurance is not working. Finding a solution requires that our leaders make some hard public policy decisions. I don't find any solutions in your report. I haven't found any in the legislature. I have stood before legislative committees and plead with them to look at this question from a public policy perspective and I can get them to see it from this angle for about 10 seconds and then they slip

back to their tried and true position--Insurance companies have a right to do business.

The assumption in that last sentence is that the insurance companies have a right to do business THE WAY THAT'S BEST FOR THEM. I disagree. They don't have that right. They are part of our healthcare system, and there are responsibilities that go along with that.

DEREGULATION OF OUTPATIENT SERVICES

I know that the Commission has discussed deregulation of outpatient services. I urge you not to recommend no regulation. Outpatient Services is the fastest growing sector of the health care industry. It is also key to cost containment. For instance, California has the lowest cost per case of AIDS in the country because of their innovative network of community based organizations offering support services to accompany outpatient care.

In addition, it is unwise to allow any bureaucracy as large as a hospital to have any part of itself protected from the eye of public oversight committees. Money can be hidden in the unregulated part of the business and moved around so that it is invisible to auditors.

20 MILLION DOLLAR BAILOUT

I oppose the proposal to request $20 million from the general fund to cover the short fall due to charity and bad debt because it doesn't go far enough. If the taxpayors of Maine are to donate $20 million to cover the shortfall, it shouldn't be for a one time bailout. General Fund monies should be allocated only for a proposal that offers a lasting solution to the bad debt and uninsured crisis in Maine's health care system.

We were all hoping that you would propose such a solution. But your report is lacking a blueprint for Maine's health care future.

I urge you to consider a lasting solution where consumers, the private sector and the public sector all contribute to a program that affords health care for all. It might look something like this.

> The goal is to get a system where everyone gains and everyone has healthcare coverage. If a fund could be generated by all sectors carrying bad debts then health care can be subsidized for those who can't afford it. This year Medicare had an $80 million short fall so if we ask them to put $65 million into the fund in return for the assurance that this fund will take care of all bad debt and charity care, they would be happy to do so. There was a $10 million shortfall in Medicaid so we will ask them to put in $5 million and they will jump at the chance because they

will save $5 million next year. There was a $40 million short fall in bad debt and charity care at hospitals this year so we will ask them to put in $30 million.

Already we now have a $100 million in our fund. If we require other players like health insurers to donate along the same lines and we ask the Legislature to donate the $20 million (or maybe it will be less) because health care for all is in the interest of the public good, we will eventually amass a fund of at least $150 million dollars.

It can work. The Robert Wood Johnson Foundation Grant for a pilot project to cover the uninsured developed the same blueprint.

I urge you to delay issuing your final report so that you can fashion solutions to these and other problems.

COMMENTS OF
THE AMERICAN ASSOCIATION OF RETIRED PERSONS
MAINE STATE LEGISLATIVE COMMITTEE
on
THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES
DRAFT REPORT of August 5, 1988
by
Clifford West
CHAIRMAN, STATE LEGISLATIVE COMMITTEE

I am Clifford West, of Winthrop, Maine, Chairman of the Maine State Legislative Committee of the American Association of Retired Persons. The State Legislative Committee is the sole entity in each state authorized to speak for the membership on state legislation, or regulatory matters. Its primary responsibility is to pass good laws affecting the lives of not only older persons, but all the state's citizens. There are 146,000 members in Maine; the national membership is in excess of 30 million and growing at the rate of 5,000 per day.

On behalf of the Maine State Legislative Committee of the American Association of Retired Persons, I want to thank you, Mr. Chairman for this opportunity to comment on the August 5 Draft Report of the Blue Ribbon Commission on Health Care Expenditures.

This brief pro forma response is intended also to convey the Committee's strong, unconditional, support

for Maine Health Care Finance Commission.

The Finance Commission's ongoing record of achievement is commendable substantive evidence of the critically important role it fulfills in state government.

There is, accordingly, no reason to undertake an affirmative defense of the Finance Commission in these hearings. We request, therefore, that the record remain open after the hearing for a reasonable period during which AARP Maine State Legislative Committee will have prepared and filed a response to the August 5 Draft Report as the Report may appear when illuminated by the record made in this hearing.

The Blue Ribbon Commission's purpose is to study the regulation of health care expenditures. The Association has long recognized the need to do a better job controlling health sector inflation. High health sector inflation has a direct effect on both access to, and the quality of health care services available to patients, young and old alike.

While the Association acknowledges and supports efforts to contain health cost inflation, health care regulation must emanate primarily from a commitment to quality assurance and not merely to cost containment. Tied strictly to a payment system that already constrains spending, utilization review can too easily become simply the means by which the end of less spending is achieved.

In the spirit of quality assurance, Mr. Chairman, I would like to acknowledge the work and leadership of the Maine Medical Assessment Foundation (MMAF) in the areas of appropriateness and quality of care. MMAF's work demonstrates that focusing on quality of care and appropriateness of care issues can produce better quality care and significant savings. The Association is very optimistic that national research efforts focusing on variations in physician practice patterns will begin to produce the data necessary to make informed decisions about our health care choices more readily available.

The Association supports the Blue Ribbon Commission's approach of providing regulators with the

flexibility necessary to be responsive to the variety of dynamics affecting health care spending. Thus, the Commission's recommendation that a number of regulatory alternatives be available for the regulation of inpatient revenues is a good one. No one regulatory method solves the problems facing the different hospitals in Maine. Per case payment may be more suitable for one type or location of hospital, but not suitable for another. Recognizing these differences and addressing them head-on portends greater ability to control health costs with minimum bureaucratic inefficiency.

The Association believes that the overall approach of the Commission demonstrates its awareness of the scope of the tools necessary to do the job and an appreciation to do what works. It is important that the Commission continue to look at the health care delivery system as a whole and to fashion policies with the system in mind. And while health care data systems are within the jurisdiction of another Commission, this Blue Ribbon Commission must be mindful of the role health care data plays in controlling health care quality and costs. Thus, it would be appropriate and helpful for this Blue Ribbon Commission to consider the type of information it deems necessary to fuel its decision making process.

The Association urges the Commission to regulate outpatient rates for hospitals on a per case payment system. Experience under Medicare's Prospective Payment System (PPS) demonstrates that failure to regulate outpatient services merely provides opportunities to game the reimbursement system with little benefit to patients; indeed, often the patient is harmed by being forced into the outpatient system. Failure to regulate all payers and all settings of care in the system, usually results in an unbalanced health care system, jeopardizing the quality of patient care, and increasing patients' out-of-pocket costs for care.

The Commission's attention to the issues of cross-subsidization of outpatient services is well warranted. The Association would reserve judgement on these issues until the nature and magnitude of the subsidies are better understood. Hopefully, as the Commission's work progresses, more detailed information about cross-subsidies will be developed and be the basis upon which the Commission and the public can make decisions.

The Commission's recommendation on payor differentials and discounts is correct: total revenue system hospitals should only be able to give discounts which are approved by the rate setting body; hospitals on the per case payment system should be permitted to

contract freely with payers for discounts or payment methods, provided that the discounts do not increase the charges to other payers.

The problem of governmental shortfalls caused by inadequate Medicare and Medicaid payments to providers is a growing problem in Maine and elsewhere around the country. Precise tracking of the cases involved as well as the amounts involved is essential to restoring a measure of rationality to Medicare and Medicaid payments. The Association supports the Commission's desire to provide a stand-by fund from which hospitals may cover any governmental shortfall, if the method for determining a shortfall is valid and suitable for challenging Medicare and Medicaid payment decisions.

Where the Commission calls for a task force to study a particular problem, or for representation by interested parties, the Association strongly urges the Commission to include consumer representatives in the group or task force. Consumers are taking greater roles in a variety of deliberations that, heretofore, were not open to the consumer point of view. Health care consumers too have a point of view; a perspective that is not heard enough in health care decisions. The Commission's recognition of the growing role of consumers in the health care market place will advance

both the Commission and consumers in the health care sector.

Given the health care needs of our people, the pace of technological innovation, and the existing gaps in services, health care expenditures are bound to go up. The challenge is to know what works and what doesn't work, and to systematically apply that knowledge to patients. Only then can we be assured that we are spending our health care resources responsibly. The Commission's draft report helps elucidate issues for decision and focus attention on difficult problems in delivering health care services to an urban/rural population. The Maine State Legislative Committee of AARP looks forward to working with the Legislature and others to secure a more stable health care delivery system for our people.

MAINE MEDICAL CENTER

John DiMatteo
Trustee, Finance Committee Chairman
Maine Medical Center

Testimony before the Blue Ribbon
Commission on Health Care Finance

September 6, 1988

Good morning. I represent the Board of Trustees of Maine Medical Center, and have chaired its Finance Committee for several years. We are a body of volunteers, representing a cross-section of our community. We are businessmen, health care professionals, and concerned citizens. We are entrusted with the health and well-being of Maine Medical Center and its patients.

We have had an unequivocal commitment to cost containment as well as to high quality health care for more than a decade. Through our Joint Conference and Finance Committees, we have always insisted that the hospital be responsible and accountable. And until just a few years ago, we were doing a very good job at keeping costs down without outside help.

Even when cost control legislation was proposed in 1983, we were not adamantly opposed. The idea of regulation wasn't appealing, but we recognized that with the cost of health care rising for a multitude of reasons, regulation was inevitable.

Accordingly, we instructed the hospital administration to work with the legislature and the regulators, to ensure a workable system. And more than workable, that it not interfere with our mission to provide the care our patients expect and deserve.

We have worked with the Maine Health Care Finance Commission in good faith for five years. But we have finally come to a point where we cannot do that any longer. Red ink -- and a lot of it in the next few years -- will seriously compromise our ability to care for our patients. That is simply unacceptable to me, to my fellow trustees, and to the people we serve.

Hospitals are not like any other business. The "business" of hospitals is life and health, and that makes them different. But that doesn't mean they shouldn't be run in an efficient, businesslike manner. When we as trustees make a decision, we must balance the mission with the money, and believe me we're as hard on the staff about one as the other.

Like any other business, however, a hospital must be able to meet a payroll, finance capital needs, make repairs, pay competitive salaries, and pay its bills on time. There may be concern about hospital "profits", but there need also be concern for the financial health of the hospital. Without "profits," we cannot repay our debts, purchase new technology, or otherwise meet the growing needs of a growing community. Without financial health, we cannot fulfill our mission, and it is our patients -- me, you, our families, our friends and neighbors -- who will ultimately suffer.

Any new regulatory system this Committee may propose must do a far better job of protecting our hospitals -- and by extension our communities -- than has the current system.

That said, let me cite in one word the key problem with the current system: inflexibility. The rules and regulations that have grown up around the law passed in 1983 -- which incidentally might have worked had it been implemented differently -- make it impossible for us to work with it, impossible for business and insurers to live with it, and I dare say nearly impossible for the regulators to administer it.

I want to make it clear that my quarrel is not with the regulators but rather with the set of rules that they are constrained to work within. The existing law assumes that health care costs can be contained by weeding out inefficient operating costs. That is not where the problem is.

The Blue Ribbon Committee report is difficult to evaluate and lacks specifics, but it recognizes the problems with inflexibility in two key statements. On page 6, it states that "different regulatory systems should be utilized for specialty hospitals and other hospitals identified by the Rate Setting Body as being unique or different within the Maine Health Care System."

And on page 9, it states "The Systems being discussed are largely formula driven, but no formula-driven system can anticipate every eventuality."

If the last 5 years have taught us anything, they have proven the accuracy of that statement.

Regulation by formula is doomed to failure. The federal government has tried it with DRGs, or Diagnosis Related Groups -- one formula-derived payment for each disease category regardless of differences in individual patients -- and it has failed. Maine has tried it with a formula-driven regulatory bureaucracy, and it has failed.

1) Formulas cannot account for the differences among the 43hospitals in Maine. They range in size from 25 beds to 600 beds, from rural to metropolitan, from community hospitals to regional centers of high technology. They operate in different economic environments, have different availability of physicians and other staff, have wide seasonal differences, and most importantly they operate in different communities. The expectations of each community, of the people who consume health care, are not accountable by formula.

2) Formulas cannot account for the rapidly changing environment of health care. The world today is much different than it was in 1983: as more care is being delivered outside the hospital, the patients remaining in the hospital are much sicker and much more demanding on our personnel and other resources; the number of people using hospitals is down nearly 11%; technology continues to advance and our patients expect it to be available.

3) Formulas do not recognize the unique nature of the hospital "business." Demand for services is very unpredictable, and furthermore formulas cannot predict demand for an individual hospital. In addition, the driving force behind the development of new technology is not cost reduction and efficiency, it is improved medical care. Therefore, advances in technology can significantly increase costs, with dramatic results.

The physician in the community determines who will come to the hospital, which exists to provide the services required of it. The consumer, the patient, is rarely the payor, and the payors are not the patients. The federal government and state governments, through Medicare and Medicaid, purchase 50% of health care. They set the price they will pay regardless of the actual cost.

The uninsured must be cared for, and someone must pay for their care. Government shortfalls and the care of the uninsured are borne by shifting those costs to business and private payors, explaining the dramatic rise in health insurance premiums. Inefficient facilities, and even seldom-needed services, must be maintained despite the cost so they are available when needed.

Regulation must recognize these differences and unavoidable inefficiencies, and must be flexible enough to accomodate them, if we are to have the health care system the public expects.

A regulatory system will need to match the needs of the community, the expectations of the community, and the ability of the community to pay for what it wants. That is called "planning." Planning is not mentioned in this report. Think of it: a 16-page report on health care expenditures, a report that purports to shape the future of health care in Maine, and no section on how to determine how many beds are needed and where, how many physicians are needed and where, what technology is needed and where, what is a reasonable and affordable standard of care...the list of unanswered questions goes on.

Do we have a solution? Yes, but not a simple one. If we must have regulation, we believe the only way to fairly regulate the cost of hospital care in Maine is a system that provides planning at the state level, understanding of the mission of each hospital, and an allocation of resources consistent with the defined role.

In regulatory jargon, we propose budget review as the most objective way to allocate resources. We understand the arguments against such a system -- the problems of comparative data, the definition of fixed and variable costs, and even the perception that hospitals always "win" in budget review processes.

But we believe there are ways to analyze and compare budgets within reasonable tolerances. Far more data is available today than ever before, and there is a data base within the state that I am told would be very good and would be helpful.

The present legislation affecting health care costs does not take into account the responsibilities of the Boards of Trustees of the several hospitals. Those Boards have long since ceased being a social position or recognition for civic achievement. They are hard-working Boards with well recognized responsibilities under Mane law.

Efforts to contain health care costs in Maine should recognize and work with those Boards that are well-acquainted on a regular basis with the needs of their respective hospitals. A strengthened planning function and budget review at the regulatory level, together with greater appreciation for the responsibilities of the Trustees of Maine hospitals, would be an appropriate and far more effective means of assuring that Maine hospitals are well managed financially.

That is a philosophy taken from the business world, where the Securities Exchange Commission has well recognized the responsibilities of corporate boards of directors and has worked through those boards to effect public purposes.

Similarly, bank regulators working through an audit process have reported to boards of directors those cases where they have felt that credit controls and other management responsibilities have not met the mark. Those practices have proven to be very effective with those boards, as they would prove to be effective with hospital boards.

The SEC has found that, as it has required boards to better face their responsibilities, they have become more independent and those members not willing to take those responsibilities seriously have been replaced.

It is only through understanding the demands on each hospital, the unique characteristics of the facility, the medical staff, and the community that a system can meet the expectations of the community.

It all comes down to expectations. What do the people of Maine -- whom you are charged to represent and we are charged to serve -- expect of us? They expect the best possible care when they need it. They expect that care to be readily accessible. They expect it to be affordable.

We all know that we can't have it all. We can't have the finest care, the latest technology, the finest staff, available round the clock to everyone regardless of ability to pay, and have that on every streetcorner, and at the same time not pay very much for it.

And yet a system that insists on regulation by formula and makes no provision for making the hard decisions about access, technology, and quality of care, expects just that.

That isn't realistic, isn't fair, and isn't workable. My fellow trustees and I will work with all concerned to develop a workable system, but this isn't it.

# # #

Testimony
Brian Rines, Ph.D., Chairman, Maine Hospital Association
Trustee Advisory Group

FROM: Brian Rines
DATE: August 25, 1988

Good afternoon Chairman Gauvreau, members of your Blue Ribbon Commission and others interested in the outcome of this Commission's study as well as health care in Maine.

I am Brian Rines, a director of the Kennebec Valley Medical Center in Augusta and chairman of the Trustee Advisory Group. We are a newly formed body of hospital Directors and Trustees hoping to come to represent the views of the Trustees of community hospitals in Maine.

We've had one statewide Forum in Bar Harbor in May and are planning another in October. We function as an advisory group to the Maine Hospital Association.

We hope to be able use our experience as Hospital trustees to influence the course of public policy, especially as it relates to our hospitals.

We are approximately 900 people, as diverse as the communities we represent. Trustees of virtually all of the hospitals in Maine have participated in one program or another of ours and trustees of a majority of the hospitals sit on our Steering Committee.

We are potato farmers, physicians, nurses and Sisters of Charity. We are also retirees, psy- chologists, accountants, lawyers and teachers. We include in our numbers former gubernatorial cabinet members and past and presently seated members of both houses of the Legislature.

Some of us have businesses so small as to be run out of our homes and others of us are employed by the largest corporations in Maine.

Others of us own, operate or manage substantially sized small businesses ourselves. We are also bankers, lawyers, housewives, teachers, ministers and priests. Some of us have been in psychotherapy and aren't particularly embarrassed about that---even more of us have been in the National Guard.

we are Maine and its people -all different people, doing different things in different places, But we have one thing in common--- representing our communities as we develop policy for one of its most valuable resources,

while trying to maintain fiscal integrity and quality health care in each of our hospitals.

In the old days, we used to do it for our own community and its facilities, hardly looking beyond the borders of our service areas. As the world changed, so did we---we merged, consolidated and incorporated with our sister hospitals. We still compete with each other, but we know that we are part of the statewide system where the impact of a major change in one hospital is inevitably felt on another---sometimes in small ways---often in large ones.

We try to deliver our services as inexpensively as possible. We economize, we join group purchasing plans. Some of us have even had the unfortunate and sad responsibility of laying off trusted employees. Helping manage a hospital today is a trying and not always satisfying endeavor. We're learning how to do it and sometimes it feels like we aren't doing so well. But we think we have identified the problem!!

Never in my wildest dreams of my youth did I think that I would be complaining about the "pointed headed bureaucrats" in Augusta. I know we all grew up complaining about Washington but Augusta?

Now, as Trustees, we find ourselves being forced to look there for approval for virtually every action of any significance that we want to take. Almost all of us are opposed to the concept and practice of the current regulatory environment.

Here in the state of rock ribbed individualism, the home of the most independent of small businessmen, the lobstermen---In a state that has always prided itself on self-reliance, we in the hospital end of health care find ourselves enmeshed in the most repressive and restrictive control system in this country.

You're going to hear some of my colleagues today; and I'll introduce them in a minute-,talk about the necessity for them to be virtually bankcrupt before they can receive permission to give their nurses a commission-approved pay raise. Others are going to tell you how the Commission's rules made it difficult for them to provide essential services in their hospitals. Others will tell you how they are being punished for operating an efficient, cost-effective and, yes, even potentially profitable operation.

I think, in summary, you will hear that the current system has replaced the

ways of Horatio Alger with those of Willie Sutton and Robin Hood.

Speaking as trustees will be **Richard Morrell** of Brunswick. Dick is the immediate past-chairman of Brunswick Regional Memorial Hospital Board and now Chairman of the Board of Mid-Coast Health Resources which is the corporate parent of the recently consolidated Brunswick Regional and Bath Memorial Hospitals.

By national standards, he is a small business- man---owning and managing a company that has been in his family for generations. He grew up in Maine, graduated from Bowdoin, went away to war and later was a distinguished member of the Maine Senate. Almost 20 years ago he got involved with his home town's hospital. You'll hear him express solidly and directly a sense of frustration and disappointment about the current environment.

Incidentally other at least one other speaker here today is a hospital trustee, serving with me on the KVMC Board. He's going to be offering another organization's viewpoint, showing again the plurality and depth of interests of maine's hospital trustees, but back to our speakers.

Burt Wilner serves as Chairman of the Board of Stephens Memorial Hospital in Norway. He, too, is a successful businessman, also managing a company that has been in his family for years. He has long been involved in community organizations and in the recent past has been focusing his attention on the role of the community hospital and its trustee in the delivery of health care services.

He has seen a successful and formerly profitable small community hospital pushed to the brink by the commission. Like Churchill he doesn't feel that he was elected to preside over the demise of his enterprise

Dr. Pete Bixler, immediate past treasurer of the parent board of the PenBay Medical center, has also served on other boards in their system. He's not only concerned that the current system has created financial distress for them, but that it has created tensions among the Boards, staff and physicians that didn't earlier exist. He's upset at being forced to play in an environment that fosters a continual "let's you and him fight, while we hold your coats" attitude.

Incidentally, he holds a doctorate in chemical engineering from MIT where he taught before entering the chemical supply business. So he's brought to his boards not only the fiscal and administrative savvy of a knowledgable and successful businessman, but the technical expertise of a professional chemist and the perspective of a trained scientist.

Finally, **John DiMatteo**, President of Guy Gannett Publishing and a senior member of the Maine Medical Center board will present the perspective of the Commission's impact on Maine's largest and most sophisticated hospital. While the current rulemaking environment can't take away the size declaration that John's institution rightfully owns, a cynical mind might believe that there is a covert move afoot to erase that sophistication, not only from MMC but from all of us.

When the legislature's health and institutions committee met 6 years ago to consider the statute that was to become the Maine Health Care Finance Commission, I told them of one of my basic fears, which seems to be becoming true.

Over 30 years ago, my grandfather needed a surgical procedure, a simple below the leg amputation which even then was considered routine and now it is being done in virtually every hospital in Maine.

But many patients had to go out of state for many procedures back then. We weren't as medically self sufficient as we are now.

The expense of those journies wasn't simply the financial ones associated with the higher costs of big city services. My grandmother and other family members had to go to Boston for long periods of time and return there regularly for the outpatient and ancillary care that was required. Of course, the physical therapy and prosthetic services weren't available here either, so many trips were made to North Andover to have his artifical leg fitted, and adjusted.

IUnless something is done soon we will return to the ways of those prior times and again start sending our loved ones away for essential medical care that today we do at home.

Finally, I know that we in the State of Maine aren't totally responsible for the problems we face or that they are unique to us. You can't take umpteen billion dollars out of a federal health care budget and not expect it to hurt down the line. President Reagan and Congress said that they want these decisions made at the state level---but who is the "state?" Who's going to

decide how to allocate or ration limited and perhaps continually shrinking resources.

I've heard today and you'll hear more of a shortfall in Maine of 150 million dollars in Medicare and Medicaid monies that are being passed on to those of us who are buying health insurance. How will that huge deficit be paid back .. by whom .. and to whom.

Who's going to determine what kinds of services, at what costs and via what payor that the under and non-insursed, the so called medically indigent, will be treated?

How are we going to decide whether we need another lithotriptor or whether we really need the next generation of technical wizardry and even more modern gizmos as they come down the line.

Who's going to create an environment that will make it financially worthwhile and humanly rewarding for people to go into the health care professions whether they be tray passers, floor nurses, family doctors, operating room technicians or physical therapists?

I guess that by now you know that I believe that there are no simple answers to these incredibly difficult problems and to paraphrase something that Casey Stengle once said, "Show me a simple answer to a complex problem and I'll show you something that doesn't work,"

I suspect that you have already discovered that here, as you try to develop a fair and comprehensive system for simply managing the hospital part of Maine health care.

But as I end, please know that we are here as trustees to tell you that Maine's hospitals are suffering under the current system. We believe its at a turning point. We think that changes must occur soonif any change is to be timely meaningful or realistic.

I am going to go back to my seat now and listen to the rest of this incredibly interesting debate. I hope that it's useful to you in your deliberations

But as I do that, Please know that the Trustees of Maine's community hospitals are standing by, available to assist you in your deliberations and

equally determined not to be left out of the decision making process this time.

We are the communities that consume the services that are being controlled and regulated. Ultimately we will be part of it as patients. We intend to be part of the process that makes the policies that answers some of the questions I asked a minute ago .

Thank you for the opportunity to have addressed you today. We offer you our best wishes as you continue with this difficult task.

GAUVREAU BLUE RIBBON COMMISSION HEARING
September 7, 1988
Bangor, Me.

My name is Judie Burke, I am the President of the Maine Medical Records Association, your health information specialist.

I would like to share with you the concerns of the Maine Medical Records Association and ask that you consider these concerns when making your final recommendations.

There are four areas I would like to address this afternoon. All of these areas revolve around insufficient funding.

a. Staffing shortages.

b. The exit of qualified personnel from the State.

c. Reduced support for professional activities

d. The inability to take advantage of new technology.

All of these factors ultimately lead to a reduction in the quanity of service, but most importantly, in the quality of service.

Regulatory changes have brought about an increased need for documentation and data collection. In most areas requirements have doubled in the last six years. Not all of this change is a result of Commission activity. Federal requirements for peer review activity and DRG's and increased needs of third party payors are also responsible. It is, however, the CAP that ties our hands in meeting these increased responsibilities.

Our manager members know how to justify the need for additional help and they know how to justify the need for improved equipment. When they take these request to their administrations they are told your

right "BUT". These continued "BUTS" have resulted in an exodus of bright young minds from our state.

This year alone the Maine Medical Records Association has lost at least two members who became disillusioned with these constant "BUTS:" . They went to states that are not so heavily regulated, where hospitals are participants in a free market system.

This past year, when the Association was selecting candidates for state officers, several members who would like to have run for office declined. Their administrators were unable to fund this activitiy. A Medical Records Professional needs to obtain 30-50 continuting education credits every two years. Our State Association provides this opportunity at a very reasonable cost but still our members cannot attend because the hospitals have had to cut funds for educational opportunities.

When we are seeking qualified help to fill openings there are few, if any, respondents. Personally I have had to fill openings for the last four years with people that had to be trained on the job. We are a small hospital whose labor market competes with Bangor. As soon as personel becomes adequately trained they leave for a higher paying job in Bangor.

Our Association recognized a shortage of trained professionals in 1980. The University of Maine was approached and a two year training program was developed. Three classes have now graduated and we are still short of help. We need to project to Maine's highschoolers that health care is challenging, finacially rewarding and has a good future in Maine.

Both of my daughters chose to go into the health care field and both married men who are in the health care field. They live out of state because they can make a great deal more money and they do not have to deal with the difficult regulatory climate in Maine.

I wish I could say that these problems are unique to Medical Records but I cannot. As you have heard over the last two days these problems are common throughout the health care professions.

Thank you for this opportunity to speak to you today. We need to work together to come up with a plan that will allow health care to grow both in scope of service and in quality of service. A plan that controls cost but is not so restrictive that it snuffs out the flame of progress.

Testimony

Harold Gerrish, DMD

Blue Ribbon Study Commission

Bangor, Maine

September 7, 1988

Chairman Bernstein, members of the Commission, good afternoon and thank you for the opportunity to speak today.

My name is Harold Gerrish. I am a long time resident of Dover-Foxcroft, Maine and I am speaking today as a hospital Trustee and as a member of the community.

I have been a Trustee of the Mayo Regional Hospital for more than 15 years. I currently serve as Chairman of the Board. I wish to acknowledge the hard work of the Commission and its current draft report and commend it for seeking to recommend significant change from the current regulatory environment.

The message I bring to you today from one small hospital in Maine is twofold:

1. The inflexible regulatory system we currently live under is beginning to seriously erode the financial viability of the small hospital and prevents me as a Trustee from exercising my primary responsibility which is to manage the

resources of this trust in a financially prudent way.

2. The second message I wish to bring to you is that Trustees can be trusted to manage resources in a responsible and reasonable manner, and do act as a restraint, in very realistic terms on proliferation of services which are not needed in the community.

We believe that we have run Mayo Regional Hospital in a very responsible manner. We have done a decent job keeping our costs down and yet we are constantly having to face unrealistic choices because the current system does not appear to allow us to meet our financial needs, to grow, and offer the services in the community that are truly needed.

For example, we have been able to attract a vascular surgeon to our community who's willing to commit his expertise for the benefit of patients in our area. Yet, we are experiencing significant delays in bringing this service on line when, we believe, the service is needed and can be offered at a very reasonable price to the people of our community, thus avoiding having to transfer them to other communities for their care at great inconvenience and additional cost.

It is almost impossible to grow under the current system since it appears to me as a Trustee to penalize growth yet reward no growth.

As a practicing professional, I do not understand the rational

basis for such a state policy.

We live in a state with an aging and growing population and I serve as a Trustee for an organization which provides an important, essential service, health care, which is constantly evolving. Yet, our hospital people are spending more and more of their time dealing with the regulatory environment and are not rewarded for running efficiently, growing appropriately and being able to offer enhanced or new services for our community.

The people out there are getting very sophisticated in their ability to choose good health care and, in fact, are now demanding quality health care.

Unless you give us Trustees a system which is flexible, which provides for timely response to meet our needs, truly reflects the costs we are incurring especially in the area of wages and compensation for our employees and the capital needs of maintaining our plant and equipment, you are fooling yourself that hospitals will not be damaged in the future.

I, for one, have never understood and continue to not understand the reason for regulating hospitals in Maine. Any reasonable measures that you have looked at must have told you that Maine hospitals are functioning in a very responsible manner and are not like hospitals in other states which have regulation, for example, Massachusetts, New York or New Jersey.

I have one recommendation to you:

I believe the Commission is obligated to put forth the reasons for regulating hospitals, the goals of such regulation and why regulation is necessary. Without such goals clearly stated, any subsequent rate setting system will be able to go off on its own and potentially continue to drive hospitals into perilous financial condition.

I urge you in as strong as possible terms, to create an environment which allows for growth, and rewards that growth comparable to what is occurring the rest of the country. Trustees will not too much longer serve on a second-rate health care system and those of us who can afford to not use such a second-rate system will most certainly leave the state for our care if we can. I truly question the wisdom of such a state policy.

I believe people of our community and the people in the State of Maine deserve better than that.

Thank you.

NEH/PBMC REKMARKS TO GAVREAU BLUE RIBBON COMMISSION
SEPTEMBER 6, 1988 UNIVERSITY OF SOUTHERN MAINE
ROOM 303 PAYSON SMITH HALL

LADIES AND GENTLEMEN. THANK YOU FOR THIS OPPORTUNITY TO APPEAR HERE TODAY. I AM HARRIS J. BIXLER A SCIENTIST AND PRESIDENT OF MY OWN INVESTMENT AND CONSULTING FIRM AND A TRUSTEE OF NORTHEAST HEALTH, THE PARENT ORGANIZATION OF PENOBSCOT BAY MEDICAL CENTER. I AM ALSO TREASURER OF NOTHEAST HEALTH, SO AM INTIMATELY FAMILIAR WITH THE CURRENT FINANCIAL STRESS ON OUR HOSPITAL AND OTHER QUALITY HEALTH CARE INSTITUTIONS IN MAINE.

I AM GRATIFIED BY GOVERNOR McKERNAN'S FORESIGHT IN ESTABLISHING THESE BLUE RIBBON COMMISSIONS TO TACKLE MAJOR ISSUES FACING THE EXECUTIVE AND LEGISLATIVE BRANCHES. CERTAINLY FEW ARE MORE IMPORTANT THAN HEALTH CARE EXPENDITURES. I ALSO WANT TO THANK THE MEMBERS OF THIS COMMISSION FOR THEIR COMMITTMENT TO SEEING THEIR TASK PERFORMED WITH IMAGINATION AND GRACE.

YOU HAVE ASKED FOR TESTIMONY ON YOUR DRAFT REPORT. OVERALL I BELIEVE THE REPORT RECOGNIZES THE PLIGHT OF A PEN BAY MEDICAL CENTER. HERE IS A HIGH QUALITY 106 BED HOSPITAL THAT ENTERED THE MHFC ERA IN EXCELLENT SHAPE. BY MAINE AND NATIONAL STANDARDS IT WAS PRODUCTIVE, CHARITABLE, AND PRACTICED A STYLE OF HEALTH CARE THAT WAS RESPECTED IN THE COMMUNITY AND IN THE STATE. FROM MY PERSPECTIVE AS CURRENT TREASURER (ALTHOUGH I WAS NOT ON BOARD AT THE TIME) IT ALSO ENTERED THIS NEW ERA OF REGULATION IN GOOD FINANCIAL SHAPE...NET MARGINS WERE A MODEST 1-2% AND ENDOWMENT FUNDS WERE GROWING TO KEEP PACE WITH INFLATION. PERHAPS MORE IMPORTANTLY, THERE WAS A SPIRIT OF COOPERATION AMONG PHYSICIANS,

TRUSTEES, THE COMMUNITY, AND HOSPITAL STAFF.

NOW IN PAYMENT YEAR III WE HAVE BECOME A TROUBLED AND DIVIDED INSTITUTION. WE LOST $1.4 MILLION FROM OPERATIONS AND $1.2 MILLION AFTER ADDING NON-OPERATING INCOME. UNRESTRICTED AND BOARD DESIGNATED FUNDS ARE DOWN 50% FROM THE BASE YEAR AND THAT AFTER SUFFERING VIRTUALLY NO DROP WITH THE MARKET LAST OCTOBER. WE ARE BORROWING SHORT TERM TO MEET PAYROLLS, AND ANOTHER YEAR LIKE LAST YEAR WOULD WIPE OUT FOR ALL PRACTICAL PURPOSES UNRESTRICTED AND BOARD DESIGNATED FUNDS. TRUSTEES AND ADMINISTRATION ARE BECOMING DISTRUSTFUL OF EACH OTHER; THE COMMUNITY IS CONCERNED THAT QUALITY OF CARE MAY SUFFER, AND PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS JUSTIFIABLY FEEL CAUGHT IN THE MIDDLE WHILE THEY TRY TO PROVIDE LEVELS OF CARE MEAASURED BY NATIONAL PROFESSIONAL NORMS WITHOUT ADEQUATE COMPENSATION FOR THE VOLUMNE OF WORK DEMANDED BY THE COMMUNITY.

WHAT HAS GONE WRONG?...OR FROM YOUR PERSPECTIVE; WHAT CAN BE DONE TO HELP A PEN BAY RECOVER IT'S FORMER STRENGTH AND VITALITY?

THE MODIFICATIONS TO PAYMENT FORMULAS YOU PROPOSE WILL CERTAINLY BE AN IMPROVEMENT OVER WHAT NOW EXISTS. ANYTHING THAT WILL ALLOW PEN BAY TO "REBASE" TO A MORE RECENT YEAR WILL PROVIDE SOME RELIEF FROM THE LOWER-THAN-MARKET WAGE INCREASES WE HAVE BEEN ALLOWED. FUNDING COMPETITIVE SALARIES AND WAGES WHICH ARE EITHER NOT REIMBURSED OR MUST AWAIT THE LONG, DEBILITATING AND EXPENSIVE PROCESS OF APPEAL HAS BEEN A SEVERE DRAIN ON WORKING CAPITAL. LIKEWISE, ANY FORMULA CHANGE THAT PROVIDES AN INCENTIVE INSTEAD

OF A PENALTY FOR SHIFTING EXPENSIVE INPATIENT CARE TO MORE COST EFFECTIVE OUTPATIENT CARE IS REFRESHINGLY FORWARD LOOKING. AS AN ADVOCATE OF A FREE MARKET WHEREVER POSSIBLE, I WOULD SUGGEST YOU MAY DO THE MOST GOOD FOR ALL PARTIES BY DEREGULATING OUTPATIENT CARE.

BUT I DON'T BELIEVE TINKERING WITH THE FORMULAS FOR REIMBURSEMENT IS ENOUGH. PEN BAY, LIKE MANY OF THE HOSPITALS REPRESENTED HERE TODAY, HAVE BEEN SLOW TO REALIZE THAT THE PRESENT HEALTH FINANCE REGULATIONS ARE NOT ONLY AIMED AT CURBING SOME OF THE EXCESSES THAT HAVE EXISTED IN HEALTH CARE, BUT ARE ALSO AIMED AT SIGNIFICANTLY RATIONING ESTABLISHED SERVICES, DENYING THE AVAILABILITY OF PROVEN TECHNOLOGY, AND DRASTICALLY CHANGING TRADITIONAL HOSPITAL STAFFING PATTERNS. HAVING COME TO THAT REALIZATION, I AM HERE TO SAY THAT EVEN IN A COMMUNITY AS RICH WITH TALENT AS THE MID-COAST WE NEED HELP WITH THIS POLICY SETTING CHORE OF DECIDING WHO IS TO RECEIVE WHAT KIND OF HEALTH CARE. THE ENABLING LEGISLATION FOR MHCFC RECOGNIZED THE NEED FOR POLICY PLANNING TO ACCOMPANY THE INEVITABLE SQUEEZE HOSPITALS WOULD EXPERIENCE WITH THE REVENUE CAP, BUT THE POLICY INPUT FROM MHCFC HAS BEEN FAR LESS VISIBLE TO TRUSTEES THAN HAS BEEN THEIR RATE SETTING FUNCTION. THIS COMMISSION COULD HAVE MADE A SIGNIFICANTLY GREATER CONTRIBUTION TO HEALTH CARE IN MAINE IF IT HAD AT LEAST ACKNOWLEDGED THAT HEALTH CARE RATIONING IS THE NAME OF THE GAME AND HAD BEGUN GIVING SOME GUIDANCE IN THE WRENCHING POLICY SETTING PROCESS.

I WOULD MAKE ONE FINAL POINT WITH REGARD TO COMPLETING YOUR ASSIGNMENT. THE ENABLING LEGISLATION FOR MHCFC CONTAINED A LOT OF POSITIVE IDEAS ABOUT CONTROLLING THE HEALTH CARE COST SPIRAL. AS SOMEONE ON THE PAYING END, I WELCOMED THE CHANCE FOR ALL PARTIES TO REASON TOGETHER ON THE FUTURE COURSE OF HEALTH CARE IN MAINE. UNFORTUNATELY, THE REGULATIONS THAT WERE FINALLY ADOPTED WERE CRAFTED IN A LESS THAN OPEN AND PARTICIPATIVE ENVIRONMENT, SO WHAT WE ENDED UP WITH IS NOT WHAT WAS EXPECTED. I CONFESS THAT THERE WAS A CERTAIN AMOUNT OF STONE WALLING BY HOSPITAL ADMINISTRATORS AND CONSIDERABLE POLITICAL NAIVETE'ON THE PART OF TRUSTEES AND PHYSICIANS IN THE PROCESS. THIS TIME AROUND WE'RE ALL BETTER PREPARED TO ENGAGE IN THE PROCESS, BUT I WOULD ENCOURAGE THIS BROAD-BASED COMMISSION TO ASSURE THAT THE PROCESS OF NEW REGULATION DEVELOPMENT IS PERFORMED IN OPEN FORUM AND THAT THE CONSEQUENCES OF CHANGE BE ANALYZED AND MADE PUBLIC BEFORE FINAL ADOPTION.

THANK YOU.

END..

TESTIMONY

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

Chairman Gauvreau, members of the commission. I am Clifton Eames. I am currently chairman of the board of trustees of Eastern Maine Medical Center. Through my years of association with the medical center I am familiar with the task you have undertaken as a commission and compliment you on your progress so far.

Over the past few years I have testified several times before a variety of committees which were considering regulation of hospitals. Unfortunately much of the regulation of hospital costs has been looked at as a means of regulating total health care costs. Actually, HCFA estimated that in 1986 approximately one third of total health care costs was for care in community hospitals. The naming of MHCFC -- The Maine Health Care Finance Commission -- is an example of this confusion of the goal of controlling the cost of health care when, in fact, MHCFC is involved exclusively with hospital costs.

Through this confusion of health care with hospital care and hospital costs, much of the impetus to regulate costs of Maine hospitals may have been inappropriately directed. I have seen comparisons made between Maine hospital costs and those of other states and areas. Total community hospital costs are generally compared on a per admission or per capita basis and have shown Maine community hospitals to have had costs 4-7% lower than the average for the United States from 1978 to 1986.[1] In making these comparisons most statisticians have overlooked that historically, Maine hospitals have provided more outpatient care than the country's average. Using American Hospital Association data, it appears that if inpatient activity is separated from the outpatient component,

inpatient care at Maine hospitals actually has been 11-13% less costly than the national average on a per capita basis for the same period.[1]

Through its efforts to control hospital revenues, MHCFC has restrained the ability of most hospitals--including EMMC--to continue their historic role of providing the outpatient services needed in their communities. In the meantime, however, other providers not under MHCFC have been expanding in their far less regulated environment.

My comments now will relate to the August 5 Draft report.

1. Rate Setting Body

I don't think we could expect all Maine hospitals to transition directly from the MHCFC system to a free market situation and deal successfully with the issues of access, quality, cost, and state/federal shortfalls. Therefore, I agree that some sort of transitional regulatory mechanism will be needed.

2. Flexible System for Inpatient Care

The Blue Ribbon Commission's suggestion that transition from the MHCFC system can have multiple solutions is very refreshing. In addition to the other factors listed in the report, any per case payment system adopted in the future

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[1] AHA Guide. 1978-1986.

should include an adjustment for disease severity. Research has shown the DRG system alone to be inadequate for rate setting among hospitals. I know from my own experience with heart disease that were I to have what would appear to be a fairly simple surgical procedure--and thus a low DRG payment rate--that my surgeon would need more intense monitoring and standby equipment and specialized personnel found in only a few of Maine's hospitals. These referral hospitals should not be penalized with an overly simplified per case payment system. Introduction of a standard component in a per case rate without adjusting for disease severity could be disastrous for those hospitals which are now, or which become, the hospitals of choice for the most seriously ill patient. Similarly, costs of medical education and capital need to be considered carefully in a per case payment system.

Whether hospitals choose a per case payment or a total revenue system, the regulated payment for inpatient services should be exclusively for acute care. As you know, most hospitals also provide some nursing home level of care. This care may take place in swing beds operated for the purpose of providing nursing home care or it may be by default--either through inadequate supply of nursing home beds in the community or inability of the local nursing homes to afford to accept a patient with need for heavier care. Payment for this non-acute care should fairly reimburse hospital costs but be outside any case rate or case adjustment for inpatient hospital care.

An improved regulatory system must also remove penalties for hospitals that experience growth. Currently, hospitals receive no additional financial requirements until admissions increase by 2%. A hospital will improve its financial position, not by meeting demand for increased access to hospital care,

but rather by decreasing patient admissions by 1.99% each year (the minimum decrease before a downward adjustment for lower volume).

3. Timely Appeals

Under MHCFC, adjustments for extraordinary unforseen expenses is primarily prospective. Hospitals often are left with large losses experienced during the time it takes to adjust their financial requirements. For example, EMMC was recently left with an $800,000 increase in liability insurance expense which was not covered by its financial requirements. EMMC was also unable to recover approximately $1.5 million of revenues from PY1 associated with handling a higher volume, yet hospitals which experienced a decrease in admissions were rewarded. A timely appeals process may have prevented this loss. You are recommending an appeal mechanism which I hope will deal more efficiently with these unforseen problems.

I am concerned, however, that the commission is considering limiting appeals to extremely large events of perhaps 2% of a hospital's total costs. In our case 2% of expenses is two million dollars. Many hospitals have operating losses or margins much below 2%. At EMMC, the average operating gain for the past 5 years was 1.4% of operating expenses. I do not feel that appeals should be limited to changes which could impinge upon the very survival of a hospital. There should be flexibility with any appeals process. Common sense and the practice of the appeals body should govern those issues for which an appeal is practical for any hospital to pursue.

4. Outpatient Deregulation Possible

The new regulatory system should allow hospitals the option of removing their outpatient services from rate setting regulation. The existing MHCFC formulas are flawed and do not permit sufficient revenues to cover incremental expenses for any real change in hospital outpatient services. The incentive now is toward dismantling hospital outpatient services and establishment of new services by less regulated providers. In Bangor we have freestanding radiology, mammography, physical and occupational rehab, laboratory, and urgent care facilities--all competing with area hospitals. None of these freestanding healthcare services are subject to MHCFC or CON.

It would be interesting to study cross-subsidies, but I believe that cross-subsidies will continue to be necessary as long as some populations (such as children and young adults) and some services (especially adult preventive care and trauma/emergency services) are underinsured. Cross-subsidization occurs throughout healthcare -- and, in fact, most businesses. Hospitals must be allowed to meet the needs of the special populations it serves.

Cross-subsidies among outpatient departments should be allowed to occur as market conditions force and/or allow. If a hospital is on an inpatient per case payment system and has its outpatient services deregulated and must deal with various payors and their concerns, then the rate setting body should not try to regulate cross subsidies at all.

5. Capital

You are aware of MHCFC's departure from customary accounting practices for dealing with reimbursement of capital expenditures. Hospitals such as EMMC have

been severely injured by this departure. The result is a capital shortfall which reduces a board's ability to develop long range capital financing plans. The financial marketplace continues to scrutinize a hospital's ability to generate a bottom line, or net income. Operating losses resulting from such "capital shortfalls" are not paper losses, as they are so frequently described. As any responsible manager or board member knows--the value of the organization is based on a measure of net income today and what is projected for the future to maintain existing services and meet future service needs.

If Maine hospitals cannot demonstrate that they are increasing their value, then the financial markets will not be willing to finance increased debt requirements--investments will be made elsewhere in the economy or in other states.

At EMMC and all other hospitals which were operating when MHCFC began, we have not been allowed to fully recover capital expenditures we have made in the past because the system became suddenly prospective. As for all hospitals, we have not been allowed to fully recover expenditures made during MHCFC. In addition, because we have been a prudent institution in the past and have funded depreciation, when we have a project approved under CON we must use our funds accumulated for replacement of existing assets and cannot recover any of our capital costs for new building and fixed equipment. We are now in the process of constructing a $3 million dollar expansion of our emergency room and outpatient surgery space, a project approved under CON. When this project is completed we will receive no increase in our financial requirements for the construction costs.

Unlike EMMC's experience, a hospital without sufficient funded depreciation is allowed to increase charges to recover interest and principal payment for at least 80% of the cost of CON-approved projects.

In fiscal 1988, $1,197,000 of our actual depreciation and interest expenses were not recognized as real expenses by the MHCFC system. This shortfall is the difference between actual book costs and MHCFC-approved revenues for depreciation, interest and principal. In fiscal 1989 this loss will increase to approximately $1,500,000.

We must have a reliable way for hospitals to plan for capital acquisitions--to replace and repair our existing physical plants and adapt to technological improvements. Even before MHCFC, we knew that funded depreciation was not adequate to keep pace. With just a few years' experience with MHCFC we see a disaster.

I urge that if you find it appropriate to regulate capital costs that your commission recommend rebasing payment for capital to conform with generally accepted accounting principles used throughout this country.

6. Certificate of Need

If the Certificate of Need process is to be retained, it should be uniformly applied to all providers of a particular type of health care service. If, for example, it was found appropriate to regulate providers of magnetic resonance imaging services, then the same system of review should be applied to all

providers. Certificate of Need should be designed to regulate and avoid duplication of costly services not simply to regulate services provided by one type of provider while allowing these same services to be provided by an alternative corporate structure.

If a project is reviewed for a CON and is found needed and financially feasible, the project should proceed. The existing Certificate of Need Development Account acts unfairly to restrain only the development of hospital services.

The CON review should be performed by an independent third party. By independent I mean independent of payors. Currently the certificate of need process is regulated by the same agency of government charged with the responsibility of providng care to Medicaid paients. This inherent conflict of interest needs to be eliminated.

7. Federal/State Shortfalls

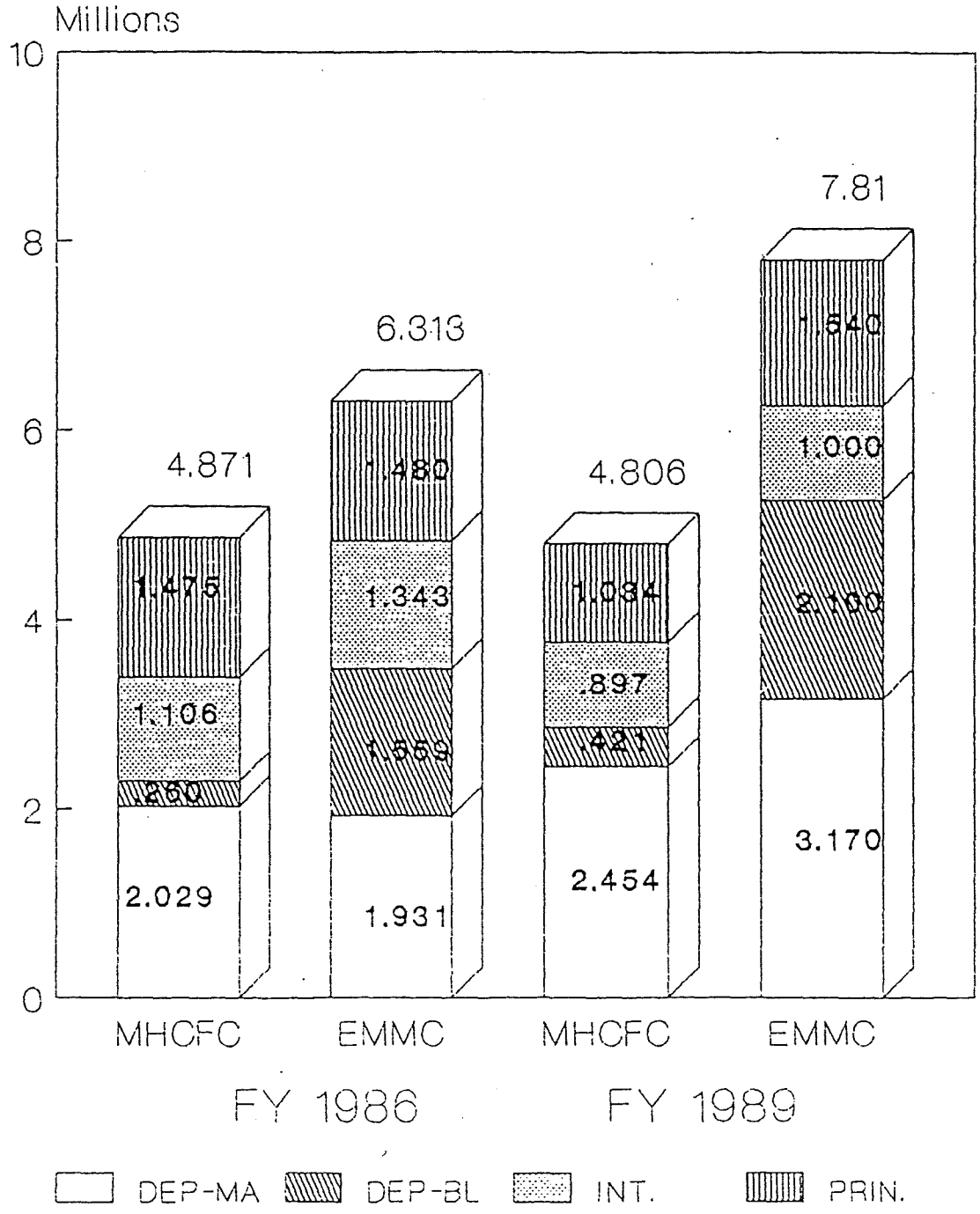
The continued underfunding of both Medicare and Medicaid has, in effect, created a new tax on the sick. I support your recommendation that the General Fund be used to cover projected shortfalls in Medicare and Medicaid payments rather than continue to burden only the sick and their insurors with this unfortunate result of governmental policy.

Thank you for your attention. I would be happy to answer any questions or work to provide you with additional information.

EXPLANATION OF CAPITAL SHORTFALL
INCOME STATEMENT FORMAT
($000)

	JULY YTD	PROJECTED 12 MONTHS ENDING SEPT 1988	SEPT 1989
Revenue			
(Capital items allowed into patient revenues)			
Depreciation	$1,956	$2,348	$2,875
Debt Service (Principal and interest)	2,067	2,479	1,931
Net Revenue	$4,023	$4,827	$4,806
Expenses			
(Capital items reported according to GAAP)			
Depreciation Expense	$4,035	$4,942	$5,270
Interest	895	1,082	1,000
Total Expense	$4,930	$6,024	$6,270
Net Income (loss)	$(907)	$(1,197)	$(1,464)

CAPITAL SHORTFALL
FY 1986/PROJ. FY 1989



ADDRESS TO THE BLUE RIBBON COMMISSION
SEPTEMBER 7, 1988
KENNETH P. TREVETT, PRESIDENT, PROJECT HANCOCK

MR. CHAIRMAN AND MEMBERS OF THE BLUE RIBBON COMMISSION. I AM HERE TODAY REPRESENTING PROJECT HANCOCK, A LEGALLY INCORPORATED CONSORTIUM OF THREE HEALTH CARE FACILITIES IN HANCOCK COUNTY -- BLUE HILL MEMORIAL, MAINE COAST MEMORIAL AND MOUNT DESERT ISLAND HOSPITALS. UNTIL ITS CLOSING THIS PAST SPRING, CASTINE WAS ALSO A PARTICIPATING HOSPITAL. MY POSITION IS BOTH A VOLUNTEER AND ELECTED ONE. CURRENTLY, PROJECT HANCOCK IS SPONSORING SHARED ULTRASOUND AND ARTHROSCOPIC CAMERA SERVICES. IT IS OUR BELIEF AND HOPE THAT ADDITIONAL SERVICES WHICH CAN BENEFIT THE HEALTH CONSUMERS OF HANCOCK COUNTY WILL BE PROVIDED IN THE FUTURE.

I ACCEPTED THE PRESIDENCY OF PROJECT HANCOCK ONLY AFTER MAKING CLEAR TO THE MEMBER HOSPITALS THAT I HAVE PERSONALLY ACQUIRED THREE STRONGLY-HELD PERSPECTIVES DURING MY YEARS AS A HOSPITAL TRUSTEE, ATTORNEY, AND ADMINISTRATOR FOR SEVERAL NOT-FOR-PROFIT ORGANIZATIONS. THE FIRST IS THAT GOVERNMENT INVOLVEMENT -- AND THE REGULATORY RESTRICTIONS THAT INVOLVEMENT IMPLIES -- IS A FACT OF LIFE IN THE MODERN HEALTH CARE DELIVERY SYSTEM AND NOT NECESSARILY AN UNDESIRABLE ONE. AN ISSUE AS CRUCIAL TO OUR NATIONAL WELL-BEING AS THE PROPER CARE OF THE SICK AND NEEDY REQUIRES THIRD PARTY

INTERVENTION AT SOME LEVEL TO AMELIORATE THE INEVITABLE INJUSTICES AND INEQUITIES BROUGHT ABOUT BY UNIMPEDED MARKET FORCES.

SECOND, I BELIEVE FERVENTLY IN THE EFFICACY OF THE COMMUNITY HOSPITAL. IF OUR HEALTH CARE SYSTEM RESULTS IN THE ABANDONMENT OF CLOSE-TO-HOME CARE IN FAVOR OF LARGE REGIONAL FACILITIES, WE WILL HAVE DEPERSONALIZED MEDICINE IRREPARABLY, CREATED UNNECESSARY FAMILY ANGUISH AND ISOLATION BY PUTTING THE PATIENT BEYOND REACH OF RELATIVES AND FRIENDS, AND ELEVATED TECHNOLOGY TO A POSITION FAR ABOVE THE HUMAN ART OF MEDICINE. IT IS AN ESTABLISHED FACT THAT COMMUNITY HOSPITALS DO MANY PROCEDURES -- SUCH AS THE REMOVAL OF AN APPENDIX -- AS WELL AS, AND EVEN BETTER, THAN LARGER FACILITIES, AND OFTEN AT FAR LESS COST. THIS IS NOT TO SAY WE DO NOT NEED OR WANT SOPHISTICATED TERTIARY CARE CENTERS IN MAINE. THE EASTERN MAINE AND MAINE MEDICAL CENTERS ARE CRUCIAL COMPONENTS -- INDEED THE JEWELS -- OF OUR HEALTH CARE SYSTEM. BUT THERE MUST BE A RESPECTED PLACE FOR FACILITIES SUCH AS THE BLUE HILL, MAINE COAST AND MOUNT DESERT ISLAND HOSPITALS TOO. THESE HOSPITALS -- AND MANY OTHERS LIKE THEM, ARE READILY ACCESSIBLE IN THE EVENT OF EMERGENCIES; EASILY TRAVELED TO FOR OUTPATIENT CARE AND FAMILY VISITS; AND LESS OVERWHELMING AND MORE FAMILIAR TO DISORIENTED ELDERLY PATIENTS OR NERVOUS NEW MOTHERS TO BE.

THIRD, HOSPITALS CAN CO-EXIST BY A CREATIVE COMBINATION OF COMPETITION AND COOPERATION. THE COMPETITIVE ELEMENT IS AT THE HEART OF OUR NATIONAL SPIRIT -- TRYING TO PROVIDE A MORE UNIQUE SERVICE, A MORE EFFICIENT SERVICE, A MORE PERSONAL SERVICE TO THE CONSUMER. THE PUBLIC IS THE BENEFICIARY WHEN QUALITY AND COST-CONSCIOUSNESS ARE THE OBJECTS OF THE COMPETITION. BUT RIVALS CAN ALSO COOPERATE -- FOR THE SAKE OF THEIR OWN SURVIVAL AND THE WELL-BEING OF THE COMMUNITIES THEY SERVE. NOT ONE OF OUR MEMBER HOSPITALS COULD TODAY JUSTIFY ESTABLISHING A DEDICATED ULTRASOUND SERVICE. EQUIPMENT AND TECHNICAL SUPPORT COSTS WOULD PROVE TOO GREAT FOR THE UTILIZATION SUCH A SERVICE WOULD HAVE. HOWEVER, BECAUSE THE ULTRASOUND UNIT IS PORTABLE, THREE HOSPITALS HAVE ACCESS TO A MUCH NEEDED SERVICE -- AND THE UNIT IS CONSISTENTLY BEING UTILIZED. IRONICALLY, A CON FOR THIS SHARED SERVICE ORIGINALLY WAS DENIED. YET, IT HAS PROVEN ITS VALUE OVER AND OVER AGAIN. SUCH COOPERATION CAN AND SHOULD EXTEND TO PERSONNEL-BASED SERVICES (PSYCHIATRY FOR EXAMPLE) AS WELL AS EQUIPMENT-BASED SERVICES. AND THIS COOPERATION SHOULD BE ENCOURAGED BY STATE POLICY MAKERS.

GIVEN MY FRAMES OF REFERENCE, YOU WILL NOT BE SURPRISED TO LEARN OF MY CONCERNS WITH THE CURRENT REGULATORY ENVIRONMENT IN MAINE. THIS EXCESSIVELY

COMPLEX SYSTEM WHICH, UNTIL RECENTLY HAS BEEN RIGIDLY ENFORCED, HAS GIVEN A BAD NAME TO GOVERNMENT REGULATION. IT HAS CAST ALL HOSPITALS AS WASTEFUL, GREEDY PROFLIGATES, AND INSURANCE COMPANIES AS INNOCENT VICTIMS OF THIS MEDICAL SPENDING SPREE. IT HAS BURDENED MANY SMALLER HOSPITALS WITH EXTRAORDINARILY LARGE ACCOUNTING AND LEGAL FEES, THUS DIRECTING RESOURCES AWAY FROM PATIENT CARE AND RESOURCE MANAGEMENT. IN SOME CASES, IT HAS REWARDED WASTEFUL MANAGEMENT PRACTICES AND PROVIDED DISINCENTIVES FOR EFFICIENCY. IT HAS DISCOURAGED INNOVATION IN SERVICE DELIVERY AND PROVIDED ROADBLOCKS IN THE PATH OF NEW AND HELPFUL TECHNOLOGY. AND, IN THE END, ONE CAN QUESTION WHETHER THE ULTIMATE GOAL OF COST CONTAINMENT EVER HAS BEEN ACHIEVED.

THIS RESULT IS NOT BECAUSE THE INDIVIDUALS IN CHARGE OF THE SYSTEM ARE INCOMPETENT OR IRRESPONSIBLE. INDEED, THEY ARE MOTIVATED, EXTREMELY BRIGHT, PUBLIC SPIRITED PEOPLE WHO ARE COMMITTED TO THE IDEAL OF COST CONTAINMENT AND EFFICIENT HEALTH MANAGEMENT. THE PROBLEM IS THAT THEIR MARCHING ORDERS WERE TOO SIMPLISTIC AND DID NOT GIVE RECOGNITION TO THE MULTITUDE OF PLAYERS ON THE HEALTH CARE FIELD.

HOW CAN WE ADDRESS THE PROBLEMS WROUGHT BY THE PRESENT SYSTEM? THE DRAFT PROPOSALS RECENTLY CIRCULATED BY THE COMMISSION OFFER SOME INTERESTING POSSIBILITIES. FIRST, THE COMMISSION WANTS TO BUILD INCENTIVES INTO THE SYSTEM VIA "DEMONSTRATION PROJECTS." THIS CONCEPT ENCOURAGES INDIVIDUAL HOSPITALS AND COOPERATIVE HOSPITAL SERVICE ORGANIZATIONS -- SUCH AS PROJECT HANCOCK -- TO POOL THEIR RESOURCES AND AVOID REDUNDANCY IN SERVICE DELIVERY. HOPEFULLY, THIS APPROACH WOULD SPAWN NEW COOPERATIVE ORGANIZATIONS -- WHICH I AGAIN SHOULD EMPHASIZE -- DOES NOT MEAN THAT COMPETITION IS ELIMINATED. GROUP EFFORTS IN WASTE MANAGEMENT, NEW EQUIPMENT PURCHASES AND TREATMENT MODALITIES, AND SHARED PROFESSIONAL RESOURCES CAN REDUCE COSTS AND ENHANCE HEALTH CARE.

SECOND, THERE IS AT LEAST SOME RECOGNITION IN THE PROPOSALS TO DIVERSIFY THE TOTAL REVENUE SYSTEM, GIVING SOME HOSPITALS THE ABILITY TO OPT FOR A DRG - TYPE SYSTEM. I AM NOT SURE WHY THE OPTION CANNOT BE EXTENDED TO ALL HOSPITALS, WITH THE PROVISO THAT IN AREAS WHERE INTER-HOSPITAL COMPETITION DOES NOT EXIST, AN EXTENSIVE, THREE-YEAR EVALUATION OF HEALTH COST INFLATION BE UNDERTAKEN.

THE PROPOSALS RECOGNIZE THE INCREASE IN OUTPATIENT CARE, BUT FRANKLY, SEEM EQUIVOCAL IN THE WAY SUCH CARE SHOULD BE HANDLED FROM A REGULATORY PERSPECTIVE. SMALLER HOSPITALS ARE WITNESSING INCREASING UTILIZATION OF OUTPATIENT SERVICES, INCLUDING SURGERY. THIS DEVELOPMENT -- WHICH ULTIMATELY WILL BE A MAJOR COST-SAVER FOR CONSUMERS AND TAXPAYERS -- SHOULD BE ENCOURAGED BY THE REGULATORY FRAMEWORK. THIS ENCOURAGEMENT SHOULD INCLUDE ALLOWANCES FOR CROSS-SUBSIDIZATION -- AT LEAST IN THE NEAR TERM.

HOSPITALS MUST BE ABLE TO USE ENDOWMENTS DESIGNATED FOR CHARITY CARE WITHOUT FEAR OF REGULATORY REPRISAL. IT IS NOT ENOUGH FOR THE STATE -- THROUGH THE MHCFC -- TO SIMPLY DECREE UNIVERSAL HEALTH CARE. HOSPITALS MUST BE GIVEN THE MEANS TO MEET THIS RESPONSIBILITY. PART OF THESE FUNDS CAN RIGHTFULLY BE SOUGHT BY COMPETING FOR THE CHARITABLE DOLLAR. IN POORER REGIONS, WHERE PHILANTHROPY IS HARDER TO OBTAIN, THE STATE SHOULD PROVIDE ADDITIONAL ASSISTANCE, KEEPING THE RESPONSIBILITY FOR MANAGING CHARITY CARE AT THE LOCAL LEVEL. WHAT WE HAVE NOW IS A NEGATIVE INCENTIVE VIS-A-VIS CHARITY CARE -- IF YOU USE DESIGNATED ENDOWMENTS FOR THIS PURPOSE YOUR REVENUE CAP IS DROPPED. IRONICALLY, THIS DRACONIAN APPROACH IS COUPLED WITH A STATE MANDATE TO PROVIDE FREE SERVICE TO ALL!

RECOGNITION MUST BE PROVIDED IN THE SYSTEM FOR CAPITAL RENEWAL -- IN SHORT, DEPRECIATION. NATIONAL ACCOUNTING GUIDELINES ARE HEADING IN THE DIRECTION OF REQUIRING NOT-FOR-PROFITS TO FULLY FUND DEPRECIATION. THIS APPROACH STRIKES ME AS FINANCIALLY SOUND. WHY SHOULD MAINE HOSPITALS BE DIFFERENT?

FINALLY, I WOULD ENCOURAGE THE USE OF ALTERNATE CARE FACILITIES -- SUCH AS HOSPICES. SUCH ALTERNATE CARE COULD BE IN THE FORM OF SWING BEDS IN EXISTING FACILITIES, SUBSIDIARIES OF EXISTING FACILITIES, OR TOTALLY INDEPENDENT INSTITUTIONAL ENTITIES. ACUTE LEVEL CARE IS NOT ALWAYS REQUIRED OR APPROPRIATE FOR OUR RAPIDLY DIVERSIFYING PATIENT POPULATION. CERTAINLY, ONE WAY WE CAN MAKE OUR COMMUNITY FACILITIES MORE HELPFUL TO CONSUMERS IS TO ENCOURAGE THEM TO TRY ALTERNATIVE TREATMENT MODALITIES.

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IN MY PRESENTATION TODAY, I HAVE NOT TRIED TO ADDRESS EVERY RECOMMENDATION OR EVERY PROBLEM. FURTHERMORE, MY ANALYTICAL APPROACH IS MORE PHILOSOPHICAL THEN QUANTITATIVE. I HAVE ATTEMPTED TO SHARE MY FEELINGS AND

CONCERNS AS A HOSPITAL TRUSTEE, PRESIDENT OF A COOPERATIVE HOSPITAL ORGANIZATION AND, OF COURSE, AS A HEALTH CARE CONSUMER. I APPRECIATE THE OPPORTUNITY TO SPEAK AND YOUR THOUGHTFUL ATTENTION. I DO BELIEVE YOU ARE MAKING MAJOR PROGRESS ON ONE OF THE STATE'S MOST NETTLESOME ISSUES, AND AS A CITIZEN, I THANK YOU FOR YOUR EFFORTS.

BLUE RIBBON COMMISSION TESTIMONY

Chairman King
Members of the Commission

My name is Mary Bennett Williams, R.N., Ph.D., Vice President for Patient Care at Eastern Maine Medical Center. I am speaking on behalf of the Organization of Maine Nurse Executives. OMNE is composed of more than 120 nursing executives representing long term health care facilities, nursing homes and the majority of hospitals in Maine. The members of our organization share with you the goal of health care cost containment. We also embrace our legal and ethical responsibility to preserve a quality level of healthcare for the people of Maine while striving for cost containment.

Over the past several years since Maine has adopted a heavily regulated healthcare cost containment environment, we have seen the quality of patient care slip from optimum to adequate and now, unfortunately, at times to undesirable. It is undesirable when a family member must be transported miles from home to another hospital because the local or regional hospital does not have the nursing staff or enough support staff to provide care. Eastern Maine Medical Center has experienced an increasing demand for critical care beds, in part because of nursing shortages outside of EMMC. As other hospitals have transferred their critical care patients to us, we in turn, have had to stabilize and transfer emergency patients. This means maintaining a current list of all vacant beds in the surrounding hospitals along with Portland, Lewiston, Augusta and Waterville. The community and health care providers are finding this difficult to accept and will not tolerate it long into the future. We are now approaching a point of

crisis in Maine in which there are times when no staffed critical care beds are available in our state. The public continues to demand and in Maine deserves the right to access the healthcare system of their choice.

Patient care once again falls to the undesirable level when the nurses' workload is increased because a patient's condition is too critical to allow transport to another institution. This further diverts the nurses' time from the many patients for whom they are responsible.

In these situations, only priority nursing care (e.g. procedures, treatments and medications) can be done. This means there isn't time to hold a crying child, stay with a dying patient or time to comfort family members. Nurses face, on a daily basis, the dichotomy of what part of society desires and what the individual in the health care system demands.

We are amidst a national shortage of healthcare providers and especially nurses. Hospitals in Maine are faced with the dilemma of caring for each individual patient with increasingly limited resources and in some settings, antiquated systems or facilities that do not support efficiency, (e.g., PAT). We find ourselves in a competitive system without an ability to readily adjust wages and benefits to compete successfully in state and national markets.

In the past, nursing has been able to readily adapt to the changing healthcare environment. We now find ourselves dealing with regulations whose intentions are honorable, but whose outcomes are in part preventing us from responding as rapidly as we must. Hospitals must have the flexibility to improve the work environment, add special programs (such as child care) to retain staff and

recruit additional staff for today and the future. The citizens of Maine have much to gain by a health care delivery system which is supported by a sufficient number of qualified nurses. OMNE urges you to consider a system that allows hospitals to adjust wages and benefits to meet the market place. Nurses are an exceptional value. From a purely fiscal perspective, we represent only about 18 percent of Medicare reimbursement costs. OMNE urges you to seriously consider a revised system, one that will more readily address the needs of its most precious resources -- its human resources. Without qualified professional nurses, the standard of care in Maine's hospitals will fall.

In our search for health care cost containment, let us not loose sight of our fundamental responsibility to the people of Maine--access to quality patient care.

Thank you for the opportunity to speak.

9/1/88

TESTIMONY

RICHARD FREDERICKS

BEFORE THE

BLUE RIBBON STUDY COMMISSION

SEPTEMBER 7, 1988

BANGOR, MAINE

Chairman Bernstein, Members of the Commission, good afternoon and thank you for the opportunity to speak today.

My name is Dick Fredericks. I am the Chief Executive Officer of the Maine Coast Memorial Hospital in Ellsworth, Maine and am speaking today as Chairman of the Board of the Maine Hospital Association.

We are pleased to see that the Commission has recognized the need for significant change in the current regulatory system as evidenced in the draft report. We are pleased that it acknowledges the need for change and that it recommends a multi-tiered approach to meet the needs of the diverse hospital system that we have in Maine. You have already heard in Portland yesterday evening from Bill Spolyar some of our specific concerns about various aspects of the report. I would like to take this

opportunity to emphasize the particular needs of our rural and smaller community hospitals which are, in essence, on the local front lines of the hospital system in the State of Maine. These are the institutions which provide the primary hospital care for most of our largely rural state . Other than in the large cities along the interstate, most of our hospitals are small or medium sized. They have a basic array of medical services available to their communities and have in large measure been able to offer services at reasonable costs, with high standards of quality and access to care.

Our small hospitals, defined by the current legislation as having 55 beds or under, total 17 and are spread across the state, but are primarily located in rural communities. I would like to express to you in the simplest terms possible that <u>these small hospitals are in grave financial peril</u>, and it is essential that any new regulatory system provide for the basic financial needs of these hospitals in a responsible and reasonable way. If it does not, many of these hospitals will not survive. This fact will have significant implications for access to care for many of our citizens throughout the State of Maine.

It is ironic to me that our justification offered for establishing the current regulatory system was that the former system "threatened the ability of some Maine hospitals to generate sufficient revenues to meet their reasonable financial requirements". Yet, today, after almost five years with this system, we can still reach the same dire conclusion.

Let me give you some examples.

In 1987, one half of the 20 hospitals that lost money from operations were in the small hospital category.

Many of those hospitals were not even able to cover those losses with income from other non-operating sources.

This means that these hospitals are without sufficient funds to meet their day-to-day obligations and will become financially nonviable in a very short period of time.

In 1987, the total operating margins for all hospitals in the State of Maine was approximately $3.3 million on a system of approximately $800 million, which is about 1/3 of 1%. But back in 1981, there was a similar $4.5million operating margin when the industry was only half the size that it currently is, over a 1% margin.

More significantly, however, of the $3.3 million total statewide operating margin for 1987, $4.7 million of that was earned by larger institutions, and $2.1 million in the medium institutions, while small hospitals operated at $3.5 million loss. For 1988 and 1989 the projections are worse and I think it is fair to say that the financial picture for many of these institutions is grim, and becoming grimmer.

Another disturbing indicator of what is happening to our small hospitals is the amount of capital infusion available to keep up-to-date and to support high quality patient care. The current system does not provide enough capital to do that job. From 1982 to 1987 the value of property, plant and equipment in hospitals increased approximately $240 million, yet only $19 million of that amount went to the small hospitals. This is only a little more than $200,000 per hospital per year which is a strong explanation for why average age of plant in small hospitals has grown by 33 percent in only five years. The small amounts of capital replacement dollars under the current system cannot reasonably provide for the replacement of plant and equipment.

For some reason, the Fram Oil Filter advertisement comes to mind. Given the choice of "You can pay me now or you can pay me later", the current system has obviously opted for the latter.

The impact of this financial picture, if allowed to continue, will be an inability on the part of hospitals to issue quality rated bonds for needed renovations or upgrading of their plant and equipment because no investor is going to want to invest in an essentially bankrupt system.

Given what I have just said, let us examine the stated intent of the enabling legislation, and review the performance of the regulatory system in carrying out those intentions. Quoting directly from the statute:

"It is the intent of the legislature to protect the public health and promote the public interest by establishing a hospital financing system which appropriately limits the rate of increase in the cost of hospital care from year to year."

The Maine Health Care Finance Commission, by law, must decide at what rate the hospital system will be allowed to grow. This most basic of health care policy decisions for the people of Maine was delegated by the 111th

Legislature to five well-meaning commissioners charged with both reducing the rate of increase in health care costs and maintaining high quality health care accessible to our citizens. How well have they done? Let's look.

In the last three years before the initiation of the current system, Maine hospitals spent 4.8 percent less per capita than the national average. In the past three years, we spent 6.2 percent less than the national average. Are the citizens of the State of Maine less deserving of hospital care than the citizens of any other state? Are they less in need?

On the contrary, they are more in need. By comparing the over 65 year olds in our population with that of the entire U.S., we find that Maine surpasses the U.S. by slightly greater than 10%. These are the age cohorts which produce the highest demand for healthcare.

On the positive side, it is my understanding that an adjustment factor is being contemplated by the Blue Ribbon Commission to account for the increased need for technology and changes in demographics. We will applaud implementation of such an adjustment factor.

Again quoting the statute, it is the intent to "Protect the quality and the accessibility of the hospital care available to the people of the state by assuring the financial viability of an efficient and effective state hospital system."

Are quality and accessibility protected by a system that forces Maine citizens to go out of state to be treated with new medical technology? Are quality and accessibility protected by a system that does not allow hospitals to pay the wages needed to hire and retain competent staff?

Is financial viability assured by a system that allowed 20 hospitals to lose money from operations in 1987? Is financial viability assured by a system that forces a hospital to prove financial hardship before awarding cost adjustments? In short, our current regulatory system is too cumbersome, complex, and time consuming to allow Maine hospitals to respond to regional and national forces affecting health care delivery.

Yet another intention of the statute is, and I quote, to "Afford those who pay hospitals a greater role in determining their reasonable financial requirements without unduly compromising the ability of those who govern and manage hospitals to decide how the resources made available to them are used."

Are hospitals' abilities not compromised by a system which is not based on generally accepted accounting principles? (I would note here that I know of one institution which recently had its bond rating lowered by a rating agency, an agency which bases its evaluation on generally accepted accounting principles.) Are our abilities not compromised by a system that recognizes no need for even the smallest operating margin to deal with the numerous issues that arise on an almost daily basis?

It is further the intent of the statute to "provide predictability in payment amounts for payors, providers, and patients."

Is predictability provided by a system of formulas so complex that hospitals (particularly small ones) require lawyers and consultants to interpret their impact? Is predictability provided by a system that requires the courts to handle hospital appeals to the results of those formulae?

I believe that any reasonable person can see that the current system has failed to carry out the intent of the legislation; it has not met the basic financial needs of hospitals and has done particular harm to our smaller institutions. To me, the system has failed in its real test by allowing responsibly managed small hospitals to operate in a deficit situation in spite of specific directions in the statute that the Commission shall take into account the special needs and circumstances of small hospitals.

We will be particularly interested in following the work of the Blue Ribbon Commission and in providing it continuing support as it takes these concepts and molds them into a more rational and responsive system. We are way beyond fixits and bandaids and must have a complete change and hope that it is not too late.

An additional thought, any future regulatory system for Maine's hospitals must enable them to give appropriate care of high quality to all Maine citizens, no matter where they live or work. But above all, it should follow the guiding principal laid down by Hippocrates in his Epidemics, "Sed primum non nocere" -- "But first, do no harm". I think we should all realize after five years of our present type of regulation that this ancient truth must be reaffirmed in the near future.

In conclusion, time is of the essence. Our small hospitals are in deep trouble with no specific relief yet in sight. The Blue Ribbon Commission and the legislature must keep their special needs in mind if they are to survive to render their essential services to our citizens. We also must remember that noble goals and intentions, once legislated, are meaningless unless they are implemented by the regulatory agency in the spirit of the legislative intent.

Thank you for your consideration of our point of view.

York Hospital 15 HOSPITAL DRIVE • YORK, MAINE 03909-1099 • TEL 363-4321

My name is Jill Fargo. I am the Vice President of Nursing at York Hospital. I am a nurse; and I am a consumer of health care.

The number one reason health care finance commissions came into existence was to control the cost of health care. Hospitals have been forced to look closely at their use of health care dollars and to decide whose priorities they would meet. This was a worthwhile first step for the Commission. Unfortunately, as time has gone on the Commission has lost sight of their own priorities and purpose. It appears the commission is out to close down hospitals and to limit health care service to only a select few.

The people in our service area need and deserve a quality health care system. This means services within their own community at costs that do not increase beyond control. York Hospital has heard this message loud and clear from our community and our Board of Trustees. York Hospital understands this responsibility and is willing to be held accountable for maintaining a balance between quality, service, and cost.

We can not meet this responsibility under the present finance commission. Its layers of hierarchy and hundreds of rules encourage closed minds and cautious action. We must be freed from this type of regulation so we can continue listening to and prioritizing our community's needs.

We need you to understand our individual differences. For many years, York Hospital has been treated like the unwanted child. The reality is that we are the Gifted and Talented hospital of this State. Our track record proves that we are responsible and accountable to our community. We are creative and innovative as our Catheterization Lab.Service and Birthing Service prove. We continue to withstand the challenges of being a seacoast border hospital.

Before you recommend that formulas should decide our health care services in Maine, I invite you to come to York Hospital and -

LOOK into the eyes of the parents of the teenager who was injured in a car accident.

LOOK into the eyes of the wife whose husband just had a heart attack.

LOOK into the eyes of the mother running into the Emergency Room carrying her child who can't breath.

LOOK into the eyes of the elderly gentleman who is recovering from a stroke - working hard to learn to walk, talk, and eat all over again.

The health care these people seek are not high tech, specialized services - this is basic health care. But, these are the services the MHCFC formulas eliminate.

Please examine the finance commissions purpose. I do not believe playing GOD is one of them. Let our local communities define their health care needs.

Public Comment Of Russell A. Peterson,
V. P., Financial Services at York Hospital

To the Blue Ribbon Commission

September 6, 1988

I appreciate the opportunity to speak with the Commission today. I am pleased with your willingness to hear the perspective of a hospital which has faired very poorly under the present regulatory system.

I expect we have all read recent articles in the Portland press describing that now even the Maine Medical Center is projecting it will not be able to run its facility within the resources defined by MHCFC formulas. Since we have heard on several occasions that some at the MHCFC believe we exaggerate our financial distress for political purposes, let me tell you that actual audited operating losses at York Hospital are relatively much larger than MMC is projecting, and have been for three years. It is only because of our supportive community that we have been able to meet the operating deficit with income from donations and endowment income.

In Payment Year Three, according to audited financials, even the application of all nonoperating income from gifts and endowment income were not adequate to cover our operating deficit. Today we are actually consuming the principal of our investment heritage to pay current expenses. That's like running your household by robbing the piggy bank.

So I guess it's no mystery how our hospital feels about your efforts. We support your efforts because they bring the hope of change.

Before I make any specific comments to the Draft Report, I offer these general comments in support of your process to ease the burden of regulation in Maine:

> Local Boards of Trustees are motivated by the same public concern as State Trustees. The local Trustees just have a better understanding of local problems than folks in Augusta. Our local Board is the best source of decision making for our hospital.
>
> Whatever recommendations are made by the Blue Ribbon Commission should be based on objectives which are clearly stated. It is not clear to me in the Draft Report what objectives the Commission has in mind.
>
> Any recommendations made by the Commission should match the authority to set limits with the responsibility to meet the needs of the community.

York Hospital is in a very competitive part of the state. I hope that the Commission will recognize that competition can play an effective role in Maine by allowing the market place to define the appropriate measure of access, quality and affordability in many Maine communities.

York Hospital is caught at the border of two states where regulatory philosophies are as different as anywhere in the nation. We recommend that the Blue Ribbon Commission's Final Report include a fifth option to define a Border Policy on Regulation.

Having made these general comments, I wish to continue with specific reference to the Blue Ribbon Commission's Draft Report.

Comments On The Regulation Of Hospital Rates Or Revenues

Option 1, a Per-Case-Payment System

This system seems a lot like the one we have now. While such a system could work if the system recognized the differences in the cost of doing business around the state, any formula driven system using data from outside our business environment is artificial and imposes limitations which have to result in a reduction of quality or access over time. I do not consider Option 1 to be a reasonable option for York Hospital.

I suggest that the State consider its role as a prudent buyer of hospital services by using the cost-per-case methodology referred to in Option 1 to negotiate purchase of services on behalf of those receiving state assistance.

Option 2, a Total Revenue System

We have a Total Revenue System now. We had a Total Revenue System before the MHCFC. Whether or not either system works is a matter of personal opinion. In my opinion, the current system could work if it were more sensitive to local patient needs and less focused on control by formulas. I believe a Total Revenue System could work if it were based on local rather than statewide measures.

I would also like to restate to the Commission my surprise that this option might be limited to areas where no direct competition exists. In my opinion there is no greater control than competition to control costs and to control the type of service in a service area. Competition makes management accountable to its community because wherever there is choice the consumer will chose that service it perceives to be of best value.

I suggest that if this alternative is recommended in the Commission's Final Report to the Legislature, any review process of total revenues be a review of the reasonableness of hospital budgets as proposed by hospital boards of trustees, not as proposed by an insensitive formula. Local Boards of Trustees are sensitive to the issues of access, quality, and affordability and are in the best position to determine a hospital's financial plan.

Option 3, Demonstration Project

Here we have an idea which I heartily endorse. Yet as recommended by the Draft Report, this may not be an option at all unless it is approved by the Rate Setting Body. If Rate Setting Body approval was determined by formula, it would carry all of the artificial restrictions I mentioned above and may not be an option at all.

I suggest that the Draft Report add a recommendation that goes beyond the demonstration concept and actually add another option, i.e. Option 5, A Border Policy on Regulation. York Hospital has consistently described how it is caught in an environment where Maine regulations tie our hands behind our backs as we compete with New Hampshire hospitals. While it can be said that all hospitals are different, here are just a

few factors that demonstrate the need for a buffer zone between the Maine and New Hampshire hospital regulatory systems:

No other hospital in Maine competes in its primary market with another hospital which is not regulated by the MHCFC. York Hospital's primary competition comes from Portsmouth Regional Hospital, a for-profit hospital approximately seven miles from York Hospital.

No other hospital in Maine competes in its secondary market with three New Hampshire hospitals closer than any Maine hospital. In addition to Portsmouth Regional Hospital, Exeter Hospital, Wentworth Douglas Hospital, and Frisbie Hospital are closer than York's secondary competition at the H. D. Goodall Hospital or Southern Maine Medical Center.

No other hospital in Maine is closer to the Boston labor market.

No other hospital in Maine is in an area of lower unemployment. In addition to the shortage of healthcare workers, and our proximity to Boston, we compete for employees with New Hampshire hospitals in an area with an unemployment rate which has consistently remained the lowest in Maine.

While there are certainly other areas of high housing costs in Maine which make recruiting difficult, no town in Maine exceeds York's property evaluation of approximately one billion dollars.

No other hospital in Maine has a Board of Trustees with as much experience as the York Board. York Hospital has on its full Board members which average ten years of service to their hospital. That's 19 members with 193 years of service.

York Hospital has consistently been a low cost, high quality provider. This assertion is supported by data from the commission, other reviewing authorities, and by our patient surveys.

York Hospital doesn't fit the mold of Commission formulas. We are not an average hospital. We have stretched our resources to the breaking point and can not operate within the resources dictated by MHCFC formulas. The formulas are deficient in following areas:

Capital
Bad Debts
Supplies
Salaries
Benefits

I suggest that an Option 5 accomplish a buffer between Maine and New Hampshire hospitals by providing in the Law that the Rate Setting Body for York Hospital be the York Hospital Board of Trustees. They have done an outstanding job for more than eighty years and can continue to assure access, quality and affordablity to the patients of this border community.

Option 4, Specialty Hospitals

I support this option because it tends to recognize that hospitals are different.

I suggest that each Maine hospital is different and that the Commission should go even further and recommend that each community be allowed to control its own hospital through its local Board of Trustees as long as that Board provides quality and access that the community can afford.

As above, an Option 5, A Border Policy on Regulation could just as well be seen as one of the specialty situations described in Option 4.

Comments On Outpatient Rates And Revenues

I agree that the current system is inadequate because it does not measure units of service properly in its application of formulas. However the unit of service measure is not the only deficiency in the formulas. Here again I assert that no statewide formula will solve the problem of bringing the right resources to bear on patient services. Changing the formula methodology without recognizing the local environment is likely to hurt our community hospital because our border environment is not likely to fit the mold of any statewide formula.

I am also concerned about any attempt to not allow cross-subsidization of outpatient services in our Emergency Room. While I recognize other hospitals may be different, we use low rates in our ER and other ancillary services to maximize the charge base over which we spread our overhead. If we could not subsidize these services, we would very likely cut back our Emergency Room Service. I recommend a competetive model where the consumer has choice and can make his choice known by using or not using the outpatient resources in a hospital setting.

Comments In Response To The Discussion Of A Standard Component Or Screens

I support the Blue Ribbon's idea of rewarding efficiency. I thought that such a reward system was to be provided in LD 290. Perhaps the delay of rules under current law speaks well of difficulty making such a system of rewards work by formula. I repeat my disagreement with the idea that any statewide formula will work, unless it takes into account the local environment. If this were a reasonable thing to do, I expect it would already be part of the current system.

I suggest to you the best way to reward appropriate efficiency is by the increase in business that always follows accurate assessment of the marketplace. The reward to the hospital can be determined by the consumer, just like rewards for quality and access.

Comments On Discussion Of Discounts

I agree with the Maine Hospital's Association assessment of August 17 which recommends no discounts by a payer or provider.

The largest cause for increases in health insurance will occur because the private sector must pay for the dicounts mandated by government programs, i.e. Medicare and Medicaid. In my opinion, further discounting in the Maine healthcare system would only make a bad situation worse.

I recommend that hospitals in Maine be allowed to compete in the open market on the basis of their ability to produce access to the right service at the right price, not by discounting.

Comment Related To The Commission's Recommendations On An Appeal Mechanism

It is easy for our hospital to agree to the provision of an appeal process, but the Draft Report is quite vague on how such a process may work. We have been appealing the current system for years now. Here we are in Payment Year 4, and we are still working on final details of an agreement for Payment Year One.

This recommendation is well intended. However, the administration of any such process depends so much on those in control of the process and on the political influence of the hospital that I suggest Option 5 mentioned above for our situation. I know today that our hospital will not fit statewide formulas, and so I prefer to have our relief defined in the Law.

Comments Related To The Commission's Recommendations Dealing With Goverment Shortfalls

I agree if Maine decides to make up for the federal shortfall that revenues from the general fund are the most fair. It's interesting to note that the amount collected in excess of current state needs which is now being returned to Maine taxpayers is just about equal to the Medicare shortfall last year.

But I don't think Maine, or any other state, should have to pay for promises made in Washington. Congress should own up to its responsibilities to Medicare patients and providers and pay its share of the national health care bill. As mentioned above the increase of the federal shortfall will be the largest factor in rising health insurance costs. I expect this to also be the single most important access issue as individuals find insurance less affordable. This cost shifting from federal to state or private payers is the largest hidden tax this nation has ever seen, amounting to over one hundred million dollars in the very near future.

I suggest to the Blue Ribbon Commission that the very convening of the Commission provides an opportunity which should not be missed. The very nature of Blue Ribbon Commission can provide a very credible message to Washington! Tell the Congress of the United States that Maine wants them to meet federal obligations.

Comments Related To The Commission's Recommendations On Cross-subsidization

As I mentioned above in the discussion of outpatient regulations, I agree that so called underpricing may be necessary to assure certain basic services. This practice is one of the effective tools a hospital can use to assure access to the Emergency Room.

I repeat my suggestion that any system allow hospitals to price its services to respond to consumer preference.

Comments Related To The Commission's Recommendation On Demonstration Projects

Sounds like the same concept as allowed under current law. We are cautiously hopeful that such a process will work for our hospital under MHCFC.

I suggest that it is very important for the Blue Ribbon Commission to describe what the overall goals of regulation are. I would suggest that they should be; to assure quality and access at an affordable cost. In my opinion, if any project can demonstrate how a hospital might achieve these goals, the demonstration should be encouraged.

Comments Related To The Commission's Discussion Of Pools For Bad Debts, Charity Care And Goverment Shortfalls

Since I have already commented on the issue of government shortfalls, my comments here are related to how we can pay for bad debts and charity care.

Most hospitals can continue to pay for bad debts and charity care by charging those payers who can afford to pay or afford adequate insurance. This is the same payment mechanism that has served the citizens of Maine for decades.

If a hospital is in an area where the state determines the payers cannot afford this burden, I would recommend that the broadest revenue source be used, i.e. the General Fund. In my judgement, it would be unfair to charge a community even more to cover costs of free care at another hospital.

The idea of a Rate Setting Body redistributing through a pool generated from additional charges to patients sends chills up my back. Our patients are already paying for our own bad debts, charity care, and government shortfall. If Maine citizens have to pay even more to meet this additional social goal, it should come from a broad-based tax on income, not an indirect tax on the sick or a tax on hospitals which are already losing money.

Other Comments

While I wish to defer comments on other areas of the Draft Report until the recommendations are more detailed, I do wish to offer these overall comments and suggestions:

> In my opinion, the recommendations of the Commission should not overlook the demonstrated ability of local Boards of Trustees to control the hospital delivery system. I suggest that Maine citizens would be best served by local control of Maine Hospitals.
>
> Any recommendations of the Blue Ribbon Commission which rely on statewide formulae should include specific reference to site specific markets. Applications of any formula which does not recognize indivdual environments will always result in winners or losers with little correlation to how well the hospital meets the needs of the community. I suggest that the competitive market place is the best way to respond to the demands of the community.
>
> Finally, I suggest that the Blue Ribbon Commission include provision for Option 5, a Border Policy on Regulation to create a buffer zone between the regulatory environments of Maine and New Hampshire.

Testimony

of Richard Morrell

before the Blue Ribbon Study Commission

Portland, Maine

September 6, 1988

Chairman Gauvreau, members of the Commission, good afternoon and thank you for the opportunity to speak today.

My name is Dick Morrell. I am a native and resident of Brunswick, and I am speaking today both as a hospital Trustee and as a businessman in Brunswick.

I have been a Trustee of the Regional Memorial Hospital Board in Brunswick for more than 12 years, and currently serve as Chairman of the Board of the merged Regional Memorial and Bath Memorial Hospitals, known as Mid Coast Health Services.

Having participated in the legislative and hearing process in years past, I can and do appreciate what you've undertaken to do on behalf of us all and thank you for taking on such a difficult task.

I am here today to try to give you a perspective from my vantage point and experience, and to emphasize the importance we all place on the work of your Commission. Your job is critically important to us all because, in my view, our hospital---and Maine hospitals generally---are approaching a crisis unless a

significant change is made in the current method of regulating hospitals and the atmosphere of bitterness that surrounds this process.

At the outset, I must emphasize that, like others who have looked at the situation in Maine, I find it tremendously difficult to justify or support regulating hospitals at all. These are non profit institutions overseen by experienced and volunteer Boards of Trustees. As you have already heard, hospitals in Maine have been performing responsibly and, by any objective measure, there is little to suggest that hospitals' costs are now or ever were out of control or to justify the heavy handed regulation these public institutions are suffering under today. There is, certainly, reason to regulate and monitor hospitals to ensure quality of performance and access to health care. I might add that all hospitals must have a system of checks and balances through utilization review techniques and quality assurance programs that are required of us by third party payors and accreditation and licensing bodies. But I strongly question the wisdom or necessity of maintaining a regulatory system whose primary, if not sole purpose is restraining costs at all costs---regardless of the consequences related to quality of care.

For any of you who have not participated in the serious process of serving as a hospital Trustee---or of attending a meeting of such a group---I'd urge you sometime to take this opportunity.

From my view I've never served with any more dedicated and cost conscious groups of folks in my life.

Personally, I feel that unless major and significant changes are made quite quickly, significant damage will be done to many of our hospitals. Damage which may not be repairable in time to save some lives or ease the pain of significant numbers of our citizens. I do not believe that this is overstating the situation at all.

I am confused over the purpose of regulation of hospitals in Maine. My understanding and belief is that the causes of increasing costs and, therefore, insurance premiums---which we as employers have deep concerns about as well---are, for the most part, outside of the control of hospitals. I believe there is much confusion and inconsistency in state policy with respect to health care policy. For example, as an employer, our company is not able to offer flexible benefit packages to our employees because the state appears to have chosen to go so thoroughly down the road of mandated benefits. This action, perhaps more than anything else, will keep the health insurance premiums we pay shooting upward.

There has been much public attention paid to the increase in insurance premiums of late. But, as you have heard from Blue Cross, much of these increases are unrelated to hospital costs and behavior, rather they are more related to legislative mandated coverage---an aging population---the effective use of

more sophisticated diagnostic and treatment technology---and the fact that cost for Medicare and Medicaid are not adequately met.

As a Trustee, it is apparent to me and I am here to tell you, as public policy makers, that if we continue down the road of suppressing hospitals from appropriate growth, we will cause significant damage to hospitals and their ability to offer up-to-date, needed health care services to their community.

Let me give you some recent examples from my hospitals of just how noticeable the danger signs are becoming.

We recently had an inspection from the Joint Commission for Accreditation of Health Care Organizations. At the conclusion of the inspection, the team made a presentation to the hospital Board. The team leader told us the team was deeply concerned over our hospital's ability---and he noted most hospitals in the state's abilities---to continue to provide care consistent with community expectations and appropriate standards under the current regulatory environment. This was a gratuitous statement, one based on the experience gained inspecting our hospitals and others in Maine compared to what they have observed elsewhere in the country.

Under the Maine Health Care Finance Commission, Regional Memorial Hospital has been forced to operate our facility without recognition of our true costs. This is true particularly in the area as how capital cost is treated. It is incomprehensible to

me why a hospital such as ours which is growing and serving a significant health care need for a growing part of the state must function without recognition of its true costs.

If we had to deal with this in our own business, we'd be out of business. In short order, that's for sure!

I am here to tell you that many of us are not going to be able to continue down that road. I also want you to consider whether you want a hospital system in Maine which is significantly different from that which exists in other states. For example, the system does not provide for comparable growth in technology with regard to replacement and acquisition of equipment, and there we are lagging behind bordering states. There are many unintended consequences of the current system which is fundamentally based on no growth, and I question the wisdom of that philosophy.

The Bath and Regional Hospitals go into their fifth payment year under this system on October 1. The Commission's allowed wage increase for nurses is 6 1/2 percent. We cannot possibly recruit and retain nurses without increases substantially greater than this despite opinions to the contrary on the part of a Commission analyst who was recently quoted in the press.

What does this mean? The Commission answers the problem by first requiring proof of financial hardship. For our Bath hospital, this is a $200,000 operating loss and for Regional Hospital it is a $330,000 operating loss. These budgeted losses then permit the

hospitals to come begging for additional revenues and begin an excruciating bureaucratic process. Based upon the experience so far, we expect the process to take at least 6 months. What do we tell our nurses in the meantime? What we do, in order to keep the hospitals open, is to budget for the loss, pay the necessary increases, and hope for the best. In any sane kind of business, I would be fired as chairman, and rightfully so, for allowing such a business plan. But I am convinced that the alternative would drastically impair the hospital's ability to staff for services and we cannot allow that to happen.

Finally, I must go on record as a Trustee and say to you that, if regulate we must, then any regulatory system imposed on hospitals must be flexible enough to accommodate the diversity of hospitals in Maine. I compliment the Commission for recommending a multi-tiered approach, and hope that those options become real and available so that various hospitals around the state can adopt the option they deem most appropriate for them.

In that regard, we must insure to the greatest extent possible that a new environment be created between the regulators and the regulated which is based on mutual trust, true accountability for the regulators and an atmosphere of good faith dealing.

The current system is far too adversarial, it is expensive and it is too time consuming. Many of our people are devoting significant amounts of time simply coping with excessive, complicated regulations instead of focusing on the hospital's

true mission in the community it serves.

As a hospital Trustee, I respectfully ask the Commission to give serious consideration to these points and hope that you understand that time is of the essence. Significant change is needed. We need a new environment created, based on mutual trust, responsibility, and courtesy as we work together as providers, payers, and consumers of health care.

September 6, 1988

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NATIONAL ORGANIZATION FOR WOMEN

MAINE

NATIONAL ORGANIZATION FOR WOMEN

Portland, Maine. September 6, 1988

I am Pamela Prodan, a resident of Wilton, Maine. I am the secretary of Maine National Organization for Women (NOW) and I am here to testify today on behalf of that board. On a personal note, I'd like to say that I have been concerned about this issue for years since I do not have any health insurance. I would like to have insurance, but I am self-employed as an artist and do not have enough income to pay the premiums. I wish I could communicate to you the the feelings I have when I tell people this and their response is often "Oh, you have to have insurance," as if somehow, my priorities are skewed, and I have made this choice to put myself at risk. Well, I don't feel it is a choice I have made myself; it is a part of my life which is not under my own control. But unfortunately, people who have these benefits and take them for granted often seem not to understand that lack of control.

Also on a somewhat personal note I want to say that I have been very impressed and pleased at the amount of interest and the depth of concern that I've heard from other Maine NOW members about the issue of affordable health care. This is an issue which has recently sparked a lot of interest in the organization. I think it must be because women are often concentrated in the care-giving occupations in our society that we do tend to be aware of when there's a problem in these areas. Also, as I'll discuss a little later, women in particular are vulnerable as consumers to problems with access to affordable health care.

Because of our great interest in this issue, Maine NOW appreciates having this opportunity to make the following comments regarding the draft report to the Blue Ribbon Commission to Study the Regulation of Health Care Expenditures. We support the Commission's efforts to find some solutions to these very pressing problems of health care costs and access to health care.

In general, we believe that some sort of system of oversight and regulation of all hospitals is a sensible approach to take. Efforts to contain costs do benefit consumers. However, we feel that if hospitals are willing to take innovative approaches to providing health care that meet the criteria of providing greater access to health care while keeping consumer costs low, we favor incentives to encourage hospitals to do that. However, in all fairness, we see no reason why some hospitals should be entirely out from under the purview of regulation.

One major concern with rising insurance costs is the tendency to drop coverage of certain types of care or worse, insurance coverage altogether. Women in particular are vulnerable to these practices since they are more often than men in low-paying benefit-lacking jobs. On the one hand, it is often the case that when certain types of health benefits are dropped, it is reproductive care and other types of care which primarily benefit women, that are dropped first. On the other hand, women and children benefit greatly from preventative care (e.g. family planning services, prenatal care and well baby innoculations) which is almost never covered in standard insurance contracts in the first place.

The idea of seeking funds to cover the cost of projected increases for the next year will help keep costs down, but will do nothing about the other big half of the problem which is access. We suggest seeking funding to begin to assure access to primary and preventative care. Such an approach is not unreasonable when we consider the overall value of prevention. In short, we recommend that general fund dollars go not necessarily to provide hospital based services, but instead go to those providers who will give preventative care to the most clients.

Access to health care is a very important issue and of growing concern to us. Ultimately, we seek a system where all of Maine's citizens will have access to health care, including primary and preventative care, based on need for care rather than ability to pay. This is not a revolutionary idea. To the contrary, our country is the only Western industrialized nation that does not provide universal access to health care for its citizens. We seek only to catch up with the rest of the world, nothing extraordinary.

We are spending more than any other industrialized nation on health care, yet there is clearly an imbalance. We now know that there are many people who desire health insurance but who are unable to pay full premiums for that insurance. And there are many who forego preventative and timely health care only to face more serious problems as a result of such neglect. We must have a system that allows individuals and families some assurance that when they need health care it will be available regardless of the ability to pay.

Increasing the amount of charity care is not a good solution to this problem. Maine people are proud and hard-working people and as a rule are opposed to the idea of accepting charity. Most would rather do without than to accept charity. A better alternative would be to institute a system whereby everyone pays according their ability. Such a sliding scale is already used by some providers, so the idea is not new. Other approaches need to be explored.

In conclusion, I would like to reiterate that many NOW members are extremely concerned about the issue of access to health care and its rising costs. We are personally affected by all this. We encourage the Commission to work for solutions to these problems. I can assure you that we will be looking forward to the development of positive steps toward the goal of comprehensive and affordable health care for all. Thank you for your courtesy in listening to all of the consumer voices here today.

MPA

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WHO ARE THE UNINSURED?

A Report on Demographics of Persons Lacking Health Insurance in Maine

August 1988

The research for this report was paid for
by a grant from the Maine People's Resource Center

EXECUTIVE SUMMARY

While many employers, insurance company executives and hospital administrators have recently begun to focus on and complain about a "potential" health care crisis in Maine, this crisis has existed and has been a horrifying reality for thousands of Maine workers and children for many years now.

There are 119,300 Maine adults and children who have no health insurance. This number includes only those Mainers who have not had health insurance for one year or more ("chronically uninsured"). The great majority of the uninsured are working (over 61%). More than seventy-one percent (71%) of working uninsured Mainers are employed on a full-time basis.

Children and young adults are the most severely affected by the lack of health insurance in Maine. Persons between the ages of 0 - 29 account for 63.5% of all uninsured persons in Maine. One out of every five Maine citizens between the ages of 18 - 29 lacks health insurance.

Approximately one out of every eight children between the ages of 0 - 5 in Maine has no health insurance. There are 23,800 children between the ages of 6 - 17 in Maine, accounting for 12% of all Maine children in this age group, who have no health insurance.

Children of the poor and working poor are more likely to lack health insurance. There are 11,900 children whose family income falls below the federal poverty level who have no health insurance. They account for 24.3% of all children in this category. There are 10,400 children whose family income is between 100% - 150% of poverty yet lack health insurance.

Children of non-poor families are not immune to the lack of health insurance. There are 4300 children whose family income exceeds the poverty level by 300% or more, yet still have no health insurance.

Children living in single parent households are more likely to have no health insurance than those living in married couple households. Nearly 30% of all Maine children in single parent households lack health insurance.

The highest numbers of uninsured Maine workers are employed in social services jobs, eating/drinking establishments, retail businesses, construction and durable goods manufacturing. These industries account for almost 30,000, or over 57%, of all uninsured Mainers.

The industries with the highest percentages of uninsured workers are petroleum/chemical manufacturing (32.6%), food manufacturing (26.4%), forestry/fishing (25.1%), agriculture (18%), and eating/drinking establishments (17.9%).

PREPARATION OF THIS REPORT

This report has been prepared by the Maine People's Alliance from data compiled by Citizen Action, a Washington, D.C. public interest organization, from the United States Census Survey performed in 1985.

The figures herein represent an estimate based on the responses of 1742 persons in their homes. The original data was compiled by the U.S. Census Bureau in March 1986.

The figures found in this report represent only those persons in Maine who have had no health insurance for one year or more. This report does not include those persons who had insurance for any period less than one year. Therefore, the "temporarily uninsured" are not considered herein. This report covers all uninsured persons in Maine between the ages of 0 - 64.

MORE THAN 119,300 MAINERS LACK HEALTH INSURANCE

More than 119,300 Maine adults and children, or 12.3% of Maine's non-elderly population, have no health insurance according to United States Census figures for 1985. This figure includes only those Maine citizens who have had no health care coverage for one year or more. These Maine citizens are categorized as "chronically uninsured" and their uninsured status is not likely to change substantially. The number of uninsured persons in Maine would be substantially higher if those persons who are insured for less than one year ("temporarily uninsured") were included herein. The "temporarily uninsured" category includes those persons who have been insured for several weeks or more or are between jobs.

The 119,300 uninsured person figure of the U.S. Census Bureau exceeds projections in the Human Services Development Institute report (HSDI) by more than 26,000 persons. The HSDI study, however, specifically excluded children. The 119,300 or 12.3% figure drastically exceeds the recent Blue Cross and Blue Shield of Maine telephone survey estimate by almost double. The Blue Cross and Blue Shield survey, however, has been identified as having many methodology drawbacks which account for its 6.2% estimate. Some of those drawbacks include failure to factor in a variable for those persons without telephones, exclusion of children between 0 - 17 years of age, inclusion of some elderly, identification of Blue Cross/Shield as the surveying company, and choice of towns.

The figures in this report are based on data compiled by Citizen Action, a Washington, D.C. public interest organization, from the March 1986 Population Report of the United States Census Bureau.

OVERWHELMING MAJORITY OF UNINSURED ARE WORKING ADULTS

There are an estimated 50,840 Maine adults who are working but have no health care coverage. Over sixty-one percent (61%) of all uninsured adults are working. This is a serious problem for workers in Maine. One out of every ten workers receives no health insurance through her/his place of employment.

MORE THAN SEVENTY-ONE PERCENT (71%) OF THE WORKING UNINSURED IN MAINE ARE EMPLOYED IN FULL-TIME JOBS

There are 36,270 Maine workers employed on a full-time, full-year or full-time, part-year basis who receive no health insurance from their employers. This number accounts for over seventy-one percent (71%) of uninsured Maine workers.

There are another 14,568 workers, or twenty-nine percent (29%) of all uninsured workers, who are employed on a part-time basis and have no health care coverage. This is due in major part to the fact that many employers offer health insurance to their workers only after a substantial waiting period or only to full-time employees.

THE HIGHEST NUMBERS OF UNINSURED MAINE WORKERS ARE EMPLOYED IN SOCIAL SERVICES JOBS, EATING/DRINKING ESTABLISHMENTS, RETAIL BUSINESSES, CONSTRUCTION, AND DURABLE GOODS MANUFACTURING.

There are almost 30,000 Maine workers without health insurance coverage in the social services/public aid, eating/drinking, retail, construction and durable goods manufacturing industries. These industries account for over 57% of all uninsured workers in Maine. There are over 9700 uninsured workers in the social services/public aid industry alone. The actual numbers of uninsured in these industries are as follows:

	Industry	# Uninsured
1.	Social Services/Public Aid	9,715
2.	Eating/Drinking	5,621
3.	Retail Businesses	5,397
4.	Construction	4,654
5.	Manufacturing Durable Goods	3,678

THE INDUSTRIES WITH THE HIGHEST PERCENTAGES OF UNINSURED WORKERS ARE PETROLEUM/CHEMICAL MANUFACTURING, FOOD MANUFACTURING, FORESTRY/FISHING, AGRICULTURE AND EATING/DRINKING.

Almost 33% of all workers in the petroleum/chemical manufacturing industry are uninsured. Over 26% of all workers in the food manufacturing industry have no health insurance coverage. Even though some of the industries listed below have fewer than 9000 workers, the percentage of uninsured within those industries are amongst the highest in Maine. The top five industries with the highest percentages of uninsured workers are:

	Industry	% Uninsured
1.	Manufacturing Petroleum/Chemicals	32.6%
2.	Manufacturing Food	26.4%
3.	Forestry/Fishing	25.1%
4.	Agriculture	18.0%
5.	Eating/Drinking	17.9%

POOR AND WORKING POOR ADULT MAINERS ARE MORE LIKELY TO LACK HEALTH CARE COVERAGE

Even though sixty-one percent (61%) of all uninsured adult Mainers are working, they are earning incomes which place them at or slightly above the federal poverty level.

Of the 72,549 Maine adults living on incomes below the poverty level, 25,900, or 35.7%, lack health insurance. Approximately twenty-nine percent (29%), or 18,900, of those adults earning incomes up to 150% of the poverty level have no health insurance coverage in Maine.

Ten percent (10%), or 23,300, of all Maine adults earning between 150% and 300% of the federal poverty level lack health insurance.

NON-POOR ADULT MAINERS ARE NOT IMMUNE TO THE PROBLEM OF HAVING NO HEALTH INSURANCE

There are 15,600 Maine adults earning incomes which exceed the federal poverty level by 300% percent or more, yet they have no health care coverage. In 1985, this included those Mainers with incomes of about $33,000 and above for a family of four, and about $17,000 and above for an individual.

MORE THAN SIXTY-THREE PERCENT OF ALL UNINSURED PERSONS IN MAINE ARE BETWEEN THE AGES OF 0 - 29

Almost one-sixth of all Mainers between the ages of 0 - 29 have no health insurance. There are about 75,700 people in Maine between the ages of 0 - 29 who lack health insurance. These children and young adults account for sixty-three and one-half (63.5%) of all uninsured persons in Maine.

About one of every five persons between the ages of 18 - 29 is uninsured. Out of the 203,000 persons in Maine who are between 18 - 29 years of age, 40,100, or 19.7%, lack health insurance.

Approximately one out of every eight children between the ages of 0 - 5 in Maine have no health care coverage. Out of the estimated 88,721 children in this age group in Maine, 11,800, or 13.3%, have no health care coverage.

Twelve percent (12%), or 23,800, of the 198,333 children between the ages of 6 - 17 in Maine lack health insurance.

NEARLY THIRTY PERCENT OF ALL MAINE CHILDREN IN MAINE LIVING IN SINGLE PARENT HOUSEHOLDS LACK HEALTH INSURANCE

Out of 61,754 children living in single parent households in Maine, 17,600, or 28.5%, lack health insurance. These children are almost four times more likely to be uninsured than those living in married couple households.

Even though children in married couple households are more likely to have health insurance coverage than those in single parent housholds, 18,000, or 8%, of children in this category lack health insurance.

CHILDREN OF THE POOR AND WORKING POOR ARE MORE LIKELY TO LACK HEALTH CARE COVERAGE

There are an estimated 48,971 children in Maine living in families whose incomes fall below the federal poverty level. One out of every four of these children has no health care coverage. Of all children in this category, 11,900, or 24.3%, lack health insurance coverage.

There are an estimated 38,661 children in Maine living in families whose incomes are betwen 100 % - 150% of the federal poverty level. Of all children in Maine falling into this group, 10,400, or 26.9%, have no health insurance coverage.

CHILDREN OF NON-POOR FAMILIES ARE NOT IMMUNE TO LACK OF HEALTH INSURANCE

Children living in families whose incomes exceed the poverty level by 300% or more are not immune to the problem of no health insurance. There are 4300 children in Maine whose family income is 300% or more of poverty, yet have no health insurance. In 1985, this included those families of four with incomes of $33,000 or more.

MAINERS WHO ARE SELF-EMPLOYED ARE MORE LIKELY TO LACK HEALTH INSURANCE

Approximately one out of every three self-employed Maine citizens has no health insurance. There are an estimated 17,315 self-employed Mainers who lack health insurance. This figure accounts for 29.7% of all self-employed persons in Maine.

Even though private sector workers are more likely to be insured than the self-employed, still one out of every nine private sector workers has no health care coverage. There are an estimated 48,125 Maine workers employed in the private sector who lack health insurance.

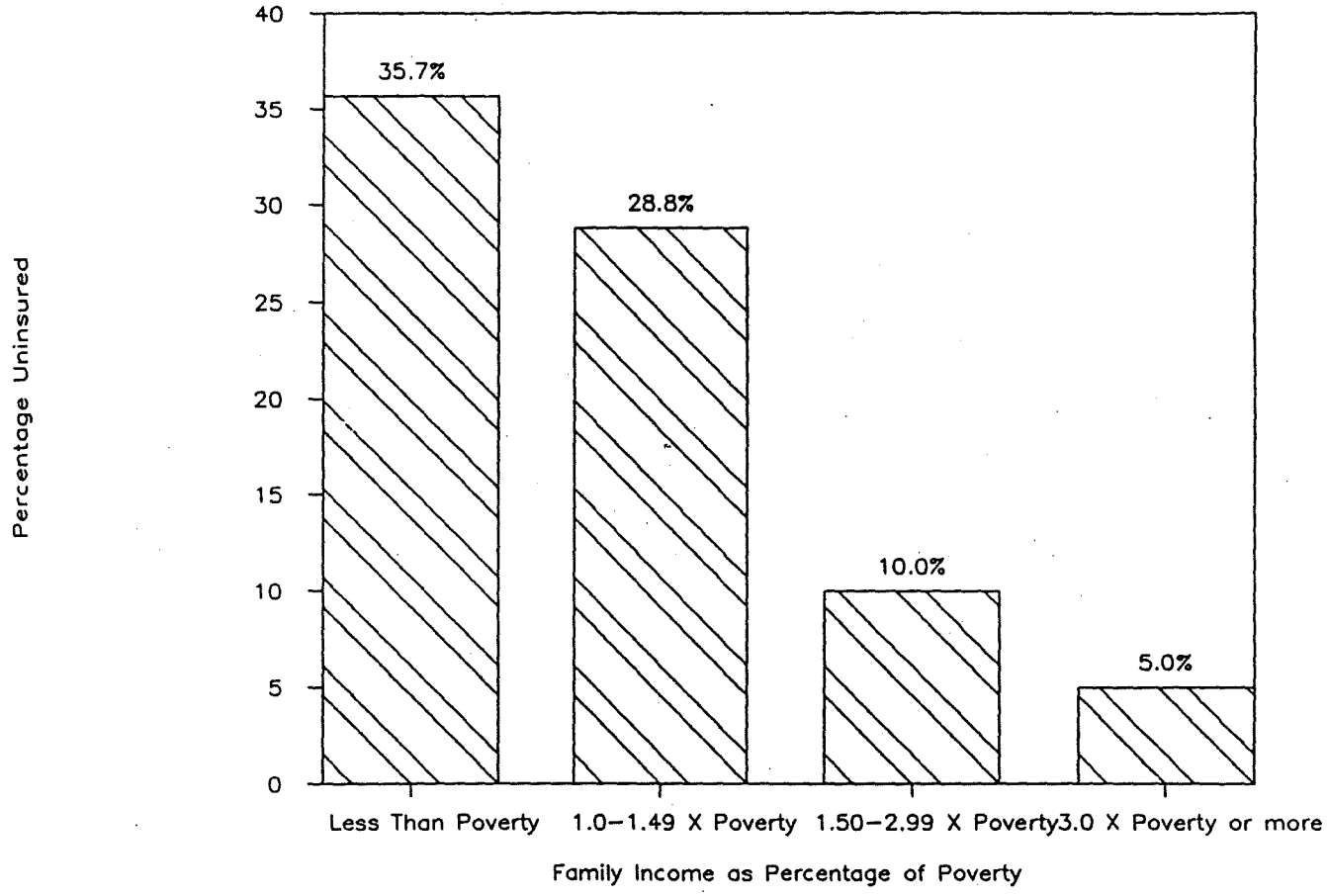
Government employees are the most likely to have health insurance. Over ninety-seven percent (97%) of government employees are insured. Only 2,384 of 91,700 government employees lack health insurance. This accounts for 2.6% of all government employees.

WHILE THE HIGHEST NUMBER OF UNINSURED PERSONS ARE WHITE ADULTS, MINORITIES HAVE THE HIGHEST PERCENTAGE OF UNINSURED ADULTS IN MAINE

There are an estimated 82,300 uninsured white adults in Maine. This figure accounts for 12.6% of all white adults in Maine. However, among all ethnic groups in Maine, minority adults have the highest percentage with no health insurance. Hispanic Maine adults have the highest rate of uninsurance with 28.4% of all Hispanic adults lacking health insurance.

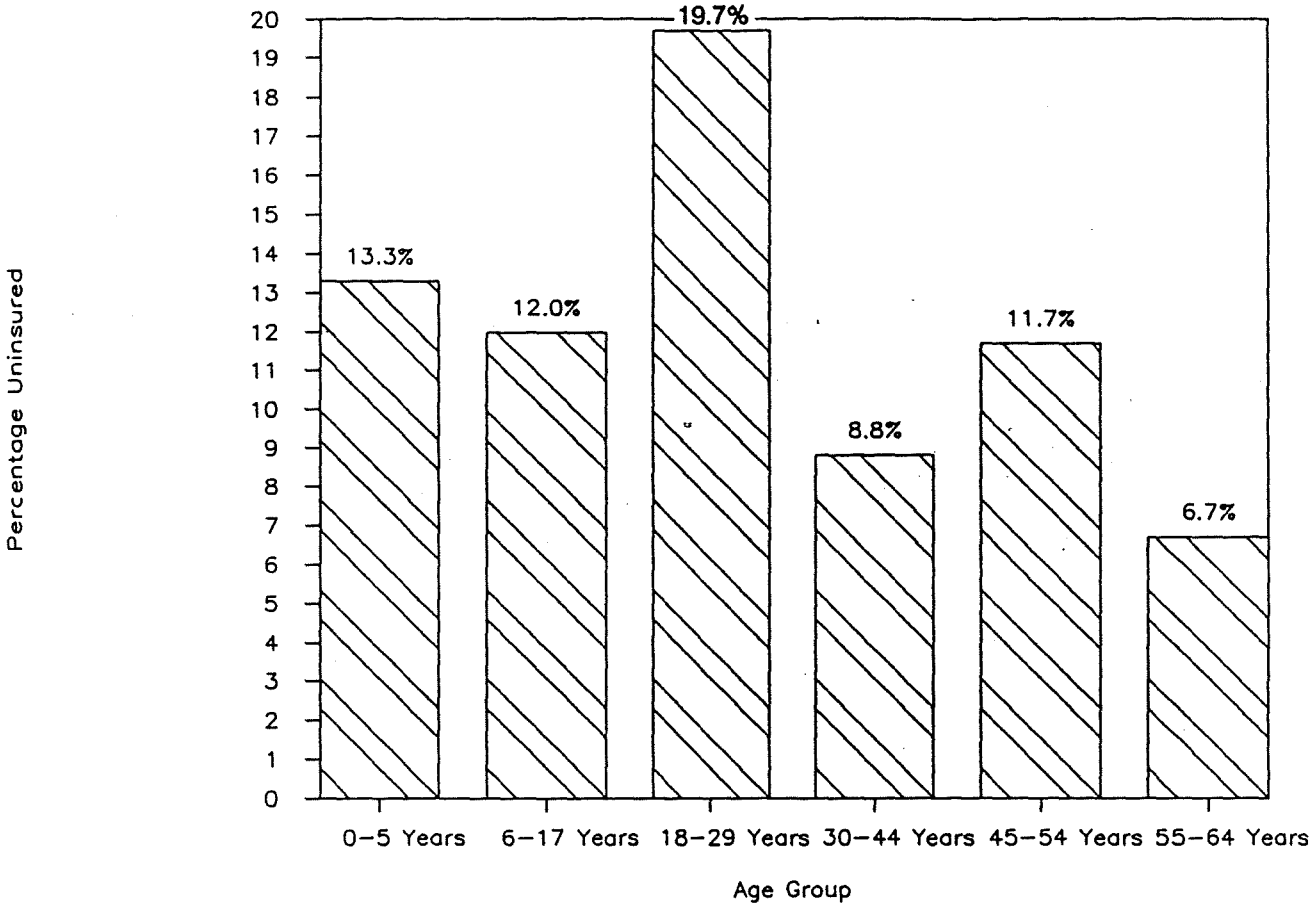
More than 32.2% of all other ethnic groups (this figure excludes whites, hispanics and blacks) have no health insurance. This group includes Native Americans.

Percentage of Adults Uninsured by Family Income
Maine, 1985



Source: Current Population Survey, March 1986

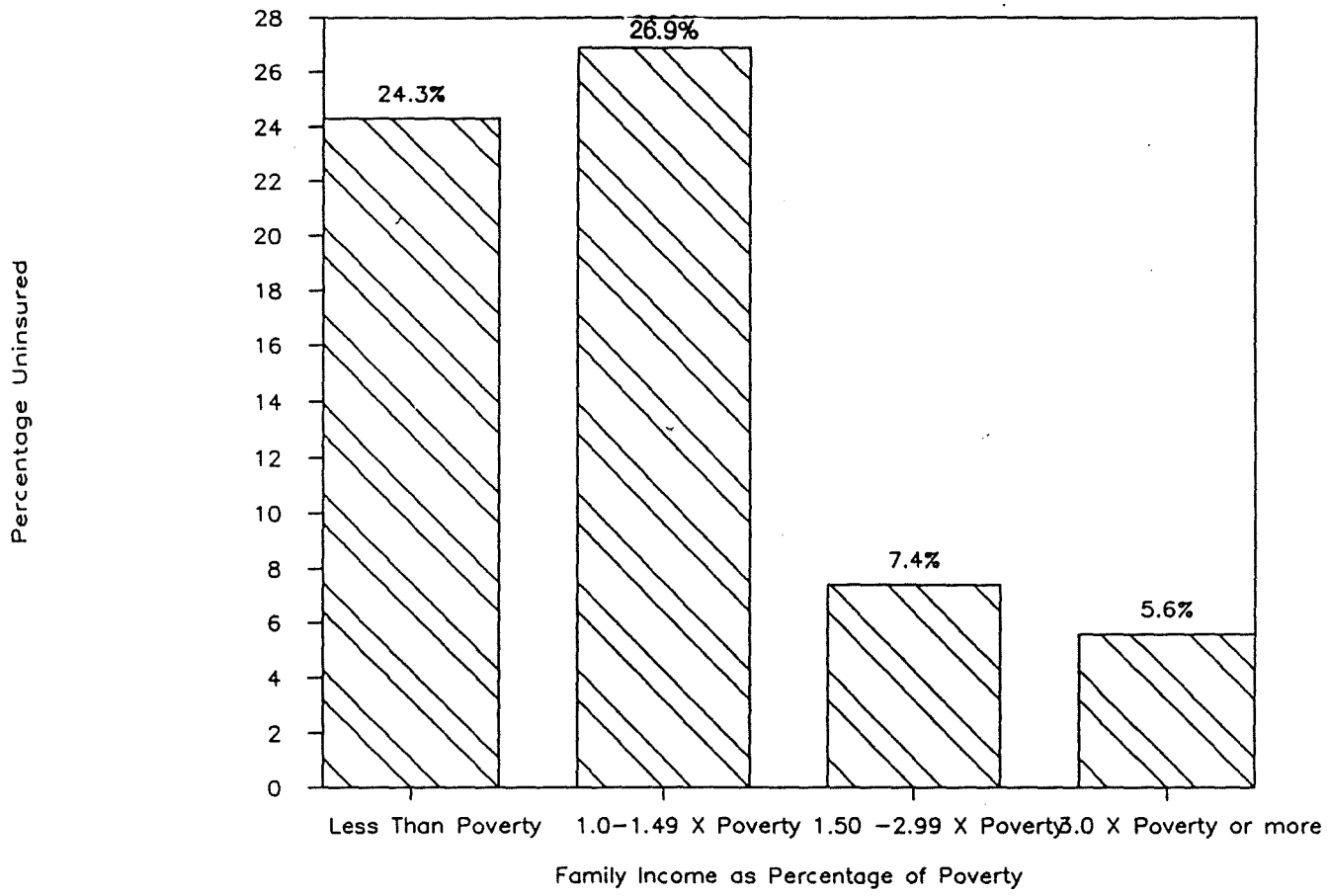
Percentage of Uninsured by Age Group
Maine, 1985



Source: Current Population Survey, March 1986

Percentage of Children Uninsured by Family Income

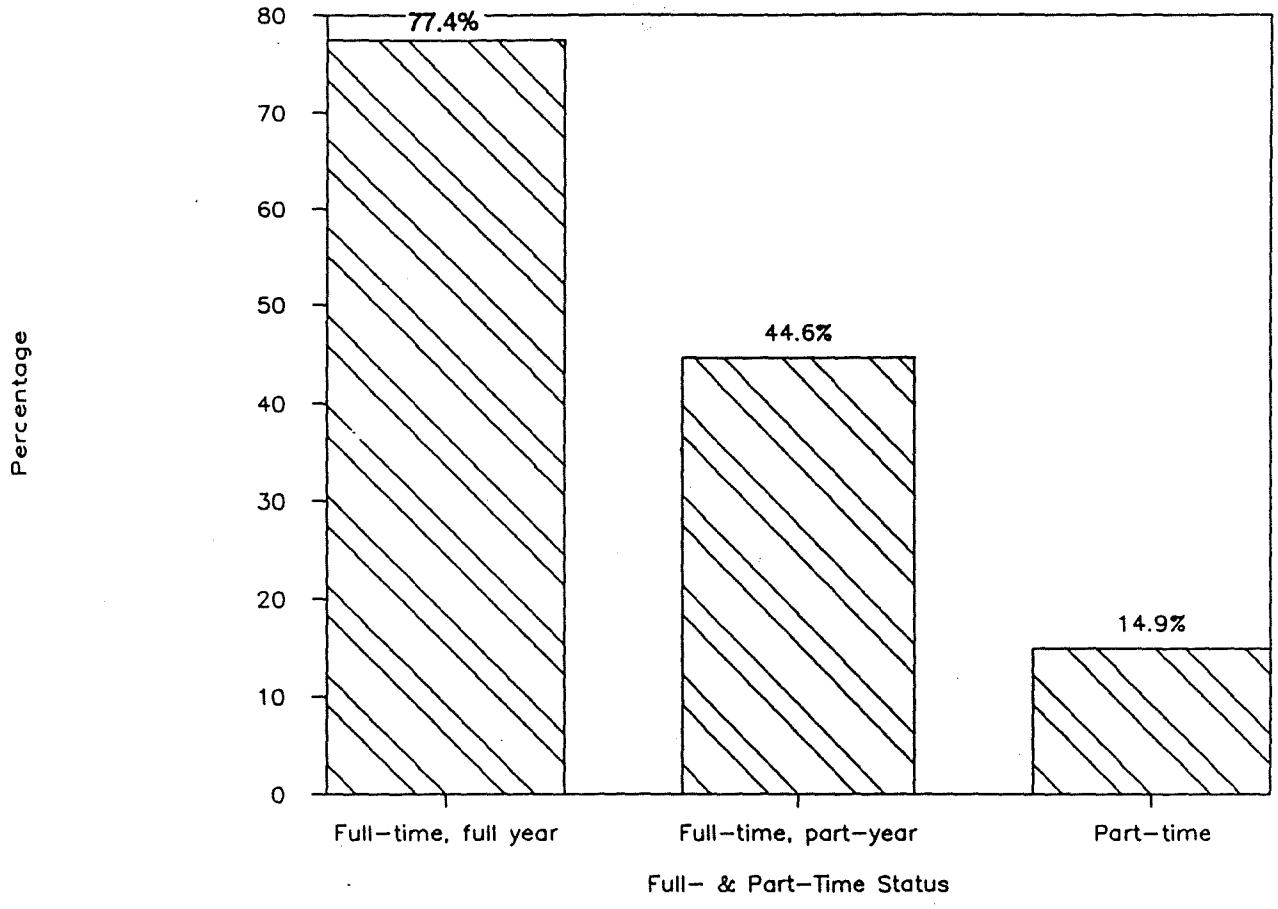
Maine, 1985



Source: Current Population Survey, March 1986

Percentage of Employees With Health Insurance As a Fringe Benefit

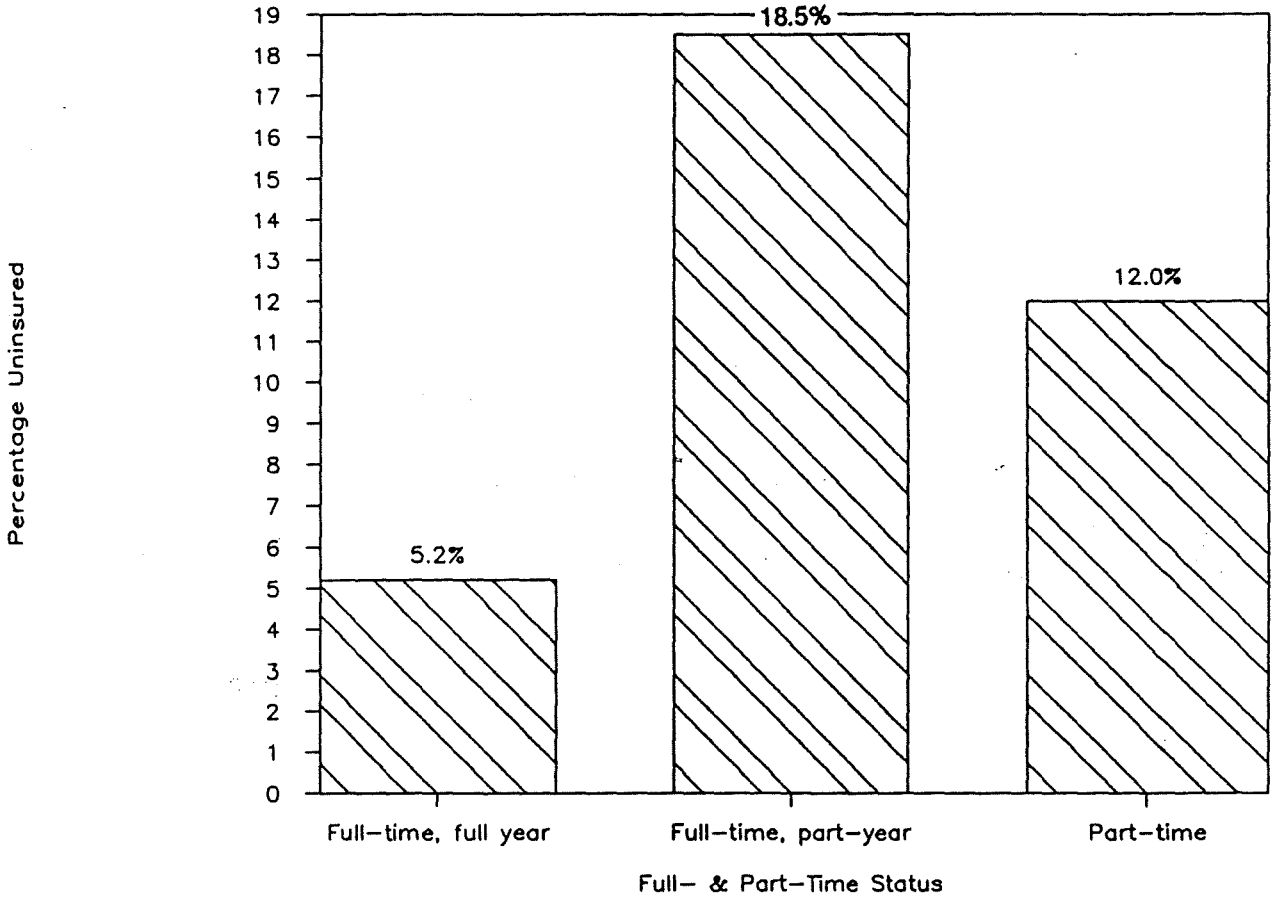
Maine, 1985



Source: Current Population Survey, March 1986

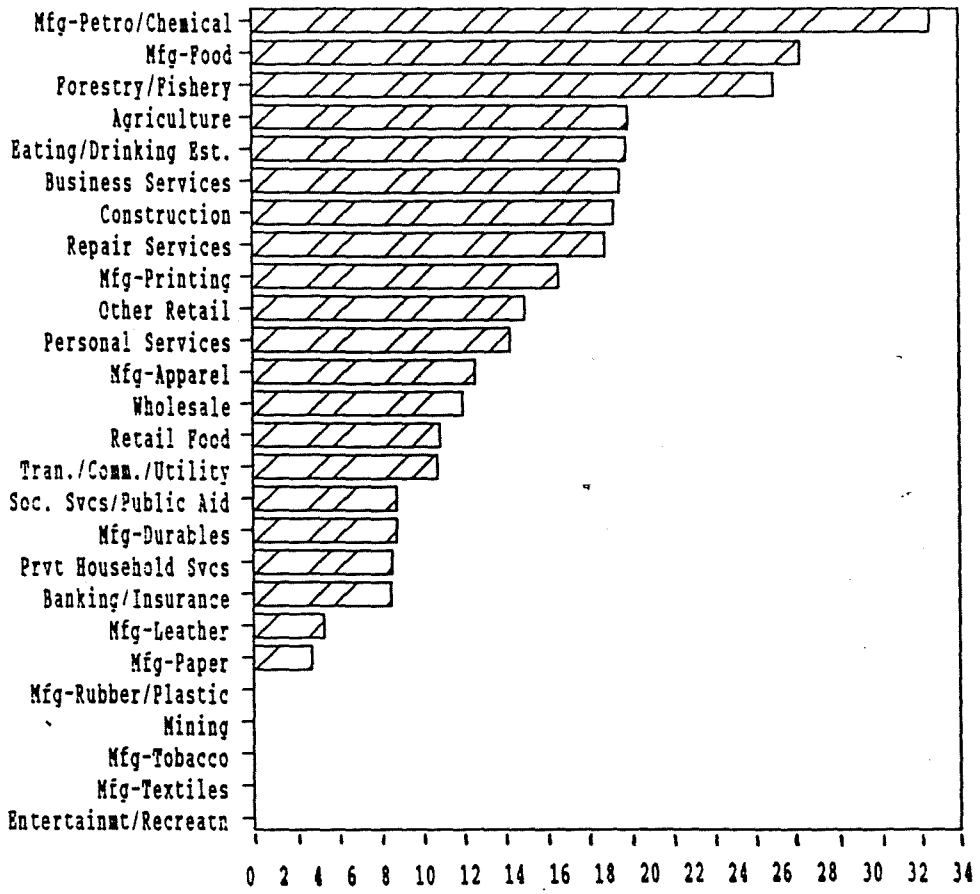
Percentage of Employed Persons Who Are Uninsured

Maine, 1985



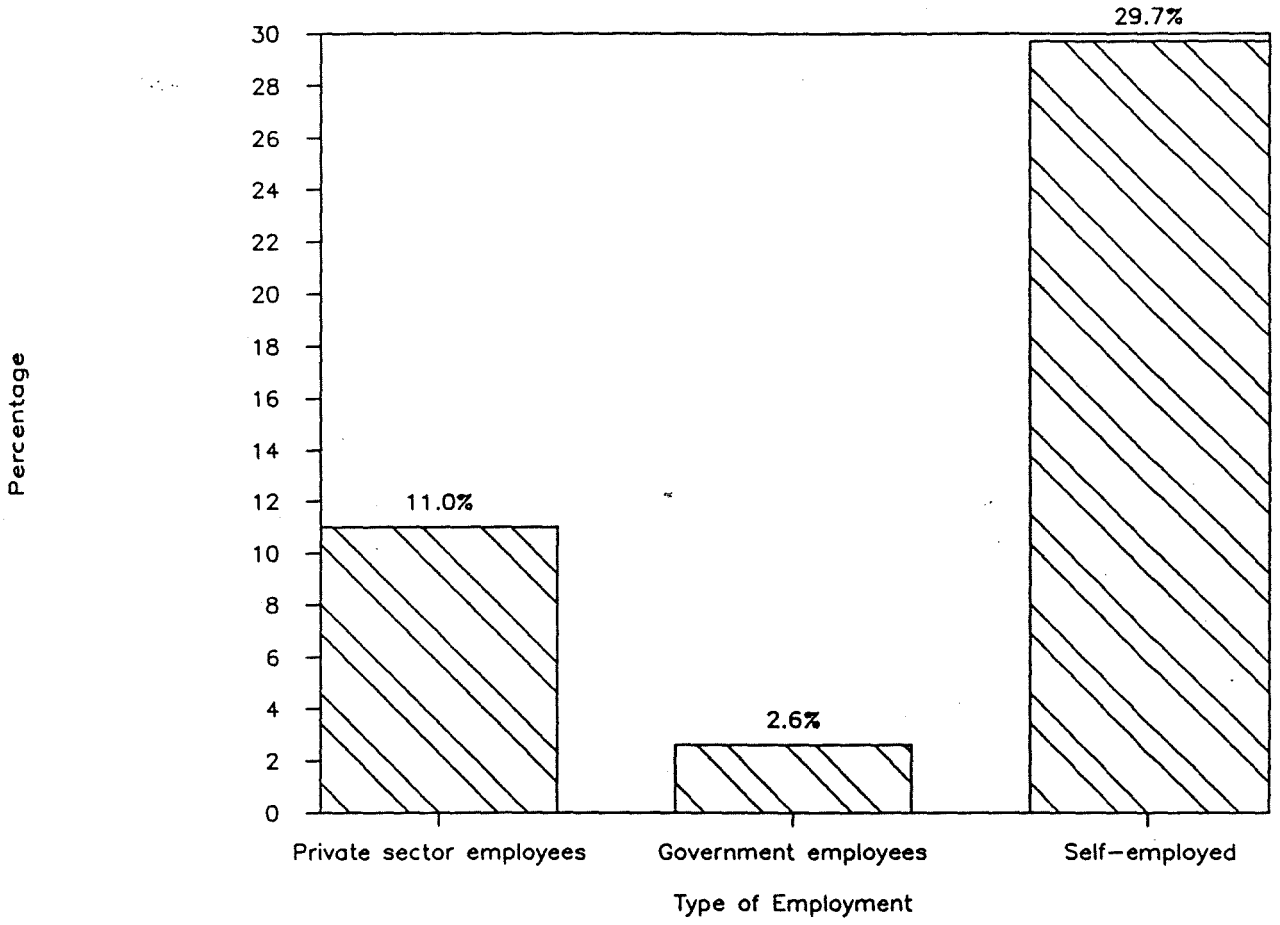
Source: Current Population Survey, March 1986

Percentage of Uninsured Employees by Industry
Maine, 1985



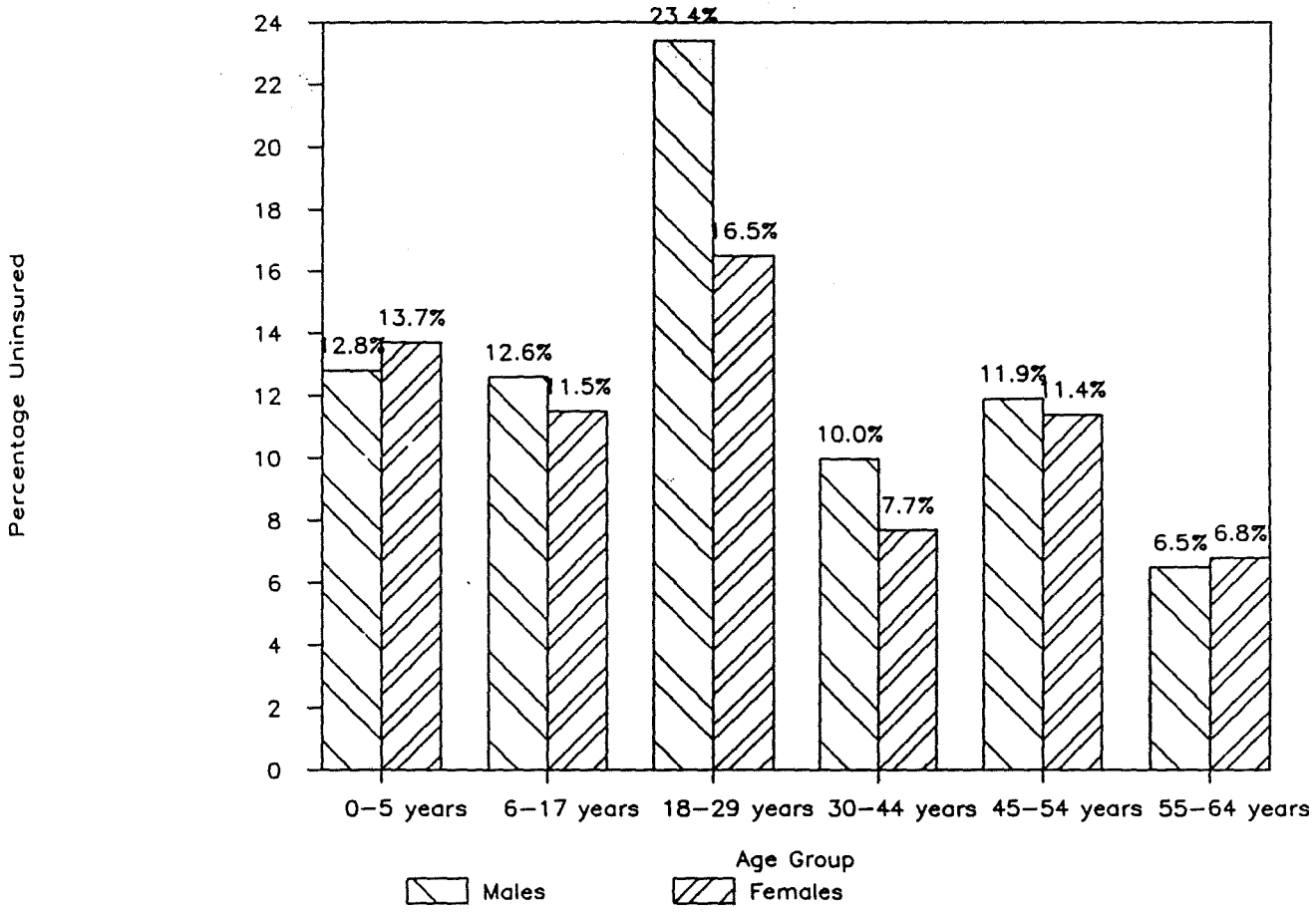
Source: Current Population Survey, March 1986

Percentage of Uninsured by Type of Employment
Maine, 1985



Source: Current Population Survey, March 1986

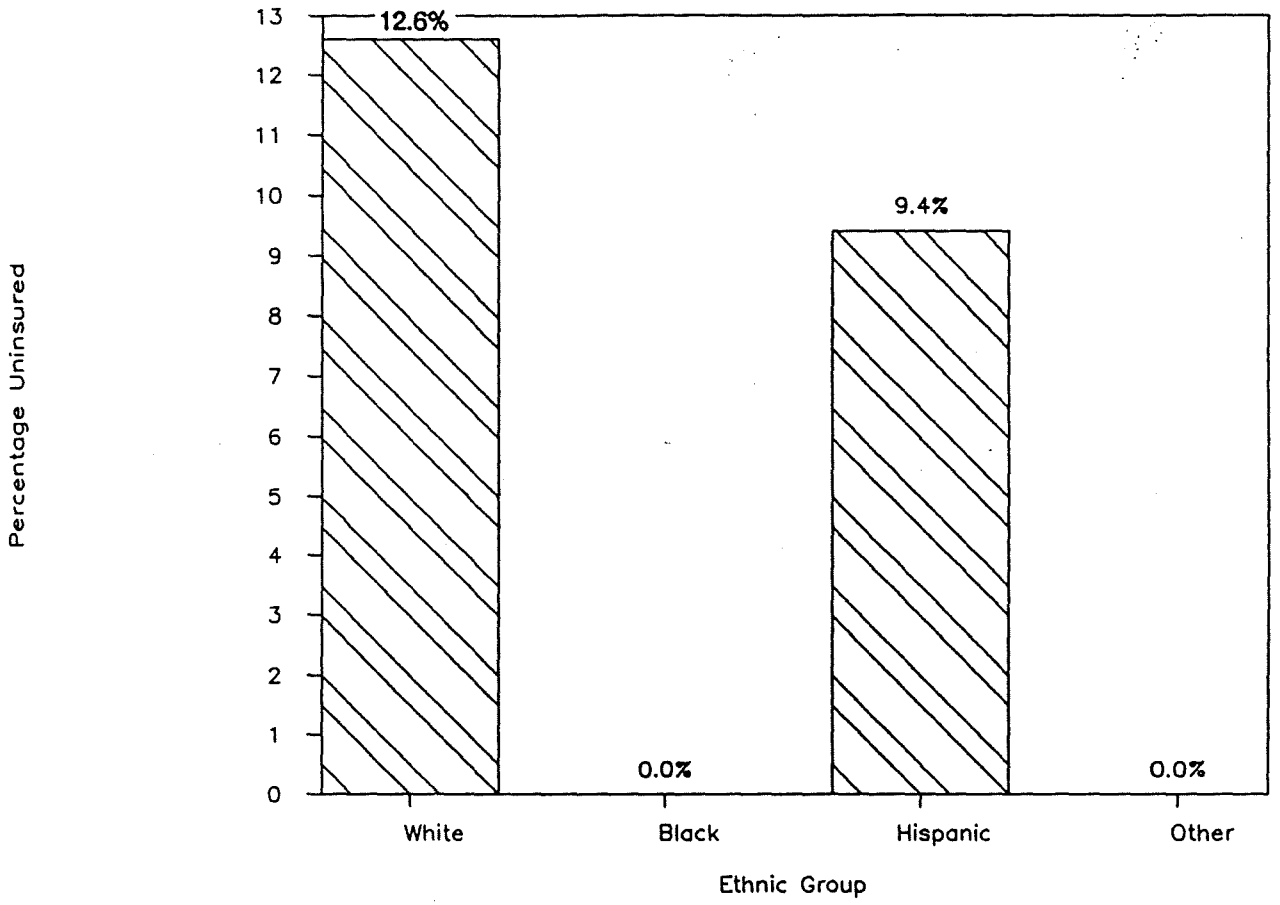
Percentage of Uninsured by Gender and Age
Maine, 1985



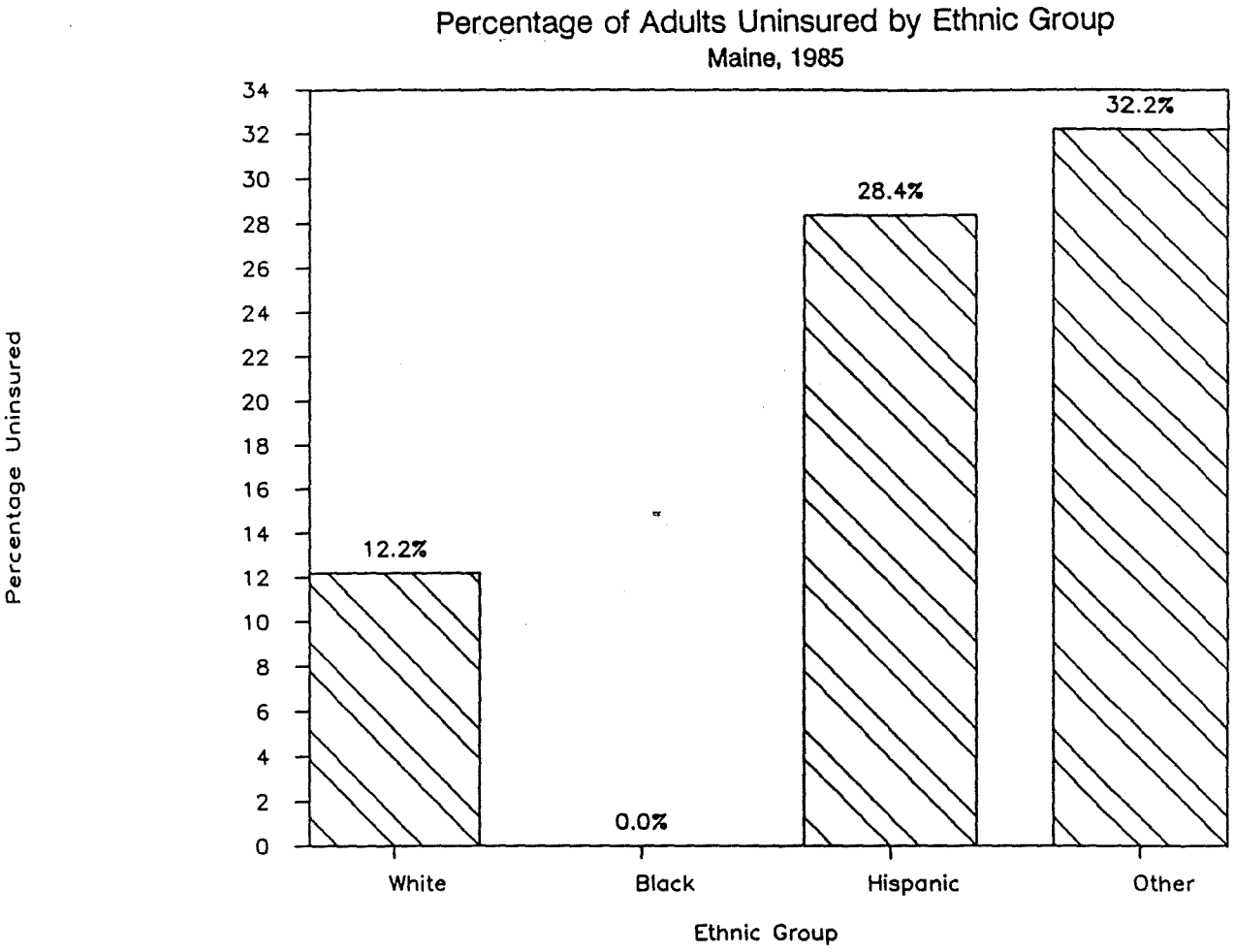
Source: Current Population Survey, March 1986

Percentage of Children Uninsured by Ethnic Group

Maine, 1985



Source: Current Population Survey, March 1986



Source: Current Population Survey, March 1986

Blue Cross
Blue Shield
of Maine

110 Free Street
Portland, Maine 04101
207/775-3536

COMMENTS BY

DAVID C. CROWLEY

DIRECTOR, HOSPITAL PAYMENTS

BLUE CROSS AND BLUE SHIELD OF MAINE

ON

DRAFT REPORT

OF THE

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

SEPTEMBER 6, 1988

MEMBERS OF THE BLUE RIBBON COMMISSION, I AM DAVID CROWLEY. I AM THE DIRECTOR OF HOSPITAL PAYMENTS AT BLUE CROSS AND BLUE SHIELD OF MAINE. I WANT TO THANK YOU FOR THE OPPORTUNITY TO PRESENT BLUE CROSS AND BLUE SHIELD OF MAINE'S VIEWS ON YOUR DRAFT REPORT. WHILE THERE IS ADDITIONAL WORK THAT HAS TO BE DONE IN ORDER TO DEVELOP A HEALTH CARE FINANCING AND DELIVERY STYSTEM FOR THE 90'S, WE APPRECIATE ALL THE TIME AND EFFORT YOU HAVE INVESTED THUS FAR. IT SEEMS THAT NONE OF THE ISSUES AND PROBLEMS YOU HAVE DISCUSSED CAN BE ADDRESSED OR SOLVED WITH EASY SOLUTIONS. PERHAPS TODAY, EVEN MORE THAN IN THE SPRING OF 1987 WHEN THE BLUE RIBBON COMMISSION WAS ESTABLISHED, THERE IS A CRITICAL NEED FOR THE KIND OF EXAMINATION OF THE HEALTH CARE SYSTEM THAT YOU ARE CONDUCTING.

WHEN YOUR COMMISSION BEGAN MEETING IN THE FALL OF 1987, THERE WAS SIGNIFICANT DEBATE AS TO WHETHER THERE WAS A NEED FOR CONTINUED REGULATION OF THE HEALTH CARE FINANCING AND DELIVERY SYSTEM IN MAINE. THIS COMMITTEE HAS HAD WIDE-RANGING DISCUSSIONS ABOUT THAT VERY QUESTION. BLUE CROSS AND BLUE SHIELD OF MAINE AGREES WITH THE FINDINGS OF THIS COMMISSION THAT THERE CONTINUES TO BE A NEED FOR SUCH REGULATION. WE WILL CONTINUE TO SUPPORT YOUR EFFORTS THROUGH OUR MEMBERSHIP ON YOUR COMMITTEE.

MY COMMENTS WILL GENERALLY FOLLOW THE OUTLINE OF YOUR REPORT.

REGULATION OF HOSPITAL RATES OR REVENUES

INPATIENT RATES OR REVENUES

WE AGREE WITH THE COMMISSION'S RECOMMENDATION THAT A NUMBER OF ALTERNATIVE SYSTEMS BE AVAILABLE FOR THE REGULATION OF HOSPITAL RATES OR REVENUES. THE SYSTEM SHOULD INCLUDE REGULATION BY THE STATE WHICH ASSURES THAT THE FUTURE RATE OF INCREASE IN HEALTH CARE COST IS AFFORDABLE TO THE CITIZENS OF MAINE. WE BELIEVE THE SYSTEM SHOULD PROVIDE FOR AT LEAST TWO TYPES OF REGULATORY MODELS FOR HOSPITALS.

HOSPITALS WITH DEFINED PATIENT SERVICE AREAS SHOULD BE REGULATED THROUGH A SYSTEM THAT PROVIDES ADDED FINANCIAL STABILITY FOR ACCESS REASONS OR ADDED PROTECTION FROM THE ADVERSE AFFECTS OF DECLINING VOLUME. AS OUTLINED IN YOUR REPORT, THE TOTAL REVENUE SYSTEM THAT WOULD REGULATE BOTH INPATIENT AND OUTPATIENT REVENUES WOULD BE DESIGNED TO MEET THE NEEDS OF HOSPITALS IN THIS CATEGORY.

WE DO BELIEVE, HOWEVER, THAT EVEN HOSPITALS THAT ARE SUBJECT TO THE TOTAL REVENUE SYSTEM SHOULD BE ACCOUNTABLE FOR MAINTAINING A REASONABLE PATIENT VOLUME.

THERE ARE TWO CASES IN WHICH WE BELIEVE THAT REDUCTIONS IN PATIENT VOLUME IN THE TOTAL REVENUE SYSTEM SHOULD TRIGGER REVENUE OFFSETS IN THE RATES ESTABLISHED FOR SUCCEEDING YEARS.

THE FIRST IS THE CASE OF A HOSPITAL WHICH EXPERIENCES CUMULATIVE REDUCTIONS IN INPATIENT VOLUME OVER SEVERAL YEARS. THE HOSPITAL'S TOTAL REVENUES SHOULD BE REDUCED TO REFLECT THE SAVINGS IN MARGINAL COSTS ASSOCIATED WITH THE DECREASE IN ADMISSIONS. SUCH A REDUCTION SHOULD BE MADE IN SUCH A WAY THAT IT WOULD NOT THREATEN HOSPITAL SOLVENCY. ADJUSTMENTS SHOULD BE MADE SO THAT THE HOSPITAL WILL BE ENCOURAGED TO TAKE PRUDENT MANAGEMENT STEPS NECESSARY TO CUT ITS EXPENSES TO A LEVEL CONSISTENT WITH THE VOLUME DECREASES.

THE SECOND CASE IS ONE WHERE A HOSPITAL EXPERIENCES CUMULATIVE REDUCTIONS IN INPATIENT VOLUME SO SUBSTANTIAL THAT ITS ABILITY TO PROVIDE HIGH QUALITY INPATIENT CARE AT A REASONABLE COST IS SERIOUSLY CALLED INTO QUESTION.

BLUE CROSS BELIEVES THAT THE MAINTENANCE OF HOSPITALS IN THIS GROUP AS INPATIENT INSTITUTIONS SHOULD BE CAREFULLY EVALUATED.

THREE CONSIDERATIONS SHOULD GUIDE THIS EVALUATION.

FIRST, CONSUMERS OF HEALTH CARE SERVICES SHOULD PAY REASONABLE CHARGES FOR THE SERVICES THEY RECEIVE. VOLUME OF SERVICES MAY DECLINE TO A POINT WHERE THE PUBLIC'S INTEREST IS NOT BEING SERVED DUE TO THE COSTLINESS OF THE CARE BEING PROVIDED.

SECOND, ACCESS TO NEEDED INSTITUTIONS OR NEEDED SERVICES WITHIN SPECIFIC INSTITUTIONS SHOULD BE MAINTAINED. IN THE INSTANCE OF INSTITUTIONS WHICH ARE DETERMINED TO BE NECESSARY, DESPITE BEING UNDERUTILIZED, THE RATE

SETTING BODY SHOULD REDUCE CHARGES IN SUCH A WAY AS TO MAINTAIN THE SOLVENCY OF THE INSTITUTION.

THIRD, APPROPRIATE CONVERSIONS TO LOWER LEVEL FACILITIES SHOULD BE CONSIDERED. MAINE CURRENTLY HAS A SHORTAGE OF NURSING HOME BEDS. BLUE CROSS SUPPORTS THE EXPERIMENTAL PROVISIONS OF THE BLUE RIBBON REPORT. UNDER THESE PROVISIONS, HOSPITALS WHOSE OCCUPANCIES HAVE DROPPED TO UNACCEPTABLY LOW LEVELS SHOULD BE ASSISTED IN THE CONVERSION OF THEIR FACILITIES TO ALTERNATIVE USES. IN SUMMARY, WE SUPPORT THE RECOMMENDATION THAT THERE SHOULD BE A TOTAL REVENUE SYSTEM THAT WOULD COVER BOTH INPATIENT AND OUTPATIENT SERVICES.

HOSPITALS WITH OVERLAPPING OR COMPETING SERVICE AREAS SHOULD BE REGULATED ON BOTH INPATIENT AND OUTPATIENT REVENUES. THIS SYSTEM SHOULD INCLUDE INCENTIVES FOR COMPETITION AMONG HOSPITALS AND PAYORS. ADEQUATE ADJUSTMENTS FOR INCREASING VOLUME SHOULD BE INCLUDED AND NEGOTIATED DISCOUNTS IN ADDITION TO APPROVED DISCOUNTS SHOULD BE ALLOWED BUT NOT SHIFTED TO OTHERS. WE ALSO AGREE WITH THE RECOMMENDATION INCLUDED IN YOUR REPORT THAT THE TOTAL HOSPITAL INPATIENT CHARGES OUGHT TO BE ESTABLISHED THROUGH A CASE MIX ADJUSTED CHARGE PER CASE SYSTEM. WE BELIEVE THAT ALL HOSPITALS IN A COMPETITIVE AREA OR THOSE WITH OVERLAPPING SERVICE AREAS, SHOULD BE COVERED UNDER THE SAME REGULATORY SYSTEM. FURTHERMORE, HOSPITALS WISHING TO CHANGE TO THE TOTAL REVENUE SYSTEM FROM THE CHARGE PER CASE SYSTEM MUST AGREE TO A COMPREHENSIVE REVIEW OF THEIR OPERATION BY THE RATE SETTING BODY WHICH WOULD HAVE THE AUTHORITY TO MANDATE CHANGES IN THE HOSPITAL'S OPERATIONS AND OVERALL BUDGET.

A CHARGE PER CASE SYSTEM WE BELIEVE IS A SENSIBLE APPROACH AND AN IMPROVEMENT OVER THE CURRENT SYSTEM OF ESTABLISHING AN OVERALL LIMIT ON INPATIENT REVENUES FOR SEVERAL REASONS. ALTHOUGH THIS METHODOLOGY WILL BE INVOLVED, IT IS SIMPLER. ALSO, CONCURRENT REVIEW PROGRAMS ARE NOT UNDERMINED BECAUSE AS PAYOR CHARGES ARE REDUCED, THROUGH CONCURRENT REVIEW EFFORTS, OUR PAYMENT WILL ALSO BE REDUCED. MANAGED CARE PRODUCTS CAN ALSO BE CONTINUED WITHOUT BEING UNDERMINED BY THE SYSTEM. AND, REDUCTIONS IN LENGTH OF STAY AND ANCILLARY USE WILL REDUCE PAYORS' OBLIGATIONS WHILE NOT ADVERSELY AFFECTING THE HOSPITAL'S TOTAL FINANCIAL REQUIREMENTS. FINALLY, DECISIONS ON RESOURCE USE BY THE HOSPITALS WILL CONSIDER THE SAME INCENTIVES FOR ALL PATIENTS -- PRIVATE PAY, MEDICAID AND MEDICARE.

WE AGREE THAT THE RATE SETTING BODY SHOULD ENCOURAGE DEMONSTRATION PROJECTS. HOWEVER, WE QUESTION WHETHER OR NOT THE RATE SETTING BODY WOULD HAVE THE AUTHORITY TO WAIVE ANY AND ALL STATUTORY REQUIREMENTS. THE RATE SETTING BODY SHOULD, AS YOU SUGGEST, BE ABLE TO WAIVE CERTAIN REGULATORY REQUIREMENTS. WE BELIEVE IT ALSO MAKES SENSE THAT THE RATE SETTING BODY SHOULD BE ABLE TO DEVISE DIFFERENT REGULATORY SYSTEMS FOR SPECIALTY HOSPITALS PROVIDED SUCH HOSPITALS CAN BE REASONABLY AND READILY IDENTIFIED. WE ALSO SUPPORT THE RECOMMENDATION THAT THE SYSTEM SHOULD BE SIMPLIFIED THROUGH THE EMPLOYMENT OF THE MARKET BASKET PLUS AN AGGREGATE ADJUSTMENT FACTOR TO ACCOUNT FOR NEW TECHNOLOGY AND SERVICES, NON-CERTIFICATE OF NEED PROJECTS, AND CHANGES IN THE PRACTICE OF MEDICINE. THIS APPROACH SHOULD RESULT IN FEWER EXCEPTIONS BEING BROUGHT

BEFORE THE RATE SETTING BODY AND, HOPEFULLY, THE LEGISLATURE FOR RESOLUTION. IT WILL ALSO PROVIDE GREATER PREDICTABILITY TO THE OBLIGATIONS OF PAYORS.

OUTPATIENT RATES OR REVENUES

AS I MENTIONED EARLIER IN MY REMARKS, WE BELIEVE IT IS NECESSARY TO CONTINUE THE REGULATION OF OUTPATIENT SERVICES. WE DO NOT BELIEVE THE MAINE ENVIRONMENT WOULD ALLOW FOR EFFECTIVE PRICE COMPETITION AMONG HOSPITALS AND OTHERS FOR OUTPATIENT SERVICES. IN THE PAST THE COMMISSION HAS DISCUSSED SETTING A RATE PER UNIT OF OUTPATIENT SERVICES AS A MEANS OF ESTABLISHING AN UPPER LIMIT ON OUTPATIENT REVENUES. WHILE THE SETTING OF THE RATE PER UNIT OF SERVICE BY DEPARTMENT WILL BE COMPLICATED, WE BELIEVE THAT IT IS AN IMPROVEMENT OVER THE CURRENT METHOD OF ESTABLISHING OUTPATIENT TOTAL REVENUES.

THE DISCUSSION OF REGULATING OR NOT REGULATING OUTPATIENT REVENUES MUST, IN OUR VIEW, CONSIDER OTHER SIGNIFICANT FACTORS. FOR EXAMPLE, WE DO NOT BELIEVE THAT IT WOULD BE APPROPRIATE TO ALLOW CROSS-SUBSIDIZATION OF OUTPATIENT SERVICES FROM INPATIENT SERVICES IF THE OUTPATIENT RATES ARE NOT SUBJECT TO REGULATION. SOME REASONABLE LEVEL OF CROSS-SUBSIDIZATION IS ACCEPTABLE IN THE EVENT OUTPATIENT REVENUES ARE REGULATED. ALSO, WE DO NOT BELIEVE THAT IT WOULD BE APPROPRIATE TO GUARANTEE THE FUNDING FROM A STATEWIDE POOL OF CHARITY CARE AND BAD DEBTS AND GOVERNMENTAL SHORTFALLS IN THE EVENT THAT OUTPATIENT SERVICES ARE NOT REGULATED.

IF OUTPATIENT CARE IS TO BE DEREGULATED, AND THUS, HOSPITAL OUTPATIENT SERVICES ARE TO COMPETE ON A LEVEL PLAYING FIELD WITH OTHER OUTPATIENT PROVIDERS, HOSPITALS SHOULD NOT ENJOY THE PROTECTIONS THAT ARE AFFORDED THROUGH INPATIENT SUBSIDIES AND THE GUARANTEE OF FUNDING CHARITY CARE, BAD DEBT AND GOVERNMENTAL SHORTFALLS.

COMPONENTS OF THE RATE SETTING SYSTEM

STANDARD COMPONENT OR SCREENS

WE SUPPORT THE COMMISSION'S RECOMMENDATION THAT THE REGULATORY SYSTEM ESTABLISH A STANDARD COMPONENT IN THE RATE. IT ALSO MAKES SENSE TO PHASE-IN SUCH A STANDARD RATE OVER A PERIOD OF TIME. THE WHOLE NOTION OF APPLYING A STANDARD COMPONENT IS REASONABLE AND MAKES SENSE PROVIDED THE SYSTEM MAY MAKE ALLOWANCE FOR REDISTRIBUTION OF REVENUE AMONG HOSPITALS AND PROVIDED THE SYSTEM IS DESIGNED WITH INCENTIVES THAT REWARD HOSPITALS FOR IMPROVED EFFICIENCY.

DIFFERENTIALS AND DISCOUNTS

THIS SYSTEM SHOULD PROVIDE FOR EQUITY AMONG PAYORS. IT SHOULD CONTINUE TO PROVIDE FOR PAYOR DIFFERENTIALS WHICH ARE JUSTIFIED AND APPROVED BY A RATE SETTING BODY ON THE BASIS OF ECONOMIC MERIT. SUCH DIFFERENTIALS SHOULD BE INCLUDED IN THE REVENUE LIMIT ESTABLISHED BY THE RATE SETTING BODY. THE SYSTEM SHOULD PERMIT HOSPITALS TO CONTRACT WITH PAYORS AND GRANT DISCOUNTS TO SUCH PAYORS PROVIDED THAT SUCH DISCOUNTS ARE NOT PASSED ON TO OTHER PAYORS. WE BELIEVE THE SYSTEM SHOULD PERMIT PAYORS TO PAY ON THE BASIS OF ANY TYPE OF SYSTEM WHICH THE PAYOR AND THE HOSPITAL MUTUALLY AGREE UPON, FOR EXAMPLE, DIAGNOSIS RELATED GROUPS, CAPITATION, PER-DIEM, OR CHARGE PER CASE, AS LONG AS SUCH PAYMENT DOES NOT RESULT IN A DISCOUNT TO THAT PAYOR THAT IS PASSED ON TO OTHER PAYORS.

APPEAL MECHANISM

BLUE CROSS GENERALLY AGREES THAT APPEALS MUST BE LIMITED OR THEY WILL DEFEAT THE PURPOSE OF THE REGULATORY SYSTEM. IT IS REASONABLE TO LIMIT THE APPEAL MECHANISM TO MAJOR ITEMS SUCH AS THOSE OUTLINED IN THE REPORT THAT HAVE AN IMPACT ON COSTS OR REVENUES OF AT LEAST 2% OF THE TOTAL COSTS OF THE HOSPITAL. WE ALSO SUPPORT THE IDEA THAT THE RATE SETTING BODY WOULD HAVE THE OPTION OF RECOMMENDING THAT CHARGES BE CUT IF A HOSPITAL HAS FILED AN APPEAL WITH THE RATE SETTING BODY AND IT FINDS THAT THE HOSPITAL'S CHARGES ARE TOO HIGH. THE SYSTEM SHOULD BE FULLY PROSPECTIVE IN NATURE WITH NO RETROACTIVE ADJUSTMENTS EITHER LEGISLATED OR

REGULATED AND THE ADJUSTMENTS TO PAYOR OBLIGATIONS MUST BE PROSPECTIVE. ADJUSTMENTS MUST BE MADE IN SUCH A WAY THAT THEY PROVIDE SUFFICIENT NOTICE TO PAYORS SUCH THAT THEY CAN BE INCLUDED IN RATE ADJUSTMENTS IN AN ORDERLY MANNER.

GOVERNMENT SHORTFALLS

WE FULLY AGREE WITH THE COMMISSION'S REPORT THAT INADEQUATE PAYMENT FROM GOVERNMENTAL PAYORS CAUSING SIGNIFICANT AND GROWING SHORTFALLS THAT MUST BE BORNE BY THE PRIVATE SECTOR, IS A SERIOUS PROBLEM THAT HAS TO BE ADDRESSED. THE CURRENT FUNDING FOR GOVERNMENT SHORTFALLS BY AND LARGE COMES FROM THOSE WHO PURCHASE HOSPITAL CARE EITHER THROUGH THEIR INSURANCE CARRIER OR THROUGH HOSPITAL CHARGES WHEN INDIVIDUALS PAY FOR THEIR HOSPITAL CARE. IN ORDER TO DRAMATIZE THE MAGNITUDE OF THE MEDICARE SHORTFALL, I WILL SHARE SOME INFORMATION WITH YOU. DURING THE FIRST PAYMENT YEAR UNDER THE MAINE HEALTH CARE FINANCE COMMISSION, WHICH BEGAN OCTOBER 1, 1984, MEDICARE REPRESENTED APPROXIMATELY 38% OF TOTAL HOSPITAL REVENUE AND PAID APPROXIMATELY $214 MILLION TO MAINE HOSPITALS. IN THAT SAME YEAR, BLUE CROSS AND BLUE SHIELD OF MAINE SUBSCRIBERS REPRESENTED APPROXIMATELY 23% OF TOTAL HOSPITAL REVENUE AND PAID $149 MILLION TO MAINE HOSPITALS. IN SPITE OF THE FACT THAT MEDICARE AND BLUE CROSS CONTINUE TO REPRESENT ABOUT THE SAME PERCENTAGE OF HOSPITAL REVENUE, WE PROJECT IN PAYMENT YEAR 5, WHICH BEGINS 10/01/88, MEDICARE WILL PAY APPROXIMATELY $232 MILLION TO MAINE HOSPITALS, WHILE BLUE CROSS SUBSCRIBERS WILL PAY APPROXIMATELY $240 MILLION. IN OTHER WORDS MEDICARE'S PAYMENT WILL HAVE INCREASED BY ONLY $18 MILLION OVER THE PAST FIVE YEARS, WHILE BLUE CROSS SUBSCRIBER PAYMENT TO HOSPITALS WILL HAVE INCREASED BY NEARLY $91 MILLION.

WHILE YOUR REPORT CALLS ATTENTION TO THE MEDICARE SHORTFALL, WE DO NOT BELIEVE THAT YOUR RECOMMENDATION GOES FAR ENOUGH TO ADDRESS THE ISSUE OF FUNDING THE GOVERNMENTAL SHORTFALLS. WE BELIEVE THE ENTIRE GOVERNMENTAL SHORTFALL SHOULD BE FUNDED TOTALLY FROM THE GENERAL FUND, NOT MERELY THE INCREASE IN THE SHORTFALL FROM SOME GIVEN POINT IN TIME. WE ALSO BELIEVE THE MEDICAID PROGRAM MUST FULLY PARTICIPATE IN THE PAYMENT SYSTEM BY PAYING ITS FULL SHARE OF ITS OBLIGATION OF HOSPITAL FINANCIAL REQUIREMENTS AND ITS FULL SHARE OF CHARITY CARE, BAD DEBT AND THE MEDICARE SHORTFALL. FUNDING FOR THIS INCREASE IN THE STATE'S OBLIGATION AND THE FUNDING OF THE MEDICARE SHORTFALL SHOULD BE THROUGH A BROAD-BASED REVENUE SOURCE. OUR GOAL IS TO ELIMINATE THE HIDDEN TAXES AT BOTH THE FEDERAL AND STATE LEVEL. IF THE GOVERNMENTAL SHORTFALLS WERE FUNDED THROUGH A MORE BROAD-BASED SOURCE OR FROM THE GENERAL FUND, HOSPITAL CHARGES TO PRIVATE PAYING PATIENTS COULD BE REDUCED SIGNIFICANTLY.

CROSS-SUBSIDIZATION

AS I MENTIONED EARLIER WE BELIEVE THAT HOSPITAL OUTPATIENT SERVICES SHOULD CONTINUE TO BE REGULATED BECAUSE THERE IS INADEQUATE PRICE COMPETITION AMONG HOSPITALS AND OTHER PROVIDERS OF CARE TO CONTROL HOSPITAL OUTPATIENT CHARGES. THE CONTINUATION OF REGULATING OF INPATIENT AND OUTPATIENT CHARGES SHOULD NOT RESULT IN A SIGNIFICANT SUBSIDY OF OUTPATIENT

SERVICES. WE BELIEVE A CONTROLLED, REASONABLE SUBSIDY MAKES SENSE. WE ALSO BELIEVE THAT IT REQUIRES FURTHER STUDY TO DETERMINE WHAT THE APPROPRIATE LEVEL OF THAT SUBSIDY SHOULD BE. AGAIN, HOWEVER, IF OUTPATIENT SERVICES ARE DEREGULATED THEN WE BELIEVE ALL SUBSIDIES FROM INPATIENT TO OUTPATIENT SHOULD BE ELIMINATED.

DEMONSTRATIONS

WE BELIEVE THAT THE SYSTEM SHOULD PERMIT DEMONSTRATION PROJECTS UNDER THE AUTHORITY OF THE RATE SETTING BODY THAT ENHANCE ACCESS TO QUALITY CARE AT AN AFFORDABLE COST TO MAINE CONSUMERS. THERE MAY BE ROOM FOR DEMONSTRATIONS THAT WAIVE CERTAIN ASPECTS OF THE SYSTEM FOR HOSPITALS AND PAYORS. THE SYSTEM SHOULD BE FLEXIBLE ENOUGH TO ALLOW SUCH DEMONSTRATIONS. WE ALSO BELIEVE THAT THE IDEA OF PROVIDING OPTIONS FOR LOWER LEVELS OF CARE WITHIN HOSPITALS MAKES SENSE. THERE ARE SEVERAL HOSPITALS IN THE STATE WITH VERY LOW OCCUPANCY LEVELS. WHILE THE CLOSURE OF SUCH HOSPITALS COULD CAUSE ACCESS PROBLEMS SUCH THAT ACUTE GENERAL CARE WOULD BE UNAVAILABLE WITHIN A REASONABLE TRAVELING DISTANCE, IT MAY BE APPROPRIATE TO REDUCE THE SIZE OF THOSE HOSPITALS AND TO PROVIDE SOME OTHER TYPE OF FACILITY FOR THE COMMUNITY. THIS IDEA HAS MERIT AND WE THINK IT SHOULD BE PURSUED.

POOLS FOR BAD DEBTS, CHARITY CARE AND GOVERNMENTAL SHORTFALLS

BLUE CROSS BELIEVES THAT CHARITY CARE AND BAD DEBTS AND GOVERNMENTAL SHORTFALLS SHOULD BE POOLED SO THAT FUNDS CAN BE EQUITABLY DISTRIBUTED AMONG ALL PAYORS WHILE MINIMIZING THE EFFECT ON AN INDIVIDUAL HOSPITAL'S CHARGES. AS YOU KNOW HOSPITAL CHARGES, OR THE PRICES THE PUBLIC PAYS, ARE NO LONGER A TRUE MEASURE OF HOSPITAL EFFICIENCY BECAUSE IN MANY INSTANCES THEY ARE SIGNIFICANTLY INFLATED BECAUSE OF INADEQUATE PAYMENT FROM MEDICARE AND MEDICAID.

BLUE CROSS SUPPORTS THE POSITION TAKEN IN THE DRAFT REPORT THAT A BROADER BASE OF SUPPORT THAN A TAX ON THE HOSPITAL INDUSTRY, AND THEREBY A HIDDEN TAX ON PURCHASERS OF HOSPITAL CARE, SHOULD BE USED TO FUND THE POOL.

MANY OF MAINE'S HOSPITALS ARE LOCATED IN RURAL AREAS WITH LITTLE OR NO COMPETITION FOR SERVICES. SOME OF THESE HOSPITALS EXPERIENCE SUBSTANTIAL MEDICARE SHORTFALLS. ALLOWING THESE HOSPITALS TO INCREASE CHARGES TO THE PRIVATE SECTOR TO MAKE UP FOR THIS MEDICARE SHORTFALL CONTINUES THE BURDEN OF A HIDDEN TAX ON THOSE WHO ARE SICK OR THOSE WHO PAY HEALTH INSURANCE PREMIUMS.

BLUE CROSS BELIEVES THAT ALL TAXES SHOULD BE EXPLICIT, AND THAT THE SOURCE OF REVENUE TO FUND THE POOL BE DECIDED AFTER SIGNIFICANT DEBATE HAS TAKEN PLACE.

RATE SETTING BODY

WE BELIEVE THAT THE RATE SETTING BODY SHOULD BE AN INDEPENDENT EXECUTIVE AGENCY. WE ALSO BELIEVE THAT THE MANNER OF APPOINTMENT, THE COMPOSITION AND THE DUTIES OF THE RATE SETTING BODY NEED FURTHER DISCUSSION.

NURSING HOMES

MANY OF THE THE RECOMMENDATIONS INCLUDED IN THE REPORT APPEAR TO BE SOUND. CLEARLY TO THE EXTENT THAT THE HOSPITALS ARE NOW HOUSING PATIENTS THAT SHOULD BE IN LOWER LEVELS OF CARE LIKE NURSING HOMES, SKILLED NURSING FACILITIES, OR SWING BEDS, ALTERNATIVES FOR HOUSING THESE PATIENTS SHOULD BE DEVELOPED.

SHORTAGES OF OTHER HEALTH PROFESSIONALS

WE AGREE WITH MEMBERS OF THE COMMISSION THAT LONG TERM SOLUTIONS MUST BE DEVELOPED TO ALLEVIATE THE PROBLEM OF SHORTAGES OF HEALTH PROFESSIONALS. WE ARE HOPEFUL THAT THE COMMISSION TO STUDY THE STATUS OF NURSING AND HEALTH CARE PROFESSIONS IN MAINE WILL DEVELOP STRATEGIES TO DEAL WITH THIS CRITICAL PROBLEM.

WE WANT TO ADD ONE NOTE OF CAUTION REGARDING THE CURRENT CRISIS AND ONE WAY, ALBEIT NOT THE ONLY WAY, THE CURRENT CRISIS IS BEING ADDRESSED.

HEALTH PROVIDERS ARE SEEKING TO RETAIN AND ATTRACT NEW HEALTH PROFESSIONALS BY INCREASING WAGES, SALARY AND FRINGE BENEFITS FOR THOSE CLASSIFICATIONS OF EMPLOYEES WHERE THE SHORTAGES EXIST. WE SUPPORT THOSE INITIATIVES AS BEING NECESSARY. HOWEVER, DEMANDS FOR ADDITIONAL DOLLARS TO PAY FOR INCREASED WAGES AND SALARIES MUST BE BALANCED AGAINST THE CITIZENS' ABILITY TO AFFORD ADDITIONAL PAYMENTS FOR HEALTH CARE SERVICES. AT THE SAME TIME, WE ARE EXPECTING THE PUBLIC TO PAY THE COST FOR HIGHER WAGES AND SALARIES THROUGH INSURANCE PREMIUMS, WE ARE ALSO EXPECTING THE PUBLIC TO PAY FOR NEW VERY EXPENSIVE TECHNOLOGY AND EXPANSION OF THE HEALTH CARE SYSTEM BOTH INSIDE AND OUTSIDE OF THE HOSPITAL AND THE GOVERNMENT SHORTFALL. IN THE FUTURE WE MUST WEIGH IN THE BALANCE OUR INVESTMENTS IN HUMAN RESOURCES AGAINST THE DEMANDS FOR NEW EXPENSIVE TECHNOLOGY AND THE FUNDING OF THE SHORTFALL. WE DO NOT BELIEVE THAT THE CITIZENS OF MAINE CAN AFFORD TO CONTINUE TO SUPPORT UNBRIDLED DEMAND TO SUPPORT THESE NEEDS. THESE COMPETING DEMANDS FOR SCARCE RESOURCES DEMONSTRATE THE NEED FOR A HEALTH CARE FINANCING AND DELIVERY SYSTEM THAT IS AS EFFICIENT AS IT CAN BE.

MANDATED BENEFITS

BLUE CROSS AND BLUE SHIELD OF MAINE BELIEVES THAT MANDATING BENEFITS AND MANDATING PROVIDERS IS INAPPROPRIATE. OUR POSITION ON MANDATES HAS ALWAYS BEEN AND CONTINUES TO BE THAT THESE BENEFITS OUGHT TO BE MADE AVAILABLE AS OPTIONS TO THOSE WHO WANT TO PURCHASE THEM THROUGH THEIR INSURANCE CARRIER, NOT FORCED UPON THE BUYERS OF INSURANCE THROUGH MANDATION OF

SUCH BENEFITS AND PROVIDERS. WE ENCOURAGE THIS COMMITTEE TO CONTINUE TO EXAMINE MANDATED BENEFITS AS ONE OF THE KEY FACTORS CAUSING HEALTH CARE COSTS FOR MAINE CONSUMERS TO INCREASE AT SUCH ALARMING RATES.

DATA COLLECTION FROM NON-HOSPITAL PROVIDERS

THE REPORT STATES THAT THERE HAS BEEN SOME DISCUSSION OF EXTENDING SOME REGULATION TO THE NON-HOSPITAL PROVIDERS. WE BELIEVE THE CURRENT ENVIRONMENT CALLS FOR THE EXPANSION OF REGULATION BEYOND THE HOSPITAL SETTING IN CERTAIN INSTANCES. A CURRENT EXAMPLE OF THE NEED FOR EXPANSION OF THE CON PROCESS IS THE RAPID EXPANSION OF DIAGNOSTIC SERVICES SUCH AS MAGNETIC RESONANCE IMAGING CENTERS OUTSIDE THE HOSPITALS AND THEREBY EXEMPT FROM CON. MRI SERVICES FIRST BECAME AVAILABLE IN MAINE IN 1986. IN 1986, BLUE SHIELD SAW CLAIMS FOR 296 MRI PROCEDURES AND PAID OUT $225,000 IN BENEFITS. IN 1987, WE SAW 1,345 MRI CLAIMS AND PAID $923,000 IN BENEFITS, MORE THAN A 300% INCREASE IN ONE YEAR. CURRENTLY, THERE ARE 3 MRI'S OPERATIONAL IN NON-HOSPITAL SETTINGS AND 4 MORE IN THE PLANNING STAGES FOR HOSPITAL INPATIENT AND OUTPATIENT USE. THIS TYPE OF COSTLY EXPANSION IN NEW TECHNOLOGY SHOULD BE MADE AVAILABLE THROUGH SOME REASONABLE COORDINATED PLANNING PROCESS. AS A MEANS OF ESTABLISHING THAT PROCESS WE BELIEVE THE SCOPE OF THE CON PROGRAM SHOULD BE EXPANDED SO THAT PURCHASES OF MAJOR MEDICAL EQUIPMENT (OVER A YET TO BE SPECIFIED DOLLAR THRESHOLD) AND ESTABLISHMENT OF MEDICAL FACILITIES SUCH AS AMBULATORY SURGICAL UNITS OUTSIDE OF HOSPITALS WILL BE REVIEWABLE, REGARDLESS OF THE SPONSOR. THE CHANGES TO THE CON PROCESS SHOULD COINCIDE WITH A COMPREHENSIVE UPDATING

OF THE STATE HEALTH PLAN. A CURRENT AND BINDING STATE HEALTH PLAN MUST BE PART OF THE OVERALL PLANNING PROCESS AND IT MUST BE KEPT CURRENT ON A REGULAR BASIS.

EARLY ON IN MY REMARKS I STATED THE SYSTEM YOU DEVELOP SHOULD INCLUDE REGULATION BY THE STATE WHICH ASSURES THAT THE FUTURE RATE OF INCREASE IN HEALTH CARE COST IS AFFORDABLE TO THE CITIZENS OF MAINE. TO MEET THIS GOAL REQUIRES A COMPREHENSIVE EXAMINATION OF THE ENTIRE HEALTH CARE SYSTEM NOT SOLELY HOSPITALS WHICH IS THE MAJOR THRUST OF YOUR DRAFT REPORT. OUR EMPLOYER GROUPS ARE TELLING US THAT HEALTH CARE IN ITS ENTIRETY IS RAPIDLY BECOMING UNAFFORDABLE FOR THEM AND THEIR EMPLOYEES.

AN ESSENTIAL GOAL FOR THIS COMMISSION THAT BLUE CROSS CAN SUPPORT IS THAT TOTAL SPENDING ON HEALTH CARE SERVICES SHOULD NOT INCREASE BEYOND CURRENT LEVELS. TO MEET THIS GOAL, A COMPREHENSIVE REVIEW OF THE ENTIRE HEALTH CARE SYSTEM AND THE FACTORS THAT ARE CONTRIBUTING TO RAPIDLY INCREASING COSTS MUST BE CONDUCTED. A COMBINATION OF REGULATION, AN EFFECTIVE COMPREHENSIVE STATE HEALTH PLAN AND PRIVATE SECTOR INITIATIVES IS NECESSARY IN ORDER TO CONTROL THESE ESCALATING COSTS. THE FACTORS THAT CAN BE ADDRESSED BY THIS COMMISSION MUST BE ADDRESSED. IF THE BLUE RIBBON COMMISSION FAILS TO REVIEW THE ENTIRE SYSTEM AND MAKE RECOMMENDATIONS THAT ADDRESS MORE THAN HOSPITALS, WE WILL NOT DEVELOP A SOLUTION TO THE PROBLEM. AS YOU CONTINUE YOUR WORK, WE RECOMMEND YOU SEEK TO ATTAIN THIS GOAL.

THIS CONCLUDES MY COMMENTS ON YOUR DRAFT REPORT. I WOULD BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

THANK YOU.

HIAA

Health Insurance Association of America

April 29, 1988

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

Dear Ms. Lane:

Mike Davis, commercial insurer representative on the Blue Ribbon Commission on Health Care Expenditures, informed me that the Health Insurance Association of America's responses to the February 18 survey had not been received by your department. I have attached another copy of the survey responses and would appreciate it if you would distribute it to the Committee. Thank you for your cooperation.

Sincerely,

Elizabeth Rothberg

Elizabeth Rothberg
Assistant Director

ECR/el
Attachment

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

HIAA

Health Insurance Association of America

March 25, 1988

Ms. Annika Lane
Legislative Analyst
State of Maine
Office of Policy and Legal Analysis
Room 101/107
State House Station 13
Augusta, Maine 04333

Dear Ms. Lane:

Enclosed please find responses to the Blue Ribbon Commission on Health Care Expenditures February 18, 1988 survey. We have tried to the best of our ability to provide complete and thorough responses to the questions but in some cases have not had access to necessary data and statistics.

Thank you for this opportunity to provide our view on very important health care matters in Maine. If you have questions about the attached information, please call me at (202) 223-7838.

Sincerely,

Elizabeth Rothberg

Elizabeth Rothberg
Assistant Director

ECR/el

Enclosure

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

RESPONSES TO BLUE RIBBON COMMISSION HEALTH CARE EXPENDITURES

FEBRUARY 18, 1988 SURVEY

FROM THE HEALTH INSURANCE ASSOCIATION OF AMERICA

WASHINGTON, D.C.

1. One general means of evaluating whether available health insurance is affordable to the public is by looking at the number of persons without health insurance. According to an Employee Benefit Research Institute March 1986 Current Population Survey, 11.7 percent of the Maine population have no insurance. Not to minimize the problem, but the extent of the uninsured problem in Maine appears to be significantly less than the national rate of 17.4 percent. Maine also compares favorably with other New England states with only one state (Connecticut) having a lower percent uninsured. Nearby neighboring states also do not fare as well as Maine. Massachusetts' uninsured account for 13.1 percent of its nonelderly population while 12.6 percent of New Hampshire's nonelderly population have no health insurance.

   Developing strategies to resolve the uninsured "problem" involves assessing the population and why they are not covered by health insurance. One should conduct a profile of the population by such characteristics as age, sex, health status, income and employment. Specific characteristics of a population must be reviewed to adequately address the problem at hand. Affordability per se is often a subjective term and the statement "I can't afford" may mean I choose to purchase another good rather than health insurance. The key is to evaluate whether health insurance coverage is accessible.

   In that regard, there is a major role for state government. A substantial number of those who find insurance unaffordable are in fact poor as measured by the federal poverty level. Thus, state government should evaluate its Medicaid income eligibility requirements and the numerous optional benefit categories which are available. In this way, the problem of affordability could be focused on those groups who have sufficient economic status to purchase available private programs. Over the last decade, states have generally covered a lower precentage of their poverty populations. Current status should be re-examined.

2. The adequacy of the nation's physician supply has been a major issue for several decades. Most recently, in 1976, the Department of Health and Human Services commissioned the Graduate Medical Education National Advisory Committee (GMENAC) to undertake a physician manpower study. The GMENAC

report, completed in 1980, concluded based on a four-year study of physician manpower that nationally the supply would exceed requirements by 70,000 physicians in 1990 and 145,000 in the year 2000. The study also projected that 18 of the 33 specialties reviewed will experience surpluses in 1990. There have been numerous studies since then looking at physician supply. Some conclude that the GMENAC study overstated the projected surplus, but most conclude there is and will be a physician surplus in the future.

Inspite of an overall physician surplus, it is clear that shortages are experienced in specific specialties and specific locations. This appears to be the case in Maine. According to a Maine manpower study conducted by the Department of Health Planning in a cooperative agreement with the Federal government, 25 out of 62 designated planning areas in Maine experienced a shortage of primary care physicians. Isolated or rural areas predominately experienced such shortages.

3. We do not have information available that indicate specific allied health care shortages exist in Maine.

4. Reimbursement for particular health care services is often a gauge of whether a service is viewed as accessible or available. Health insurance plans offered in Maine cover acute hospital care, mental health care, alcoholism and drug addiction, maternity and complications of pregnancy and home health care at a minimum.

   Thus, absence of coverage for these benefits is not due to availability but to other factors. Younger populations may not perceive the need for coverage. Economic status as discussed under question #1 is also a major factor.

5. Nursing homes in Maine are operating at occupancy levels averaging 95 percent. It is also our understanding that many patients are waiting for placement. On the surface, there appears to be an access problem, but Maine is also one of the most heavily bedded states in the country according to the Department of Health Planning. One can conclude that supply may be creating demand. A study conducted for the Department of Health Planning in 1986 concluded that fewer nursing home beds are needed in Maine and that home care and other community-based alternatives would more appropriately serve the elderly population. Maine now has 57 intermediate care facility (ICF) and skilled nursing facility (SNF) beds per 1000 elderly population. In the 1986 study, Oregon was presented as a role model in its ability to transform care for the elderly. Oregon moved from 50 ICF/SNF beds per 1000 elderly population to 43 ICF/SNF beds per 1000 elderly population and developed more small group homes and fewer medically-oriented nursing home beds. This approach deserves serious consideration as our population ages and often requires more personal than medical care.

6a.) The question that needs to be posed is to what extent is there excess acute care capacity in Maine. Beds should not be available unless necessary. Otherwise, unnecessary use is generated to produce financially stable hospitals, which is clearly not in the public interest. The 1986 statewide hospital occupancy was around 60 percent. The highest occupancy, 82 percent, was at Maine Medical Center in Portland. Department of Health Planning projections based on population and use data project 1500 excess beds by 1990. Clearly, there is substantial overcapacity that is unnecessary for the public welfare and financially burdensome to all parties. Patients should pay a fair price for services and should not be expected to shoulder the burden of excess capacity. To do so simply makes health care and health care coverage less affordable.

b.) We recognize and support the need for retaining general acute care sole community providers. Isolated Maine residents need and deserve access to medical care. At the same time, it is important that hospital use not be artificially driven up. This requires a fine balance of making general acute care services available without driving demand by virtue of supply.

7a.) Small area analysis studies have shown clearly that there are emerging patterns of health care delivery that have a wide variation in practice. We see varied practice patterns that are not necessarily connected with appropriate medical practice. Commonly cited problem areas include the overabundance and wide regional variations in operations such as C-sections and hysterectomies, for example. We would emphasize reducing <u>unnecessary</u>, not necessary, health care services. For example, Peer Review Organizations (PROs) review five medical areas to assess the appropriateness of hospital admissions. This way, limited financial resources are directed only at medically-necessary hospitalizations. The health care system is "bloated" with unnecessary medical services and these could be cut in order to maintain necessary services.

b.) Insurance premiums for private health insurance increase automatically as health care costs increase. Over 90 percent of the first dollar received for premiums is paid out in benefits to providers. Self-insured employers (businesses that assume the financial risk for health care claims) are paying these cost increases directly. A recent HIAA survey found that as many as 42 percent of medium and large businesses are now self-insured.

We recognize that it is often necessary to raise additional revenue to improve access to health care. We support broad-base methods of increasing financial resources such as through general revenue to support enhancement of the state-run Medicaid program. Expanding categories of

individuals eligible for Medicaid and increasing the dollar threshold for eligibility are common methods used to expand the Medicaid program.

Thank you for the opportunity to provide the Health Insurance Association of America's comments to the Blue Ribbon Commission survey. If we can be of further assistance, please call Elizabeth Rothberg at (202) 223-7838.

York Hospital 15 HOSPITAL DRIVE • YORK, MAINE 03909-1099 • TEL. 363-4321

May 16, 1988

Members of the Blue Ribbon Study Commission
Office of Policy and Legal Analysis
Room 101/107, State House Station 13
Augusta, Maine 04333

Dear Blue Ribbon Study Commission Member,

We understand that in a few days the Governor's Blue Ribbon Commission will be attending a retreat to review options for the Committee's recommendation to Governor McKernan. While you consider the future of health care regulation in Maine, we ask that you take this opportunity to consider issues which are part of the reality of a border hospital.

While these issues may not be unique to us, or of equal importance to all other Maine hospitals, the resolution of these issues will determine whether or not York Hospital can continue to deliver quality care to our community.

This border hospital can not survive in the current system

Without relief from the adverse impact of Commission formulas, York Hospital will lose approximately $1,500,000 this fiscal year. Not next year....this year!

This border community has lost local control of its community hospital

The present system replaces the judgement of our local Board of Trustees with the judgement of a central state committee. We not only disagree with a system-wide formula for determining our resources, but also feel that it is inappropriate for the Commission to hold so much authority while leaving hospitals with all the responsibilty for the provision of care. No formula approach to health care can improve on the judgement of local residents regarding what is appropriate for their own community.

Our border position is in a very competitive marketplace

The present system does not recognize York Hospital's position on the border of New Hampshire, the least regulated state in New England. We are forced to cannibalize our assets by spending gifts and bequests given over the last eighty four years to find the resources necessary to compete for patients and employees.

York's position on the border is in the area of highest employment in the state

The present Health Care Finance Commission formulas ignore that York County has the lowest unemployment rate in Maine, and that the town of York has the lowest unemployment rate in York County.

We have turned patients away to more expensive New Hampshire hospitals due to lack of staff.

York's position on the border is in a housing market which is among the most expensive in Maine

York is a community of less than 15,000 people, yet its billion dollar property valuation is exceeded only by the cities of Portland and South Portland. The enormously expensive cost of housing is another significant element of our border environment which is not properly considered by the MHCFC.

York Hospital is forced to charge future generations for facilites used by today's patients

The present system does not adequately meet the capital needs of our facility. The results of the formulas are inconsistent. Although some hospitals actually receive amounts in excess of their capital needs, others are not allowed to charge for costs of buildings and equipment. This implies a judgement that it is better to increase costs to future generations in the name of current so-called "savings" to current consumers.

Our pursuit of resolution of border issues has resulted in adversarial relationships with regulators

The present system has created adversarial relationships when organizations have been backed into untenable financial and organizational dilemmas.

Our attempts at informal negotiations have resulted in a proposed settlement offer from the Commission which would assure an untenable financial position indefinitely, even though the legislature intended to solve the problem.

Inappropriate emphasis on political influence

The present system has politicized health care and has tended to divide Maine hospitals into groups of winners and losers. Trends indicate that large hospitals will continue to be more successful than small hospitals in the current system. Success in today's system is not a measure of management effectiveness, except as it relates to political influence.

Recommended considerations for new regulatory system

We recognize the difficulty in addressing our border issues. To provide you with our perspective of what a new regulatory environment should look like, we are including our recommendations for your consideration.

Sunset the MHCFC

End the adversarial relationships that exist between regulators and hospitals by allowing the MHCFC sunset.

Return local control to community hospitals

Allow local Boards to determine what is appropriate health care in their community. Local Boards of Trustees have the same community interest that regulators have with the additional advantage of understanding local issues. Hospitals are as different as Maine communities are different. State regulators should respect those differences.

Determine Maine's health care objectives

Focus on the State of Maine's health care objectives to determine what services it wishes to provide to its citizens. Then figure out how the State will pay for what it wishes to provide.

Focus on utilization to control costs

Accept the burden of its commitment to health care by controlling utilization not by controlling organizations. If the State wishes to control organizations to control cost, it should investigate state-run institutions. Although we doubt that state-run facilities are any more efficient, state-run institutions may provide the control some regulators may wish to achieve.

Use the free market as a partner in regulation

The American free market system has long been the primary regulator of the application of resources in the market place. While we recognize a role for government to assure a basic level of quality and public safety, we recommend that further government regulation be focused on what services it wishes to buy for its citizens. The competitive pressures of the free market provide enormous pressures to spend health care resources wisely and to meet the real demands of the consumer.

Establish a Consumer Information Bureau

An independent organization should be created to provide Maine consumers with service and quality information about Maine Hospitals. This information would assist Maine citizens in making informed decisions about their care.

If hospitals provide quality, accessible, competitively priced care, don't regulate them

We support a multitiered system which would:

Monitor quality of care.
Regulate where consumer protection is not provided by competition.
Regulate where access needs to be subsidized.
Not regulate where quality, access and competitive pricing exist.

If you have any questions about these issues, or our recommendations, please call Jud Knox at 363-4321.

Cordially, the York Hospital Trustees

Charles D. Downing
James S. Erwin
Frank E. Hancock
Stillman N. Bradish
Robert N. Kendall
Henry F. Warner, Jr.
Thomas T. Hutchins
Milton F. Todd
Jeffrey W. McConnell
Robert H. Kline, M.D.
Carolyn G. Babcock
Charles C. Lefferts
John G. Mulvihill, M.D.
Helen E. Rollins
Judith A. Andrews
Frank H. Witham
Rebecca L. Linney
Carol A. Upton

Trustees/chm
cc: Joint Standing Committee on Human Resources
Graham Atkinson, Special Assistant

MAINE HOSPITAL ASSOCIATION

March 29, 1988

Senator Paul Gauvreau, Chairman
Blue Ribbon Commission to Study the Regulation
of the Health Care Expenditures
State House Station 3
Augusta, Maine 04333

Dear Senator Gauvreau:

The Maine Hospital Association appreciates the opportunity to respond to the February 18, 1988 questionnaire provided by the Blue Ribbon Commission to Study the Regulation of Health Care Expenditures.

The Association commends the Commission for its careful and deliberate approach to its important work. The examination of government regulation of Maine's health care system clearly is an emotionally charged issue. That the Commission has achieved both the full cooperation of its members and a common purpose is indeed noteworthy.

Some have said the Commission is not moving fast enough. Others believe it has not addressed all elements impacting Maine's health care system. From the Maine Hospital Association's perspective, faster movement may have jeopardized the different informational needs of Commission members. To have involved a broader range of issues, however, would have established a work load that went far beyond the Commission's resources. In short, the Association's consensus viewpoint is that the Commission is moving at the speed most suitable for its members. The Association also believes the scope of the Commission's work is sufficiently broad so as to have significant impact.

In closing, the Association respectfully suggests the time has now come for the Commission to carefully articulate its goals in the areas of access, quality and cost. The attached paper, submitted in response to the final question in the Commission's February 18 questionnaire represents recent discussions of Association members on these and other topics. We hope the Commission will find it useful.

160 CAPITOL STREET AUGUSTA, MAINE 04330 TEL. (207) 622-4794

If after reviewing this paper, the Association can provide additional information or clarification, please contact my office.

Sincerely,

James R. Castle
President

JRC/cml

cc: Graham Atkinson, Ph.D.
Annika Lane

MAINE HOSPITAL ASSOCIATION
Response to the
Blue Ribbon Commission to Study the Regulation of
Health Care Expenditures

March 28, 1988

The following is a response to the final question in the Blue Ribbon Commission's February 18, 1988, survey. When reviewing this response it is important to note these comments do not represent a formal position adopted by the Maine Hospital Association. The response also does not reflect the views of any one hospital. Instead it is a paper which highlights the collective thoughts of a number of hospital executives condensed from numerous conversations over time. The observations, thoughts and suggestions that follow are offered as points for constructive discussion. They are not offered as finished components for the new system. The comments have been grouped into the following categories:

* Values, beliefs and principles
* Goal setting
* General observations and concerns

Values, Beliefs and Principles

Before setting about the task of redesigning Maine's Health Care Finance system it may be useful to spend time identifying the shared values of Commission members. These values would simply serve as checkpoints for the Commission in the design process. Over the past several months hospitals have spent considerable time discussing such values. A simple listing of the results of these discussions, which we have attached for your information, may be a useful illustration of this point. Please realize these statements are not formal positions of the Association or of an individual hospital. Nor is it reasonable to expect the Commission to support them as they represent only the perspective of hospitals. At the same time, they might serve as a useful starting point for the Commission.

Goal Setting

The Association urges the Commission to give considerable attention to setting specific goals with respect to the three critical areas of <u>access</u>, <u>quality</u> and <u>cost</u>. In each of these areas goals should be designed to encourage a balance between the roles of providers, government, other payers and patients.

<u>Measuring Progress</u>

The goals need to be measurable. If reducing the rate of increase in health care is to be a goal, for example, the Commission has some responsibility to determine how the reduction

The Association encourages the Blue Ribbon Commission to look at a broader range of options when examining these issues. As an example, when the Commission discussed new services and technologies a great deal of time was spent debating the need to expand Maine's Certificate of Need program. Too little time was spent clarifying exactly what it was the Commission was trying to accomplish--setting goals and listing alternatives to Certificate of Need. It was only at the very end of the discussion that another option -- limiting payment to only those services and/or settings -- was deemed appropriate. This particular option has the advantage of allowing third party payers to individually decide on services for their subscribers and recipients. While there are certainly arguments against this option, the point is that when payers or patients--or both--assume more responsibility a wider range of options can be explored and a wider range of individuals and organizations can be involved in working toward a goal.

General Observations, Concerns and Suggestions

Affordability

The affordability of health care has received a good deal of attention from the public, the media and others over the past several months and deserves attention by the Commission. The Association urges the Commission to recognize that what is considered "affordable health care" varies between those individuals and organizations with a responsibility to pay for it. Clearly, some individuals and some organizations have both the ability and willingness to pay for higher levels of health service. It is just as clear some individuals--and even some organizations--are not able to afford what would be considered the most basic of health care services. The system that is designed for the future should allow for those with sufficient resources to obtain as much service as they desire. The argument can be made that the system of the future should also be designed to ensure that those without resources have the ability to obtain needed services.

The challenge to the Commission is to decide if those without resources to pay should be able to have the same level and quantity of service as those who can afford to pay.

Historically it has been left to the providers to ration their resources. More recently the Maine Health Care Finance Commission has assumed some of that responsibility. MHCFC has assured access for Medicare recipients by requiring other insurers to make up the difference between what the federal government has decided it can afford to pay and the true cost of those services. Those required to pay more, of course, have traditionally not been allowed to participate in that decision. On the other hand, MHCFC has not permitted providers to obtain

to providing health care services in rural areas and to the poor, it seems only reasonable to expect the cost to be higher here than those states that offer less services.

Periodic Adjustments Needed

Experience suggests that the system of the future needs to be one where periodic adjustment is simplified. The system needs to be responsive to experience and the knowledge gained from experience. It needs to reflect the varied needs and values of Maine's communities.

Even the best designed system should be programmed for a life of only five to six years, given the rapidly changing environment of health care and today's economy. Therefore, it is the Association's recommendation that the new system sunset in 1995, and that a new Commission be scheduled to convene in 1993. The purpose of the 1993 Commission would be to design the health care regulatory system for Maine from 1995 to the year 2000.

Attachment

Suggested Princples, Characteristics and Elements of a New Health Care Finance System

The regulation of health care should be guided by the following principles:

1. That access to affordable quality health care be available to all citizens and maintained at current or enhanced levels.

2. That a viable community hospital system is an essential part of providing quality health care consistent with national standards.

3. That the responsibility for limiting increase in the cost of health care and assuring appropriate quality and access is shared by providers, payers, purchasers, consumers and government.

4. That the role of the State in regulating any health care activity be consistent with this shared responsibility.

5. That regulation not discriminate among providers of health care services except where necessary to preserve the public's interest.

6. That the role of the State be clearly defined and its regulatory authority asserted only when it is essential to assure a viable community hospital system in the interest of the public and when private sector initiatives are not capable of accomplishing or satisfying the public's interest.

7. That the regulation adopted by the State shall be simple, flexible and, to the maximum extent possible, reflect local, community needs and values.

8. That the State not compromise local control and authority by hospital governing boards except where essential to preservation of the public's interest.

Any new system proposed and adopted should be consistent with the above principles and should exhibit the following characteristics:

1. provide for access to health care for the people of the State;

2. be built upon a philosophy of trust and mutual respect among all parties;

MAINE HOSPITAL ASSOCIATION
Response to the
Blue Ribbon Commission to Study the Regulation of
Health Care Expenditures

March 28, 1988

The following is a response to the final question in the Blue Ribbon Commission's February 18, 1988, survey. When reviewing this response it is important to note these comments do not represent a formal position adopted by the Maine Hospital Association. The response also does not reflect the views of any one hospital. Instead it is a paper which highlights the collective thoughts of a number of hospital executives condensed from numerous conversations over time. The observations, thoughts and suggestions that follow are offered as points for constructive discussion. They are not offered as finished components for the new system. The comments have been grouped into the following categories:

* Values, beliefs and principles
* Goal setting
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Values, Beliefs and Principles

Before setting about the task of redesigning Maine's Health Care Finance system it may be useful to spend time identifying the shared values of Commission members. These values would simply serve as checkpoints for the Commission in the design process. Over the past several months hospitals have spent considerable time discussing such values. A simple listing of the results of these discussions, which we have attached for your information, may be a useful illustration of this point. Please realize these statements are not formal positions of the Association or of an individual hospital. Nor is it reasonable to expect the Commission to support them as they represent only the perspective of hospitals. At the same time, they might serve as a useful starting point for the Commission.

Goal Setting

The Association urges the Commission to give considerable attention to setting specific goals with respect to the three critical areas of <u>access</u>, <u>quality</u> and <u>cost</u>. In each of these areas goals should be designed to encourage a balance between the roles of providers, government, other payers and patients.

<u>Measuring Progress</u>

The goals need to be measurable. If reducing the rate of increase in health care is to be a goal, for example, the Commission has some responsibility to determine how the reduction

is to be measured. It could be argued that much of the debate revolving around Maine's current regulatory system may have been avoided if the measure of cost reduction had been determined before the system was put in place. If a goal cannot be stated in quantifiable terms, how will anyone know if there is progress or if the goal has indeed been reached?

Testing Goals

Having set the goals and determined how progress will be measured, the Association suggests the Commission actually test the goals. Too often goals are set which appear plausible when viewed individually. One example is the notion that the per/capita cost of health care should not rise more than the rate of increase in personal income. When taken alone, this seems a laudable goal. Maintaining the relative position of health care services and technology between Maine and the nation is perhaps a second reasonable goal. Unfortunately, the Association believes such goals lack what might be called "internal consistency." Several facts argue against the consistency of the two goals mentioned above.

1. Because our population is aging the consumption of health care resources will almost certainly increase.

2. There is evidence the rate of the expansion of health care services and technology in other states exceeds Maine's rate of growth in personal income.

3. The health care market basket -- what hospitals themselves must pay for supplies and services -- is going up at a faster rate than personal income.

Again, the point is not that one or the other of the two above goals is wrong. They simply lack consistency.

Quantifying Goals

A word about quantifying goals...It may be useful to consider quantifying goals by establishing relationships between the current norm in Maine -- or the norm among a group of hospitals-- and the desired result. One example might be quality. There are numerous standards that have been established for quality including infant mortality and admission and hospitalization rates. The same is true in the areas of access and cost.

Examining Many Options

The health care system of the future should be one which strives to balance responsibility between the provider, the patient, the payer, the insurer and the regulator. There is a tendency to look at the issues of access, quality and cost as "either-or" situations. Either the state regulates health care, or it is unregulated.

The Association encourages the Blue Ribbon Commission to look at a broader range of options when examining these issues. As an example, when the Commission discussed new services and technologies a great deal of time was spent debating the need to expand Maine's Certificate of Need program. Too little time was spent clarifying exactly what it was the Commission was trying to accomplish--setting goals and listing alternatives to Certificate of Need. It was only at the very end of the discussion that another option -- limiting payment to only those services and/or settings -- was deemed appropriate. This particular option has the advantage of allowing third party payers to individually decide on services for their subscribers and recipients. While there are certainly arguments against this option, the point is that when payers or patients--or both--assume more responsibility a wider range of options can be explored and a wider range of individuals and organizations can be involved in working toward a goal.

General Observations, Concerns and Suggestions

Affordability

The affordability of health care has received a good deal of attention from the public, the media and others over the past several months and deserves attention by the Commission. The Association urges the Commission to recognize that what is considered "affordable health care" varies between those individuals and organizations with a responsibility to pay for it. Clearly, some individuals and some organizations have both the ability and willingness to pay for higher levels of health service. It is just as clear some individuals--and even some organizations--are not able to afford what would be considered the most basic of health care services. The system that is designed for the future should allow for those with sufficient resources to obtain as much service as they desire. The argument can be made that the system of the future should also be designed to ensure that those without resources have the ability to obtain needed services.

The challenge to the Commission is to decide if those without resources to pay should be able to have the same level and quantity of service as those who can afford to pay.

Historically it has been left to the providers to ration their resources. More recently the Maine Health Care Finance Commission has assumed some of that responsibility. MHCFC has assured access for Medicare recipients by requiring other insurers to make up the difference between what the federal government has decided it can afford to pay and the true cost of those services. Those required to pay more, of course, have traditionally not been allowed to participate in that decision. On the other hand, MHCFC has not permitted providers to obtain

additional payments in cases where a community or individuals or other payers desire more services. The new system needs to allow greater opportunities for those who are being asked to pay more to voice their opinions before a publicly-accountable body. The system of the future also needs to have the capacity to allow those who wish to provide more service--and those who are willing to pay more for those services--to reach agreement without undue interference from the State.

Flawed Assumptions

Hospitals are concerned about a commonly-held assumption that more health care expense is bad. Little attention is given to the savings that often occur as a result of increased health care funding. For example the new drug TPA that prevents heart muscle damage during heart attack costs $3,000 to $4,000 per treatment. This cost is assigned to health care. Yet the cost of a disability claim, avoided through the administration of TPA, is seldom if ever considered in the equation. When health care costs are examined, such savings should be factored in when determining the true cost of health care to society. Similar examples could be given as a result of the treatment of substance abuse and mental illness. Again the cost of intervention shows in the health care column, while savings to society are rarely considered in terms of dollars and cents.

Hospitals also are concerned by the viewpoint by some in Maine that spending less on health care is good, while spending less on schools and education is bad. When the Commission looks at data that suggest Maine is spending much less each year on health care per capita than other states, the response is generally positive. Yet if it were shown that Maine is spending substantially less on education each year, it would be viewed negatively. There seems to be the belief that Maine can somehow maintain its health care system at the same level as other states while investing less in that very system. Such a belief is like saying an individual can maintain his or her relative standard of living despite having a smaller percentage increase in pay year after year than friends and neighbors. The gap will inevitably widen between the standard of living that person can afford to maintain and what others can afford.

It should also be noted that other regulated states had average health care costs well above the national average when regulation began. When regulation started in Maine our costs already were well below the national average. The quality of care and the level of services in Maine will inevitably suffer when the state seeks to lower costs that are already below the national average.

Many people who argue we pay too much for health care are quick to compare the cost of health care in Maine with states such as New Hampshire that spend less. At the same time, however, they are unwilling to accept the level of service that lesser funding provides. Given the size of Maine and its historical commitment

to providing health care services in rural areas and to the poor, it seems only reasonable to expect the cost to be higher here than those states that offer less services.

Periodic Adjustments Needed

Experience suggests that the system of the future needs to be one where periodic adjustment is simplified. The system needs to be responsive to experience and the knowledge gained from experience. It needs to reflect the varied needs and values of Maine's communities.

Even the best designed system should be programmed for a life of only five to six years, given the rapidly changing environment of health care and today's economy. Therefore, it is the Association's recommendation that the new system sunset in 1995, and that a new Commission be scheduled to convene in 1993. The purpose of the 1993 Commission would be to design the health care regulatory system for Maine from 1995 to the year 2000.

Attachment

Suggested Princples, Characteristics and Elements of a New Health Care Finance System

The regulation of health care should be guided by the following principles:

1. That access to affordable quality health care be available to all citizens and maintained at current or enhanced levels.

2. That a viable community hospital system is an essential part of providing quality health care consistent with national standards.

3. That the responsibility for limiting increase in the cost of health care and assuring appropriate quality and access is shared by providers, payers, purchasers, consumers and government.

4. That the role of the State in regulating any health care activity be consistent with this shared responsibility.

5. That regulation not discriminate among providers of health care services except where necessary to preserve the public's interest.

6. That the role of the State be clearly defined and its regulatory authority asserted only when it is essential to assure a viable community hospital system in the interest of the public and when private sector initiatives are not capable of accomplishing or satisfying the public's interest.

7. That the regulation adopted by the State shall be simple, flexible and, to the maximum extent possible, reflect local, community needs and values.

8. That the State not compromise local control and authority by hospital governing boards except where essential to preservation of the public's interest.

Any new system proposed and adopted should be consistent with the above principles and should exhibit the following characteristics:

1. provide for access to health care for the people of the State;

2. be built upon a philosophy of trust and mutual respect among all parties;

3. be designed to reward desired behavior;

4. encourage the creative, less costly and more effective delivery of health systems;

5. encourage development of flexible, innovative and efficient health care delivery and payment systems;

6. encourage and be based upon sound economic principles;

7. assure a viable community hospital system;

8. assure substantial equity among nongovernmental payers;

9. provide for availability of accurate and relevant information;

10. provide increased flexibility for helping hospitals continue services despite federal shortfalls;

11. include a mechanism for all employers to offer health care insurance and a mechanism to provide insurance for those who are currently uninsured.

The following elements should be considered in the design of a new health care finance system:

1. Medicaid would become a DRG payment system with the authority to experiment with a variety of payment systems that encourage cost-effective utilization.

2. Medicaid should institute a managed care program which includes a minimum prior authorization of selected admissions and second opinion surgery.

3. Third-party payers should be encouraged to increase payments to primary care physicians, including family practitioners, obstetricians, pediatricians and general internists.

4. Third-party payers would be encouraged to adjust reimbursement levels for certain medical specialities to encourage greater interest in primary care in rural areas and improve payment equity between physicians.

5. The use of mail order prescription drugs should be encouraged as a cost containment mechanism particularly for Medicaid and Medicare.

6. When considering the concept that there are a core set of hospital services that should be available to all Maine residents, it should be recognized that maintaining services in rural areas represents higher costs to the system.

7. A fund or pool should be created to underwrite the cost of indigent care and care for the uninsured as well as for Medicare and Medicaid shortfalls. The following taxes should be considered as funding sources: **a)** a broad-based tax (including income tax); **b)** employer taxes, property taxes; **c)** sales tax, excise tax; **d)** sin taxes on alcohol and tobacco; and **e)** hospital tax.

8. A state commission should be created to administer the pool. Funds would be used to purchase care through traditional services, HMOs or manager care plans (private/public sector initiataves)

9. Monies generated for the pool or fund for indigent care should be used to maximize the federal Medicaid benefits.

10. All equipment having a cost of over $200,000 would be subject to a Certificate of Need review without regard to setting. All changes in hospital bed size would require a similar review.

11. The State should insure physicians against medical malpractice for treating Medicaid patients.

12. There should be a tax on excess hospital profits.

13. The recognized financial requirements of hospitals should be consistent with accepted business practices and standard accounting procedures.

14. A state plan should be developed defining core community hospital services.

15. A system of interim payment should be established to assure adequate cash flow for smaller institutions.

16. Financial incentives should support selected services being provided exclusively through institutional and/or hospital settings consistent with a state health plan.

PORTLAND PRESS HERALD
Sept 7, '87

Hearing blasts health system

By JOHN LOVELL
Staff Writer

The Maine Health Care Finance Commission had no friends Tuesday at a public hearing of the Blue Ribbon Commission to Study the Regulation of Health Care Expenditures in Maine.

Since its legislative creation in 1983, the finance commission's goal has been to hold down the rising costs of medical care. But hospitals, doctors and others associated with health care say this cure has proven worse than the disease — and now, the Blue Ribbon Commission is looking at ways to change it.

Witnesses speaking before an audience of about 140 in a University of Southern Maine classroom condemned the current regulatory system for endangering the financial health of hospitals and employers while undercutting the quality of health care and its availability.

"We in the hospital-end of health care find ourselves ~~enmeshed in the most repressive~~ and restrictive control system in this country," charged Brian Rines, chairman of the Maine Hospital Association's Trustee Advisory Group.

"Unless you allow health care services and capacity to grow consistent with up-to-date costs and standards," warned the Maine Hospital Association's new chairman, William Spolyar, president of Mid-Maine Medical Center in Waterville, "the health care system in Maine will begin to erode and affect access and quality in very meaningful ways."

He said the erosion is already under way, caused primarily by "the basic philosophy of the Maine Health Care Finance Commission and its statutory authority" — its belief that "Maine hospitals can somehow function significantly below (national) norms or standards."

Five years of forced cost-cutting, Spolyar said, has meant that "hospitals have great difficulty hiring or retaining employees across the board because the wages and compensation allowed by the (Finance)

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Health

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Commission are formula-driven and do not relate in any meaningful way to the marketplace."

Maine Medical Center, after having "worked with the Maine Health Care Commission in good faith for five years," said trustee John DiMatteo, has "finally come to a point where we cannot do that any longer. Red ink — and a lot of it in the next few years — will seriously compromise our ability to care for our patients.

"Any new regulatory system," DiMatteo continued, "must do a far better job of protecting our hospitals, and by extension, our communities, than has the present system."

DiMatteo, president of Guy Gannett Publishing Co., faulted the Blue Ribbon Commission's recent draft report for lacking any mention of planning, and urged the commission to adopt a method of planning called "budget review" as a way to allocate health care resources.

Not only are hospitals health-care providers, but they also are struggling like other employers to pay mounting health care costs for their workers, said Mercy Hospital President Howard Buckley.

Mercy has faced a 40-percent rate increase in its health insurance plan, he said, illustrating that the current regulatory system "is not accomplishing what it intended to accomplish, and the total costs of health care are not totally attributed to hospital costs alone."

John Dexter, chairman of the Maine Chamber of Commerce & Industry and head of a broad employer Coalition for Responsible Health Care, predicted that as health care costs continue to increase, by 1990 or 1991 they will reach $2.90 per hour "for every hour that the average employee works.

"Who's going to pay for this increase? Clearly, business can't. Nor can or should employees," Dexter said.

The Blue Ribbon Commission plans a second public hearing today in Bangor, scheduled for 3 p.m. at the Bangor Civic Center.

The 17-member panel's chairman, State Sen. Paul Gauvreau, D-Lewiston, said the panel hopes to issue a final report this fall to the governor and lawmakers, followed by proposed legislation to create a new regulatory system in time for next year's legislative session.

BANGOR DAILY NEWS Sept 8 '88

Blue ribbon panelists hold public hearing on health care costs

By Carroll Astbury
Business Writer

A lot of people are getting concerned about the skyrocketing cost of health care. A year ago, the Maine Legislature's Blue Ribbon Commission on Health Care Expenditures started studying the problem with an eye to making a recommendation to the Legislature.

The task of the state commission is to study the financing and delivery of health care and the possible methods of regulating the industry and the expenditures for health care.

The commission recently finished a draft report containing its recommendations and came to Bangor Wednesday to hold a public hearing on the report. Representatives of hospitals, health-care agencies, labor and business came to the Bangor Civic Center to voice their opinions on the report's recommendations.

The 17-member commission, with Sen. Paul Gauvreau, D-Lewiston, as chairman, is scheduled to report its final findings to the Legislature in January. The commission's 16-page draft report addresses different methods of paying for hospital inpatient services, methods of paying for outpatient services, the problem of the federal government not paying the total bill for Medicare and Medicaid patients, and a bevy of other topics including shortages of physicians and nurses, AIDS, nursing homes, hospices, and the methods of setting rates for health-care services.

Included on the commission are representatives of large, medium and small hospitals, businesses, labor, insurance companies, and state agencies. The moderator for the Bangor hearing was Martin B. Berstein, who represents the Northern Maine Medical Center in Fort Kent.

The health-care problem is complex but the bottom line is cost. Everyone is concerned with paying the bill.

Roger Mallar, former head of the Maine Department of Transportation and chairman of Gov. John R. McKernan's Economic Development Strategy Task Force, came to the hearing to represent the Coalition for Responsible Health Care. The coalition is made up of a number of business organizations that have joined forces to make sure that their concerns about health care are made clear.

"We believe that the commission should aim its recommendations at addressing the overall problem of the potential for the collapse of our health-care system, not just finding a more acceptable method of hospital regulation," Mallar said.

The coalition is concerned with projections showing the cost of health insurance doubling by 1991. The fear is that many companies and individuals simply can't afford such an increase. With growing numbers dropping their insurance, the whole system could be in jeopardy.

Mallar also addressed the fact that the federal government doesn't reimburse all of the costs incurred by Medicare and Medicaid patients.

The current payment system in Maine lets hospitals charge its paying customers, in the form of higher rates, for the costs for Medicare and Medicaid patients that aren't paid by the government. Those costs are estimated to be about $100 million a year.

Mallar recommended that the governor and the Legislature find a "broad-based source" to pay for the shortfall, or the difference between what the care for the Medicare and Medicaid patients costs and the amount that the federal government will pay.

"Purchasers of health-care insurance should not be required to pay for unfunded governmental programs," he said.

The commission seems to agree with Mallar. Its draft report recommends that money to cover the shortfall be taken from the state's general fund. "The amount would be distributed among the hospitals most affected by the shortfalls," the report states.

While cost is perhaps the major problem faced by the commission, there are other concerns. For example, Bonnie Brooks, executive director of Opportunity Housing in Bangor, came to testify about the shortage of psychiatrists, "at any cost," who will deal with her agency's clients.

Opportunity Housing's clients are people who are both mentally ill and mentally retarded. There often is no one to help them, Brooks said.

Sea-urchin roe becor international delica

By Susan P. Morrissey
Midcoast Bureau

WALPOLE — It's green and spiny outside, and its insides taste ah — m Covered with sharp spines and found fr shallows to the depths of the Gulf of Main as common as stony beaches along the co just two seasons, it has become the state test-growing contribution to the interna seafood market.

In Japan, where most of them are const the roe of the spiny green sea urchin is s for $50 per pound. Last year, Maine harv and processors sent most of the 6 m pounds of urchins dragged up and picked bottom of the Gulf to Japanese markets year, the harvest is expected to top 20 m pounds.

To give the state's urchin business the they think it deserves, the Department o rine Resources, the University of Maine's erative Extension Service and the Da Center for Marine Research at Walpole collaborated to produce a piece of equip adaptable for use on fishing vessels large small. The latest in seafood harvesting e ment is low-tech, simple to operate and cl It is a vacuum cleaner for sea urchins.

"It was built with the small harvest mind," said co-designer Ben Baxter of th operative Extension Service.

Since fishermen began harvesting the st wild population of urchins in earnest two y ago, all of the spiny green delicacies broug table here and abroad were dragged up in hand-picked on the bottom by divers or lar incidentally in lobster traps. Dragging is d aging to the sea bottom, hand-picking is lab ously slow, and trap pickups are at incidental. The vacuum cleaner, designe agricultural engineering students at the versity of Maine, seems the solution to a p problem.

"The vacuum has little impact on the bed," Baxter said.

The green sea urchin is harvested from tober to March, a slack season for many fis men but the peak of the reproductive cycle

Ocean resear

States News Service

WASHINGTON — Legislation to expand entific research and monitoring of pollutio the Gulf of Maine and other U.S. coastal wa cleared a key House subcommittee Wednes setting up a tight race to win congressi approval of the measure before Congress journs next month.

The bill, passed unanimously by the Ocear raphy Subcommittee, would establish 11 gional centers across the country to plan coordinate the research efforts of state ag cies, universities and private laboratories.

Supporters of the measure, which would about $34 million annually, contend the cent are needed to help scientists more closely id tify and monitor the problems specific to th region. The program would be paid for by

Teachers in unorganized territories

"It's cess wi all inc

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Maine Health Care Association

April 4, 1988

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

Dear Ms. Lane:

I have carried your memo of February 19th several thousand miles and, obviously, several days beyond its deadline, thinking at some point inspiration would come to me that would allow me to respond to the survey in such a way as to relate to the Commission's scope of work. That inspiration has not come. The questionnaire, like the proverbial camel, seems to be a horse built by a committee.

There is a truism in planning that has been used so often it is a cliche', but like so many cliches, it contains fundmental truth. It says, "if you don't know where you are going, any road will take you there." It seems to me, and my observation of the Commission is limited, so I could well be wrong, that the commission needs to agree on some fundamental policy issues, a foundation if you will upon which we can build the structure of a different health care system, if that, indeed, is what we intend to do.

I believe we should start with the very basics, those things upon which we all agree, and move on. If we can't agree on the basics. then let's agree on that and let the system fall where it may. But let's do something, one way or another. With that having been said, I would lay out the following as basic policy foundation, Level I if you will.

A. The demand for Health Care spending is insatiable.

B. Responding to that demand does not make anyone a bad person, while not responding to it could.

C. The Provider Community, therefore, needs some type of external control mechanism if we are to limit dollars spent on Health Care.

D. We need to limit dollars spent on Health Care.

E. Providers will always respond to financial incentives.

F. We need to structure our incentives, then, in such a way as to lead Providers in the way we would have them go.

This is the point where I would stop and ask for agreement. If there is none, I would spend the summer enjoying our wonderful Maine weather.

If we can all agree on the basics, then we can go on to the next level and see if we can agree some more. The Level II policy issues are:

A. There is no "free" Health Care.

B. Non-Profit does no means no profit, it means non-tax paying.

C. All facility-based Providers need an excess of revenues over expenses to survive and provide that extra that is quality.

D. All Providers need external cost controls that are reasonable and fair, but that permit failure.

E. All facility-based Providers need to be allowed equal access to resources if we are to build an equitable system.

F. We need to build an equitable system.

This is another stopping point. At this point, we may have disagreement and need to reassess where we are. If there is agreement, I would move to the Level III Policy issue. It is an option:

A. Cost shifting in and of itself is legal, but ought to be minimized.

OR

B. Cost shifting in and of itself is illegal and our system must be based on each payer providing adequate funding for its clients, or in the alternative insist that Providers find ways to provide services within the payment limit.

I guess that is the final stopping point for now. Once these policy issues are agreed upon, resolved or not resolved, I would be willing to offer further comments or recommendations, or respond to further questions.

If Option IIIA is selected, we can move in one direction. If Option IIIB is our choice, then it requires a whole different direction. I would be pleased to offer additional comments once I know where the Commission is with regard to the policy issues raised.

Sincerely,

Ronald G. Thurston
Executive Vice President

RGT/pd