# ASSURING ACCESS TO HEALTH CARE

A Report
of the
Special Select
Commission
on Access to
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(Resolve 1987, Ch. 347)

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# ASSURING ACCESS TO HEALTH CARE

## A REPORT OF THE SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

### Executive Summary

The Special Select Commission on Access to Health Care was created by the 113th Session of the Maine Legislature to "investigate and make recommendations to the Governor, the Commissioner of Human Services and the Legislature to assure access to adequate health care for all citizens." Through its deliberations over the past year, the Commission reviewed existing programs, solicited testimony from those affected by and involved in the health care delivery system, and identified criteria for use in designing a plan which would improve access to health care for Maine's citizens. The resulting recommendations represent the Commission's initial proposal to address the barriers to adequate health care services and insurance in Maine.

The Commission proposes a combination of expanded health insurance coverage and service delivery initiatives in its plan.

To expand insurance, the plan:

- establishes a state-funded Medicaid Buy-In program, available to all individuals with incomes below 100% of poverty at full subsidy, and to individuals with incomes between 100 and 150% of poverty with a sliding scale premium.
- creates a program to help reduce the cost of health insurance for employers with less than 10 employees by subsidizing the cost of reinsurance, and
- provides a tax credit for a limited period to encourage small employers not currently offering health insurance to do so.

To expand services, the plan establishes a grant program to fund local health care providers to:

- deliver preventive and primary care services in their communities; and/or
- provide health promotion and health education services to their communities.

The Commission believes that its recommendations which will cost approximately $30 million will provide significant improvements in access to health care for Maine people and that they represent a win/win strategy for consumers, payors, and the health care system. Their implementation will not only assist individuals but will result in a reduction in the cost of uncompensated hospital care, thereby alleviating the hospitals' bad debt experience and the resulting financial burden to other payors. The Commission looks forward to legislative approval of its recommendations and ongoing discussion with providers, insurers, business, and consumers so that the goal of adequate and accessible health care for Maine's citizens can be achieved.

# ASSURING ACCESS TO HEALTH CARE

## A Report of the Special Select Commission on Access to Health Care

### INTRODUCTION

The Special Select Commission on Access to Health Care was established by the 113th Session of the Maine State Legislature (P.L. 87, Chapter 347). It is an eleven member Commission, appointed by the Speaker of the House and President of the Senate. The Commission's duties are to "investigate and make recommendations to the Governor, the Commissioner of Human Services and the Legislature to assure access to adequate health care for all citizens." The legislation further stated "the Commission's investigation shall include, but not be limited to, a review of all Medicaid options in which the State does not presently participate, and the possibilities of private and public medical insurance programs for people who cannot purchase their own insurance."

Over 130,000 people in Maine lack health insurance[1] and considerably more face other barriers to access to health care. This report presents the Commission's proposed plan and recommendations to address the barriers to adequate health care and insurance in Maine. It reflects a year of deliberations by the

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1 Based on estimates from the Human Services Development Institute's report Health Insurance Coverage in Maine: An Analysis of the Problems, its Effects and Potential Solutions. Estimates were adjusted to reflect the lack of insurance in the entire population, including children.

Commission and active participation from a number of interested parties, including the business community; hospitals, physicians, and other provider groups; insurers; and consumers and their advocates. With the assistance of a consultant firm, Lewin/ICF, the Commission conducted five seminars in the summer and fall of 1988 to determine the extent of the problem of inadequate health care in Maine and to determine potential solutions. These seminars were participatory in structure, benefiting from extensive input from representatives of those groups noted above. The proposals that follow represent the Commission's initial recommendations for its continuing agenda to address the problem of access to health care in Maine. The plan focuses on efforts to expand insurance coverage, supplemented by service delivery initiatives designed to improve access to needed services.

This report describes the components of the Commission's plan and is organized into four sections:

Section A presents the approach to designing a health care plan.

Section B describes the insurance initiatives.

Section C describes the service delivery initiatives.

Section D describes other recommendations.

## A. APPROACH TO DESIGNING A HEALTH CARE PLAN FOR IMPROVING ACCESS TO HEALTH CARE

Early in its deliberative process, the Commission identified the criteria which it would use in designing its health care plan to improve access to health care for Maine's citizens. The proposals presented in this report takes major steps in meeting those criteria.

The access problems identified by the Commission include financial barriers but are also broader than lack of insurance coverage. Some of Maine's citizens have difficulty accessing the health services they need for one or more of the following reasons: a lack of appropriate providers in the community; providers unwilling or unable to treat low-income people,

including Medicaid recipients; a lack of transportation to health care providers; and providers not available on weekends and in the evening, creating access barriers forthose low-wage employed persons who lose income if they take time away from work to seek care.

Neither insurance nor service expansion alone will solve Maine's problem of inadequate health care for its citizens. Both insurance and service delivery initiatives are integral to the success of a health care plan for four reasons:

- Insurance initiatives, while expected to cover many additional people, would still leave a significant number of people uninsured.
- Many of those people who are insured remain uninsured for specific services (e.g., primary care, prescription drugs, dental care) and would need a service system in place to provide those services.
- Since many low income insured persons confront deductibles and coinsurance that may make access to care costly and difficult, the availability of care on a reduced fee basis may be a critical factor in these families obtaining timely care.
- Having insurance does not necessarily guarantee that the services are in place or that services are accessible. This is especially true for certain conditions, such as AIDS, for certain groups of people, such as the homeless, for certain geographical areas, such as rural areas, and even for certain types of services such as prenatal care.

1. Criteria Used to Design the Health Care Plan

The Commission used a number of criteria as guiding principles in designing the components of its proposed health care plan. The criteria are:

- Expand equal access to appropriate and necessary care. No one in Maine should be denied access to needed medical care; this care should be received in settings that are appropriate to the nature of the medical condition. For example, emergency rooms are not appropriate settings for ongoing primary care.
- Assure cost-effective and affordable health care. People in Maine should be able to obtain needed health services at a price they can afford and be covered by a health insurance plan which promotes appropriate use of medical care.

- Rely on broad-based financing sources. Providers, employers, the public sector, and the consumers themselves all share in financing health care. Solutions should seek to avoid an imbalance in this distribution.

- Assure that services are available on a sliding scale. Consumers should be able to obtain care at a price they can afford based on their income.

- Maintain a mixed system of insurance and service delivery approaches and public and private sector approaches. Solutions should build on the current mixed public-private system of insurance coverage and service capacity and not duplicate or replace it.

- Promote preventive and primary care, not just catastrophic. Solutions should assure that care is received early enough in the stage of the illness to prevent more serious health outcomes and treatment expenses.

- Maintain and improve quality of care. The plan should encourage the use of high quality and efficient providers.

- Encourage reality-based solutions and build on the current system. The plan should build on existing mechanisms rather than replace them.

- Be acceptable to health professionals. The plan should not place onerous requirements on health professionals; it should reimburse providers fairly for treating patients.

- Prevent an adverse impact on the business community; it should not be a disincentive for economic development. The plan should not place a disproportionate share of the responsibility of the uninsured solution on the business community and thereby lessen Maine's ability to compete with other states in attracting and retaining job-creating industries.

- Foster the perception that people be treated fairly. Business, providers, insurers and consumers should view the plan as fair.

- Assure administrative feasibility. Solutions should not be overly complex or pose undue administrative burdens on the health care system.

## 2. Overview of the Commission's Proposed Plan and Recommendations

The major goal of the Commission's proposed plan and recommendations is to expand access to health care in Maine. The plan seeks to maximize insurance coverage by providing a subsidized Medicaid-like product and establishing incentives to encourage employers to offer insurance. To supplement the insurance initiatives, the plan also includes service

delivery initiatives designed to improve access to needed services for uninsured and newly insured persons. For example, it provides resources to help link patients to primary care services.

To expand insurance, the plan:

- establishes a state-funded Medicaid Buy-In program, available to all individuals with incomes below 100% of poverty at full subsidy, and to individuals with incomes between 100 and 150% of poverty with a sliding scale premium.
- creates a program to help reduce the cost of health insurance for employers with less than 10 employees by subsidizing the cost of reinsurance, and
- provides a tax credit for a limited period to encourage small employers not currently offering health insurance to do so.

To expand services, the plan establishes a grant program to fund local health care providers to:

- deliver preventive and primary care services in their communities; and/or
- provide health promotion and health education services to their communities.

The Commission deliberated on several other issues, including the availability of adequate numbers of health professionals in Maine, and the effects of medical malpractice on access to care. Comments and recommendations on these issues conclude the report.

## B. INSURANCE INITIATIVES

The proposed insurance initiatives build on existing mechanisms, namely the Medicaid program and employer-based insurance. The insurance expansion consists of a three-tiered approach targeted toward different segments of the uninsured and underinsured population. The three components of insurance expansion are:

- A State-funded Medicaid Buy-In program, which is the major insurance initiative and is targeted toward persons whose incomes are below 150 percent of the federal poverty level.

- Small group employer health insurance subsidy program, providing subsidized reinsurance coverage, which is targeted toward employers with fewer than ten employees.
- Tax credit program, which is to encourage small employers to provide insurance. This is targeted to employers who have not previously provided health insurance to their employees.

While these insurance initiatives are designed for different segments of the uninsured population, some overlap is likely to exist among those eligible for the Medicaid Buy-In program and employer-based incentives. The plan seeks to assure coordination among plan components to maximize coverage, but minimize duplication and inefficiency. Each of the insurance initiatives is described below.

1. State-Funded Medicaid Buy-In Program

Maine has traditionally had a comprehensive Medicaid program and has adopted most of the recent optional Medicaid expansion options including the SOBRA provisions.[2] This has permitted the state to leverage federal funds to help pay for medical care to the poor since 67 percent of Maine's Medicaid services funds are federal.[3] Maine recently extended Medicaid eligibility to pregnant women and infants whose incomes are below 185 percent of poverty, to children under age 5 who are below the poverty level, and to elderly and disabled persons who are below the poverty level. The only remaining Medicaid expansion option which would receive federal matching dollars is to extend eligibility to children between age 5 and 8 who are below poverty.

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2 The SOBRA provisions are optional expansions of Medicaid including extending coverage to pregnant women and infants whose incomes are below 185 percent of poverty, children under 8 in families with incomes below the poverty level, and the elderly and disabled with incomes below poverty.

3 State match rate for Maine's Medicaid program in SFY '89 is 0.3322; in SFY '90, that rate will increase to 0.3443.

The Commission proposes to build on the existing Medicaid program by establishing a state-subsidized insurance program similar to the Medicaid program. This initiative would enable low-income uninsured persons to obtain a Medicaid-like benefits package on a sliding scale premium related to their income. The comprehensive benefits of this program are particularly appropriate for this population since out-of-pocket costs of deductibles, copayments and uncovered services such as primary care present significant barriers to access to care. This approach has six major advantages:

1. it builds on the existing Medicaid infrastructure in Maine, such as benefits, costs, and reimbursement, and administrative mechanisms.
2. it enables people who lose Medicaid coverage as a result of becoming employed to obtain affordable coverage;
3. it extends Medicaid-like coverage to other members of a family where infants or young children are already covered through the SOBRA expansion;
4. it offers a Medicaid-like program to additional population groups, thereby potentially reducing the stigma associated with being on Medicaid;
5. the state can apply the premiums for enrollees toward the Medicaid income limits for determining "spend down," and thereby leverage federal dollars for those persons with large medical expenses; amd
6. the covered benefits can be designed so as not to duplicate existing available coverage, and therefore, take maximum advantage of the federally-matched Medicaid program.

This state-subsidized health insurance plan would have the same benefit package as the Medicaid program (see Exhibit 1) and would be available to persons with incomes below 150 percent of poverty ($17,400 for a family of four, 1988) with a sliding scale premium. For persons enrolling who have incomes below 100 percent of poverty, the State would pay the premium, while persons with incomes between 100 and 150 percent of poverty would receive a subsidy for part of the premium based on a sliding scale. The Commission proposes that an individual's share of the premium would not exceed 3 percent of his/her gross income.

New beneficiaries with incomes above 150 percent of poverty would not be eligible for the program. However, participants in the state-subsidized health plan whose incomes increased beyond the eligibility level could continue enrollment during a transition period. After meeting certain criteria (e.g., lack of employer insurance) these individuals could continue to participate in the program for up to two years after they were no longer financially eligible. A rate schedule of appropriate premium contributions would be established. A special appeals process would consider continuing coverage for individuals with no other affordable insurance option.

To discourage individuals from dropping any current insurance in favor of the Medicaid Buy-in program, the plan would coordinate with existing health insurance coverage. For those individuals who currently have a group or individual policy or who are on Medicare, the Buy-in Program would be secondary, serving as a "wrap-around" for those other insurance products. The Buy-in would serve as a wraparound in four ways:

1. provide coverage for benefits not covered by the existing plans, such as prescription drugs;
2. provide coverage to dependents when employer-based insurance is only available to the employee;
3. provide a subsidy for the enrollee's current copayments and deductibles provided certain income criteria are met; and
4. provide a subsidy for the enrollee's private insurance premiums when the individual's premium share exceeds 3 percent of gross income.

By structuring the Buy-in Program as a wraparound, the program seeks to encourage employers to continue to provide insurance and would not compete with private insurance plans.

Initial estimates of participation in and cost of the program suggest the following:*

- Up to 52,000 individuals (adults and children, elderly and disabled individuals with incomes to 150% of poverty) are expected to enroll during the initial year of the program. The majority of those enrollees are likely to be uninsured, but some may purchase the coverage to supplement their current insurance.
- Costs of the Medicaid Buy-in program for 52,000 individuals approximate $24 million. These cost estimates are based on FY '88 AFDC/Medicaid expenditures, adjusted for FY '89 physician fee increases and expected increases in Medicaid hospital expenditures for FY '89.

The Department of Human Services would be the designated state agency to administer the program. Administrative costs would include initial program design and development, and ongoing marketing, outreach, eligibility determination, and claims processing. Adequate staff and support resources must be allocated to this initiative to ensure the success of this program.

2. Small Group Employer Health Insurance Subsidy Program

The Commission also proposes the development of a small group employer health insurance subsidy program, to subsidize employment-based health insurance coverage provided by the private sector. This subsidy would be available for insurance offered by businesses with fewer than ten employees, in the interest of making a health insurance product available to those employers who have particular difficulty accessing insurance coverage due to cost and medical underwriting practices.

*An explanation of the methodology used to calculate eligible populations, participation rates, and cost estimates is available as a supplement to this report.

To reduce business costs of providing insurance the State would subsidize the cost of reinsurance. This would amount to a full subsidy of any cost exceeding $25,000 per episode of illness. The savings to the insurance carriers generated by this provision would be passed on directly to program participants in the form of premium reductions. It is anticipated that the estimated cost to the State of providing reinsurance coverage would be $2.5 million.

The Small Group Employer Health Insurance Subsidy Program would be available on a statewide basis, and uniform criteria would be applied to all prospective carriers of the insurance product. All businesses meeting the criteria of fewer than 10 employees (FTE) would be eligible to purchase insurance, regardless of their insurance status at application.

Criteria for the terms of the product, for which reinsurance would be funded, would be established by rulemaking with input from interested parties. By establishing criteria for the benefits to be offered, the state could assure that it is subsidizing a product which includes coverage of primary care. Those criteria would include:

- minimum benefit package
- program eligibility
- medical underwriting criteria
- minimum employer contribution to employees' premium
- minimum length of time of employer participation

Any insurer licensed in the State who offered small group coverage would be eligible to apply as a carrier, and would negotiate the cost of the product with the State. The State would serve as a resource to small businesses, providing information about the terms of the coverage and the participating insurance carriers.

3. Tax Credits for Employer-Based Insurance

The Commission recommends the creation of a tax incentive plan to assist small businesses who are first time purchasers of health insurance for their employees. The plan would provide a tax credit for each employee who is actually covered by an employer sponsored group medical insurance policy. The amount of the credit would be comparable to the subsidy provided for reinsurance coverage per employee, in the program described above. To qualify for this credit, the employer must offer a health insurance product which meets State-specified criteria. Employers would be eligible to participate in either the reinsurance subsidy program, or the tax incentive plan but not both.

The credit would be available to all employers who have fewer than 10 FTE employees and who have not previously offered group coverage. Once enrolled the tax credit would be available to employers for a period of up to 3 tax years, as long as the employees continue to be enrolled in a qualified group plan during this time and regardless of the number of FTE persons employed.

Employers would be required to contribute to the cost of the employees' premium, based on criteria specified by the administrative agency of the state. The tax credit would be in the form of a refund, enabling all employers to receive a cash benefit, regardless of their current tax obligation. Those plans qualifying for the credit would be comparable to those approved under the Small Group Employer Health Insurance SubsidyProgram, so that coverage for primary care services would be included. The direct cost of the tax credit program to the State is estimated at $700,000 for the first year of operation.

C. SERVICE DELIVERY INITIATIVES

Persons who have insurance, as well as any persons remaining uninsured, need providers available and willing to serve them. The expanded Medicaid coverage through the Buy-in program is expected to insure a large number of uninsured people in Maine, yet even many of those currently on Medicaid report difficulty getting services from certain providers.

Access to medical services is a particular problem in rural areas. Some areas do not have adequate numbers or types of health professionals; lack of transportation may prevent people from reaching providers; and the absence of a "critical mass" of people limits the provision of certain services in rural areas. Even if each person in rural Maine were insured, support for the service system would also be needed to assure access to care.

To alleviate the problems of access to services, the Commission's plan includes a Community Health Program. Through this program, the state would subsidize local health providers who offer health care on a sliding scale adjusted to the consumer's income.

1. Community Health Program (CHP)

The Community Health Program (CHP) would expand health and medical resources available to local communities through a grant program while encouraging the development of greater efficiencies in care for low-income persons. Through CHP the state would help fund existing local health providers or new organizations where existing providers are unwilling or unable to participate, who would directly provide or arrange access to the following services:

- Primary and preventive services.
- Referral to specialty and inpatient care.
- Prescription drugs.

- Ancillary services.
- Case finding/outreach to bring people into the system.
- Health Education.

These grants could support the direct delivery of primary care services, outreach efforts to bring people into the system, and referrals of patients to other parts of the system.

The precise approach for each grant would depend on available local resources and organizations and the specific needs of the community. No single model for using the grants is specified; instead grants would be designed to maximize flexibility and respond to the diverse needs of local communities while still meeting the guidelines established by the Community Health Program.

Grants for providing access to services would be awarded to health care providers in local communities who demonstrate the capacity to provide an organized system of primary care. Funds from this program would be targeted to preventive and primary care services; they would not be available to subsidize inpatient services. Eligible grantees would include, but not be limited to, groups of physicians, community health centers, or hospital outpatient departments.

The Department of Human Services would administer the Community Health Program. As the administrative agency it would solicit proposals from qualified applicants and award funds on a competitive basis. Grants would be renewable, provided that open, competitive bidding for funds be conducted at least every three years. The selection and amount of grant awards would be based on:

- documented health status needs;
- documented financial hardship (e.g., area unemployment);
- evidence of problems of access to health care services; and
- evidence of local commitment to the program.

Grant proposals would be reviewed by a panel consisting of state officials and outside advisors. Applicants would have to meet the following criteria:

- Arrangements for services 24 hours a day, 7 days a week.
- Full hospital privileges for all primary care physicians or arrangements to refer patients for inpatient hospital care and specialist services. Arrangements must be in writing and/or the provider must be able to demonstrate that the patients are being accepted and treated.
- Provision of follow-up care from the hospital and/or specialist to the patient's primary care provider.
- Access to ancillary services including laboratory, pharmacy, and radiology.
- Linkage to WIC, nutritional counseling, and social and other support services.
- Acceptance without limits of Medicaid patients and uninsured persons, including public notice of appropriate sliding fee scales.
- A medical record system with arrangements for the transfer of records to the hospital, specialist, and back to the primary care physician.
- Quality assurance mechanisms to evaluate the quality and appropriateness of patient care.
- Evidence of community-wide input into the design and provision of health services to be funded under this program.

A portion of the CHP funds would also be available for health promotion and health education programs. Applicants in this area would be required to demonstrate their ability to coordinate their services and programmatic efforts with local primary care providers and to provide a plan for follow-up care for the consumers whom they serve.

The Commission proposes that a sum of $2 million be allocated annually to the funding of community health programs.

## D. OTHER RECOMMENDATIONS

### Availability of Health Professionals

The Commission focused a part of its deliberations on the availability of health professionals throughout the state. In a few areas of the state the access problem is one of absolute lack of health professionals such as physicians, physician's assistants, nurses, and physical and occupational therapists. It is extremely difficult to attract health professionals to practice in those areas, and to retain them for an extended period of time. Beyond the particular areas of crisis there is an almost universal problem with an adequate supply of health care workers to meet the needs of Maine's population.

The Commission considered several alternatives to address this problem, such as training and preparation programs, community incentives, and loan repayment, but elected not to make a specific recommendation at this time. In its ongoing deliberations, it will await the results of a survey of health professionals, conducted by the Katahdin Area Health Education Center, and monitor the progress of the Department of Human Services' physician loan repayment demonstration project. Further, it will review any legislation submitted during the 114th Legislature which addresses this issue and participate in the legislative deliberations.

### Medical Malpractice

The Commission concludes that the high cost of medical malpractice insurance restricts access to health care in some geographical areas of the state and for some services. Rising and unstable malpractice premiums also causes restricted access for some individuals whose health insurance payments are low or who are perceived as being a high risk and likely to seek a judgment. The Commission recommends that the Legislature study the

effects of the malpractice reforms previously enacted to identify those that have been most effective in stabilizing premium rates. The Commission also feels that action should be taken by the Maine Legislature to reduce the price of medical malpractice insurance. Strategies which the Commission feels should be considered during the 1989 Legislative session include insurance reform, tort reform, risk management and insurance subsidies for certain providers in order to promote access.

## CONCLUSION

In the course of its deliberations, the Special Select Commission on Access to Health Care reviewed existing programs in Maine, received testimony from many providers, payors and consumers, and examined the proposals and activities of other states. The Commission is convinced that its recommendations will provide significant improvements in access to health care for people in Maine, and will place Maine in the forefront as a state which is seriously addressing the problem of access to health care for its citizens. It recognizes that these proposals are first steps, and that further work will be necessary to continue to address other barriers to health care delivery and the complexities of the rising costs of health insurance.

The proposals recommended by the Commission will provide benefits not only to individuals, but also to the businesses and private payors in Maine who are currently carrying the burden of hospital bad debt and charity care, estimated to cost $40 million a year. With the implementation of the proposed programs and, ultimately health insurance coverage for previously uninsured persons, the aggregate cost of their uncompensated care will be reduced. This reduction in charity care costs, through the infusion of public and private funds is expected to alleviate the hospitals' bad debt experience and the resulting financial burden to other payors.

The Commission believes that its proposals represent a win/win strategy for consumers, payors and the health care system. The most significant aspect of this plan however, is that it affords the opportunity to improve the public health of the citizens of Maine.

EXHIBIT I
MEDICAID BENEFITS IN MAINE

- Inpatient hospital care
- Ambulance
- Outpatient hospital care
- Rural health clinic
- Physician services
- Skilled nursing facility services
- Family Planning
- Preventive Health Program (EPSDT)
- Home health care
- Independent laboratory and x-ray
- Nurse midwifery services
- Dental, dentures (with age limitations)
- Veneral disease screening
- Podiatrist's services
- Medical supplies, equipment
- Speech and hearing centers
- Speech pathology
- Optical
- Chiropractic
- Intermediate care facilities
- Intermediate care facilities for the mentally retarded
- Home and community-based care for the mentally retarded, for the elderly, and the physically disabled
- In-patient pyschiatric services for under age 21 and age 65 and older
- Prescription drugs
- Optometry
- Transportation
- Medicare Part A deductible and co-insurance
- Medicare Part B deductible and co-insurance
- Medicare Part B premium
- Audiology
- Residential treatment facility
- Hearing aid dealers
- Physical therapy
- Personal care
- Private duty nursing
- Psychology
- Psychological examiners
- Substance abuse treatment
- Occupational therapy
- Day habilitation services for persons with mental retardation
- Ambulatory Care Clinics
- Case Management

1. Current, as of February 1989