The Cost of Health Care in Maine

An analysis of health care costs,
factors that contribute to rising costs,
and some potential approaches to stabilize costs.

Report of the

YEAR 2000 BLUE RIBBON COMMISSION ON HEALTH CARE

to

Governor Angus S. King, Jr.

November, 2000

The Year 2000 Blue Ribbon Commission on Health Care was appointed by Governor Angus S. King, Jr. on February 1, 2000 to identify the cost elements of Maine's health care system, identify factors that are driving up health care costs, examine cost shifting, and offer some potential strategies for stabilizing health care costs.

Members of the Commission

Robert Woodbury, *Chair*: Acting Dean, Muskie School of Public Service, University of Southern Maine; Former Chancellor, University of Maine System; Former President, University of Southern Maine.

William Beardsley: President, Husson College; Chairman, New England School of Communications; Treasurer, Member of the Board, Finance Authority of Maine; Member, Past Chairman, Maine Higher Education Council;

Joseph Carleton: Attorney at Law; Former Member of the Maine State Legislature's Banking and Insurance Committee which deals with health care.

Thomas Moser: Founder, Thos. Moser, Cabinetmaker; Founding Board Member, Maine Employers' Mutual Insurance Company; Member, Board of Visitors and Osher Library, University of Southern Maine.

Pamela Plumb: Principal, Pamela Plumb and Associates; Former City Councilor and Mayor, Portland, Maine; Former President, National League of Cities.

The Maine Development Foundation served as the Commission Secretariat, with Craig Freshley as lead staff. Henry Bourgeois, the foundation's president, was integrally involved.

The research was performed in partnership with the Edmund S. Muskie School of Public Service, University of Southern Maine, with Gino Nalli as principal researcher.

Visit the website of the Commission on Health Care at www.mdf.org/chc for background papers, bibliography, minutes of meetings, text of presentations, and more.

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Background papers and bibliography available at website

EXECUTIVE SUMMARY

On February 1, 2000, Governor Angus King appointed the Year 2000 Blue Ribbon Commission on Health Care by Executive Order, comprising Robert Woodbury, chair, William Beardsley, Joseph Carleton, Tom Moser, and Pam Plumb, the commission had four primary charges:

- identify the cost elements of Maine's health care system, taking into account the state's demographic profile;
- determine the current allocation of costs and cost shifting among participants in the health care delivery system;
- recommend potential strategies for stabilizing overall health care costs;
- identify payment options for health care services, including the impacts of such options on costs and utilization.

To meet those challenges, the commission, with administrative support from the Maine Development Foundation, engaged research consultants, held both working and topic-specific meetings, solicited comments from members of the health care community and the general public, and held an all-day conference.

The commission's first task was to examine the myths and realities of the state's health care system. Among the things we discovered:

- We don't allow health care delivery to operate as a market in the true economic sense. Unlike in a traditional marketplace, we are not prepared to let those unable to pay go without. Furthermore, the health care system has no real accountability, contains few incentives to encourage better behavior, and encompasses no common understanding of terminology. Its consumers and providers are neither sensitive to—nor in many cases aware of—price, and its market in Maine is too small and too sparse to encourage meaningful competition.

- Mainers are not particularly healthy. In fact, and despite a general belief that there is nothing an average citizen can do to decrease health costs, Mainers smoke too much, eat too much, and generally do not live healthy lives. Thus many of the most expensive medical procedures stem from individual behavior.

We also examined the social context in which health care takes place, that is, the importance of health care in the community, of public health efforts, and of other government policies and programs. In addition, we considered the relevance of environmental and economic development policies to health care. Some of the conclusions we reached:

- "Health care" is much broader than services in a physician's office or hospital. It also encompasses a great deal of care provided by family members and communities, as well as public health efforts, and even recreation and fitness opportunities.

- Federal policy drives much of Maine's health care delivery system. Approximately one-third of the state's citizens are covered by Medicare (federal program that insures health care for the elderly) and Medicaid (state program funded mostly from federal sources).

- Maine has the highest percentage of uninsured people in New England. On the whole, that group - 40 percent of which earn between $10,000 and

$15,000 annually - has much higher rates of serious disease and morbidity than the rest of the population. In other words, those individuals need more acute - and expensive - care than others, and are more likely to die at a younger age. About 18,000 of Maine's children are uninsured (11,000 of these children appear to be eligible for government insurance programs but are not enrolled). The fact that so many children are uninsured holds serious implications for the cost of health care in the future: children who do not receive needed health care often become adults with serious health problems.

We performed a significant study of the actual cost of health care in the state. Among its many findings:

- The citizens of Maine spend almost five billion dollars a year for personal health (an average of nearly $4,000 per person), an amount representing nearly 14 percent of Maine's gross state product. By 2010, that number is expected to be approximately $9 billion, with the largest increases coming in home health care and drugs, and the smallest in hospital and physician services.

- Compared to the nation as whole, Maine spends more on home health care, nursing home care, and insurance administration. It spends less, however, on hospital care and physician services. It also spends much less than the national average on public health efforts.

- Maine receives less federal reimbursement for Medicare than most other states: about 80 cents for each dollar spent. The shortfall—approximately $100 million—is shifted to other populations for payment.

- The cost of health services differs widely across Maine, sometimes by thousands of dollars.

- Charity care and bad-debt write offs account for about $163 million annually in Maine.

- Drivers of high health care costs include both the concrete and the abstract: high demand; emotional considerations; aging population; insensitivity to the costs of treatments; the price of prescription drugs; lack of meaningful performance measures; the sheer complexity of the system; and government mandates all contribute.

- Cost shifting occurs in many forms and contributes to system complexity and uneven treatment of consumers.

With an understanding of the social factors that affect health care in Maine, as well as with data analysis upon which to peg our real work, we arrived at a three-part statement of the problem with health care in Maine:

The health care delivery and financing system is inefficient, unreasonably complicated, and unfair. Like the rest of the United States, Maine is not getting the most for its health care dollar. The system is marked by bureaucratic snarls, overwhelming paperwork, duplicative and unnecessary services, inefficient means of delivery, considerable finger-pointing, and nearly incomprehensible financing. Further, the system does not treat people fairly in terms of access to services and how much is paid out-of-pocket.

People in Maine are not as healthy as they could be, and efforts to improve health status are inadequate. There is much evidence that Maine's health problems stem in large part from poor personal choices and behaviors, albeit that the choices of many are limited. To the degree that behaviors change, the overall cost of health care will decrease. Further, Maine's public health endeavors could be more effective.

Many in Maine are unable to obtain health care of the type and quality that they need. "Access" is a significant problem in health care in Maine: access to insurance; access to physicians; access to hospitals; access to relevant data and information of all kinds; and access to sustained, systemic public health efforts. Access in all those areas depends greatly on geography and socioeconomic status, as well as on an ability to comprehend the system.

Prior to identifying various approaches to affect the long-term costs of health care, we determined a set of principles we believe should serve as a starting place for discussion:

• All Maine citizens should have ready access to basic health care regardless of income, location, or pre-existing or chronic conditions.

• Maine's health care system should be characterized by excellence, zero tolerance for medical errors, and appropriateness of care in accordance with outcome-based evidence.

• An increasing portion of the state's health care expenditures should go directly to disease prevention and public health efforts.

In the context of all we have learned, we offer a set of approaches worthy of serious consideration, even though we do not each fully support each approach. These approaches are aimed at stabilizing overall health care costs and improving the value of the health care delivery system.

Health Status

1. **Encourage healthy communities** via improved integration of social, economic and political factors.
2. **Establish a network of public health physicians** to identify and react to public health threats.
3. **Improve youth health** via school based health centers and coordinated school health programs.

Public Policy

4. **Create a Maine Health Policy Council** to establish consensus objectives and monitor progress.
5. **Improve information for consumers and policymakers** via improved reporting and data availability.

Efficiency and Quality

6. **Improve medical records** in terms of portability and personal involvement.
7. **Improve clinical information** for better physician decision making.
8. **Improve administrative efficiencies** via streamlined claims forms and credentialing.

Access

9. **Change Medicare reimbursement policies** through a number of avenues.
10. **Expand insurance coverage among individuals and small groups** via one or more of the three following approaches:
    a. Encourage and facilitate private insurance companies to cover small businesses and individuals.
    b. Create a mutual health insurance fund to provide coverage to the uninsured, small businesses, and individuals.
    c. Create a universal, single payment program that protects all citizens from catastrophic financial loss as a result of sickness or accident.
11. **Expand health care insurance coverage for all children** via increased enrollment in, and expansion of, current government programs.
12. **Expand Medicaid coverage** to more disadvantaged people and review reimbursement rates.
13. **Advocate for a national financing system** that is centrally financed but delivered via decentralized, market-based mechanisms.

Lastly, we each offer our own final comments that serve to emphasize various aspects of the report, and in some cases, register disagreement with certain aspects. We came together with vastly different, and in many respects, relatively uninformed opinions about the cost of health care in Maine. While we learned a great deal together, and developed many shared perspectives, we none-the-less developed some individual opinions we thought worth sharing.

At our website, www.mdf.org/chc, one can find a bibliography for this report, background papers and much other information related to our work.

Chapter 1
INTRODUCTION

In late 1999, the health insurance market in Maine was beset by trouble and change. Specific problems included:

- Significant underwriting losses reported by the major health insurance companies in the state;

- A decision by Tufts Health Plan, a major provider of insurance to small employers, to cease operations in the state;

- Uncertainty as to the continued operations of Harvard Pilgrim Health Plan;

- The acquisition of Maine Blue Cross Blue Shield, the state's largest not-for-profit health insurance company, by Anthem Blue Cross, a mutual insurance company headquartered in Indiana;

- The decisions of a number of smaller, indemnity insurance plans serving the individual market to cease operations;

- Dramatic increases in premium costs among those companies still writing insurance in the state.

In response to those issues, and the rising cost of health care in general, Governor Angus S. King, Jr. appointed the Year 2000 Blue Ribbon Commission on Health Care on February 1, 2000. Comprising Robert Woodbury, chair, William Beardsley, Joseph Carleton, Tom Moser, and Pam Plumb,[1] the commission had four primary charges.

- Identify the cost elements of Maine's health care system, taking into account the state's demographic profile;
- Determine the current allocation of costs and cost shifting among participants in the health care delivery system;
- Recommend potential strategies for stabilizing overall health care costs;
- Identify payment options for health care services, including the impacts of such options on costs and utilization.

To meet those daunting challenges, the commission members have worked diligently for nine months. With administrative support from the Maine Development Foundation, we commissioned research and reports; held four regional meetings, six topic-specific exploratory meetings, and 18 working meetings; heard 17 presentations by experts; and solicited both general and specific comments from countless physicians, scholars, administrators, patient advocates, health-care providers and public interest groups, as well as from many of Maine's citizens. We also held an all day conference on our preliminary findings, one that encouraged participants to help us refine our thinking and our recommendations. (The minutes of our meetings, along with background reports, presentations, and public comments, are on-line at www.mdf.org/chc.)

Any report of this scope owes a considerable debt to many. The members of the commission wish to thank the myriad able, committed, conscientious health care professionals who took the time to comment on our efforts, attend our sessions, provide us with relevant information, increase our understanding, and point out our errors. Their assistance was invaluable as we struggled to craft a useful, credible document for the governor, the legislature, and the citizens of Maine. We are grateful for their aid to

our deliberations.

In addition, it is very important that the commission acknowledge that we saw and learned many exceptionally good things about Maine's health care system. Maine leads the country in some critically important measures of community health, such as childhood immunizations and low rates of teenage pregnancy. In addition, the state has made impressive progress in insuring children. Within the state, cardiac, oncology and other sophisticated acute care services rival those of the nation in quality and, in some cases, in cost effectiveness. Maine's system of providing home and community-based long-term care services is commendable.

And there are dedicated people working diligently to improve health care in our state. For example, national recognition is attaching to efforts in Franklin County to enhance community health. In addition, a program in central Maine is attempting to better coordinate free physician and pharmacy services provided to the uninsured.

As a commission, we acknowledge and compliment those efforts. We wish to build on them by identifying additional opportunities for improvement.

Before focusing on the specifics of our findings and our options for further consideration, we summarize here, from a broad policy perspective, our observations.

Maine spends a large amount of money on health care. Personal health care expenditures in 1999 are estimated to be $4.7 billion. At nearly 14 percent, Maine's health care spending, as a proportion of total gross domestic product, is larger than that of the United States as a whole (US health care spending is about 12.3% of gross domestic product). Furthermore, the cost of health care and health insurance has risen far faster than inflation in recent years.

In many ways, health care enterprises are an enormously positive part of the Maine economy. In general, they have many of the employment and economic characteristics that we welcome and prize in other business activities. The health care system offers productive, meaningful employment for thousands of the state's citizens: one in 10 Maine jobs is tied to health care; hospitals are the state's fourth largest employer.[2] To the extent we tinker with the health care system, we may significantly affect the prosperity of many of our neighbors.

Maine lags behind other states in important measures of health. Mainers live three fewer years than our neighbors in New Hampshire, for example.[3] Dr. Dora Mills, director of the Bureau of Health, indicates that cancer, diabetes, heart disease, and lung disease are responsible for 70 percent of the health care problems in Maine. While all four of those can strike people who take care of themselves, they affect more often those who have not done so. Thus some of our most chronic and costly health problems are preventable: results of our own choices.

Given those observations, does Maine's health care system provide a value commensurate with a $4.7 billion investment? We believe that better value can be achieved.

Health care may be the most complex domestic issue that faces Maine and the country. As this report reflects, there are no easy answers or "silver bullets" Maine can adopt to ameliorate health care costs. As professionals in areas other than health care, the commissioners were impressed with the complexity and interdependencies of the industry as a whole. It became very clear that factors contributing to higher costs are often linked to other underlying social and economic priorities.

Rural hospitals provide a ready example. In some cases, those institutions are underutilized, or utilized inappropriately, and are expensive and financially at risk. Thus one might make an objective argument that such institutions should be closed and replaced with other, less capital-intensive facilities. However, for many communities hospitals offer, in addition to nearby health services, the largest concentration of well paying jobs, are a source of pride and community identification, and, like good schools, represent an opportunity to attract new business and jobs to the area. In such cases, local economic considerations, not health care concerns alone, may drive opposition to closings.

Our values and culture often do not allow "competitive market forces" to operate when it comes to providing health care. The commission heard and read a great deal about the relative advantages of a market-based approach to allocating health care resources. And indeed, in some cases, the market works very well.

Our societal values and culture are not prepared to deny health services to individuals in need. Similarly, we believe that an individual should receive whatever services are necessary and appropriate in times of need. Yet a traditional market-based system does not accommodate such a birthright to health care. Thus our culture is unlikely ever to accept market dynamics alone to resolve fundamental issues as they relate to access, availability, and affordability-particularly in times of medical need.

Indeed, the health care market has a near-complete nontraditional dynamic. While an exhaustive analysis of medical economics is outside the scope of this report, the members of the commission believe some of the differences are important to our work.

Traditionally, demand is tempered by price. In health care, however, many consumers are largely protected from price through either public or private insurance arrangements. Thus they usually do not consider price when they consent to a particular diagnostic test or therapeutic treatment suggested by their physicians. Neither do physicians have sufficient price information to make recommendations based on cost of treatment. Finally, most physicians and consumers do not face direct financial consequence of their purchasing decisions.

In addition, traditional markets also presume that consumers have information adequate to exercise rational and efficient purchasing decisions. Health care consumers, however, will probably never achieve that level of knowledge. While there have been laudable attempts to provide more information to consumers in recent years, scientific advances in medicine and treatments will undoubtedly outpace individual understanding. Technology has certainly facilitated more understanding of the practice of medicine, but in fearful and anxious times, consumers find it easier and more comforting to trust their doctors.

Then, too, meaningful measures of quality health care are primitive—and exceptionally complicated. It will be difficult for an average consumer, for instance, to ever understand what "age-adjusted death rate" is.

The question of barriers to entry is also different in the health care system. In a true "market" the only barrier to entry is one of money or ideas. In health care, however, providers face licensure requirements, as well as myriad other government regulations.

Finally, traditional markets are supposed to create a financial stake for their participants. That approach is approximated in health care as "managed care," wherein providers are put at risk of losing reimbursement for "unnecessary" procedures. As is well known to all, however, Americans find "managed care" unacceptable. They are quite vocal in their opposition to participating in health care where their providers have a financial interest in the outcome.

That said, there are clearly some opportunities for elements of the market to be part of the delivery and financing of health care. Empowering consumers through information, as well as through measures of accountability, can and should be, fostered whenever possible. Providers should be encouraged to compete on price and quality for business in those service areas where consumers can reasonably make decisions.

Insured medical care is only one part of health care. As noted above, concerns as to the availability and affordability of medical insurance led the governor to create and charge this commission. However, we came to learn and appreciate that insured medical services represent only one, albeit important, part of a health care system that touches Maine citizens in many and often subtle ways.

Within the broad context of health care, policymakers must consider Maine's investments and policies with regard to:

- Environmental Health. The state of our water, our air, and our soil critically affect the health of our

communities. Environmental factors, both natural and man-made, contribute to diminished health status and increased costs. Lead-based paint, polluted water supplies and soil, increased exposure to chemicals of all kinds: all have serious negative impacts on a community's health. Developmental sprawl is another culprit; an increase in vehicle-miles-traveled has meant an increase in smog and a corresponding increase in certain debilitating health conditions.

• Public Health. Immunizations, food handling, sanitation, school health, alcohol and tobacco education, and community clinics might be all considered within the domain of the state's public health system. In some cases, that system provides services to uninsured populations who would otherwise do without. In many other cases, public health services complement the activities of the insurance-based health care system.

• Family Supports. Much of the care provided to the elderly, disabled, and children is provided through families. While generally considered to be "free" services, they do have costs: time lost from work as well as the constraints imposed on caregivers.

Within an even broader scope, issues related to public safety, parks and recreation, housing, nutrition and education affect a community's health costs—and extend beyond physician and hospital services.

Government plays an enormous role in how health care is provided and financed. While the state's role is not insignificant, the federal government is the dominant player. The Medicare and Medicaid programs offer insurance coverage to nearly one in three Maine residents. That population accounted for more than one-half of the 1999 personal health care expenditures in Maine.

Federal programs have undergone tremendous change in the last few years, driven by changes in national public policy. On one hand, they have put forth new initiatives such as the Medicaid expansion for children, known in Maine as Cub Care. On the other, faced with mounting costs, and under the mandate of the Balanced Budget Act of 1997, federal reimbursement to Maine hospitals has been especially problematic. In the private insurance market, federal regulations, as they apply to companies that have self-insured arrangements, preempted state laws and effectively put such schemes outside state control. Finally, federal support for medical research and education is a significant force in both the public and private sector.

Given the particular role of the federal government, some conveyed to the commission that the debate about a national health care program is moot: the nation is almost there. Others noted the reverse: it is government's involvement in financing health care that has caused many of the today's health care problems.

What is clear to the commission, however, is that the federal government is an integral player— and will continue to be. Decisions made in Washington as to who receives services, how those services are provided, and how much is paid for them, profoundly affect the costs of health care financed by state government, by private employers, and by consumers.

The employer-based system of health care is under tremendous pressure, and may be at risk of failing. Nearly 60 percent of Maine's citizens have some of their personal health expenditures covered under an employer-based insurance program. The degree to which the United States relies on private employment for health insurance is unique to this country, and is facing significant problems.

As discussed later in this report, cost shifting by government and uninsured groups, as well as consumer demands for unimpeded access and comprehensive coverage, are placing enormous pressures on the private insurance system. Those pressures are typically manifested in the form of cost increases significantly larger than increases in other business expenses. Given present labor shortages, however, employers are reluctant to reduce medical benefits or require higher employee cost sharing. But should the economy soften, many experts predict that health care benefits will be the first cost-cutting priority. Indeed, some national companies are questioning the underlying structure of their commitment to medical benefits. Instead of a defined benefit approach, they are suggesting a fixed financial health care com-

mitment to their employees. Employees, in turn, could use that set amount to identify and purchase health insurance on their own.

It is very difficult to accurately sort out price, charge, and cost for health services. Traditionally, cost is the amount it takes to develop, produce, and sell a product; price is the amount a consumer must pay to purchase that product. In the realm of health care, however, there is no generally accepted financial *lingua franca*: the terms cost, charge and price have no clear meaning. They are affected significantly by many factors: government reimbursement, charity care, and write-offs, for example. There is often no real relationship between the actual costs of health care provided to the prices that are ultimately charged for it and ultimately to the reimbursements that are made to providers.

Cost shifting is varied and pervasive. Typically, cost shifting refers to situations in which low-income individuals receive charity or low-cost care from physicians or hospitals, care covered by higher costs paid by those financially better off—or with better insurance: a clear case of the rich subsidizing the poor. It also refers, however, to cases where higher-income individuals pay for their health care with pre-tax dollars or employer-based insurance, options not open to all. In such cases, it is the less advantaged who are doing the subsidizing. Furthermore, reducing monies available for charity care increases the burden on the poor. Finally, large corporations have considerable leverage in purchasing insurance for their employees, which results in lower costs to them, and often to their employees. Thus the cost to a patient can vary dramatically, depending on whether she is poor, whether she works for a large or small employer, and whether she purchases her insurance on her own.

Much of what's wrong with our health care system is reflected in the uninsured population. There is, justifiably, a great deal of attention focused upon the uninsured and underinsured.[4] Health care provided to those groups is often too late, fragmented, episodic and expensive.

Based on different sources, the commission learned that in Maine:

- 34 percent of the uninsured report never having had health insurance of any kind; seven percent of the currently insured population reported not having any kind of health insurance for six months or more within the last three years.

- 71 percent of uninsured adults are employed on a full or part-time basis. 40 percent of the uninsured earn between $10,000 and $15,000 a year; five percent earn more than $50,000 annually.

- Adults most likely to lack health insurance are between the ages of 19 and 34 years of age, and 53 percent of them are male.

- With approximately 15.7 percent of its 18-64 population uninsured, Maine ranks 25th in the country, but highest in New England.

Nationally there is good evidence that care for the uninsured is sub-optimal. 30 percent of the uninsured do not fill prescriptions because of the cost[5] and uninsured individuals are three times more likely to die in the hospital than the insured.[6]

And while cost shifting is clearly a phenomenon, tightening reimbursement policies by government and private payers are creating less flexibility for providers in their pricing and in turn contribute to making health care even less affordable to those in need.

Many Mainers hold fundamental—and incorrect—beliefs about their own health and their health care system. Contrary to popular opinion, however:

- Maine residents are less healthy than other Americans: we smoke too much, exercise too little and do not eat well.

- Maine's population is older than average, and its proportion of elderly is expected to continue to exceed that of other states.

- All Maine's children do not have health insurance. Approximately 18,000 children still lack coverage.

• Maine does not spend more than other states on all aspects of health care than do other states. Expenditures for prevention and public health are lower in Maine than in the rest of the country. The state's emphasis is on medical treatment, not consumer behavior or preventative programs.

• A national, single payer system may be the only approach that will work to control costs, assure access and rationalize the delivery of health services.

We believe that this report can serve as the foundation for sound health care policymaking in the future. It is designed to be the basis of a long-term strategy, not merely a presentation of quick and easy "fixes."

[1] See inside front cover for brief biographies of the commission members.
[2] Steven R. Michaud, Maine Hospital Association, presentation to the commission, March 13, 2000.
[3] National Institute for Health Care Management, NICHM Health Care System DataSource, 1999.
[4] For purposes of this report, the term "underinsured" refers to those individuals who have only catastrophic health insurance, i.e., policies that take effect only when some high personal deductible—typically $5,000 per year—has been reached. Such policies are, of course, better than no health insurance at all, but individuals covered by them often cannot afford preventive care.
[5] *Consumer Reports*, "Second Class," September 2000.
[6] American College of Physicians and American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick.* www.acponline.org.

Chapter 2
COST PROFILE

Introduction

This is the centerpiece of the Commission's work: a thorough analysis of who spends what money for what services in what categories of health care in Maine. Its focus is upon personal health expenditures: those goods and services associated with direct prevention and cure of disease, as well as treatment of physical injuries. It comprehensively estimates the cost of personal health care in the state, and identifies factors contributing to those estimates.

The chapter estimates 1999 personal health expenditures for the citizens of Maine across five population subgroups, broadly defined by their primary insurance programs, and according to eight major categories of services that parallel reporting schemes adopted by the U.S. Office of the Actuary, Health Care Financing Administration (HCFA). Also discussed are indications of geographic variance in costs, the nature and impact of cost shifting, cost drivers, and recommended areas for additional and future investigation, analysis, and refinement of personal and total health care costs in Maine.

Findings of this chapter indicate:

• Health care is a large part of the state's overall economy: one out of every seven dollars spent in Maine is related to health care. Expenditures covered by federal dollars under Medicare and Medicaid are very significant and represent "imported" revenue; that is, money coming into Maine from away.

• The largest service expenditures are for institutionally based services, namely hospital care and nursing home care. Those two service categories represent 50 percent of all non-administrative expenditures.

• Cost shifting can have dramatic impacts. While the degree of cost shifting by Medicare as a result of the Balanced Budget Act was not independently confirmed in this study, it is clear that any reductions in federal expenditures not absorbed by providers will represent significant increases for other payer groups. In regard to the uninsured, cost shifting has been estimated to be on the order of $160 million in 1999.

• Health care expenditures have increased—and will continue to increase—at a faster rate than other goods and services. Expenditures related to pharmacy services and other personal health care are projected to represent the largest contributors to future increases. As a result, health care will be an increasingly larger part of Maine's economy.

• Health care costs vary geographically. These variances are due to local competition—or lack thereof—and local community planning, as well as to service volume. The latter factor may be particularly significant in rural locations where hospitals often maintain under-utilized infrastructure.

• Expenditures related to administering insurance claims are significant—and represent only one part of the non-clinical overhead costs of providing services in Maine.

• Other states share many of the same issues and challenges with Maine.

Personal Health Care Expenditures

Approach

This study uses a population-based, rather than program-based, approach. That is, personal health expenditures are reported for major populations groups as defined by predominate insurance arrangements. Those expenditures include insurance payments, as well as out-of-pocket expenditures for services and insurance premiums. For example, Medicare (excluding persons who also had Medicaid insurance) covered approximately 173,000 Maine residents in 1999. While it was the principal insurance program for those individuals, they incurred expenses beyond those covered by Medicare. Such expenses include, but are not necessarily limited to, pharmacy costs, co-payments, and deductible expenses, which may have been covered by supplemental insurance programs or paid directly by the beneficiary. The reported estimates for personal health expenditures include all those different amounts.

Total personal health expenditures were tabulated from actual claims experience, supplemented by survey and other information that permitted approximations for each identified population.

Finally, the approach of this study differs from the one used by HCFA, which is based on estimates of provider receipts from different payment sources—and considers out-of-pocket expenses as a single, combined payment source. As a result, HCFA does not report such expenditures by specific population groups.

Limitations

In reviewing the data and findings, a reader must consider a number of limitations.

• Aggregated data and findings are the most valid. The greater the specificity in terms of population and service category, the less valid the data.

• This study estimates personal health expenditures for calendar year 1999. Although data were collected for the most recent period available, in many instances it was necessary to extrapolate available information from earlier years to 1999.

• The health care market is very dynamic; it has a constant inflow of new—and sometimes contradictory—developments. For example, the study reports an uninsured population of approximately 13 percent of the total population. Anecdotal information indicates that number has increased in recent months, particularly in the small group and individual markets as a result of increasing insurance premiums, and decisions by a number of carriers to leave the state.

In late September 2000, however, the Census Bureau reported a large decline in uninsured Americans, noting that the strong employment economy was positively affecting the number of persons provided health insurance through place of work. For Maine, the bureau estimated an uninsured rate of nearly 12 percent in 1999, and a three-year average uninsured rate of slightly more than 13 percent.

While troublesome, the material impact of those discrepancies is thought to be small within the context of total expenditures, and of the application of the information to broad policymaking in Maine.

• Whenever available, data specific to Maine were utilized. For example, the study uses Medicare and Medicaid data, as well as a significant proportion of the private insurance information, specific to recent Maine experience. When state-specific information was not available, the study relied on national data and experience. That is particularly true for estimated personal health expenditures related to the uninsured population.

• There is an underreporting of expenditures incurred in certain service locations and among certain populations, i.e., public health clinics, school care programs, prisons, veterans programs, and the Indian health services.

• Dental services are not included in this profile. While HCFA identifies dental care as an explicit service category in its inventory of personal health ex-

penditures, sufficient data, particularly for persons with private insurance, were unavailable. Private dental insurance is typically underwritten separately, and there are no indications that the availability of dental insurance has been materially affected by recent turmoil in Maine's private insurance markets.

• Detail with regard to important services and costs are often masked in aggregate data. For example, personal expenditures for mental health services are included within **Hospital Care**, **Physician Services**, **Other Professional Services**, as well as other categories. It is, however, not possible to segregate such expenditures for separate analysis.

• Personal health expenditures do not include very significant indirect subsidies. For example, employer-sponsored health insurance programs enjoy preferential tax treatment to the extent that the cost of the benefit represents tax-free compensation to employees. Similarly, the nonprofit status of all Maine hospitals and many other health care organizations creates a subsidy funded by other taxpayers.

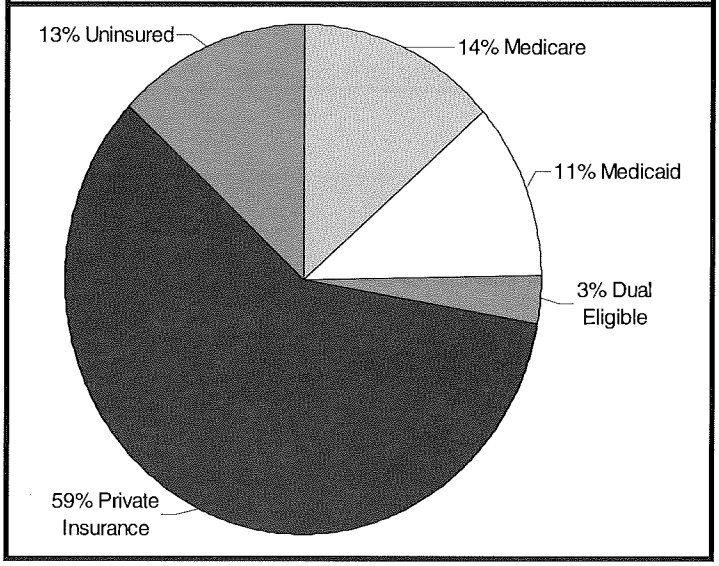
• Finally, informal and usually free care, including that provided by family and friends, is not included in the estimates. A recent survey by the Maine Development Foundation determined that 14 percent of the respondents were helping care for an older family member and 10 percent for someone with a disability or disease.[1] The median commitment for the former group was reported to be between five and 10 hours per week, more than 11 hours per week for those caring for someone with a disability or disease. Moreover, the survey reported that 12 percent of the respondents routinely took time off from work to care for an elderly person. Clearly, those informal services would represent very real additional costs if compensated providers were utilized.

Findings

For Maine

Figure 1 shows how Maine's population breaks down by insurance program: Medicare recipients; Medicaid recipients; those beneficiaries who have both Medicare and Medicaid insurance (the term "dual eligible" is used to refer to such individuals); those who have private insurance; and uninsured citizens. (See also Table 1 in Appendix A)

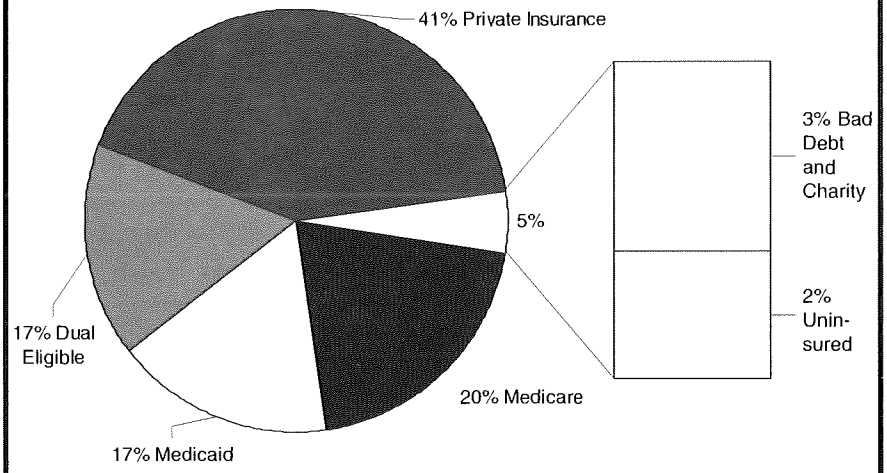
Figure 1
Estimated % of Total Population In Maine By Population Groups (1999)



The recent Maine Development Foundation survey also identified some characteristics of the uninsured. They had lower incomes than the insured, for example: 78 percent reported incomes of less than $35,000 per year. While 63 percent of the uninsured had an educational level of high school or less, one third reported college education. Respondents with a community or technical college education were most likely to have insurance (only three percent of that population indicated that they were not currently covered by a health care plan).

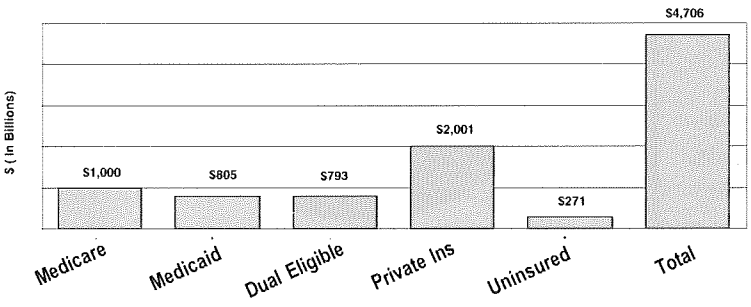
The most frequent reason given for not having insurance was high premium costs (66 percent). While 20 percent of all respondents reported that their employer did not offer a sponsored health insurance plan, only 11 percent of those uninsured noted that as the reason that they do not have coverage.

Figure 2
Estimated Percent of Total Personal Expenditures By Population Groups In Maine (1999)



Note: Bad debt and charity amounts are implicitly included in Private Insurance, which increases to 43%.

Figure 3
Estimated Total Personal Expenditures By Population Groups In Maine (1999)



Note: For the uninsured, the amount reported in this chart represents the total personal health expenditures. Actual amounts expended directly by the population are estimated to be about $107 million. The difference between those two amounts are the estimated charity and bad debt, implicitly included in the expenditures of other populations (particularly those with private insurance). In order to avoid a double count, the total reported above includes only the estimates for actual expenditures by the uninsured.

A recent survey by the Muskie School of Public Service reported additional insights specific to uninsured children (age 0 through 18 years).[2] The number of Maine children without health insurance is estimated to be nearly 18,100. Approximately 11,000 of those children reside in households with incomes that are less than 200 percent of the federal poverty levels, and therefore would be eligible for either Medicaid or Cub Care. In those cases, the problem is not lack of access to coverage, but that their parents have failed to enroll them. The remaining 7,000 children represent approximately two percent of all children through age 18.

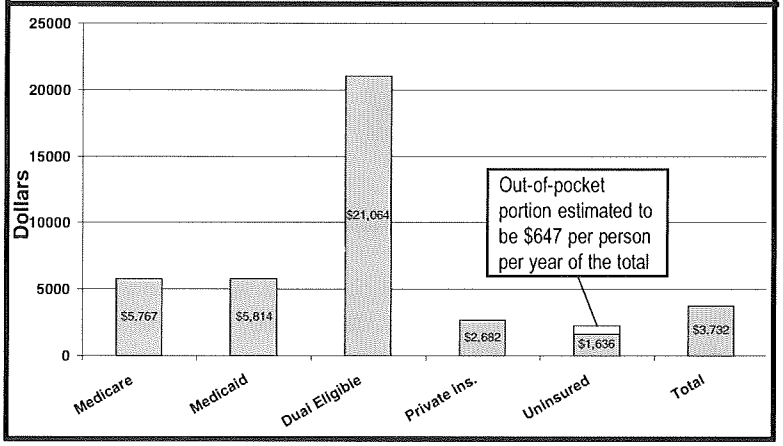
As Figure 2 shows, personal health expenditures by persons covered primarily by a publicly funded insurance program, Medicare and Medicaid, represent more than 50 percent of the total expenditures in the state. That amount is even greater if private insurance programs for state employees, public school teachers, municipal workers, and state university employees are included. Contrary to common understanding, possibly 60 percent of all expenditures are grounded in programs supported by public money.

The coverage and reimbursement policies adopted by Medicare and Medicaid have immense implications for the financial viability of provider groups, as well as for cost shifting to persons insured primarily through a private plan. Hospital administrators in Maine claim that Medicare shortfalls are in the amount of $100,000,000 per year.[3] To the extent that claim is valid, those shortfalls are either absorbed by institutions or shifted to other payers, principally those persons with private insurance.

As Figure 3 shows, estimated personal health expenditures of all groups totaled about $4,706 billion, representing nearly 14 percent of Maine's gross state product. That figure stands in contrast to the U.S. where it is estimated that personal health expenditures represent 12.3 percent of the gross domestic product.[4]

As shown in Figure 4, per-person expenditures on health care range widely, from a low of $1,636 for the uninsured (actually, $647 per-uninsured person after charity care and write-offs for bad debts are considered) to a high of $21,064 for dual-eligible beneficiaries. (See also Table 2 in Appendix A.)

Figure 4
Estimated Per Capita Personal Health Expenditures By Population Groups in Maine (1999)



For persons with either Medicare or Medicaid coverage, personal expenditures are similar: approximately $5,800 per person in 1999, or slightly more than twice the expenditures of those persons with private insurance (nearly $2,700). That is not surprising. The higher morbidity associate with age, poverty and/or disabilities (all conditions associated with eligibility for either Medicare or Medicaid) will have higher accompanying expenditures.

Expenditures for persons with *both* Medicare and Medicaid are more than three and one-half times greater than persons with either Medicare or Medicaid alone. Approximately 70 percent of the combined amount is covered by the Medicaid program. While most of the dual-eligible beneficiaries are the frail elderly, adults with significant disabilities are also included. More than half the expenditures for that population is associated with **Home Health Care** and **Nursing Home Care**, reflecting the significant utilization of long-term care services.

Personal health expenditures for uninsured Maine citizens are estimated to have totaled about $271 million, or $1,636 per person, in 1999. The actual amounts paid for care by the uninsured totaled $107 million, or nearly $650 per person. Out-of-pocket expenditures by the uninsured are highest for physician and pharmacy services. Approximately 60 percent (or more than $163 million annually) of personal health expenditures incurred by the uninsured is estimated to be "covered" under charity and bad debt provisions made by providers.

Notwithstanding the above estimates of charity and bad debt, estimates for the uninsured suggest a lower rate of expenditures than those made by the privately insured. That difference may be attributable to two factors: the cost of health care prevents the uninsured, as well as the underinsured, from seeking services; or more-healthy populations with lower expenditures voluntarily decline insurance coverage. The latter population appears to be small. Only five percent of those respondents without health insurance reported in the Maine Development Foundation survey that they were healthy and did not feel they needed coverage.

Based on a recent Market Decisions survey, it appears that uninsured Mainers do receive hospital care. The report notes: "hospital care is not deferred because of a lack of health insurance."[5] That observation is consistent with our findings that estimates of personal health expenditures for hospital care are approximately equal to the amount that hospitals report for charity and bad debt. In other words, the uninsured go to hospitals when they perceive a need, but costs associated with such utilization are largely written off as bad debt or charity care.

Figure 5
Estimated Percent of Out of Pocket Share of Personal Health Expenditures in Maine (1999)

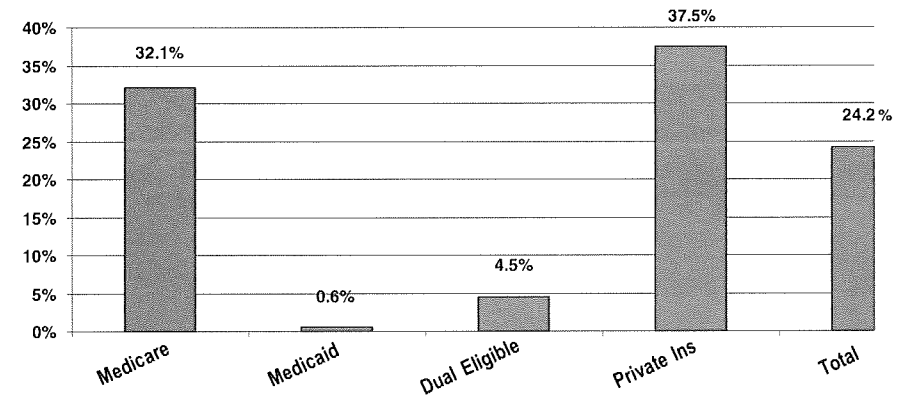
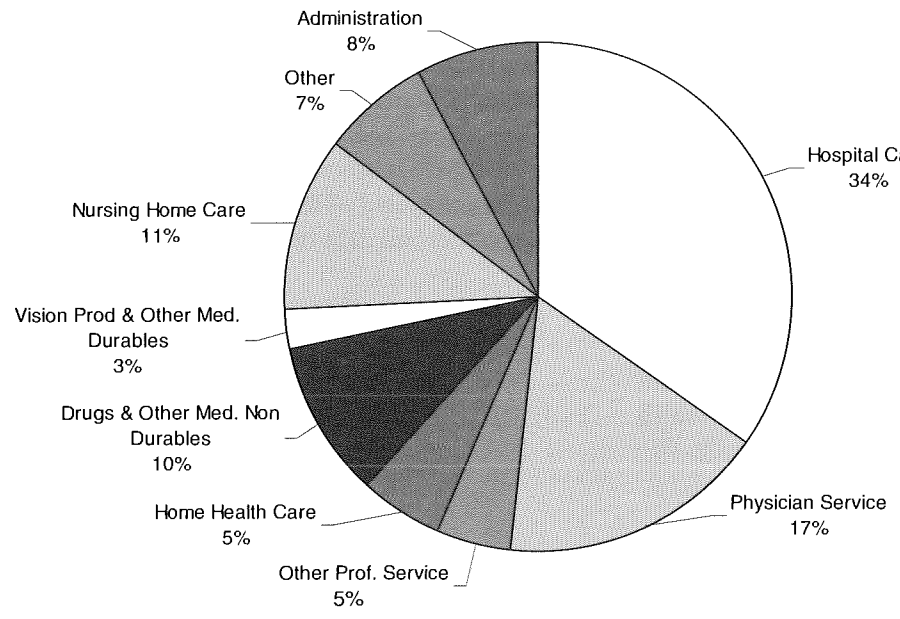


Figure 5 shows that the amount of personal health expenditures directly paid out-of-pocket by individuals also varies widely. Excluding the uninsured, out-of-pocket expenses include direct contributions to health insurance premiums, cost-sharing provisions at the time services are rendered, and expenditures for services not covered by an insurance program. In 1999, out-of-pocket expenditures averaged about 24 percent, and ranged from a high of 37.5 percent for those with private insurance to less than one percent for those covered principally by Medicaid. (See also Table 3 in Appendix A.)

Those estimates correlate reasonably well with survey information provided by Market Decisions. Survey respondents reported that the median percent of personal health expenditures paid out-of-pocket was 20 to 29 percent. In terms of dollars, the median response was in the range of $1,000 to $1,999.[6]

Figure 6 reports the personal health expenditures in Maine according to major service categories. While providing some insights, the categorization provides little information as to personal health expenditures based on care needs. For example, it is not possible to identify personal health expenditures related to behavioral diagnosis. Such expenditures are included among different provider types.

Figure 6
Estimated Percent Of Total Personal Health Expenditures By Service in Maine (1999)



Since 1994, as shown in Figure 7 and Figure 8, health care costs in Maine have increased faster than the consumer price index. (See also Table 5 in Appendix A.) The largest increase has been in **Drugs** and **Other Medical Non-Durable Services**. As the figures also show, total annual personal health expenditures (without **Insurance Payer Administration**) are estimated to almost double in ten years, to nearly $8 billion. The service categories estimated to increase the most are: **Home Health Care, Drugs and Other Medical Non-Durable Services** and **Other**. In contrast, **Hospital Care** and **Physician Services** are estimated to make relatively modest contributions to future personal health expenditures.

Figure 7
Estimated Total Personal Health Expenditures in Maine for Select Years (without Insurance Administration)

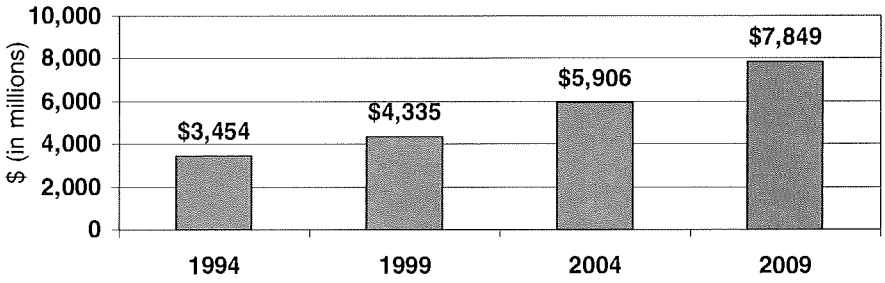
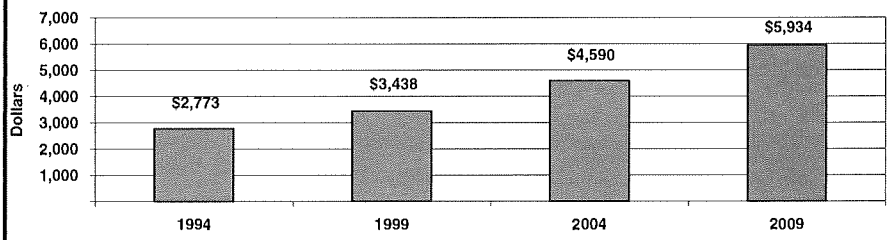


Figure 8
Estimated Per Capita Personal Health Expenditure in Maine for Select Years (without Insurance Administration)



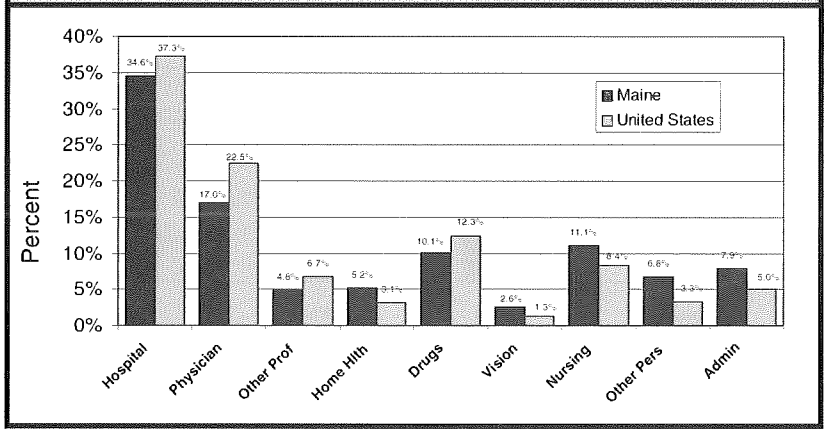
Notwithstanding the magnitude of the expenditures reflected in the projections, they do not include the impact of aging baby boomers. That population begins to reach age 65 in 2011, and will further accelerate increases in health care expenditures in subsequent years.

National Comparisons

As mentioned earlier, about 12.3 percent of the national gross domestic product is spent on health care, whereas the amount in Maine is about 13.9 percent. The difference between Maine costs and U.S. costs relative to GDP reflects, in part, the smaller Maine economy. Still as a measure of relative priorities, Maine devotes a larger share of its gross domestic product to health care than does the country as a whole. A comparison of the actual costs, however, looks very similar: health care spending in Maine is about $3,732 per person (including insurance administration), while U.S. health care spending is about $3,798.

As Figure 9 shows, the distribution of health care expenditures for Maine and the United States varies notably among service categories (See also Table 2 in Appendix A). As a percent of total expenditures, Maine's allocation to **Home Health Care**, **Vision Products** and **Other Medical Durables, Nursing Home Care, Other Personal Health Care** and **Insurance Payer Administration** is larger than that of the United States. The proportionally smaller allocations for **Hospital Care** and **Physician Services** in Maine, as compared to the nation, are noteworthy.

Figure 9
Per Capita Estimates of Personal Health Expenditures, by Services, Maine and USA (1999)



Interstate Comparisons

Figure 10 compares Maine's costs with those of North Dakota, Wyoming, West Virginia, and Vermont: states identified by the State Planning Office as similar to Maine in demographic and income characteristics (See also Table 4 in Appendix A.)

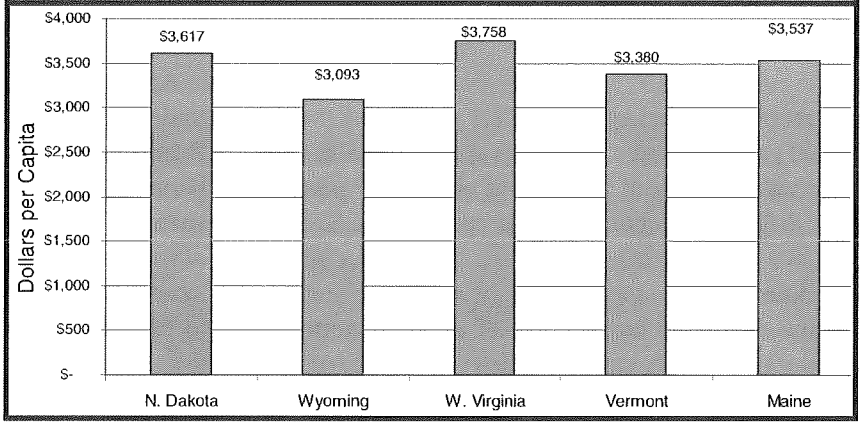
The percentage distribution of personal health expenditures in Maine is generally consistent with other, similar states. The same can be said for total personal health expenditure as measured by dollars. There are some exceptions, however. **Hospital Care** represents a smaller percent of personal health expenditures in Maine. To a lesser extent, the same can be said for **Physician Services** and **Other Professional Services**. In contrast, **Nursing Home Care** represents a larger percent. (While expenditures for **Nursing Home Care** in North Dakota are similar to those of Maine, the similarity disappears when **Nursing Home Care** is combined with **Home Health Care**). These findings parallel the comparison of Maine to the entire United States.

In 1999, the Maine Health Data Organization sought to examine geographical variations with Idaho, a state demographically similar to Maine.[7] The two states have almost identical populations, 1.2 million, though Idaho has a larger land area. Personal income is similar, the gross state products are almost equal, and the mix of occupations and business types is also close. Neither state is racially diverse: both are almost entirely white. One key difference is that Idaho has a larger proportion of young people—32 percent under age 20, as opposed to Maine's 26 percent—and a smaller elderly population. Some 11 percent of Idahoans are older than 65. Idaho's median age is 33, while Maine's is nearly 37. Those age differences have a significant impact on differences in utilization patterns.

The overall health ranking averages of the two states are similar, but there are also significant differences. Maine has a lower infant mortality rate, one of the lowest in the country, as well as a higher immunization rate. On the other hand, its cancer rate is the third highest in the nation. Idaho has low chronic disease and death rates. Hospital wages are quite similar, as are the costs of practice for physicians.

In the broadest national index of hospital spending, Maine's cost per capita is slightly above the national average ($1,159 against $1,143), but Idaho's is much lower, possibly the lowest in the nation.

Figure 10
Estimated Per Capita Personal Health Expenditures among Comparative States for 1999 (without Insurance Administration)



A detailed comparison shows the reasons for the striking differences in hospital costs.

- Although the two states have about the same number of hospitals of similar sizes, Maine has far more hospital beds and physicians, leading to annual revenues about one third higher.

- In 1996, Maine had 3,407 hospital beds, while Idaho had 2,736.

- There were 3,365 full-time registered nurses at work in Maine hospitals, 2,274 in Idaho.

- The number of surgeries was about 25 percent higher in Maine.

- Although the two states had roughly the same number of general or family practice physicians, Maine had far more specialists. In other studies, specialists have been shown to be far more aggressive in the treatment of various ailments than general practitioners, ordering greater number of tests and procedures and performing surgery more often.

As various observers of the Maine-Idaho study have pointed out, the results do not necessarily mean that Maine has too many hospital beds or physician specialists. And it is possible that Idaho residents receive their hospital care out-of-state. In addition, Idaho has publicly funded county hospitals, while all of Maine's hospitals are community-owned, private, nonprofit entities. Nonetheless, the comparison is useful in considering the questions of how much care is needed in what settings, and whether there are possible alternatives for hospitals to consider.

Intrastate Variations

This cost profile does not fully consider price and cost variation within Maine but there are, however, a number of indications that the variance between rural and non-rural areas in Maine is considerable. Rural hospitals have a larger proportion of Medicare and Medicaid patients—payers that, according to interviewees, reimbursed hospitals at lower rates than are needed to cover costs.[8] In addition, those institutions have more limited labor pools, which may increase salaries, and thus cost in general. According to Market Decisions, there is also some indication that smaller hospitals have a larger number of uninsured patients.[9]

Maine's geography also has a powerful effect on health care prices. A recent study detailed the size of Maine's hospitals in relation to their service areas.[10] Intuition would seem to dictate that the number of hospital beds in any given area would be closely related to the number of people its hospitals serve. That is not the case, however: Maine hospitals have as many as 663 people in their service areas for each licensed bed and as few as 214: a greater than three to one variance. Population concentrations, or availability of acute care, did not affect that variance: among small group hospitals doing mostly routine procedures, one hospital has 613 people per bed in its service area, another just 223 people per bed. Hospitals, however, typically have more licensed beds than beds that are actually staffed at any given time.

Furthermore, there is much scientific and anecdotal evidence that where there are more doctors and more hospital beds in relationship to the population, there are higher rates of medical procedures. In 1980, it was found that in one area of Maine, women were twice as likely to have a hysterectomy as those living elsewhere.[11] In 1983, three new surgeons in one area collectively performed more than 60 percent more back surgeries than otherwise would have been expected.[12] And in 1999 twenty-one percent of Maine births took place through Cesarean sections, a percentage higher than the national average, which most health experts agree is itself too high.[13]

Estimates related to the possible state authorization of six additional catheterization facilities bear out those findings. If normal utilization rates were to be met at all those locations, Maine would probably have the highest rate of cardiac catheterization, angioplasty, and open-heart surgery in the nation, even though no extant data confirm a need for that level of surgical procedures. In such cases, "improved access" would not seem to lower the costs—or better the outcomes—of health care. The commission is not suggesting that Mainers should be required to travel long distances to obtain quality care,

or that new catheterization facilities would not improve health care in the state, merely that duplicative efforts do not typically lower the overall costs of obtaining such care, and that hospital costs are generally greater at smaller and more rural locations.

An analysis of Medicare cost and charge data revealed regional differences between northern Maine, southern Maine and the greater Boston metropolitan area.

Figure 11
Margin between Hospital Charges and Costs

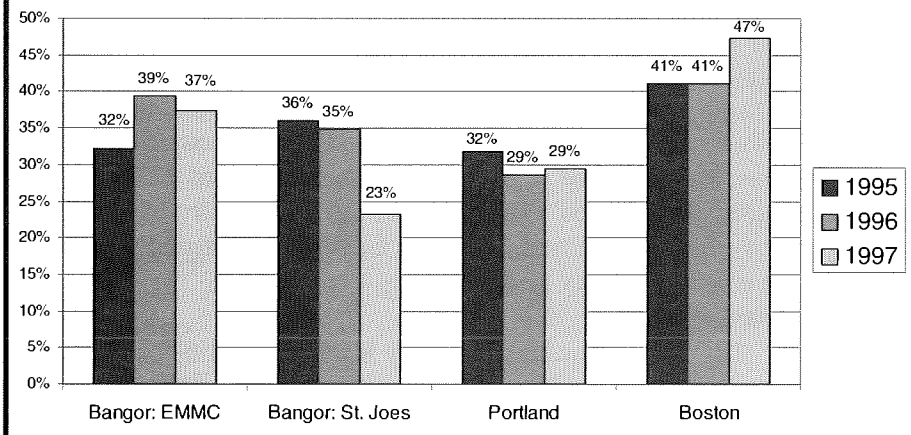
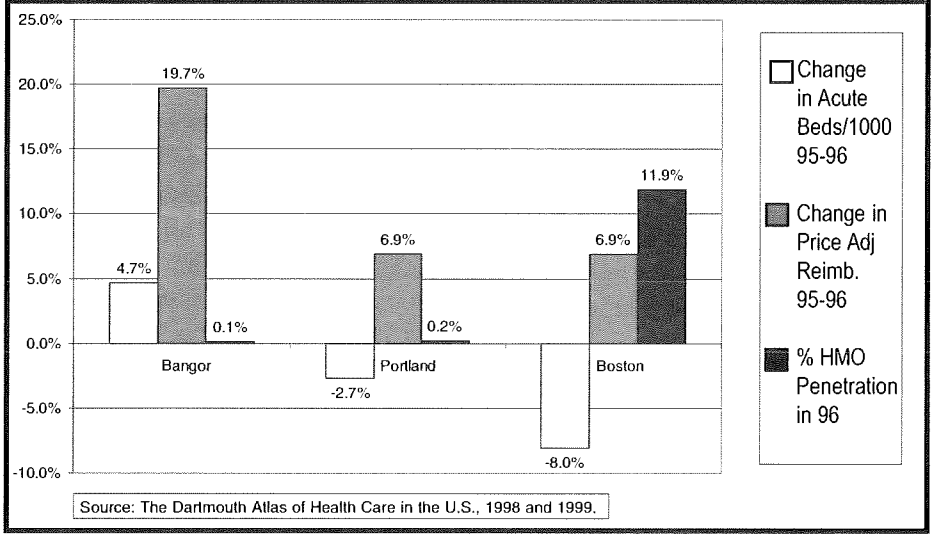


Figure 11 reports the difference between charges and costs as reported for Medicare beneficiaries for 1995, 1996 and 1997. Those margins are clearly largest in the Boston region and may, to the extent the data can be extrapolated to other payers, explain the larger discounts that managed care companies indicate they enjoy in Boston. Over the three-year period, Portland hospitals reported the lowest margin. Overall, the data indicate some geographic differences in hospital charges as a function of costs, at least for Medicare beneficiaries.

Changes in bed capacity, price-adjusted reimbursement for Medicare beneficiaries, and HMO penetration are reported in Figure 12. In both Portland and Boston, the total number of acute care beds (per 1000 population) declined between 1995 and 1996. The opposite was true in Bangor. Price adjusted reimbursements for Medicare increased less than seven percent in Portland and Boston, nearly 20 percent in Bangor. Finally, HMO penetration in Bangor and Portland was virtually nonexistent in 1996, as compared to nearly 12 percent in Boston.

For Boston, the data suggest that increases in Medicare reimbursement, as measured by HMO penetration, were moderated by an increasingly competitive marketplace. In response to less demand, Boston hospitals also reduced capacity, although it may be argued that they had excess capacity at the start of the study. None-the-less, that appears to be an instance where a competitive market worked as predicted: less demand resulted in lower prices and reduced supply.

Figure 12
Hospital Capacity, Medicare Price Adjusted Reimbursement and HMO Penetration



During those same years, in contrast, Portland experienced voluntary downsizing via hospital mergers. Rather than competition, Portland hospitals were attempting voluntary, community planning. Interestingly, that approach seems to have been as effective as Boston's competition.

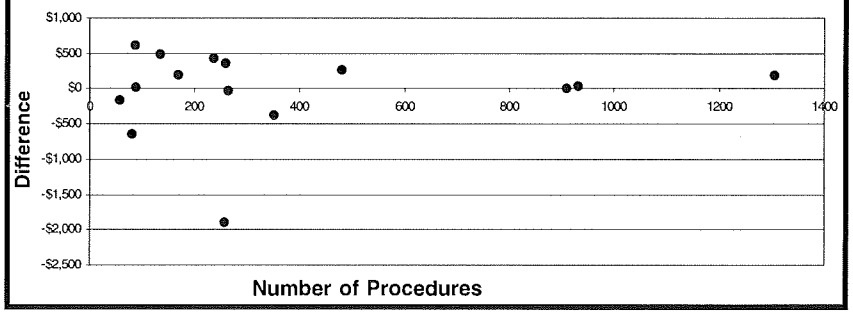
As measured by those indicators, neither a competitive nor planning model appeared to be at work in the Bangor region. That conclusion may still be valid. Based on total per-member, per-month costs for the twelve-month period ending June 2000, one insurer's experience in the Bangor market was that charges there were 35 percent greater than in the Portland market.

Service volume is an important cost factor, in addition to geographic variation. Because fixed costs represent such a significant portion of a hospital's overall cost structure, institutions with a larger-than-needed capacity may have higher costs. It follows, then, that hospitals in rural locations with smaller populations and service needs may have higher costs. Figure 13 supports that conclusion. The data indicate that hospital charges of low-volume (i.e., smaller) hospitals are more variable, and frequently higher, than those of larger institutions.

There are, however, caveats in that analysis. Charges do not necessarily equate with actual reimbursements and the "expected" charges are strongly influenced by the large volume hospitals. As Figure 14 indicates, the correlation between volume and charges was much less variable for normal births. Here issues of case-mix and other factors do not play an important role. The analysis does provide some evidence that for certain conditions and procedures, small hospitals may be more costly than larger facilities.

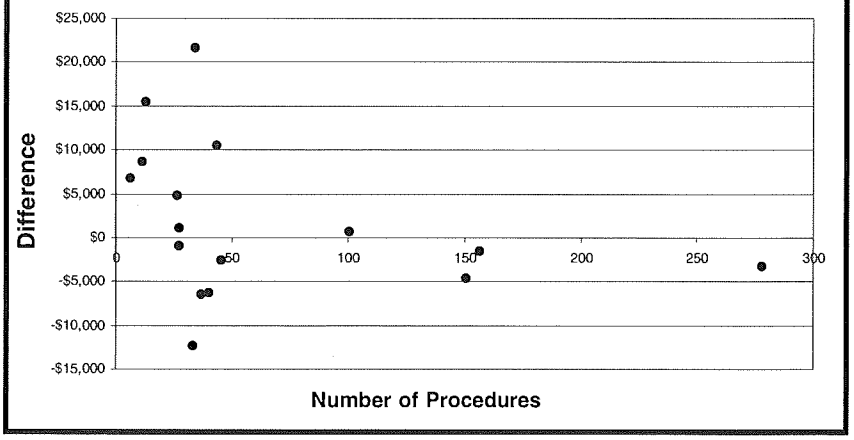
Hospitals in Maine vary significantly in charges for surgery even when adjusted for case mix. While small volume hospitals are more likely to charge more than large volume hospitals, there are exceptions in Maine. The average charges of two out of eight large hospitals are well above expected charges while charges of nine out of thirty small hospitals are below expected charges.

Figure 14
Actual vs Expected Charges for Vaginal Deliveries w/out Complications
(Select Hospitals, 98-99)



Taken together, all the data in this section indicate that geographic variances, particularly as they affect service volume, appear to be an important contributor to cost differences within Maine.

Figure 13
Actual vs Expected Charges for Major Bowel Procedures
(Select Hospitals, 98-99)



Cost Shifting

There is little consistency among what is paid by individual consumers for medical services. Neither is there consistency among the cost, price and charge for health care services. Like an airline flight comprising 78 passengers who each paid a different amount for passage, health care has nearly as many "prices" as it has people participating in the system. Not surprisingly, those inconsistencies have led to confusion and uncertainty as to the "real" cost of a medical service, as well as to a complicated patchwork of cost shifting between and among various payer groups.

Furthermore, it is impossible to determine if the costs paid by a patient accurately reflect the costs of delivering services. Although hospitals may engage in serious cost accounting, there are a number of additional elements that factor into what they actually charge. For instance, hospitals are guided by the prospects for reimbursement and expected levels of reimbursement from both government and private insurance programs.

The fact that large employers can negotiate smaller fees for the insurance they provide to their employees means that individuals who purchase their own, more expensive, health care incur more than their "fair share" of costs. Medicare and Medicaid payments have also been criticized as shifting costs from one population to another. Medicare reimbursement rates to Maine service providers are among the lowest in the country. Hospital administrators identified that as the most important cost-shifting factor—on the order of $100,000,000 annually.[14] Providers also fault Medicaid, which includes both federal and state funding for not paying its fair share of the costs of health services.

To the extent that Medicare and Medicaid fall short in paying rates in line with costs, the impact is significant. Because they pay more than half the health care bills in Maine, any shortfalls by the programs require providers to either reduce their costs or shift the shortfall to other payers with less purchasing clout: typically, private insurance programs or individuals who pay directly for services.

The political and regulatory policies for cost shifting by Medicare, and to a lesser extent Medicaid, are beyond Maine's ability to control. The issue reflects the tug of war between federal and state initiatives and priorities to meet a variety of social needs, to contain budgets and to respond to political realities.

Thus costs both increase for all and shift among and between segments of society sometimes borne by the rich, sometimes by the poor, sometimes by individuals, sometimes by governments. It is not surprising, then, that potential solutions primarily address the margins of the problem: the dilemma itself is almost too amorphous to define. Addressing the essence of the problem will require immense reserves of social and political capital, as well as heretofore-unknown collaboration among all the actors on the health care stage.

Cost Drivers

It can be argued that costs are not the problem. Rather, they are symptoms that reflect a variety of underlying causes, dynamics, priorities, expectations and, ultimately, contradictions.

In addition to identifying those facts that shift costs, testimony and materials provided to the commission identified a plethora of factors that drive costs. Unfortunately, many of those drivers will not be easy to fix. In some cases, they are largely outside the control of Maine or any other government jurisdiction. An aging population, for example, cannot be changed by government fiat. In other cases, solutions will require long-term and far-ranging social, political, and financial investments.

Use of Costly Procedures and Treatments

Consumer demand and knowledge factor into rising costs. The general public is much more knowledgeable about medical advances than it once was. Today's medical consumers insist on the "best, newest" treatments. For many, a long and healthy life is no longer an accident of fate but a right.

In fact, health care managers interviewed "theorize that the environment has become competitive due to consumers demanding access and services as never before." Furthermore, "consumer issues such as convenience, breadth of services, and depth of services, long limited to traditional consumer services, appear to be rearing their heads in the medical arena."[15]

Technological advances, while resulting in improvements in the delivery of care, also contribute significantly to increasing overall costs. If useful technology is available, it is difficult to deny it to a patient in need.

Utilization of medical services is largely driven by physicians. It is a doctor who orders a test, prescribes medication, makes a referral, admits to a hospital. That is particularly true in the case of elective medical care and procedures such as surgery and tests. Despite the fact that consumers know there are often alternative treatments for their conditions, and despite an increasing interest in shared decision making, physicians continue to exert a strong influence on the choices their patients make.

Thus physicians, along with their patients, need more comprehensive information about the cost-effectiveness and outcomes of alternative treatments for various conditions. When provided with reliable information about the risks and benefits of alternative treatments, patients will often opt for less complex and invasive treatments.

It is also clear that there are conditions for which utilization of hospital services is more strongly correlated with the hospital bed capacity available to the local population. Some have argued that where there is greater local capacity, patients will be admitted to the hospital for medical conditions that, in areas with less capacity, are treated in the ambulatory setting.

Rising pharmaceutical costs, fueled in large part by our increasing appetite for new and expensive drugs to treat a broad range of diseases and to improve quality of life, is a significant cost driver as well. In fact, consumers most often identified cost of drugs/ prescriptions as leading the increase in Maine's health care costs.[16]

The desire of many hospitals and other health care facilities to attract consumers can also drive up prices. New services, however, often entail large capital investments that, in turn, must be recovered through high utilization. In such cases, supply induces demand.

Finally, while the commission is reluctant to identify advances in gene technology as a cost driver, there are indications that genetic mapping may lead to new possibilities for medical interventions, which has potentially serious cost consequences.

Lack of Consumer Concern about Price

Because much health care insurance amounts to prepaid health care services (that is, it covers many preventive and discretionary procedures) people are in effect insulated from the real costs of the care that they are receiving. They simply do not know how much many of their drugs, tests, and treatments cost. And because most of those who have insurance do not pay a significant portion of their health care expenses, they have no real incentive to choose cost-effective approaches. And even if they attempt to do so, they will find little or no link between expenditures and outcomes. Thus it is not surprising that most Americans know more about what it costs to run their automobiles than what it costs to keep them healthy.

In fact, when asked what information would be most helpful when choosing a health-care provider, only four percent of Mainers indicated the cost or method of payment, and only six percent indicated health insurance coverage as a factor. In contrast, measures of quality and reputation were listed by one-third of the respondents.[17]

Unhealthy Behaviors and Lifestyles

Avoidable consumer behavior contributes to higher costs in many cases. Use of tobacco, lack of exercise, poor personal safety decisions, and poor eating habits often contribute significantly to poor health status and increased health care costs. While individual decision making may be at the root of un-

healthy behaviors and lifestyles, these decisions are often made in the context of extremely limited choices and powerful influences beyond the individual's control.

It is likely that solutions to this cost driver are outside of the traditional medical system with its emphasis on curing illness and repairing injury. Rather, they reside within the broader context of health care. Examples range from mandatory seat belt and helmet requirements, to developing opportunities for exercise, such as urban trail systems linking parks and playgrounds, or swimming pools.

Emotion and Expectations

Finally, high emotion and unreasonable expectations often drive health care costs. Despite an intellectual understanding that no nation or state can possibly provide every possible health benefit to every citizen, individual Americans want their own family members to receive each of those benefits, regardless of cost. And while that may be in the best interest of those individuals and families, it is not necessarily in the best interest of society as a whole, contributing as it does to the increasing cost of health care.

Aging Population

In part, responsibility for increasing costs lies with the demography of the state's population. Like the rest of the country, Maine has more elderly people than it once did, but Maine's proportion of elderly in future years is estimated to be higher than in most other states. In a few years, for the first time in history, more of Maine's citizens will be older than 65 than will be younger than 18. That elderly population, naturally, needs more medical care than most other segments, which drives up overall costs. Those older than 75 are particularly costly, and that population is expected to grow relative to the population as a whole.

Administrative Inefficiencies and Programmatic Oversight

Maine's health care system is burdened by expensive, duplicative, administrative requirements. Using the PaineWebber calculation that 25 percent of health care expenses go to administration and waste; this implies that Maine spent more than $1 billion of its health care dollars in 1999 on administration and waste.

These inefficiencies were certainly highlighted by healthcare administrators interviewed by Critical Insights. Providing some very informal corroboration of the PaineWebber estimate, Critical Insights reports that estimates provided by hospital administrators vary "but anywhere from 15 percent to 20 percent of administrative time and/or costs tended to be the average estimate." Interviewees noted the growing administrative effort that is needed to comply with various business and medical management requirements imposed by payers: their perception being that the third party payer system achieves "cost savings by rejecting claims."[18]

Not surprising, insurance companies challenge those claims. Their representatives felt that many Maine providers, and particularly small physician-groups, exhibited a level of administrative inefficiency that included "unnecessary duplication of tests, inaccurate coding of procedures, paperwork that is incomplete or not completely properly, and lost records."[19]

Finally, human resource directors noted: "the complexity of the billing process for individual payers has geometrically increased, creating a similar increase in the number of forms required."[20]

Government Mandates and Regulatory Oversight

In addition to costs associated with administration of medical services, mandated benefits as well as regulatory activities (e.g., government protocols related to licensure, Certificate of Need), were noted by payers as well as providers as contributing to higher costs.[21] Of course, not all government mandates cost money, many of them actually save it.

In contrast to many of the other cost drivers, a significant number of mandates and regulatory oversight decisions can be addressed at a state level.

Poor Quality of Outcomes

Preventable medical errors add costs, as does a lack of continuity of care. As the health care system becomes more fragmented, diagnosis and effective, ongoing treatment becomes more costly and more difficult.

Environmental Factors

Environmental factors, both the natural and man-made, contribute to diminished health status and increased costs. In Maine, second hand smoke and ground-level ozone increase incidences of asthma and other lung disorders. Lead paint and asbestos have been shown to induce health problems in children. Lack of upper air ozone contributes to sun poisoning and increases the risk of skin cancer. And workplace injuries and illnesses remain a serious problem.

Further Research

The cost profile provides an important baseline and reference for policymakers and administrators in examining how Maine currently allocates health care resources, as well as how such allocations might be made in the future. As is always the case in studies of this nature, the data and findings create an appetite for additional and more detailed information. The commission hopes the data in this cost profile will provide a foundation for updates and refinement. Specifically, the commission believes that future study should be directed to:

- Including health care costs that were not addressed in this study. Those include, but are not limited to, mental health, dental care, Native American services, veteran's services, and school care.

- Developing a companion utilization profile that reports resource consumption in terms of diagnosis, hospital days, patient visits, tests completed and other service measures. Such data would begin to link cost and clinical information.

- Better understanding the composition of specific population groups, as well as the differential consumption patterns of each group. In addition to better examining the composition of populations, better differentiation of small versus large privately insured groups, populations with disabilities, and the frail elderly would provide valuable insights for the future.

- Better differentiating service categories. Those include but are not limited to: mental health and substance abuse services; secondary versus tertiary hospital services; primary versus non-primary professional services; and acute versus long-term care.

- Capturing more complete cost information from hospitals, physicians and other providers.

- Refining geographic differences within Maine, in terms of regional county groups and rural versus non-rural locations.

- Continuing the update, refinement and calibration of the estimates to reflect the rapidly changing health care marketplace, as well as new data sources. Doing so would mean an excellent historical record of changing cost and consumption patterns.

[1] Maine Development Foundation Annual Survey of Maine Citizens, November, 2000.

[2] Ormond, Salley, Kilbreth, "Health Care Access Project: Profiling the Uninsured in Three Maine Counties." Institute for Health Policy, Edmund S. Muskie School of Public Service, June 2000.

[3] Critical Insights, "Attitudes Toward Administrative Inefficiencies in Health Care," 2000

[4] The national percent is less than the often-quoted amount of nearly 14 percent. The latter amount reflects total health care expenditures, which includes amounts for research, construction and other activities that are not included in compiling personal health expenditures.

[5] Market Decisions, Citizen Perceptions of Health Care Issues, July 2000

[6] *Id.*

[7] An Aggregate Comparison: Maine and Idaho Hospitals, Maine Health Data Organization, September, 1999.

[8] Critical Insights, *op. cit.*

[9] Market Decisions, *op.cit.*

[10] Maine Health Data Organization, 1999.

[11] Journal of State Government, 1980.

[12] Maine Medical Assessment Foundation, 1983.

[13] Journal of Rural Health, 1999.

[14] Critical Insights, *op. cit.*

[15] Critical Insights, *op. cit.*

[16] Market Decisions, *op. cit.*

[17] Maine Development Foundation, 2000.

[18] Critical Insights, *op.cit.*

[19] *Id.*

[20] *Id.*

[21] *Id.*

Chapter 3
THE PROBLEM WITH HEALTH CARE IN MAINE

Armed with at least a partial understanding of the myriad social factors that affect health care in Maine, as well as with data analysis (discussed in the previous chapter) upon which to peg our real work, we began to organize our problem statement. Holding the *cost* of health as paramount, while recognizing that it is inextricably entwined with issues of access and quality, we divided the problem of high health care costs into three contributory elements, described below. Taken together, these elements not only drive up costs, they generate confusion, frustration, and general dissatisfaction. Such exasperation often precludes meaningful discussion of possible solutions. In other words, the sheer enormity of the problems seems to overwhelm most efforts to fix them.

A. The health care delivery and financing system is inefficient, unreasonably complicated, and unfair.

Whether the nation is spending too much on health care may be debatable, but markedly inefficient spending is an integral part of the system. Among industrialized nations, the United States gets far less for its health care dollar than do most other countries. According to the World Health Organization, this nation ranks only 37th out of 191 countries on several measures of health system performance. Although some have criticized the report's methodology, the fact remains that the world's richest country does not have the world's best health care system.

Expensive, duplicative administrative requirements are one of the reasons for poor value in our health care system. All estimates of administrative costs or health outcomes as related to expenditures are poor in comparison to the rest of the world.[1] Indeed, PaineWebber estimates that administration and inefficiency account for approximately 25 percent of the total annual U.S. healthcare expenditures.[2] Certain administrative costs are necessary, of course, but a figure of 25 percent seems high. In Maine alone, a 25 percent administrative outlay would have meant more than *$1 billion* in 1999.

Finally, and perhaps most tragically, a recent report states that the nation's health care delivery is prone to an excessive incidence of medical errors: that they cause 45,000 to 98,000 deaths annually in the United States.[3] In Maine, that would mean roughly one person dies each day as a result of medical error.

In addition to both administrative and medical inefficiency, there is considerable variability in how "fairly" Mainers are treated by the health care system. Two people receiving the same treatment might pay vastly different amounts out of their own pockets depending on their employment status, socioeconomic standing, age, and where they live. Related, people also have varying degrees of access to health care services based on demographic characteristics. The fact that charges are only somewhat related to cost connotes unfairness.

Providing insurance coverage at lower rates to people who are less likely to need it is a standard approach to lower costs. Indeed, insurance premiums cost less for those who are healthy and less at risk of becoming ill. People who are at greater risk of needing health care are left in a "pool" which, as a group, demand higher levels of care which translate into higher premium costs. As premium costs rise, the

most healthy in the pool opt out making the residual pool even less healthy and even more expensive. This is known as adverse selection and exacerbates the problem of uneven treatment based on socioeconomic characteristics.

B. People in Maine are not as healthy as they could be, and efforts to improve health status are inadequate.

While there are encouraging signs of improving awareness, such as the recent Healthy Maine 2000 conference and the antismoking campaign, Maine has numerous public health problems that are not yet being addressed comprehensively: alcohol and drug abuse, poor diet, sexually transmitted diseases, workplace safety, domestic violence, lack of exercise, and obesity, among them.

A survey by Maine Turning Point indicates considerable public support for public health efforts. A clear majority of respondents indicated that "delivering preventive medical care to keep people healthy" was their most important public health concern, and that they would be willing to pay fees or higher taxes to fund such initiatives. That willingness would pay off in the long term. If coronary bypass surgery and angioplasty—which are often the result of poor health choices—were reduced by only 20 percent, for example, the state would save $38.3 million a year.[4]

On the other hand, the Market Decisions survey reports:

> "When prompted about personal responsibility, less than a majority (42 percent) of respondents cited maintaining a health lifestyle as a personal step to reduce health care costs. Some 53 percent, say they "can't do anything or there is nothing that they can do" to reduce health care costs."[5]

In fact, of the seven most frequently given responses by consumers as to what accounts for the high cost of health care in Maine, greed accounted for three: on the part of insurance companies, on the part of pharmaceutical companies, and simply in general. There is apparently a disconnect between what Mainers are willing to pay for and what they are willing to do themselves.

Among adults, there are encouraging signs; dramatic examples of how relatively simple, low-cost programs can have major effects. Beginning in the 1970s, physicians in Franklin County, perceiving the widening gap between preventive medicine and the dominant fee-for-service system began offering free blood pressure screenings in an effort to reach the entire population. The county's public preventive programs have since increased in scope and sophistication. By the late 1990s, they were reporting measurable and significant improvements in cardiovascular health. The implications, both for building a healthier population, and controlling health care costs, are profound.

C. Many in Maine are unable to obtain health care of the type and quality that they need.

"Access" is a significant problem in health care in Maine: access to insurance; access to physicians; access to hospitals; access to relevant data and information of all kinds; and access to sustained, systemic public health efforts Access in all those areas depends greatly on geography and socioeconomic status, as well as on an ability to comprehend the system.

In recent years, medical costs for most people have risen at a much faster rate than their incomes. Ability to pay for medical care has become increasingly difficult for many, and has reached crisis proportions for some.

In fact, Maine (along with Hawaii, Massachusetts, Wisconsin and Washington) is among the five states with the highest insurance rates in the nation.[6] Obviously, then, a growing number of Mainers cannot pay for even the most basic health care insurance. The problem is particularly acute for employees of small businesses, who comprise the largest working population in Maine. Smaller employers, faced with increases in premium costs of between 15 and 40 percent since 1998, are increasingly unable to provide comprehensive health care for their employees. Even larger employers saw increases in that time of 8 to 20 percent.[7] Contributing factors to relatively high insurance rates include: poor health status, low population density, and government mandated universal availability.

High insurance rates have a direct bearing on access to health care: those without insurance are far less likely to seek care even if they feel they need it. In a recent study of the uninsured, for example, researchers found that 25 percent of children without insurance had unmet health needs, and that 15 percent of uninsured adults were going without needed medical care[8]. Such delay—or denial—of health care often results in more serious health problems. The result may be death or diminished quality of life, as well as increased long-term costs to an individual or to society.

Given the distribution of Maine's population, geography is also a significant factor in access. Those in more populous parts of the state have more opportunities for care. The southern part of the state simply has more physicians and more hospitals in closer proximity to where people live.

The much-discussed problem of pharmaceuticals is also an issue of access. For a large segment of the population, both insured and uninsured, paying for prescription drugs is becoming exceptionally difficult. The problem is particularly acute for the elderly: in 1998 alone the price of the 50 drugs that population takes most often rose by more than four times the rate of inflation.[9] When one considers that more than one third of all Medicare recipients lack prescription drug coverage, that nearly half of them have incomes below 200 percent of the poverty level—about $15,500 for an individual, $21,00 per couple—and that nearly 80 percent of them must take prescription drugs regularly, it is easy to see why the situation is of such fiscal and social concern.

Finally, expectations as to the type and quality of health care to which Mainers are entitled are largely undefined. Although guidelines for federal programs such as Cub Care are in place, the state as a whole has not determined procedures for consistent actual or prophylactic health care. In addition, Mainers often lack mental health services, as well as dental care. Thus, many receive far poorer overall care—and fewer services— at a higher price than they expect or can afford.

[1] PaineWebber, *Industry Outlook,* April 25, 2000.
[2] *Id.*
[3] National Institute of Medicine, "To Err is Human: Building a Safer Health Care System," 2000.
[4] Maine Turning Point, "Survey Shows Mainers Willing to Pay for Better Health," press release, May 8, 2000.
[5] Market Decisions, *op.cit.*
[6] *Michaud,* op. cit.
[7] *John E. McDonough, "Health Care Jitters,"* CommonWealth, *Summer 2000.*
[8] *Ormond, Salley, Kilbreth,* op.cit.
[9] The League of Women Voters and the Henry J. Kaiser Family Foundation, *Your Guide to Health Issues in the 2000 Election,* 2000.

Chapter 4
PRINCIPLES

Having identified the societal, governmental, market, and personal-responsibility elements of health care costs, as well as what is driving and shifting those costs, we attempted a set of principles to guide future policies and activities. Doing so reminded us of a dialogue from Lewis Carroll's *Alice in Wonderland.* "Would you tell me, please," asked Alice of the Cheshire cat, " where to go from here?" "That depends a great deal on where you want to get to," the cat replied. We think that the question of how to stabilize health care costs is similar; and that the best way to determine our destination is to develop a set of principles before beginning the journey.

The commission's principles are based on deep concern, in part on science, in part on experience, and in part on our faith on the good sense and compassion of Maine's citizens. They are not presented as absolutes, but as a foundation for a statewide discussion of our public values, our societal priorities, and our ethics that ought to guide our overall approach to health policy and finance. We intend them to be developed further by the citizens of Maine in cooperation with their elected officials, their non-governmental organizations, and private sector leaders.

Key Principles

Access

1. All Maine citizens should have ready access to basic health care regardless of income, location, or pre-existing or chronic conditions.

Quality

2. Maine's health care system should be characterized by excellence, zero tolerance for medical errors, and appropriateness of care in accordance with outcome-based evidence.

Efficiency

3. An increasing portion of the state's health care expenditures should go directly to disease prevention and public health efforts.

Supporting Principles

Personal and Community Responsibility

4. Primary responsibility for individual health lies with each person's ability to make wise decisions on individual behavior, as well as informed decisions with regard to preventive care and treatment of disease.

5. Individuals receiving health care should be aware of the cost of that care, and make health care decisions based on their needs and on the quality, service, and cost of potential treatments.

6. Community norms should greatly affect personal behavior choices.

The System

7. The health and satisfaction of the individual consumer should be the focus of the system.

8. Health care delivery and financing should be relatively simple, transparent, and understandable by consumers.

9. The health care system should encourage innovation and entrepreneurial approaches to solving complex problems.

10. There should be a shared sense of fairness about how costs are allocated and shared.

11. Information about health status, incidence of disease, treatment outcomes, and costs should be readily available in formats conducive to policy planning and individual decision making about behavior and disease treatment.

Role of State Government

12. State government should provide leadership and develop and maintain a statewide, long-term plan for coordinated health care delivery and financing based on demographic and economic trends, outcome performance measures, and citizen input.

13. State government should maximize leverage of federal government health care resources.

14. State government should streamline regulations in order to maximize opportunities for efficiencies and where state government action is necessary and appropriate, favor behavior incentives over punitive regulation.

15. State government has a minimum threshold responsibility to promote and maintain public health.

Chapter 5
APPROACHES TO CONSIDER

Introduction

In this chapter, the commission outlines a number of different approaches to stabilize overall health care costs and improve value within the health care delivery system. They are based on our analysis of the cost profile of Maine's health care expenditures, in addition to input received, and were selected from many ideas that we considered. They are *not* recommendations: indeed, some of them do not have the unanimous support of the commission members. They represent those approaches the commission found most worthy of further analysis.

The commission also asks readers to keep in mind several other considerations:

- The approaches have the potential to help stabilize costs over the long term, but some require an up-front investment;
- The approaches are described in concept, not in detail;
- Each approach requires much more analysis prior to implementation; and
- State government involvement in implementing the ideas will depend upon budgetary constraints, changing federal policy, and other compatible initiatives.

Policy Constraints

In the course of our work, we came across a number of factors that serve as barriers, or at least constraints, to potentially effective approaches. In many respects, those constraints served as boundaries within which we confined our approaches.

The State/Federal System: Health care delivery is influenced by a complex overlay of federal and state laws, tax policy, and spending policies. Many federal laws and budgetary policies constrain what Maine, or any state, can do. For instance, the federal Employee Retirement Income Security Act of 1974 (ERISA) governs all employee health plans established by private-sector employers, or by employee organizations such as unions. Furthermore, it supersedes many state health care initiatives such as employer insurance mandates and some types of managed care plan standards. In addition, Medicare spending, estimated to be about 20 percent of the total health care spending in Maine, is governed entirely by the federal Health Care Finance Administration. Finally, while Medicaid is largely a state-run program, it receives two-thirds of its funding from the federal government, and has strict and complex restraints on access to federal funds.

Employer-Based System: Employers began providing health care insurance to their employees as a result of wage caps imposed by the federal government during World War II. Today, employers are profoundly involved in providing health care insurance, and many workers have come to expect and rely on such benefits. Further, ERISA constrains state policy that might encourage movement away from the employer-based system.

Ambiguous Role of "Government:" Government's role in health care is not transparent. Unlike public education, for example, we are not deliberate about taxing citizens to provide funding for universal health care. Rather, we require the disadvantaged to be served through deeply entrenched, piecemeal government mandates, many of which promote cost

shifting and uneven distribution of the financial burden.

Cultural Norms and Values: As Americans, we expect exceptional health care delivered by the best doctors and best technology in the world. We are generally unwilling to accept less than that when a loved one is in need. That cultural expectation stifles our ability to consider rationing care.

Because of those and related constraints, the commission did not pursue certain options, notwithstanding their appeal.

For example, many testified that a universal health care program represented the ultimate solution to providing cost-effective, quality health care. Suggestions ranged from a "nationalized" single payer/provider system to a single payment program. Except for a modest adaptation of that concept (see Approach 10c), the commission concluded that a universal health care program was beyond the capacity of an individual state, requiring federal action.

Some advocated for comprehensive community rating, which requires insurance companies to apply similar rates to large groups of people, regardless of varying characteristics within the group. Although Maine currently has limited community rating, the commission concluded that expanding its scope might drive even more insurance companies from the state—and contribute to rising health insurance costs.

A related concept put forward is known as "pay or play," under which all Maine employers would be required to provide health insurance coverage for their employees, or to pay a tax that would allow the state to provide coverage. Federal preemption, concerns about further erosion in the private insurance market, and concern about negative impacts on economic development caused the commission to not pursue that approach.

The commission was very aware and sensitive to the impact of rising pharmaceutical costs on all Maine residents, particularly on the elderly and uninsured. Concurrent to the commission's deliberations, a great deal of legislative activity was focused on that issue. Thus we concluded that the state is paying adequate attention to the issue, and that there was probably little it could add.

Finally, there were a number of suggestions regarding purchasing alliances, the forming of large groups of people capable of negotiating volume discounts. There is evidence to suggest that such alliances have had only limited success in other states, and that the state could not form a large enough pool to make a substantial difference. In addition, a legislative committee and other groups are currently exploring the feasibility of alliances. None-the-less, we have introduced a modified version (see Approach 10b).

Policy Guidelines

The commission feels that to stabilize health care costs over the long run Maine's policymakers should agree on a common set of guidelines for future policy development. Doing so would ensure that policies are not in conflict with each other, and that all approaches are at least moving us in a common direction—toward cost stabilization. The commission urges that all health-care policies consider the following guidelines, which are presented in no particular order.

Promote Informed Choice

In the absence of a system of health care in which neither regulation or the free market is successfully stabilizing costs, we suggest a third way: informed choice. The notion rests on the premise that more complete information invariably results in better choices and better decisions by consumers, providers, and policymakers.

If consumers knew how much every procedure cost, the price of every prescription, every test, every therapy, it would affect the health care choices they made, even if it did not change their own out-of-pocket contributions. In other words, total transparency and full reporting of health care costs would have a significant cost-stabilizing effect over the long run.

If providers knew the cost of every procedure and

drug they prescribed, or how their treatments compared to those of other providers, or if they were more aware of risks and benefits of certain procedures, that knowledge might have an effect on the choices they make.

Further, full reporting of utilization rates, health outcomes, and health status by region and demographic factors would greatly assist policymakers in determining where to direct scarce resources.

Thus future policies should not further shield consumers and policymakers from knowing actual costs of specific procedures, but should move toward total transparency and full reporting.

Target Prevention

Poor health drives health care costs. To stabilize costs over the long run, we must invest in preventing poor health. Short-term investment in prevention will return better health and lower health care costs in the long term.

Prevention investment should be targeted towards those populations where it will have the largest effect on future health care costs: among children and poor adults. And public health efforts should be delivered at the community level.

Collaborate for Mutual Gain

The Maine health care market is too small, its services too costly, and health care itself too precious for us not to collaborate to provide the highest quality, most cost-effective services possible.

Collaboration for mutual gain might take the form of consolidating facilities and other aspects of service delivery; pooling groups of people to purchase insurance, health care services, and pharmaceuticals; consolidating the processing of claims and billing; sharing information; and collaborating with other states.

Future policies should move in the direction of increased collaboration, not toward proliferation of duplicative services. While collaboration may at times reduce access, as a state we need to ponder what level of access we can afford.

Encourage Personal Responsibility

Assuming greater individual responsibility for personal health would result in better understanding of the risk factors and health outcomes of certain behaviors. It would mean better understanding of treatment options, as well as and making health decisions in collaboration with medical care professionals. It would mean taking responsibility for personal medical records, and making them available to health care professionals when needed. It would also mean taking steps to provide financially for unforeseen tragedies.

Future policies should encourage people to take greater responsibility for their personal health and health care, and should not encourage unreasonable shifting of responsibilities.

Discourage Cost Shifting

Some cost shifting is legitimate and perfectly appropriate. At its best, it recognizes that although not everyone has the same ability to pay, no one should go without health care. Indeed, insurance itself is a form of cost shifting in which most of us voluntarily participate.

But health care cost shifting has evolved to a point of unreasonable complexity and unfairness. Despite its aim to provide basic health care to all, it lacks a deliberate, equitable means to cover its costs. As a consequence, some people pay far more for services than those services cost, while others pay less than actual costs. In other words, charges for services often have little relationship to the actual costs of providing them.

The system is complex, frustrating, and unfair. From a policy perspective, it is very difficult to determine where to direct efforts to stabilize costs, because actual costs, un-shifted, are often not discernable. Future policies should discourage cost shifting and move toward a more honest system of redistribution of health care dollars among various classes of people.

Approaches

We have tried to provide enough information on each of the approaches below to judge its usefulness and feasibility, but we have not delved into the details of implementation, thinking that best left to others. While the long-term cost impact of each approach is discussed in general terms, we have not done any modeling or forecasting of long-term savings or return on investment. Precise cost estimates are not provided: neither are specific funding sources. And for the most part, specific implementing organizations or agencies are not identified. They are not presented in priority order.

Health Status

Of all the approaches the commission is proposing, none are more important over the long run than strategies aimed at improving the health status of Maine's citizens. Focus on health status is critical because it is at the root of future health care costs. "An ounce of prevention is worth a pound of cure."

We put forth three integrally related approaches: focus on communities; shore up the state's obligation to protect the public health; and concentrate on youth. Of all the suggestions we have heard on this issue, we feel that community-based efforts with a special focus on children is the most practical, cost effective avenue. We are suggesting the "healthy communities" approach that brings into account all social, economic, geographic and political elements that affect life for all citizens, accompanied by integrated service delivery. Responding to evidence that Maine's public health capacity is lacking, we offer an approach to build capacity in a modest way scaled to Maine communities and Maine needs. Lastly, we suggest consideration of more attention to children in schools, where the infrastructure already exists and the returns on investment the greatest.

1. Encourage Healthy Communities

Approach

Promote the Healthy Communities approach, which has the following characteristics:

a. Focus on the total community: Involve private citizens, nongovernmental organizations, government, business, and health care providers in considering local social, economic, geographic, and political factors relevant to health.

b. Integrate several systems: The formal and informal community systems that contribute to "healthy communities" include: education, learning, and skill building; safe and adequate housing; recreation and culture; public safety; youth mentors; voluntarism; the workplace; wages; family; nonprofit organizations; health promotion and prevention services; the faith community; the media; and government.

c. Institutionalization: Identify and empower a local entity in each community, one that is accountable for monitoring, planning, and evaluating population-based health indicators and other essential public health services. Perhaps the geographic areas served could be based on the public health districts. Consider redefining the role that hospitals play in local communities.

d. Implementation: The lead entity's staff coordinates local public health needs assessments, data collection, and health planning activities in cooperation with all members of the coalition; develops solutions and finds the financing to implement the plans; and facilitates communication among the partners. The staff normally does not provide direct clinical services. In each community, the work is coordinated with local school health programs and the local public health provider (see other approaches below).

Rationale

Research has shown that health status depends 50 percent on lifestyle and behavior, 20 percent on environment and socio-economic class, 20 percent on heredity, and only 10 percent on medical care and access.[1]

Healthy environments that support shared responsibility enhance healthy choices and thus lessen the impacts of disease. Changes in societal attitudes toward smoking, drunk driving, and wearing seatbelts are good examples of encouraging better personal health choices.

Investing in promotion of healthy behaviors at the community level is extremely effective at reducing overall costs over the long run. Reducing risks posed by preventable conditions is the most cost-effective approach.

Once an individual takes on a healthy lifestyle, it doesn't take long to see substantial savings in health care costs. For instance, a 1999 *Journal of the American Medical Association* study, examined health care costs of individuals over an 18 month period and found that total costs for physically active nonsmokers with a healthy weight were half those incurred by overweight and physically inactive smokers.

2. Establish a Network of Public Health Physicians

Approach

The Bureau of Health should engage a public health medical director for each of the 30 recently established Health Districts. Each director might be a practicing local primary care physician, and might work about a day a week. Those individuals would not provide patient care, neither should they be confused with the current notion of a "health officer." Rather, they would have responsibilities in the following three areas:

a. Emerging Infectious Diseases: Assist in disease surveillance and provide local public health leadership for dealing with emerging infectious diseases;

b. Practice Standards: Promote clinical implementation of evidence-based health promotion and disease prevention interventions.

c. Community Health: Provide linkages for health coalitions on primary prevention, and promote clinician cooperation.

Rationale

In the absence of a formal public health infrastructure, Maine has neither the ability nor a vehicle to effectively identify and react to important public health threats. For example, the Bureau of Health can probably not provide adequate surveillance for emerging infectious diseases such as Lyme disease, West Nile virus, and Group A streptococcus. Whether it has the capacity to provide clinical guidance and public health leadership in the case of widespread disease is also questionable.

Failure to propagate physician knowledge and use of evidence-based health promotion and disease prevention interventions results in less-effective health care provision, which ultimately increases costs to the health care system.

Communities with effective long-term community-based health promotion coalitions that also include clinical providers with public health responsibilities are likely to succeed in reducing rates of chronic disease and other health problems that in turn will result in long term cost savings.

3. Improve Youth Health

Approaches

A. Support school-based health centers. They should coordinate with the Healthy Community coalitions and the public health medical directors (see above approaches), and affiliate with a community-based provider such as a hospital or physician practice. Services provided by the centers might range from treatment of acute illness and minor injuries to screening, referrals and counseling.

B. Support creation of a health council in each school district to focus on:

- Encouraging the participation of parents and youth in policy development and school involvement; including the integration of community providers with schools;
- Supporting the implementation of Maine's Learning Results in the area of Health and Physical Education;

- Providing physical health and behavioral health services including substance abuse services;
- Serving balanced and nutritious food and snacks;
- Promoting work-site health activities that support healthy behaviors and lifestyles; and
- Providing safe and aesthetic physical structures, school grounds and transportation.

Rationale

It has been demonstrated that early intervention and prevention has enormous long-term pay-offs in a society's overall health status. Further, learning health behaviors in childhood translates into healthy habits later in life.

Inactivity and poor nutrition among our youth is a well-documented public health problem. Twelve and a half percent of children between the ages of six and 17 are already seriously overweight,[2] twice as high as the rate 30 years ago. In addition, about 60 percent of overweight children between five and 10 years of age already have high blood pressure or elevated insulin levels, which puts them at risk of heart disease.[3]

Maine's children have unequal access to preventive care in their schools. Some have excellent health programs, but most do not. In fact, only twenty of the state's elementary and secondary schools have school-based health centers.

The long-term overall cost impact of early disease prevention and development of healthy behaviors is significant. There are also immediate cost savings. For instance, Maranacook Community School has had a school-based health center for the past several years and Medicaid costs related to patients in that school district have typically been between 10 percent and 20 percent lower than statewide averages—a discrepancy for which socioeconomic factors do not otherwise account.

Public Policy

Public policies have a major influence on the health care system in Maine. To ensure that those policies are adequately informed by the best possible information and analysis, the state should improve infrastructure for providing useful information and should consider establishing a health policy council to provide leadership, analyze information, develop ideas, and issue reports. Such analysis and data reports would assist the health-related decisions of state and local governments and non-profit organizations.

To improve information not only for policy makers but for consumers, so they can make better choices in consultation with their providers, we suggest considering the establishment of an all claims database, accessible via the worldwide web, that would include charge and paid data, utilization information, and quality indicators.

4. Create a Maine Health Policy Council

Approach

Establish a health policy council to serve as common ground for developing ideas and reporting information useful to policymaking. The council would not regulate activities or control investments in health care services. Its functions would include:

a. Developing health goals for the citizens of Maine to address: health status (perhaps using the Healthy Maine 2010 goals); service capacity and distribution; access and quality of health care; and other issues. The goals could be both quantitative and qualitative, and achievable in five to 10 years.
b. Developing health-related objectives that, if achieved, would reach the stated goals;
c. Preparing a biennial report card on the health status of Maine citizens, as well as on the results of efforts to achieve the council's goals and objectives;
d. Identifying, analyzing, and evaluating alternative approaches to the delivery of health promotion, risk reduction, or health care service programs;
e. Reviewing and revising the commission's principles (see Chapter 4), and using citizen input to determine their most appropriate use;
f. Establishing what constitutes "reasonable access" to health care facilities and recommending revisions to the Certificate of Need process so that it is more proactive, provides incentives, considers a wider range of factors, and is implemented in the

context of a larger vision;
g. Serving as a forum for innovation and emerging approaches, and for researching issues that affect health care costs. Issues the council might consider include analysis of health care staffing with regard to scope of service and impact of shortages in certain disciplines, developing a comprehensive information improvement strategy (which might include the commission's approaches 5, 6, 7, and 8), and emerging questions related to long-term care and death with dignity.

The council might comprise up to fifteen members, a majority of whom should be employers and consumers, i.e. not affiliated with providing health care or insurance. The governor, the speaker of the House, and the president of the Senate should appoint the members.

The council should sunset in six years, its performance evaluated, and reconstituted with appropriate modifications. The council should have a small, nonpartisan staff to provide management and research support. Professional research support should also be provided from a variety of sources. Funding should allow the council to support core expenses and contracts with organizations to fulfill the mandate in a high-quality, professional manner. The council could also be given authority to seek and accept grants from foundations and other sources.

A review should be made of existing efforts with similar missions to achieve consolidation and avoid unnecessary duplication of effort.

Rationale

Nearly five billion dollars is spent on medical care each year in Maine—a majority of that amount paid by government—and there is no comprehensive set of goals and objectives to guide spending priorities and policy decisions, or measures to assess progress toward those goals.

While a regulatory commission does not seem desirable in charting Maine's health care policy, neither is a dearth of organized thought. The commission therefore deems it prudent to suggest a middle ground: a council with power vested in the information it produces.

The council has the potential to reduce replication of endeavors, foster public/private collaborations, and galvanize objectives among diverse interests, thus improving the state's collective ability to achieve goals. Any of those effects would result in slowing the growth of rising health care costs.

5. Improve Information for Consumers and Policymakers

Approaches

A. Develop and maintain an all-payer claims database system that will include charge and paid data, utilization information, and quality indicators. The information should be provided from the database on the worldwide web in a user-friendly format accessible and understandable to consumers, providers and policymakers, and should comply with relevant patient confidentiality laws. Facilitating collection and provision of those data would best be accomplished by working through existing organizations.

Data of at least the following types should be available: charges for procedures; utilization rates; measures of patient satisfaction and quality of outcomes; and patient demographics.

The data should be accessible with breakdowns by provider (hospital, physician practice, etc. – perhaps differing degrees of specificity depending on size of organization), insurance carrier, region (perhaps by public health district), and for the state as a whole.

B. Require all health plans and third-party administrators to provide all claims data on their membership.

C. Require hospitals and physicians to provide information regarding the costs of specific procedures.
a. Hospitals and physicians should be involved in determining appropriate levels of detail, as well as the appropriate format for data reporting.
b. A state agency should be given regulatory author-

ity to establish rules and enforce compliance.

D. Increase the sample size of the Behavioral Risk Factor Surveillance System (BFRSS) survey to make data statistically valid at the county level.

Rationale

Health care consumers and health care policymakers do not have adequate information to make good decisions. Consumers are unable to evaluate providers in terms of cost of procedures, quality of outcomes, and patient satisfaction. And opportunities for community involvement in nonprofit governance are often unknown and or/unclear.

Policymakers often do not have enough relevant data to guide Certificate of Need decisions, formulate insurance regulations, or make other planning decisions. In addition, policymakers are not able to assess the BFRSS data on a regional basis, or by various demographic characteristics, because the sample size is too small.

Improved availability of data would allow individuals and policymakers to consider cost as part of their health care decision making. That would invariably result in lower-cost choices, which would serve to stabilize overall costs. Furthermore, having those data would facilitate the analysis and development of cost stabilization policies.

Efficiency and Quality

Having learned a great deal about how much of the health care system is caught up in administrative-type activities, and having learned that the sheer complexity of the system contributes to medical error, we suggest considering a number of approaches to combat inefficiency and poor quality. Because the current system contains both specific and general inefficiencies, the commission's suggestions encompass both narrow and broad reform.

Among the first steps toward making the system more responsive to the needs of patients and providers would be conducting a statewide pilot of software designed to make individual medical records portable, private, comprehensible and accessible.

Another approach is the establishment of an on-line medical reference system available to all providers, one that would provide state-of-the art, best-practice information to assist with diagnosis and treatment.

Finally, the commission suggests approaches to reduce paperwork requirements for patients, providers, and hospitals: support for the State Uniform Billing Committee; and an examination of the feasibility of third-party certification.

6. Improve Medical Records

Approach

Launch a pilot study of an integrated health information system that allows for individual medical records to be entirely portable among providers, be private, and be accessible by the patient.

The multifaceted pilot project should be implemented as follows:

a. Install VistA/CPRS, or a similar software program, as an integrated health information system for a Maine hospital. That would demonstrate its feasibility, and would provide credible data on cost and effectiveness.

b. Install VistA/CPRS, or a similar software program, for an organization with multiple outpatient sites. That would demonstrate the feasibility and cost-effectiveness of a system that makes patient clinical information available across sites.

c. Develop and test a secure remote medical consumer interface. That project would be the first demonstration of cross-institutional access and control of medical data by medical consumers.

d. Consult with an information-security firm to analyze potential security and privacy problems and the influence of HIPAA (the Health Insurance Portability and Accountability Act).

e. Conduct an independent audit of institutional impact on clinical functioning, billing, and cost effectiveness.

f. Bring together, perhaps through a statewide conference, those interests that are crucial for long-term

effective implementation to examine medical information and privacy issues.

This approach is not intended to tell any health care provider what services to provide or how to provide them; the only requirement of providers is to participate in a shared expectation of how consumer health information is communicated.

Rationale

There is little continuity and uniformity regarding medical records. Patient information is often entered multiple times, contributing to errors and inefficiency. Health care providers have difficulty accessing a new patient's medical history. Consumers do not feel personal responsibility for, or control of, their own medical records. But new models of financing health care, such as "defined contributions," depend upon informed consumers. In addition, new efforts to combat medical morbidity associated with lifestyle issues and chronic illness must involve medical consumers more effectively.

While the feasibility of exchanging health information and improving consumer access to it still needs demonstrating, it has great potential. If successful, it would not only prevent medical errors that result from duplicating information, but would allow consumers to take more individual responsibility for their health. Simplified record keeping would also allow the anonymous aggregation of data, allowing for more relevant research on health issues. A pilot project would provide a wealth of data on cost-effectiveness, safety, and consumer acceptance, as well as useful information for community health efforts and research.

It is estimated that a 20 percent increase in medical productivity would result from installation of effective integrated clinical information systems in health care providing institutions.[4] The epidemiological database created would be extremely important in detecting and addressing new health threats in our communities. As clinical information to support billing becomes more reliable, more consistent in format, and cheaper and faster to submit, the expenditures for administrative costs should decrease. The proposed system would also lead to a significant reduction in preventable patient deaths.

Providing consumers with effective access to information would allow them to take life-style and prevention issues seriously at home—not just at a doctor's office—providing one of the most effective ways to reduce a category of health care costs.

7. Improve Clinical Information

Approach

Improve useful information for clinical decision making, and to allow comparison regarding practice styles and utilization rates. Effective research should be conducted in order to nurture shared decision making, improve quality of care, and advance the scientific basis of clinical practice. Examples include:

a. Develop programs in lifetime learning for health professionals.

b. Focus on population-based monitoring of practice patterns and outcomes of care; as well as on the development and maintenance of an infrastructure for quality, outcomes research, and lifetime learning at the local community level.

c. Disseminate information about clinical practice patterns, successful quality improvement approaches, appropriate evidence-based practice guidelines, and research findings through a database providers could access in their offices.

d. Assist in the development of innovative methods to educate patients, and support shared decision making between providers and patients thus enhancing the patient's role in determining treatment.

Rationale

Physicians and other health care providers have difficulty keeping up with the latest medical developments and information. In many instances, they do not have access to state-of-the-art information technology, which could inform them of diagnostics and outcomes. Even if access to information technology is not a barrier, there is simply not adequate availability or dissemination of information about state-of-the-art quality improvement.

Furthermore, it is often difficult for physicians and

other health care providers to ascertain what is "appropriate care." Such doubt often leads to the precautionary approach of over-prescribing procedures.

A 1992 study estimated that 20 percent of all health care dollars were spent in that year on unnecessary procedures and services.[5] There are also considerable variations in the use of health services across relatively small geographic areas both within Maine and across the nation. Research has shown that providing physicians and patients with accurate information regarding treatment options, fosters shared decision making and results in decreases in variation and improvements in the quality of care.[6]

The approach described above, often implemented by quality improvement foundations, has proven to stimulate moderation in the variations in practice patterns associated with many disease conditions. That, in turn, results in an improvement in the quality and appropriateness of care, as well as in the associated cost of care.

8. Improve Administrative Efficiencies

Approaches

The commission found already underway several promising endeavors that deserve support. We suggest that those interested in reducing health care costs:

A. Endorse and encourage the work of the UB-92 State Uniform Billing Committee to standardize the way in which the UB-92 is filled out.

B. Create a HCFA 1500 Uniform Billing Committee to establish uniformity among medical professionals and insurance companies that use the form.

C. Bring together licensing boards, insurance companies and hospitals to explore uniform credentialing. Specifically, examine the feasibility of third party certification and examine increasing state licensing standards such that insurance companies and hospitals could accept a licensed person with no further credentialing. The work should build on previous similar efforts.

D. Examine the feasibility of sunset review of regulations relating to scope of service for specific professions.

Rationale

As discussed elsewhere in this report, the health care delivery system is fraught with administrative waste. The Critical Insights survey reported that some practice managers claim that "15 minutes out of every patient hour" is spent on paperwork protocols and administrative tasks.[7] In that same survey, hospital administrators estimated that waste and duplication amount to between 15 and 20 percent of all hospital costs. Adding to the administrative burden is the fact that many small providers do not file claims electronically.

Reducing duplicative efforts and streamlining claims and credentialing will achieve savings in the long run without reducing quality of care. In particular, increasing the number of claims filed electronically will increase efficiency.

A note on the Health Insurance Portability and Accountability Act (HIPAA): This is a federal law that will require use of a single form for billing among all those who file claims electronically. However, there are questions about the long -term costs savings of HIPAA. Although the federal government estimates that HIPAA will save $30 billion over 10 years, others estimate that implementing HIPAA could cost that much.

Access

Improved access to health care insurance results in more people getting treatment sooner for existing conditions, and in more people getting preventive care for conditions that may be avoided. In both cases, early intervention is more cost effective than treating illness at a later stage. Furthermore, increasing the pool of insured individuals spreads risk and reduces cost shifting.

An important effort to consider should be to attempt to change federal Medicare policy so that Maine hospitals and other providers get better reimbursements.

The commission suggests that Maine lobby for a more equitable distribution of Medicare funds, improve its submission of data to HCFA, and support efforts to reduce administrative requirements—all of which would increase Mainers' access to hospital care, and would cut costs.

Another aspect of access lies in the ability of individuals to obtain affordable health insurance. For those that are most unable to afford coverage, the commission suggests the state consider expanding Medicaid coverage. We also suggest studying the possibility of making coverage mandatory for children. To make health insurance more affordable, we offer three options: encouraging and facilitating the ability of private insurance companies to cover small businesses and individuals; creating a mutual health insurance fund; and establishing a universal, single-payment program for catastrophic sickness or accident. Lastly, we suggest considering stepping up advocacy for a national financing system.

9. Change Medicare Reimbursement Policies

Approaches

A. Support federal advocacy efforts to improve Medicare reimbursement through changes to federal policy. Work to increase the reimbursement rate for currently covered services, and to expand reimbursement to services not currently covered.

B. Support efforts to improve wage-index and case-mix information submitted to the Health Care Finance Administration (HCFA).

C. Work with HCFA and the Fiscal Intermediary to improve handling of Medicare cost report data.

D. Support efforts to achieve administrative simplification and reduce the financial impact of Medicare's administrative requirements

Rationale

Because rural hospitals are compensated for Medicare services at a lower rate than urban hospitals providing the same care, and because 58 percent of the state's hospitals are classified as "rural," statewide Medicare returns only 80 percent of the expenses incurred in treating those covered by the program. In turn, of course, those hospitals—along with other health care providers such as nursing homes—shift that 20 percent shortfall to other payers.

Increasing Medicare reimbursement rates and expanding the scope of reimbursable procedures would have a substantial effect on cost shifting. It would increase the amount of funding that comes into Maine. And simplifying administration of Medicare reimbursements could result in lowering overall health care costs.

10. Expand Insurance Coverage among Individuals and Small Groups

Approaches

The commission identified three approaches for further study and analysis. While the commission feels it important to take steps to expand insurance coverage among people who are either not covered or have policies through individual or small group markets, the members differ on what approach to take.

10-A: Use three avenues to encourage private insurance companies to cover small businesses and individuals:

The intent of these approaches is to foster the availability of more insurance products and encourage more young and healthy people to voluntarily obtain coverage.

1. Increase flexibility (in rating and otherwise) in the individual and small group markets.

Allow greater rate variations to provide carriers flexibility in addressing health behavior and health problems, and allow greater variation based on age and geographic area. Permit the Maine Bureau of Insurance to allow variations in rate and geographic accessibility standards for a limited provider network when an enrollee has access to a larger provider network that meets current geographic standards. Eliminate "standard" and "basic" health insurance plans

required under the Maine Insurance Code. While those required plans are technically available, and do facilitate comparison among plans, their relative cost has resulted in the sale of very few.

Current rate regulations were designed to provide cross-subsidies wherein individual insurance purchasers would subsidize high-cost users. High-cost users are less likely to be concerned about the premium rate than about having access to an individual health insurance policy. Lower rates for younger and healthier individuals should attract more of them to the market, thereby lowering rates overall.

2. Establish favorable state tax treatment of:
- Health care premiums paid by individuals.
- Medical savings accounts (MSA's) and similar instruments that allow funds to be accumulated for health care expenditures on a federal tax-favored basis, presuming that Congress extends those benefits beyond 2000. Consideration should also be given to requiring carriers in the individual and small group markets that offer high deductible plans to offer MSA's.

3. Collaborate with other states to:
- Pool the individual small group market and enter into joint purchasing alliances. In order to allow maximum flexibility, such a pool may exclude Maine-specific benefit mandates when the mandate is not present in all participating states.
- Streamline insurance regulations and statutes in order to make it easier for carriers to enter the "New England" market.

10-B: Create a mutual health insurance fund to provide coverage to uninsured children, small businesses, and individuals.

This approach intends to provide guaranteed issue in a very visible way, provide an umbrella program which includes Medicaid and thus would minimize any stigma associated with Medicaid coverage, and to create a large, financially stable risk pool with bargaining leverage that would replace, in part, the loss of a major not-for-profit insurance company in the state.

Such a fund might be established as follows:

1. Seek a waiver from the federal government to include the Maine Medicaid program. Use state and federal Medicaid funds: premiums for those populations would reflect differences in expected utilization paid by the state. To the extent that the economic circumstances of Medicaid-covered individuals change, beneficiaries could pay all or part of the premium, and continue participation. In addition to expanding the population base, that approach may serve also to reduce the stigma attached to the Medicaid program, particularly in the eyes of providers.

2. Make the mutual health insurance program open-ended enough so that the state could elect it for coverage of state employees, and so larger corporations and institutions could move into the program if it proved financially attractive. By doing so, the mutual fund might stimulate healthy competition in the insurance market.

3. Seek possible expansion of the program into other states, particularly in New England where interest may exist in making coverage available to similar populations.

10-C: Create a universal, single payment program that protects all citizens from catastrophic financial loss as a result of sickness or accident.

This approach has several intents: to provide catastrophic coverage for all Maine citizens, increase affordability for catastrophic coverage, rationalize health care insurance by pooling catastrophic losses, reduce cost shifting caused by bad debt and charity care, encourage standardization of administrative procedures among all health insurance programs, encourage healthy behavior, and yet allow the competitive market to operate.

It is the most far-reaching of the three approaches, and includes the following:

1. Creating a non-profit company that assumes the risk for medical expenses in excess of a catastrophic limit for all Maine citizens, except those covered by Medicare.

2. Requiring all citizens to have coverage through place of employment, Medicaid or direct purchase.

Because this approach requires an individual, rather than an employer, to have catastrophic insurance, it may avoid constraints imposed by ERISA. The analogy is one of owning a car and requiring the owner to have a certain level of automobile insurance. For those who purchase directly, premiums would be collected annually through state income tax filings and subsidized for qualified, low income persons.

3. Complementing a competitive health insurance industry. Under a catastrophic deductible, the insurance market will be free to develop and promote benefit programs for employers as well as individuals.

4. Increasing affordability of small group and individual insurance programs that underwrite for services below the catastrophic deductible limit.

5. Developing educational and risk management programs that manage health care costs.

Rationale

The recent turmoil in the private insurance market that led to the formation of this commission is in part a market adjustment. In the latter half of the 1990s, health insurance organizations engaged in aggressive marketing and pricing: initial premium costs and increases were very attractive and, as subsequently demonstrated, unrealistic.

In addition, many of the cost reduction strategies employed in out-of-state markets were not as effective in Maine. The absence of competitive provider— particularly hospital—markets in most Maine locations, as well as sophisticated provider organizations that could effectively bargain with insurance companies, contributed to that situation.

While it is clear that recent premium increases are grounded in those factors, there are other structural characteristics of the insurance market in Maine that contribute to costs. Those include:

1. Mandated benefits. Notwithstanding the merits of specific benefits or services, required coverage levels contribute to the cost of health insurance.

2. Prescribed operational requirements. Similar in impact to mandated benefits, requirements imposed on managed care organizations with regard to any willing providers, minimum travel distances, minimum length of stay, and other operational activities represent a regulatory cost to the organization.

3. Segmentation of the insurance risk. Any insurance plan works best when risk is pooled across large numbers. While all insured participants are afforded financial protection, the very high claims incurred by a relatively few number of people are "spread" among all persons who pay an equal and modest premium amount.

That fundamental concept breaks down when subsets (and particularly subsets who have a better experience) of a large pool leave and create their own insurance arrangement. In such cases, the cost of insurance for the residual population in the pool increases, potentially leading to another round of "adverse selection." Those dynamics are at work when large groups of employees select out of a pool under experience-rated or self-insured arrangements; insurance companies selectively market to the better risk; and healthy individuals decide not to buy insurance.

Such segmentation creates significant variances in the cost of health insurance among different populations: typically small groups and individuals represent the residual populations that have been shifted against. To the extent that individuals and employees in small groups defer insurance because of cost—and then incur the need for services—a very significant financial liability is incurred, as is bad debt and charity care for providers. Those latter costs are often shifted to other private insurance payers.

Generally speaking, more Maine people with adequate health insurance coverage would result in lower long-term health care costs because people with coverage are more likely to seek medical care earlier, which most prevents the need for more costly treatments.

To the extent that each of the three approaches would result in increased coverage, the cost impacts vary.

11. Expand Health Care Insurance for All Children

Approaches

The commission puts forward two complementary approaches.

A. Improve Medicaid and Cub Care coverage of children in the following ways:

1. Improve enrollment in existing programs. This could be done by continuing efforts that have resulted in recent positive enrollment trends, as well as by increased outreach and awareness at places frequented by children such as schools, pre-schools, hospitals, and the offices of health care providers.

2. Expand Medicaid coverage to maximum levels allowed by federal law. This could be done by amending the state plan to cover children in families that currently earn too much money to be eligible.

B. Mandatory coverage of all children, with an emphasis on prevention. Codified in law, all Maine parents would be responsible for providing health insurance for their children. . An affordable policy should be available: one that covers basic screening, immunizations, and preventive services. The last should be available through school-based programs where possible and reimbursable.

Rationale

Many Maine children are not receiving appropriate preventive care because they don't have health insurance, their parents are otherwise unable to pay for care, and free care is not available to them. Access to insurance would dramatically increase children's access to health care, especially to preventative measures that prevent further illness and associated health care costs.

Even if Maine has the second largest percentage of insured children in the nation, 18,000 children without insurance is still too many. Furthermore, Maine children are not as healthy as they could be, and many have poor health care habits. Teaching them healthier ways of living now would result in individual and societal rewards later. Investing in them results in a greater long-term return than investing in other groups. And the infrastructure, namely the public schools, already exists to facilitate deliver of preventive services.

The cost of covering Maine's uninsured children is small relative to future cost savings as a result of early screening, disease prevention, and development of good health care habits. Investing in the protection of Maine's children from disease would mean the state would need to spend much less money down the road to ensue a healthy workforce. And that is an investment from which the entire society benefits.

12. Expand Medicaid Coverage

Approaches

A. Amend the state plan to provide Medicaid coverage for all adults below the federal poverty line, based on a reasonable timetable in light of budgetary constraints.

B. Increase Medicaid reimbursement rates of certain under-funded procedures.

Rationale

Data shows that lower income people are disproportionately in poor health and are less likely to be able to obtain insurance in the private sector. In a recent survey covering three Maine counties, 21 percent of adults with incomes below the poverty level reported "fair" or "poor" health, compared to 5 percent of adults with incomes between 201 percent and 300 percent of the poverty level.[8]

Other studies consistently confirm that health insurance for low-income people is a critical factor in their health status.[9] Thus providing health insurance for the uninsured is an important factor in stabilizing costs in the private sector.

When asked the most effective way to extend health insurance to the uninsured, absent a complete overhaul of the system, experts who spoke to the commission invariably responded that Medicaid was the most realistic and cost-effective route. The com-

mission also heard that low Medicaid reimbursement rates cause providers in some disciplines (e.g., speech and occupational therapy and durable medical equipment) to refuse service to Medicaid clients, thus exacerbating the access problem faced by low-income individuals.

When low-income people obtain free care in hospitals, or from other providers, those costs are passed on to insurers, and ultimately, to payers of insurance premiums. In 1998 Maine hospitals spent $29 million on charity care and another $71 million in bad debt.[10] Coverage for all the uninsured—and underinsured—would eliminate the shift of those costs to the private sector. The expenditures would be covered and would ameliorate the inefficient and expensive system of treating the uninsured in the emergency room—often after a minor health problem has progressed to a major one. By investing $5.2 million state dollars per year, Maine would gain an additional $10 million in federal matching dollars—and would provide coverage for those who qualify for charity care, and are least likely to be able to pay their bills.

13. Advocate for a National Financing System

Approach

Advocate for a national health care financing system with other states. Such a system should have the following characteristics:

a. Universal health care coverage.
b. A decentralized delivery system, governed by states, but based in the market to allow for consumer choice.
c. A single nonprofit payment source, though perhaps decentralized claims administration.

Potential activities:

1. Convene the state's congressional delegation, and perhaps special interest groups, to develop an agenda and strategies to use at the federal level.

2. Convene New England governors to discuss strategies and develop a common agenda.

3. Encourage passage of proposed legislation currently being considered by congress that would allow a limited number of states to experiment with a single-payer system.[11]

Rationale

The commission came across several problems with the current system, all contributing to increased costs, that would be addressed with the establishment of a system of central financing and universal coverage. Such a system would:

- Reduce cost shifting
- Shrink administrative waste
- Provide transparency
- Improve fairness
- Increase access
- Provide for true shared risk (community rating)
- Aggregate data
- Allow for global budgeting

The commission found, as did the Health Care Reform Commission of 1995, that it is not feasible for a single state such as Maine to establish such a system alone. But the members do feel that Maine could join with others to promote a national system.

To the extent that a central financing system would reduce redundancy and administrative waste, reduce cost shifting, improve access, and fairly distribute risk, the cost impact could be enormous.

[1] Mills, Dora Anne. "Chronic Disease: The Epidemic of the Twentieth Century." *Maine Policy Review.* 9.11(Winter 2000):
[2] National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, 1999.
[3] A. Wolf, and G.A. Colditz, "Current estimates of the economic cost of obesity in the United States," *Obesity Research,* 1998;6(2):97-106, quoted in *Priorities in Prevention: Excess Weight and the Obesity Epidemic.*
[4] Medical Information Trust of Maine, correspondence to the Commission, October 14, 2000.
[5] "Wasted Health Care Dollars." *Consumer Reports.* July 1992.
[6] Maine Medical Assessment Foundation, October 17, 2000.
[7] Critical Insights, *op.cit.*
[8] Ormand, Salley and Kilbreth, *op.cit.*
[9] See generally, *No Health Insurance? It's Enough to Make You Sick, op.cit.* .
[10] Pohlmann and St. John, *Within Reach, Health Coverage for Working Parents (*Maine Center for Economic Policy, 1999)
[11] H.R. 4412, 106th Congress, 2nd Session.

Chapter 6
FINAL COMMENTS

We each offer the following final comments because, while we learned a great deal together and developed many shared perspectives, we none-the-less developed some individual opinions we thought worth sharing. These individual comments emphasize various aspects of the report, and in some cases, register disagreement with certain aspects.

Final Comments of Pam Plumb

Serving on the Blue Ribbon Health Care Commission has been an extraordinary education on the state of health care in our state and country. Dozens of thoughtful, committed health care professionals and experts in the field have patiently served as our teachers, sharing their knowledge and opinions. They brought us mountains of information and a wide spectrum of opinions.

After all the presentations, reading and discussions a few things, in particular, stood out for me. First, Americans pay far more for their health care per person than the nearest competitor for the title of most expensive, Canada. Most of the world spends less than half of what we do. We cherish the myth that we are getting much better health care for our money. In some areas, such as advanced medical technologies, we are. However, when it comes to the general health of the whole population, we are lagging well behind. It is not acceptable that we are spending so much and still not keeping the American people as healthy as the residents of many other nations.

Second, although there are some distinct features to the health care in Maine, such as its rural nature, the aging of the population and the number of smokers, the causes that make health care so expensive in Maine are the same as those for the rest of country. The systemic problems are national in scope. The state of Maine alone will be unable to make the kinds of systemic changes that are needed to significantly impact costs. The need for national change is my greatest frustration with this report, which is, of necessity, focused on Maine with less than .005 percent of the nation's population. We have recommended what we felt could impact and improve the cost of health care in Maine, but the real opportunities for change lie at the national level and we should become active advocates for change.

Third, in our current health care system, where 1) the person receiving the service most often does not pay directly for it and often doesn't know the cost, 2) providers often compete on how much modern equipment they have rather than price, 3) fees for service are related to reimbursement schedules rather than cost, 4) the services are generally a mystery to the patient and often overlaid with the emotions of life and death, 5) marketing drives demand for services or medications which may not be necessary or appropriate, the private market system doesn't have a chance to work. Contrary to the normal laws of economics, in Maine at least, competition is generally driving costs up, not down. There are certainly a few areas in health care where market competition may work, but unless we change the system dramatically, it won't work generally. We are the only country in the world trying to run our whole health care system on the private market system and the only industrialized country not insuring health care for

the entire population.

Last, even though our charge was to find ways to reduce costs in health care, it is impossible to discuss the subject without running into questions of access and quality. In fact, one of the ways to reduce costs is to force everyone in the pool, which would better spread the risk and reduce the number of people not getting preventative care. But, it is more than a question of cost for me. It seems morally unacceptable to me that we cannot find a way to provide basic health care for everyone. This country has looked more than once at national systems to accomplish this basic task, but has not had the political will to carry it off. We must make the issue central to the political debate so that it is resolved.

Final Comments of Thomas Moser

At our first meeting on February 4, 2000 we were told by Dr. Robert Keller, the chairman of the last commission to study health care in Maine, that normal market forces don't work in healthcare and all must be covered for insurance to be effective. As a champion of Adam Smith and a strong advocate of the free market I didn't buy it at the time. Now, eight months and 22 meetings later I have come to see certain wisdom in this.

One hundred and fifty year's ago public education in Maine, as in the rest of America, came to be seen as a right of citizenship. Our political leaders came to realize that only an educated electorate can make informed choices and our democracy could not prevail without such public funding to augment private schooling. Although we may argue over public schools versus vouchers, nobody of sound mind would argue against public funding for universal education.

That moment in our history was pivotal and set the course for an economic and cultural journey unimagined in the Old World where privilege determined access. Might we now be at a similar moment vis-à-vis healthcare? Might we as a people be ready to fund and define universal healthcare? Do not confuse fund with deliver, they are vastly different, for the former uses principally the power to tax while the latter performs the service. Look how close congress is to funding pharmaceuticals for those over 65; this would not have happened 10 years ago. Its called "readiness" and we are getting ready.

In the early pages of this report we assert that..."Our values endorse the notion that an individual has the right to receive whatever services are necessary in times of need." The phrase "whatever services are necessary" is arguable but who is so bereft of spirit as to take issue with this concept of compassion? What is at issue is the means of provision, not the necessity for providing.

Then a bit later we write..."A national single payer system may be the only approach that will work to control costs, assure access and rationalize the delivery of health services." As a strong advocate and practitioner of free enterprise it came as quite a revelation that we are over halfway toward the single payer system already when one factors in the reality that employer funded medical insurance premiums are paid with pre-tax dollars.

Throughout this report we speak of administrative expense which we believe consumes one-quarter of every dollar spent. Of the two billion dollars paid into the system by insurance companies 15% goes to their expense ratio. It cost these carriers at least $300 million to collect the premiums; the IRS, on the other hand, spends about 2% to collect the revenue to fund both Medicare and Medicaid. Nobody disputes the cost effectiveness of the IRS. The legislative challenge, however, will be in crafting a set of laws for the distribution of these funds by federal and state agents that will be less onerous than the whipping boy known as the HMO. We have to craft Federal and State programs that allow sufficient regulation to guarantee equitable coverage while at the same time providing for differences of access, based upon the individuals ability to pay. This same system must also be able to leverage behaviors, i.e., destructive life style choices should result in some negative consequences while wholesome life style choices should reward the individual with more than just longevity.

In the meantime, there is much that Maine can do to address many of the issues we've raised. Ultimately, however, our salvation is in a National single-payer system.

Final Comments of Joe Carleton

I would like to thank my fellow Commissioners, especially our Chair, for the collegial manner in which we were able to conduct our work. We have learned much, and although we do not agree on everything, I think we can advance public understanding of this very complex issue.

People look for magic bullets to save our health care system. There are no magic bullets. There are, however, magic words. Words like "competition" or "single payer" or "HMO" magically cause minds to close, tempers to rise and voices to shout. We need to forget magic bullets and magic words and go way back, back to some of the basics, to get our bearings about what health care means in this country, what a health care system can and cannot do and where it should fit in our lives. What follows are things that I think get too little attention. Our ignorance about these things is the single biggest impediment to a good health care system, in my view.

1. Health care reform needs to be undertaken very carefully. During its meetings, the Commission heard and frequently referred to the "balloon theory" of health care. Health care is like a balloon, the theory goes, because poking the balloon in one place will simply cause it to expand out someplace else. The health care "system" is many different systems acting independently, interacting with each other in unpredictable ways. Poke it in one place and something strange happens somewhere else.

2. Private insurance and government benefits increase costs. Ten friends dine out, intending to share an inexpensive meal and good conversation. To make things simple, they ask for one bill and agree to split it equally. A waiter, hearing this and knowing he will make more money by serving an expensive meal, leans down and whispers to each patron in turn, encouraging the diner to order a filet mignon or a lobster dinner. The waiter explains to each person that since the total bill is split ten ways she will pay only a small portion of the extra cost - 90% will be paid by others in the group. All people in the group make an individual decision to order costly meals. Pooling the bill has led to expenditures that no one of them would have chosen had they acted alone. As former Surgeon General C. Everett Koop once said about the bill pooling device known as health insurance, "It's like saying to someone, 'We are buying you a new car. Now what do you want, a Cadillac or a Chevy?'"

3. Health care is a business to the providers of health care. We all know that our medical care providers are caring people, but hospitals and doctors and other health care providers are not immune from the economic incentives that affect everyone else. This is true even for "non-profit" institutions who, after all, need resources to continue provide their services. We oftentimes forget that the usual economic incentive in health is to provide treatment. This frequently results in care which is costly, not medically necessary, and perhaps even harmful.

4. Providers of health care are fiercely protective of the turf carved out for them by licensing laws. This fragmentation increases costs. Many providers wage huge battles among themselves, played out in the Legislature, over the scope of practice allowed to them by the state. State boards are made up mostly of practitioners in the fields they regulate, and they have an incentive to keep a monopoly. A few years ago Medical Care Development Foundation sponsored a study of licensing laws. This field ought to be looked at again.

5. Health care will drain every available public and private dollar unless restrained. This is so because:

a. Health care is more art than science. Therefore, health providers have wide discretion in treatment. Different health care providers do prescribe widely varying treatment. The first witness before the Commission, Dr. Robert Keller (who chaired the previous health care commission) emphasized how some medical treatments are much more common in some geographical areas than others. All this is well known and has been extensively studied. Many of the pioneering studies have been done right here in Maine.

Furthermore, the type of treatment prescribed by health care providers varies widely with the health care provider. Chiropractors will generally prescribe chiropractic for back problems, M.D.'s will prescribe treatment within their scope of practice, and so forth.

b. Demand for health care is potentially limitless. Should an expensive diagnostic test be performed if there is a very small likelihood that it will be helpful.? How small is "very small"? One in a hundred? One in a thousand? One in a million?

c. Increased supply of health care providers creates increased usage of those services. Health care providers determine how much health treatment and what kind of treatment should be given. They have much discretion about this because health care is more art than science and the patient doesn't mind if the bill is covered by insurance (public or private).

Here are some summary thoughts about common myths:

a. Beware those whose solution to the high cost of health care is to have someone else pay for it.

b. Beware those whose solution to the high cost of health care is to put themselves into a group likely to have low health care needs, resulting in lower costs for them but higher costs for everyone else.

c. Beware those who judge our health care systems solely in terms of the numbers of people with or without health insurance. These statistics can be misleading and are often selectively used.

d. Beware those who demonize the insurance companies, or drug companies, or the government as the cause of problems with our health care systems. The truth is much more complex. The nearest culprit can be found by looking in the mirror.

e. Beware those who argue that health care decisions should be solely between a doctor and a patient. This statement has an appealing ring to it and would be true if the patient paid the entire bill, but this is rarely the case. Insurance payments represent the pooled resources of many policyholders and public benefits come from taxpayers. They have a stake in making sure the financial resources they provide are used wisely.

f. Beware talk about people getting all the health care they "need". Need can be a very slippery concept in health care. We can probably all agree what health care is needed in some circumstances, but beyond that, need has to be tempered by the finite resources available.

Here is my reaction to two common approaches to control health care costs.

1. Let the competitive free market work! Competitive markets, which work so wonderfully in other areas of our economy, do not work very well in health care for several reasons. Insurance (private or government) insulates the consumer from much of the cost. In addition, the complexity of health care means that the health care providers instead of consumers make most of the decisions. The provider has an economic incentive to increase services and therefore increase costs. We are unwilling to place limits on what the provider can prescribe. Also, personal health is a matter of such high personal priority that we want health treatment, no matter how unlikely it is to help and no matter what the cost is. We willingly accept the price charged. Finally, supply creates demand, as Dr. Keller suggests.

Health care providers do not advertise their prices. This is an excellent clue that free markets don't work in health care. There are no newspaper or radio ads saying that the hospital or doctor offers great prices. Although hospitals and other health care providers compete, they don't compete on price. Perhaps markets can be adjusted to provide better price competition, as Commissioner Beardsley suggests, but it hasn't worked so far and it will be difficult to do.

2. Health care needs to be regulated! When a patient and a doctor are in the examining room discussing treatment, neither of them cares about cost. The insurance company and the government (who will be paying all or a portion of the bill) are not in the room. The doctor has considerable discretion in treatment. The field of medicine is very complex. Patients feel very strongly about their right to care. Medical technology is changing rapidly. This means that regulations (either by the government or an insurance company) are complicated. General rules will necessarily have loopholes and exceptions, which in turn require more rules to deal with them. These in turn

give rise to further loopholes and exceptions. What can result, and has resulted, is an army of clerks battling each other over mind boggling minutiae as well as forests of paper filled with incomprehensible jargon, some of which must necessarily be labeled "THIS IS NOT A BILL."

Inadequacies of the market and regulatory approaches mean that we ought to look for other models. The Commission report has listed a single payer system as an alternative to look at. Some Commissioners have gone further and recommended that a single payer system should be enacted on the national level to address the inequities of the present systems.

In light of the charge given to us by Governor King to address costs, I suggest that one approach, known as global budgeting, allows us to make a conscious decision about the resources we spend on health, so that we don't end up like the friends who paid more for their restaurant meal than any of them intended. The decision about how much to spend on health should be under our collective control, as it is not now.

Providers of health care under global budgeting need not be subject to detailed rules and regulations set by insurance companies or the government. A designated sum of money is collected and allocated for health care expenditures within their geographical area. Health care providers make decisions about how this money is to be spent, keeping within the budget, without detailed regulations.

Commissioner Beardsley and I strongly disagree with inclusion of the approaches set forth in paragraphs 11 and 12 in the Commissions' report, relating to expansion of Medicaid programs, for the following reasons:

1. Medicaid expansion may reduce costs in individual cases where discovery of a health condition in its early stages will prevent more expensive treatment later on. This does not mean that it will stabilize or reduce overall costs, short term or long term. I am sure that it will not.

2. Although the scope of Medicaid programs is a significant issue, there is already wide public debate about it. There is much value in a report that focuses solely on the cost of health care. Paragraphs 11 and 12 blur that focus.

3. Medicaid has a significant impact on the state budget. It is presumptuous of the Commission to suggest how the myriad demands on the state budget should be prioritized. This is the job of the Governor and Legislature.

Final Comments of Bill Beardsley

A Minority Report by William H. Beardsley is attached to this report.

Final Comments of Robert Woodbury

The five members of the Commission, over hundreds of hours, shared good will, much learning, vigorous debate, and uncommon commitment. We sometimes differed and sometimes changed our minds. But I will always be grateful to all my colleagues, and Governor King, for providing a very special opportunity. I hope our collective thinking will be helpful in the larger debate about health policy in Maine.

One issue, finally, stands out for me amongst all others: the extent of inequity and unfairness in our health care system. The uninsured and other people of limited means, numbering in the many tens of thousands in Maine, receive second class health care at best and experience tragic denial at worst. This reality not only diminishes our values as a community but inflicts extra costs on our health care system as a whole.

Some have suggested that proposals for the expansion of Medicaid or other health services lie outside the scope of our charge. Considerable evidence exists, however, that delayed medical attention, inad-

equate preventive steps, and treatment sought in hospital emergency rooms escalates costs. Removing financial barriers for the less advantaged may diminish overall costs to the system and lessen cost shifting. Expenditures by state government in the short run, therefore, whether for Medicaid or public health or information gathering, may bring some long run stabilization to health costs as a whole. There is much we can do in Maine to diminish unfairness that is wholly consistent with controlling costs.

But the best strategy for addressing fundamental inequities in the system lies at the national level. I am persuaded, as I was not nine months ago, that only a national and universal financing system "with broad pooling of risks and progressive financing", as Consumer Reports concluded in its September 2000 issue, can both ameliorate the consequences of unfairness in our current system and address some of its most wasteful aspects. That would still leave a large agenda for Maine and its communities, as we have suggested throughout our report, in making the system work in a cost effective and humane way.

A MINORITY REPORT OF THE YEAR 2000 BLUE RIBBON COMMISSION ON HEALTH CARE

William H. Beardsley

November 15, 2000

EXECUTIVE SUMMARY

The Report of the Maine Blue Ribbon Commission on Health Care is comprehensive. It is based on broad input and substantive analysis. It proposes a significant increase in public expenditures and public sector involvement rather than cost stabilization. Cost stabilization was the charge to the Commission. This minority report is focused on cost stabilization.

The minority position is that Maine can and should take steps to stabilize health care costs by moving towards a consumer based, market driven, health care system. Policies recommended include:

- *Tax credits or deductions for premiums on catastrophic insurance*
- *Replacement of the employee state single payer system with a federal style multiple payer system*
- *Elimination of, or significant curtailment of, the certificate-of-need process*
- *Elimination of barriers to entry for qualified providers*
- *A sunset review of state licensing procedures*
- *A comprehensive review of barriers-to-entry regulations*
- *Targeting of data collection on epidemiological studies*
- *Consolidation of health boards and commissions*
- *Acceleration of moves towards standardization of billing and authorization*
- *Establishment of a task force to develop a multi-stage strategy to move Maine towards a consumer based, market driven health care system.*

A MINORITY REPORT

Governor Angus S. King, Jr., established a commission to identify cost elements of Maine's health care system, how cost are allocated, and to "recommend potential strategies for stabilizing overall health care costs"... and "payment options for health care services."

Collectively, the policies recommended in the majority report propose an expanded public planning, policy, and regulatory role, an increase in Medicaid expenditures, and an expanded role for quasi-public and private health policies agencies. Rising insurance premiums, the contraction of HMO's, the need for more health information and effective policy formulation, the chronic under-coverage of Maine's population, shortfalls in reimbursements and the perceived value of health education have given the Commission a rationale for proposing an array of policies that lead to a significant increase in public expenditures.

Further, the cost analysis of health care in Maine, as presented, is a valuable building block and the discussion of cost drivers and principles reflect the views of various constituencies with whom the commission met across the state. The final report provides a frame of reference for policy discussion and a broad database upon which to build in future years.

The minority member of the commission has the highest regard for fellow commissioners, the open process, the in-depth background cost analysis and the discussion of cost shifting, cost drivers, and the need for future research. The recommended majority policies, however, do not fully reflect commis-

sion deliberation. At the most fundamental level, the report states that "our culture is unlikely ever to accept market dynamics alone to resolve fundamental issues as they relate to access, availability, and affordability..." (p.6) This underlying philosophy permeates the report and has necessitated a minority report.

At the outset, while the primary purpose of the minority report is to set forth recommended steps to stabilize health costs, there are other concerns that should be mentioned.

• The report recommends that Maine schools become a major vehicle for delivery of health care services. Given current funding problems and the sheer complexity of providing quality education, legislature should be very cautious in adding another major function to an already burdened school system.

• The report recommends a significant expansion of Medicaid services while at the same time documenting the massive growth of, magnitude of, and high cost per recipient of the Medicaid system. Legislature should weigh very carefully the allocation of additional state resources to Medicaid vis-à-vis other citizen needs.

• Cost differentials and trends in different geographic locations, as presented, leave inferences about the effect of over-capacity, competition and HMO's on costs that are questionable and overlook such explanations as the percent of a provider's client base that is on Medicaid and Medicare, case mix, and differentials in Medicaid wage indices. To date, there is not enough analysis to legitimately set forth conclusions.

• There is a staff propensity to include such advocacy terms as "health is a birthright," "environmental health," and that "a national, single payer system may be the only approach that will work to control costs." These positions were not fully addressed or resolved by the commission.

In general, it is a minority belief that recommended policies of the report fall well outside the charge to the commission, at best, and could exacerbate the very cost problem the commission was established to address. The charge was to stabilize health cost, not to set forth a plan for expanded public expenditures. This minority report offers no "elegant solution." Rather, it proposes a very different array of policy recommendations for consideration, recommendations which could help to stabilize costs and lead towards a more consumer oriented, market driven, health care environment in the long run.

General Observations

1. Health care costs in Maine are higher than in the past and not unlike the national statistics both in levels and in trends. Similarly, Maine's health care challenges are numerous and similar to other states: costs are rising faster than incomes, cost shifting leads to inequities, and segments of the population are under-served.

2. There is a highly regulated, evolving, expansive system of providers, payers, consumers, policy advocates and regulators with very complex interrelationships, operating in a quasi-free-market/quasi command-and-control environment. The vested interests are extraordinary and persuasively argue for more public funds injected into the status quo, offset by public policy groups and soft money consultants who offer an extraordinary array of ideas, ideologies, and services.

3. Currently, there are very positive trends concerning Maine's uninsured. The percentage of Maine's children that are uninsured has declined from 16 percent in 1995 to 5.9% in 1999, placing Maine among the top four states in the nation in terms of child coverage. The percentage of overall uninsured has also declined significantly. The general public is more informed about health care costs, healthy living, insurance and public subsidies than in the past and appears to be making ever better choices, as are providers and payers. The system appears to be improving.

4. There is little evidence that health care costs as a percent of the gross state product (at about 14%) should decline. However, there is considerable evidence that partially funded federal mandates, state regulations and policies, and an array of "soft money" organizations and the vested interests of the status

quo providers and payers, have collectively made change in the direction of a cost effective, consumer based market driven system very difficult.

POLICY RECOMMENDATIONS FOR STABILIZATION OF HEALTH CARE COSTS IN MAINE

I HEALTH CARE PREMIUMS

Background: Lower income and elderly consumers benefit from Medicare and Medicaid but reimbursement levels are largely below provider costs. Large employers have negotiated very competitive services. That leaves individuals and small businesses as the residual consumers. The resulting economics dictate that providers therefore must load up these "residual consumers" with most of the overhead costs. This drives up premiums to a point where the lower income self employed and employees of small firms are priced out of the market. These uninsured/under-insured consumers may go without care and/or go to hospital emergency rooms for charity service which hospitals are required to provide. These hospital charity costs are then passed on to individual policyholders and small businesses in the form of yet higher premiums. One solution is to take steps to help make the market work more effectively by more closely tying costs to benefits for the paying and charity consumer alike.

Policies to Stabilize Health Insurance Costs and Reduce Cost Shifting

1. Establish a state personal income tax credit or deductions for the purchase of high deductible catastrophic insurance, targeted to those most in need. The goal is to use incentives, not prescriptive measures, to help consumers meet their greatest insurance need. This would make insurance more affordable to at least one segment of the uninsured.

2. Eliminate the single insurer policy for public employees and replace it with a federal-employee style array of choices thereby establishing a large insurance pool for competitive insurance plans. This new markets will attract insurers. The goal is to create a greatly expanded individual insurance market, promote competition and economies of scale.

3. Seek Maine's fair share of Medicare funds and apply it, first and foremost, to adequate reimbursement levels. The goal should be to reduce provider cost shifting and, hence, reduce insurance premiums to non-Medicare/Medicaid consumers. This Medicaid shortfall may be as high as $100 million.

II MARKET FORCES

Background: Barriers to entry for health providers exist at all levels in Maine. The resulting collective inefficiencies are significant. Each barrier, however, has a strong constituency and vested interest; hence, the array of constraints-on-trade is often presented in the guise of consumer protection.

Policies to Reduce Constraints-on-Trade

4. Eliminate the Certificate-of-Need process. It has failed in Maine; it stifles innovation, limits competition, restricts entry, and discourages creativity. Greater Lewiston/Auburn has the same population as Rochester, Minnesota (75,000) yet there is little doubt Maine's CON process would never allow a Mayo Clinic. Direct and indirect costs of the CON process are significant. If CON is eliminated, it is also critical to eliminate such mandates as charity care/24 hour care that have historically accompanied CON approval or cost inequities will occur.

5. Enact "all qualified clinical provider" legislation. For each consumer's clinical need, Maine should remove regulatory and other barriers to provision of such services by the least expensive "qualified" service provider be it nurse practitioner, medical assistant or whomever. For example, only Anthem will reimburse many allowed nurse practitioner services rendering it difficult for an N.P. to establish a free standing rural practice. Harvard Business School studies and economic principles suggest that such artificial barriers to entry are a major cause of health cost inflation and lack of access in rural areas.

6. Enact "consumer protection" licensor legislation. There is evidence that the licensing process in Maine has evolved into a "professional-protection" system rather than a system to "encourage entry" and "consumer protection." A comprehensive sunset review of all state licensing statutes and regulations related

to health care is recommended for consideration.

7. Enact "constraint-of-trade" review legislation. State laws, regulation and practices are rift with artificial barriers to competition and entry. To illustrate:

- the state offers education loan forgiveness to veterinarians but not to nurse practitioners and physicians' assistants in shortage areas.
- medical assistants may report to physicians but not to qualified nurses and may not carry out such duties as making beds in hospitals without redundant CNA qualifications.
- new regulations offer dentists in shortage areas loan forgiveness but only if they agree to provide "free" service, a policy which favors salaried public-clinic dentists over fee-based private dentists.
- physicians and nurse practitioners are limited in their ability to develop partnerships, as they are "unlike-professions."

8. De-massification of health care. While Maine is fairly progressive, there are barriers to telemedicine, mobile health services, non-traditional (often un-reimbursed) services, especially in rural areas where, isolation magnifies the cost of traditional service. The state should be proactive in establishing incentive rather than prescriptive legislation/regulation that would minimize barriers-to-entry for decentralizing technologies, especially for rural Maine. FAME style loan guarantees and/or subsidized loans should be considered as an incentive for investment in new technology.

III EFFICIENCIES

Background: There is a wide array of government agencies, licensing boards, commissions and other quasi-government entities with health care responsibilities and/or interests. There is limited formal interface between these groups. There are separate data collection efforts, limited standardization of procedures, challenges of redundancy and overlap. Much of the public session input to the commission was lobbying for contracts and more funding for planning, analysis, data collection and staffing rather than cost relief for consumers. The majority report addresses this by proposing the addition of a new oversight council. The minority report would prefer further consolidation.

Policy Recommendation in the Area of Efficiencies

9. The state should consider significant health agency consolidation and overhaul of its health responsibilities. Areas for consideration:
A. The state should consider having Medicare/Medicaid administered by a neutral third party much as FAME administers student loans. The goal would be to build a firewall between allocation and advocacy.
B. Basic data collection should be centralized in an existing central planning function such as the State Planning Office. The goal is to "mainstream" heretofore isolated and non-comparable health and demographic data.
C. While Maine has done a good job consolidating health departments and bureaus, boards and commissions should undergo a sunset review with a view to consolidation. This could be mandated by legislation or encouraged through an informal Governor's Kitchen Cabinet for Health not unlike the Kitchen Cabinet for Children.

10. A comprehensive review of opportunities for cost efficiencies should be undertaken. Areas showing promise include:
A. Protocols for standardizing the way uniform billing forms are filled out with a focus on U.B. 92 forms hospitals fill out for insurers and the federal HCFA 1500 Uniform billing procedure.
B. Protocols and incentives to replace pre-certification with post-certification by insurers for approved providers. For example, addressing this issue could be a positive consideration in bids for state insurance contracts.
C. Develop standardized application procedures for statewide approval for practice privileges and uniform credentialing. Such standardization does not limit a hospital or clinic's right to withhold privileges but it could reduce bureaucratic obstacles in the process.

IV LONG TERM COMPLEX STRUCTURAL CHANGES

The State of Maine should consider a strategic long-term objective of moving towards a consumer based, market driven health care insurance system as a prototype for the nation. At the heart of the transformation would be very difficult but worthwhile shifts including, but not limited to:

11. Elimination of tax deductions for health insurance premiums for corporate income tax but only if there is a concurrent revenue-neutral shift of responsibility and resources to the consumer. Since corporations usually have community rating policies, current employees have very diverse health benefits. Those diverse levels of benefits would probably have to be passed on to individuals at the outset to avoid adverse selection and the transferred funds would probably have to be used for insurance. Federal ERISA regulations must also be addressed. A task force to address such a potentially bold solution should be established.

12. The practice of mandated charity obligations for some but not all health providers creates massive cost equity distortions and should be phased out concurrent with direct consumer-based-assistance centered on consumer need and responsibility.

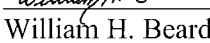
Finally, the market works best when information and price signals are available. Too much information, however, especially if mandated, can be counter productive and add expense. If one were to use tobacco settlement money to collect information that would most likely improve the functioning of the market, that investment could well be for much needed epidemiological studies.

13. Epidemiological Studies. The state should establish and annually update a detailed epidemiological report that is geographical, socio-economical, and demographically specific. It should be produced independently of any advocacy agency or group and must be of sufficient quality to provider, payer and public policy interests to be useful in substantive decision makers. The State Planning Office, as a candidate for this work, offers many advantages as it also collects, analyzes and reports on non-health data.

14. Pricing Information. Legislation should be enacted and some funding should be made available to industry associations to establish a voluntary, formal, yet understandable, pricing disclosure system for consumers. Failure by the providers and payers to achieve such a standardized disclosure system could/ should lead to a government action to do the same.

15. Medicaid Reimbursement. Under-reimbursement in Medicaid appears at the root of cost shifting in Maine. Medicaid can be improved with no increase in funding. The state should mandate that Medicaid reimbursement cover what the state deems to be reasonable direct costs of service, adding funds where too little reimbursement is currently available, cutting back on marginal consumers if that is the only way to achieve at least "minimal reimbursement." The entire administration of Medicaid in Maine needs an in-depth review. In Maine, Medicaid expenditures exceed $800 million. This does not imply there are known problems but rather its rapid growth and sheer size needs to be assessed and rationalized for the citizenry's peace of mind.

Signed by:



November 15, 2000

William H. Beardsley Date

Appendix A
Cost Profile Technical Notes and Tables

Table 1
Summary of Estimated 1999 Personal Health Expenditures in Maine

	for populations whose primary insurance is:						
	Medicare	Medicaid	Dual Eligibles	Private Insurance	Uninsured		Total
					Subtotal	Adjusted	
Population	173,333	138,420	37,667	746,180	165,440		1,261,040
Hospital Care	$ 427,977,317	$ 298,452,056	$ 150,043,097	$ 741,445,832	$ 115,073,252	$ 10,073,252	$ 1,627,991,554
Physician Services	$ 189,085,161	$ 33,683,403	$ 43,568,947	$ 496,228,250	$ 77,015,199	$ 38,507,600	$ 801,073,361
Other Professional Services	$ 34,434,350	$ 66,053,356	$ 16,637,368	$ 102,270,755	$ 15,872,540	$ 7,936,270	$ 227,332,099
Home Health Care	$ 57,970,935	$ 61,810,456	$ 111,012,353	$ 11,259,474	$ 1,747,483	$ 1,310,613	$ 243,363,830
Drugs & Other Medical Non-Durables	$ 87,174,548	$ 55,306,164	$ 71,941,979	$ 223,854,000	$ 34,742,400	$ 34,742,400	$ 473,019,091
Vision Prod & Other Med Durables	$ 61,299,376	$ 7,504,189	$ 15,741,932	$ 35,099,270	$ 5,447,447	$ 4,085,585	$ 123,730,352
Nursing Home Care	$ 95,947,810	$ 129,894,304	$ 292,722,168	$ 1,909,941	$ 296,425	$ 222,319	$ 520,696,543
Other Personal Health Care	$ 24,392,051	$ 100,639,418	$ 51,175,129	$ 131,815,035	$ 20,457,846	$ 10,228,923	$ 318,250,557
Sub Total	$ 978,281,549	$ 753,343,346	$ 752,842,973	$ 1,743,882,558	$ 270,652,592	$ 107,106,961	$ 4,335,457,386
Insurance Payer Administration	$ 21,247,130	$ 51,428,821	$ 40,592,255	$ 257,073,870	$ -	$ -	$ 370,342,075
Total	$ 999,528,678	$ 804,772,167	$ 793,435,227	$ 2,000,956,428	$ 270,652,592	$ 107,106,961	$ 4,705,799,462
						-Pct of ME GDP	13.9%
						-Pct of US GDP	12.3%

NOTE: For Uninsured, two amounts are reported. "Subtotal" represents the estimated personal health expenditures for this population. The "Adjusted" amounts are the estimated, out of pocket payments made by this population. The difference between these two amounts are the estimated charity and bad debt, implicitly included in the expenditures of other population groups (particularly the Privately Insured), is $163,545,631. In order to avoid double counting, The Total for the entire population includes the Adjusted amount for the Uninsured.

Technical Notes for Table 1

1.1 Total population for Maine provided by State Planning Office, Richard Sherwood, July 25, 2000, including estimated undercounts. Medicare population based on 1999 AARP report, *Reforming the Health Care System* and reduced for number of dual eligible persons. Medicaid only and dual population based on 1999 client-count reported by Muskie School, August 30, 2000. Privately insured population based on 1998 EBRI study reporting that 68.8 percent of non-elderly persons in Maine had employment-based coverage (website, EBRI).

1.2 Personal health expenditures for persons principally covered by Medicare are based on 1997 Medicare claims data for Maine as reported by the Muskie School, August 30, 2000. The data were trended to 1998 based on national trend rates by service category (HCFA website, June 2, 2000). No increases were projected for 1999, based on preliminary and aggregate reports as to the impact of the Balanced Budget Act. The claims estimates were increased for out-of-pocket expenses based on data in the March 2000 MEDPAC Report to the Con-

gress: Medicare Payment Policy , "Out of pocket spending on health care by category for all beneficiaries, 1992-1996, adjusted for inflation" (page 41). These data were trended to 1999 and inflated. Resulting amounts were allocated to the reported service categories based on a consensus of the Data Advisory Group. These national estimates were adjusted to Maine based on ratio of per capita Maine personal health expenditures (EBRI Health Benefits Databook, 1st Edition, Wash. D.C. 1999, pg. 21) for 1993 (by service category) to the US (HCFA website, July 11, 2000). Per capita amounts were multiplied by the Medicare population in Maine to determine total expenditures. HCFA estimates administrative expenses to be 3.2 percent of claims (HCFA/ OACT, August 1998).

1.3 Medicaid Paid Amounts and Patient Liability for calendar year 1999 provided by the Muskie School, August 30, 2000 in specified service categories. Drug expenditures reduced 2.1 percent for rebate, based on rebate history for state fiscal year 1998 and 1999 (State Medicaid Report). Third-party liability costs were not removed, since they are legitimate expenditures of this population. Combined state and federal administrative costs for the Medicaid program is estimated to be 6.5 percent of claims (personal communication, HCFA, 8/00). That amount is reduced slightly by including out-of-pocket expenditures in the denominator to calculate the percentage of total personal health expenditures.

1.4 Medicare, Medicaid and out of pocket personal health expenditures for dual eligible beneficiaries were calculated as described above in notes 1.2 and 1.3 except that out of pocket expenditures related to Medicare coverage was not included. Only patient liability expenses associated with the Medicaid program were included.

1.5 Except for that about drugs and other medical non-durable services, private insurance data are grounded in claims information provided by the Maine Health Information Center for the twelve-month period ending September 1999, and for a population of 136,211 employees and dependents associated with the Maine Health Management Coalition (private communication, June 12, 2000). Those data were trended 1.5 percent to a full calendar year. Because Coalition members represent principally large employers in Maine, an adjustment was needed for small employers. The 1997 Medical Expenditure Panel Survey (MEPS website) reported that 45 percent of Maine employees receiving insurance were employed in firms of less than 50 employees. Based on discussions with Bureau of Insurance, it was estimated that health insurance costs for small groups are 25 percent greater (R. Diamond, personal communication, August 11, 2000). Based on these data, a weighed average was calculated for large and small employers. This amount was reduced by 25 percent, representing average employee share of premium expenses in 1998 (EBRI Databook, ibid.) and grossed up 63 percent reflecting the amount of total health expenditures covered by private insurance in 1998 (EBRI Databook, ibid.) Completion factors for personal health expenditures outside of those covered by insurance were based on a consensus of the Data Advisory Group. Finally, personal health expenditures for **Drugs and Other Medical Non-Durable Services** were based on a separate analysis (G. Nalli, personal communication, May 2000).

1.6 **Insurance Payer Administration** was estimated based on filings made with the Maine Bureau of Insurance by major HMO and indemnity carriers providing insurance coverage for 370,000 persons, for the calendar year ending 12/31/99 (G. Griswold, 6/14/00). Given very significant administrative levels in 1999—related in part to reorganization by some companies—an average of 1998 and 1999 levels was used.

1.7 It is estimated that personal health expenditures for **Uninsured** approximate 70 percent of the expenditures for **Private Insurance** (Long, S.H. and Marquis, M.S. "The Uninsured Access Gap and the Cost of Universal Coverage", Datawatch, Health Affairs, Spring 1994, pp. 211-220). That factor was consistently applied across all service categories. Resultant amounts were reduced for bad debt and charity. Personal health expenditures for **Hospital Care** were reduced $105 million based on 1999 estimates provided by Maine Hospital Association (T. Butts, personal communication, June 19, 2000). Except for **Drugs and Other Medical Non-Durable Services,** reductions in the order of 25 percent to 50 percent were applied to all other services based on

anecdotal information and personal communications. No bad debt and charity reductions were taken for **Drugs and Other Medical Non-Durable Services**. Based on those approximations, the total reduction in estimated personal health expenditures for the uninsured population was 60 percent, an amount noted in the literature (Young, R.A., "Third part funding of health care services for the uninsured of Tarrant County", Texas Medicine, 95:8, pp. 50-54).

1.8 In October 2000, HCFA release an update to its estimates of personal health expenditures, by state. Comparing comparable categories of expenditures and trending 1998 data to 1999, estimates in this study vary by 7.9 percent with the HCFA estimates. Assuming a mid point in these estimates and a factor of approximately 5.65 percent as the difference between total personal health expenditures and those expenditures represented by the identified insurance programs in this study, an amount of $270 million is estimated as expenditures related to other payment activities, such as veterans administration, Indian health service, public health clinics and the like.

1.9 Gross domestic product for US calculated based on data reported at HCFA website, June 6, 2000. Gross domestic product for Maine provided by Maine State Planning Office (G. Rose, personal communication, August 1, 2000).

Table 2
Estimated 1999 Health Personal Health Expenditures in Maine as Compared to US

	Medicare		Medicaid		Dual Eligible		Private Insurance		Uninsured				Total			
	Annual Per Person	% Distrib	Annual Per Person	% Distrib	Annual Per Person	% Distrib	Annual Per Person	% Distrib	Subtotal Ann'l/Per	Subtotal Pct	Adjusted Ann'l/Per	Adjusted Pct	Annual Per Person Maine	Annual Per Person US	% Distribution Maine	% Distribution US
Hospital Care	$ 2,469	42.8%	$ 2,156	37.1%	$ 3,983	18.9%	$ 994	37.1%	$ 696	42.5%	$ 61	9.4%	$1,291	$1,417	34.6%	37.3%
Physician Services	$ 1,091	18.9%	$ 243	4.2%	$ 1,157	5.5%	$ 665	24.8%	$ 466	28.5%	$ 233	36.0%	$ 635	$ 853	17.0%	22.5%
Other Professional Services	$ 199	3.4%	$ 477	8.2%	$ 442	2.1%	$ 137	5.1%	$ 96	5.9%	$ 48	7.4%	$ 180	$ 255	4.8%	6.7%
Home Health Care	$ 334	5.8%	$ 447	7.7%	$ 2,947	14.0%	$ 15	0.6%	$ 11	0.6%	$ 8	1.2%	$ 193	$ 119	5.2%	3.1%
Drugs & Other Med. Non-Dur	$ 503	8.7%	$ 400	6.9%	$ 1,910	9.1%	$ 300	11.2%	$ 210	12.8%	$ 210	32.4%	$ 375	$ 468	10.1%	12.3%
Vision Prod & Other Med Dur	$ 354	6.1%	$ 54	0.9%	$ 418	2.0%	$ 47	1.8%	$ 33	2.0%	$ 25	3.8%	$ 98	$ 51	2.6%	1.3%
Nursing Home Care	$ 554	9.6%	$ 938	16.1%	$ 7,771	36.9%	$ 3	0.1%	$ 2	0.1%	$ 1	0.2%	$ 413	$ 318	11.1%	8.4%
Other Personal Health Care	$ 141	2.4%	$ 727	12.5%	$ 1,359	6.4%	$ 177	6.6%	$ 124	7.6%	$ 62	9.6%	$ 252	$ 127	6.8%	3.3%
Sub Total	$ 5,644	97.9%	$ 5,442	93.6%	$ 19,987	94.9%	$ 2,337	87.2%	$ 1,636	100%	$ 647	100%	$3,438	$3,608	92.1%	95.0%
Insurance Payer Admin.	$ 123	2.1%	$ 372	6.4%	$ 1,078	5.1%	$ 345	12.8%	$ -	0.0%	$ -	0.0%	$ 294	$ 190	7.9%	5.0%
Total	$ 5,767	100%	$ 5,814	100%	$ 21,064	100%	$ 2,682	100%	$ 1,636	100%	$ 647	100%	$3,732	$3,798	100%	100%

NOTE: For Uninsured, two amounts are reported. "Subtotal" represents the estimated personal health expenditures for this population. The "Adjusted" amounts are the estimated, out of pocket payments made by this population. The difference between these two amounts are the estimated charity and bad debt, implicitly included in the expenditures of other population groups (particularly the Privately Insured) On a per capita basis, this amount is estimated to be $989.
In order to avoid double counting, the Total for the entire population includes the Adjusted amount for the Uninsured.

Technical Notes for Table 2

2.1 Except for Medicare, annual per-capita expenditures were calculated by dividing personal health expenditures for each service category by the population. Per-capita U.S. expenditures were based on HCFA data (website, July 11, 2000)

2.2 Aggregate **Insurance Payer Administration** for the U.S is based on EBRI data (Health Benefits Databook, 1999, Table 1-2).

Table 3
Estimated 1999 Out of Pocket Expenditures for Health Care in Maine

	Medicare		Medicaid		Dual Eligible		Private Insurance		Uninsured		Total i/o uninsured	
	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket
Hospital Care	$ 2,469	10.9%	$ 2,156	0.0%	$ 3,983	0.0%	$ 994	30.8%	$ 61	n/a	$ 1,477	17.0%
Physician Services	$ 1,091	29.3%	$ 243	0.0%	$ 1,157	0.0%	$ 665	39.6%	$ 233	n/a	$ 696	33.0%
Other Professional Services	$ 199	69.5%	$ 477	0.0%	$ 442	0.0%	$ 137	43.2%	$ 48	n/a	$ 200	31.1%
Home Health Care	$ 334	5.4%	$ 447	0.0%	$ 2,947	0.0%	$ 15	30.0%	$ 8	n/a	$ 221	2.7%
Drugs & Other Med. Non-Dur	$ 503	98.7%	$ 400	0.0%	$ 1,910	0.0%	$ 300	40.0%	$ 210	n/a	$ 400	40.1%
Vision Prod & Other Med Dur	$ 354	45.0%	$ 54	0.0%	$ 418	0.0%	$ 47	49.2%	$ 25	n/a	$ 109	37.5%
Nursing Home Care	$ 554	58.2%	$ 938	3.7%	$ 7,771	12.3%	$ 3	29.3%	$ 1	n/a	$ 475	18.6%
Other Personal Health Care	$ 141	64.0%	$ 727	0.0%	$ 1,359	0.0%	$ 177	56.4%	$ 62	n/a	$ 281	29.2%
Sub Total	$ 5,644	32.1%	$ 5,442	0.6%	$ 19,987	4.8%	$ 2,337	37.5%	$ 647	n/a	$ 3,859	23.9%
Insurance Payer Admin.	$ 123	32.1%	$ 372	0.0%	$ 1,078	0.0%	$ 345	37.5%	$ -		$ 338	27.9%
Total	$ 5,767	32.1%	$ 5,814	0.6%	$ 21,064	4.5%	$ 2,682	37.5%	$ 647	n/a	$ 4,197	24.2%

NOTE: Total amounts for Uninsured are estimated to be: $ 1,636 Charity and bad debt, implicitly included in the expenditures of other population groups (and particularly the Privately Insured), are estimated to be $989.

Total column does not include Uninsured expenditures or population count.

Technical Notes for Table 3

3.1 Adjustments to principal insurance payments discussed above explicitly determined out-of-pocket expenditures. Those amounts are reported as percentages of the total personal health expenditures for each population group and service category, except **Uninsured**. Because 100 percent of estimated expenditures are paid by an uninsured individual, there is no differentiation in out-of-pocket expenditures. As suggested in the footnote, approximately 60 percent of the total expenditures for that population are offset by charity and bad debt considerations.

Table 4
Maine Compared to Identified Benchmark States for 1999

	North Dakota		Wyoming		West Virginia		Vermont		Maine	
	Annual Per Person	Percent Distrib	Annual Per Person	Percent Distrib	Annual Per Person	Percent Distrib	Annual Per Person	Percent Distrib	Annual Per Person	Percent Distrib
Hospital Care	$ 1,480	40.9%	$ 1,291	41.7%	$ 1,623	43.2%	$ 1,208	35.8%	$ 1,347	38.1%
Physician Services	$ 790	21.8%	$ 563	18.2%	$ 702	18.7%	$ 616	18.2%	$ 630	17.8%
Other Professional Services	$ 219	6.0%	$ 246	8.0%	$ 272	7.2%	$ 308	9.1%	$ 265	7.5%
Home Health Care	$ 34	0.9%	$ 88	2.8%	$ 122	3.2%	$ 128	3.8%	$ 117	3.3%
Drugs & Other Med. Non-Dur	$ 414	11.4%	$ 397	12.8%	$ 521	13.9%	$ 462	13.7%	$ 440	12.4%
Vision Prod & Other Med Dur	$ 49	1.3%	$ 48	1.6%	$ 51	1.4%	$ 50	1.5%	$ 45	1.3%
Nursing Home Care	$ 477	13.2%	$ 238	7.7%	$ 267	7.1%	$ 336	9.9%	$ 460	13.0%
Other Personal Health Care	$ 155	4.3%	$ 222	7.2%	$ 200	5.3%	$ 271	8.0%	$ 233	6.6%
Sub Total	$ 3,617	100.0%	$ 3,093	100.0%	$ 3,758	100.0%	$ 3,380	100.0%	$ 3,537	100.0%

NOTE: Amounts for Maine vary modestly from earlier amounts, reflecting different methodology used to make State comparisons. While previous estimates are considered more accurate, state comparisons are better made utilizing similar methodology.

Technical Notes for Table 4

4.1 Based on demographic and income characteristics, the State Planning Office ranked the forty nine states as to their similarity to Maine, based on demographic and income characteristics (R. Sherwood to C. Freshley, personal communication, July 13, 2000). The three most similar states were North Dakota, Wyoming and West Virginia. Because there was interest in comparing another New England state to Maine, Vermont was also included. Vermont ranks seventh to Maine based on this index.

4.2 Personal health expenditures by state were reported in a 1993 HCFA analysis. Per capita expenditures were calculated with 1993 population data provided by the US Census (website, July 22, 2000). Based on national trends, these data were inflated on a service specific basis to 1999. Adjustments for inter-state expenditures were provided by HCFA and made on a service-specific basis (personal communication, August 2000). Based on 1999 populations, total personal health expenditures were calculated for each state.

Table 5
Change in Estimated Personal Health Expenditures in Maine (without Insurance Administration) for Select Years

	1994		1999			2004			2009		
	Per Capita	Total (000)	% Chg-PC	Per Capita	Total (000)	% Chg-PC	Per Capita	Total (000)	% Chg-PC	Per Capita	Total (000)
Hospital Care	$ 1,130	$1,407,518	14.3%	$ 1,291	$ 1,627,992	27.1%	$ 1,641	$ 2,111,190	21.8%	$ 1,998	$2,642,845
Physician Services	$ 531	$ 661,444	19.6%	$ 635	$ 801,073	30.7%	$ 830	$ 1,068,389	24.5%	$ 1,034	$1,367,369
Other Professional Services	$ 131	$ 163,800	37.1%	$ 180	$ 227,332	36.9%	$ 247	$ 317,451	27.0%	$ 313	$ 414,418
Home Health Care	$ 154	$ 191,917	25.3%	$ 193	$ 243,364	35.3%	$ 261	$ 335,943	36.0%	$ 355	$ 469,855
Drugs & Other Med. Non-Dur	$ 236	$ 293,535	59.2%	$ 375	$ 473,019	50.0%	$ 563	$ 723,938	38.5%	$ 779	$1,030,696
Vision Prod & Other Med Dur	$ 88	$ 110,241	10.9%	$ 98	$ 123,730	23.5%	$ 121	$ 155,947	19.5%	$ 145	$ 191,649
Nursing Home Care	$ 341	$ 425,234	21.0%	$ 413	$ 520,697	25.5%	$ 518	$ 666,594	25.2%	$ 649	$ 858,196
Other Personal Health Care	$ 161	$ 200,507	56.8%	$ 252	$ 318,251	62.2%	$ 409	$ 526,701	61.4%	$ 661	$ 874,183
Sub Total	$ 2,773	$3,454,197	24.0%	$ 3,438	$ 4,335,457	33.5%	$ 4,590	$ 5,906,153	29.3%	$ 5,934	$7,849,210
	Consumer Price Index:		12.3%								

Note: 1999 is the base year for all the above projections, as adjusted by national trends on a service specific basis. For 1994, 1999 estimates were reduced by the per capita percent reported in 1999. 1999 per capita estimates were increased by the 2004 percent to project 2004 expenditures. 2004 per capita estimates were increased by the 2009 percent to project 2009 expenditures.
Note: PC means per capita

Technical Notes for Table 5

5.1 Estimates for 1994, 2004 and 2009 were based on national trends reported by HCFA on a service-specific basis (website, July 11, 2000). The adjustments were applied to the 1999 per capita estimates for Maine. Population estimates were provided by the State Planning Office to calculate total expenditure levels (R. Sherwood, personal communication, July 25, 2000).

5.2 Consumer price index information based on data reported by the Bureau of Labor Statistics for US (website, July 22, 2000).

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