Submitter Information

Organization:

Individual submitter’s name:

Title:

Comments

1. Please identify and briefly describe the top (2-3) cost-related barriers consumers in Maine face when attempting to access necessary health care.
2. Of the barriers described in question one, are there characteristics specific to Maine (geographically, economically, demographically) that contribute to the significance of the issue here?
3. With as much specificity as possible, please identify and describe the top state health policy changes your organization would recommend reduce or eliminate these barriers.
4. Please share any additional comments.

Ms. Garratt-Reed:

I am Tom Sterne, MD, M. Sc., a member of the Board of Maine AllCare, and writing on behalf of the organization, submitting testimony to the Office of Affordable Health Care.

Cost looms largest among the many barriers (geographic, undersupply of primary providers, mental health, women’s and abuse services, et.) to accessing quality healthcare in Maine, as it does for the entire nation. The reasons for this are multifactorial but boil down to the three most important contributing elements- the sheer cost of administering a complex, inefficient, wasteful coverage and payment “system;” the bloated pricing of goods and services, and the ever-expanding fraction of costs borne as out-of-pocket payments.

1. Estimates vary, but there is general agreement that the cost of the administrative overhead attached to the multiple and varied insurance products in the marketplace account to anywhere between 18% to 25% of total health related expenditures. These reside predominantly with the insurance companies, but not insignificantly with providers, institutional and individual, which devote large resources to the processes of billing, re-billing when claims and denied, prior authorizations, etc. They must forward claims to multiple agencies, each with their own set of benefits and submission requirements. ALL other developed nations have overhead expenses of half or less of this fraction. The dollars devoted to this enterprise amount to literally hundreds of billions of dollars nationally, and over $ 1 billion in Maine. By way of contrast, the cost of administering the Medicare program is between 3-5% of total expenses.

There is no way around acknowledging that this is a systemic problem, one that cannot be done away with via piecemeal, nibbling measures. The way forward is to move to a system where all contributions go to a single funding agent ( or at least as close to this ideal as possible), where the benefits package is clear, where payments to providers are prompt, where choice is not controlled by preferred networks, and where shareholder profit plays no role.

What can the State do to move towards this goal? It can legislate the option of consolidation of contributions toward funding for all residents, with an ample benefits package that reflects real needs, and with the minimization of out of pocket payments that constrict access to services. LD 1045 (2021) is an example of a prior attempt to achieve such a result. The dollars saved in overhead expenses would be used to offer improved coverage ( eye, ear and dental care), and residents and employers would drop their current inadequate coverage. Another current plausible strategy would be to increase the income eligibility for Medicaid, and allow for a buy-in for those of higher incomes.

1. Medication and medical device prices here are double or more than in the nations that have either single payer systems or strict price controls in the marketplace. There exists no effective bargaining power, except in the VA system, for negotiating lower prices. Patients have to hoard or avoid important chronic medications to be able to meet their financial obligations. Pharmacy benefit managers are ineffective if not useless in this regard.

If a Statewide plan existed , including the ACA and Medicaid population, as well as previously commercially insured patients, there would exist sufficient numbers to better negotiate prices.

1. We harbor naïve hopes if we aim solely to assure that all residents are “insured,” and neglect to analyze the long-term effects on health behaviors and outcomes with the kind of insurance that residents hold. Virtually all coverage vehicles short of platinum plans purchased by individuals and employers require very significant deductibles before payment can begin, in the general neighborhood of five to ten thousand dollars annually, obviously more for a family with children. Combined with the monthly premiums, even when subsidized, this means that a family earning $60,000 a year gross would have to lay out 20% of earnings before insurance coverage starts. Instead, they delay preventative and health educations visits, even for their children, and postpone care until need is emergent. Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2014 ( repeated in 2016), found (in insured persons 19 to 64yo):
2. 23% had such high out of pocket costs or deductibles that they should be labeled underinsured;
3. that half of those underinsured reported problems with medical bills or debt;
4. that 44% of these reported not getting needed care because of debt.

I can find no long-term studies specifically evaluating the effect of being underinsured on heart disease, diabetes, asthma chronic lung disease, or high cholesterol, but have to hypothesize that there are significant down-stream impacts on both health and cost.

The State should intervene to assure that even in our current system, no products should be offered that, given a family’s income, renders them underinsured. There is no evidence that having “ skin in the game” has saved money by limiting unnecessary expenditure. The State’s management of the marketplace should be strict on this issue immediately. Any new system should eliminate deductibles entirely, and develop mechanisms to manage changes in demand, if any. The time saved by physicians in management of billing, authorizations and medical need can be used to increase their patient visit capacity.

I hope that the OAHC will make recommendations that fulfill its mission to make care truly affordable…..

Tom Sterne, MD, M. Sc.