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October 2, 2023

To: Meg Garratt-Reed

Office of Affordable Health Care

Subject: 2023 Public Hearing Written Comments

Dear Ms. Garratt-Reed:

My name is Dan Colacino, and I am the Vice President and Legislative Chair of the Maine Chapter of the National Association of Benefit and Insurance Professionals (NABIP-ME). I am pleased to provide NABIP-ME’s comments in regard to the Public Hearing solicitation. We are responding as an advocacy organization. Our comments are in the same order as the solicitation request.

1. The top barriers to accessing healthcare are easily identified as high premiums preventing individuals from obtaining health insurance and, for those who have insurance, high cost sharing amounts for some or all of the healthcare services. Premiums represent the cost insurers and government pay to healthcare providers. Cost sharing represents the attempt to make the insurance affordable by splitting the cost between insurer and policyholders. The cause of both of these can be traced directly to the high cost of healthcare. This is not meant to lay the blame all on the healthcare providers. The healthcare system, defined as the set of interdependencies among healthcare facilities, professional providers, ancillary providers and medical supply providers, is complex and is very reactive to stresses applied to any of the participants. Supply chain issues, government regulation, insurer requirements, patient demand all result in higher costs. The point being, therefore, that any approach must be more global in nature than simply focusing on one or two elements. Changing the payer of record to one with lower reimbursement to achieve lower premiums won’t result in lower demand or lower costs to the healthcare provider. The approach must recognize the entire healthcare market, defined as that economic arena which includes consumers, payers and the healthcare system members.
2. Recognizing that most of the issues causing high healthcare costs in Maine are the same ones causing high healthcare costs in the rest of the country, we see two issues that are unique to Maine.
   1. Age of the population. Healthcare costs increase with age and Maine, having a higher average age than the rest of the country (eleven years over the national average), naturally will have higher costs. We hesitate to call this a barrier since it’s not something that can be overcome by any legislation or cost control measure.
   2. Rural areas with lack of internet access. One of the successes in overcoming a lack of healthcare in rural counties has been telemedicine. This relies on having a strong internet capability which is lacking in many rural areas.
   3. The reimbursement rates from the Government plans, Medicare and Medicaid, are significantly below cost and lead to higher commercial plan reimbursement rates, which then leads to higher premiums. The cost shift to commercial plans is inevitable and in fact, those higher commercial rates keep many providers from closing or leaving the State. The Medicare Payment Advisory Commission (MedPAC) reported that hospitals experienced an -8.5% margin on Medicare services in 2020 and expects that margin to increase to -9% in 2022. Realizing that the overwhelming percent of hospitals have 50% or more of their inpatient days paid by Medicare and Medicaid, the cost shift to commercial plans is not only understandable but expected. While the expansion of Medicaid eligibility was appropriate and a move that we endorsed, the State needs to recognize that it resulted in a decrease in income to most providers.
3. As far as State policy is concerned, the focus should be on costs since that drives premiums and subsequently, high cost-sharing. Our suggestions can be categorized as below;
   1. With item 2( c ) above in mind, we suggest that the State look at the way providers are reimbursed. Based on the recent Anthem/Maine Health dispute, it appears that facility reimbursement is cost or charge based, rather than resource or outcomes based. Many states and the Medicare program have had success with DRG reimbursement, inpatient and outpatient.
   2. As far as Medicaid reimbursement, a baseline could be set to provide regular increases in reimbursements to offset the increasing cost shift to commercial plans. This will result in higher costs to the State but will have a positive impact on commercial premium rates, which are driven by carrier’s reimbursements.
   3. Professional reimbursement policies should move from fee-for-service to an outcome-based system. Global reimbursement policies have not been accepted or as successful as value-based reimbursement, which may be the better option.
   4. Recognizing that benefit mandates need to be priced out by the Bureau of Insurance during the legislative process, we would strongly suggest that the Legislature be sensitized to the cumulative impact these bills have on premium rates. The ACA does require that, in the small group and individual markets, the State picks up the cost of any mandate outside the essential health benefits (EHB) of the Benchmark Health Plan, so if the mandate falls outside the EHB, state taxpayers pick up the tab instead of insured plan participants. Either way, the mandate forces an unfunded cost on the taxpayers.
   5. This category is more far-reaching with little or no immediate returns in savings but ultimately necessary for the long term sustainable control of health care costs. The point is constantly made that the U.S. has higher healthcare costs than OECD countries but lesser outcomes. The comparisons are not as direct as maybe thought since the U.S. is much more demographically and economically diverse than the comparison countries and leaves out the point that the U.S. is significantly less healthy than the comparison countries. Since EEOC and ADA regulations make incentives difficult to build into any health plan, public health education is the more appropriate approach. Public health education is not a cost containment tool with quick results but it does offer the best hope for long term containment. Continued and even increased funding for public health is essential.
   6. The National Association of Insurance Commissioners estimates that healthcare fraud in the private sector exceeded $36 billion. Medicare exceeded $60 billion. We would recommend legislation to require carriers to report on their fraud and abuse activities to insure that they are actively and aggressively investigating losses attributable to improper billing, up-coded billings and other similar schemes. Medicaid should also be included in any mandated reporting legislation.
   7. Providers report that they invest a considerable amount of money and labor to bill insurers for covered services. In spite of the Administrative Simplification regs in the original HIPAA legislation and the more recent HITECH bill, there are still differences in claim billing among carriers and the process remains overly and probably needlessly complicated. At a HCIFS hearing in 2017, we suggested that the State investigate ways to require carriers to use a single universal billing and coding methodology. We still think this could be low hanging fruit as far as savings based on the anecdotal reports from providers. Since Maine is a highly sought after vacation destination, out of state claims are prevalent. An approach to simplifying this could be the establishment of a claims clearinghouse to which the providers could submit their Maine-approved billings and the clearinghouse would file with the out of state carriers. A regional focus in this area could incorporate other New England states in a cooperative approach to claim filing.
4. As an overall comment, we would strongly recommend that any legislation focus on areas where achievable and documentable results can be obtained. The barriers related to costs are mostly in the commercially insured (individual and group markets) and the uninsured population. The Medicare and Medicaid populations don’t have these issues to the same extent so any proposal trying to roll both of these programs into the same solution is overreaching, extremely costly and ultimately unnecessary. A one-size-fits-all solution won’t work.

Additionally, as pointed out in 3 (e), estimates from the CDC show that up to 50% of health care claims are due to preventable or modifiable health behaviors. This is truly the best way to “bend the cost curve” but it’s doubtful that there is any type of legislation which can address this without being labeled as discriminatory. That’s where the public health education approach, mentioned above, can be applied.