

Testimony of the Maine Primary Care Association before the Joint Standing Committee on
Insurance and Financial Services In Consideration of LD 1397
“An Act To Allow Efficient Health Insurance Coverage”

Kevin Lewis
May 7, 2009

The Maine Primary Care Association (MPCA) supports parts of LD 1397, “An Act To Allow Efficient Health Insurance Coverage,” but has considerable concern regarding the proposal’s impact on primary care access in the state, particularly among the state’s underserved areas. Our support for the bill comes from our commitment to reduce overall costs of health care while upholding the highest standards of quality. The necessary leveraging factor to accomplish both of these goals is the promotion of access to the right care in the right place at the right time.

MPCA supports the language found in the proposed paragraph B under §4303, sub-§1. This change will make permanent normalization of what has been a pilot to institute greater flexibility in the manner in which access considerations are met while adhering to quality of care standards. This part of the bill focuses on non-primary care specialists, leaving aside primary, preventive, maternity, obstetrical, ancillary or emergency care services. Planned procedures can be performed at a greater distance from the patient’s residence without impinging on the quality of the outcome. In fact, the quality of the outcome should be enhanced if performed in a setting that has a higher volume of a given procedure and a demonstrated track record of high performance and patient safety.

This flexibility directly relates to the underlying principle of the right care in the right place at the right time. If time is not a factor, then there is a much wider field to work with in selecting the right care in the right place. Furthermore, paragraph B retains access standards such that the specialist cannot be more than two hours from a person’s residence.

However, shifting to more time sensitive care needs of primary care and preventive services, network establishment of primary care providers without any restrictions on geographic proximity to the carrier’s members threatens to cause more harm to patient health outcomes. Reduced health care costs are associated with more, not less primary care. The possibility of pushing the location of this care to more distant primary care providers reduces members’ access to the preventive and routine primary care services known to improve health outcomes and drive down costs. *Thus, we would ask that primary, preventive, maternity, obstetrical, ancillary and emergency care services be left out of the consideration of this new pilot program.*

An additional concern is the ability of carriers to justify the distancing of primary and preventive care along any of the factors of higher-quality care, improved patient safety or improved efficiency, any one of them apparently enough to serve as justification. However, limiting the basis *to any one of the three considerations of cost, quality or patient safety*, will not induce the change in our health delivery and payment system that both improves health outcomes and reduces overall health expenditures. All three should be necessary components for the upper tier of the proposed health plan pilot to skirt Rule 850 access standards entirely. (Incidentally, the language found in the summary of the bill does a much better job in this regard.)

Among the bright spots on the health care horizon is the development of the patient-centered medical home. Three of the hallmarks of the PCMH include: patient empanelment, continuous and team-based healing relationships, and care coordination. MPCA is working with our members to support the application of the PCMH as broadly across the primary care safety net as

possible. Our enthusiasm for the PCMH is based on the improved access to care that it precipitates as well as improved patient outcomes and patient safety.

Given our focus on providing comprehensive, high quality primary care that would seem to be attractive to a carrier forming a network that seeks to reduce its overall health care costs, one might question the basis for our concern. This concern boils down to the manner in which efficiency may be measured as a comparison among primary care providers. Federally Qualified Health Centers (FQHCs) provide comprehensive care which includes mental health, substance abuse treatment, and dental care. They all reside in defined medically underserved areas of the state. National studies show that FQHCs are responsible for cost savings of 41% of total health care costs as compared with care provided elsewhere. In Maine, FQHCs have been shown to dramatically improve access to care. Nevertheless, downstream health care cost savings may not be considered in the measure of efficiency offered by the pilot, especially if the carrier is not convinced that its members today will be its members tomorrow. In other words, the carrier's health care costs are not necessarily aligned with total health care costs, reducing the business imperative for investing more in preventive health care benefits with longer term payouts.

Cost comparisons without regard to the value of the service being offered will unfairly judge the true benefit of the FQHC – or any other safety net provider – as a primary care access point within the plan network. Network creation that disadvantages local primary care, especially the investments made in FQHCs among medically underserved areas, will only increase the cost of care at those locations by raising the average cost due to lower volume with the same fixed costs.

It is from this perspective that we are concerned with the possible impact on local communities and the people living in medically underserved areas from the creation of pilots that have an upper tier without regard to any access standards even for the foundation of improved health outcomes: primary and preventive care services.

We ask that the Committee amend the language of paragraph C to read as follows:

C. Notwithstanding paragraph B, a carrier may develop and file with the superintendent for approval a pilot program that allows carriers to reward providers for quality and efficiency through tiered benefit networks and providing incentives to members. The upper tier, or the upper tiers if there are 3 or more tiers, under a pilot program approved pursuant to this paragraph is exempt from geographic access requirements set forth in this Title or in rules adopted by the superintendent **with the exception of primary, preventive, maternity, obstetrical, ancillary or emergency care services, as defined in Bureau of Insurance Rule Chapter 850.** Any carrier offering a health plan under the pilot program must collect data on the impact of the pilot program on premiums paid by enrollees, payments made to providers, quality of care received and access to health care services by individuals enrolled in health plans under the pilot program and must submit that data annually to the superintendent. The superintendent shall report annually beginning January 15, 2010 to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on any approval of a pilot program pursuant to this paragraph.

The basis for tiering benefits under a pilot program must be to provide incentives for higher-quality care, improved patient safety **and** improved efficiency ~~or a combination of those factors.~~ The superintendent shall consult with the Maine Quality Forum under section 6951 in assessing quality. The superintendent shall disapprove or withdraw approval of a pilot program if the superintendent finds that approval or continued operation would cause undue hardship to enrollees in the pilot program or reduce their quality of care.