

MaineHealth

**MaineHealth Member
Organizations:**

Franklin Community Health
Network
LincolnHealth
MaineHealth Care At Home
Maine Behavioral Healthcare
Memorial Hospital
Maine Medical Center
NorDx
Pen Bay Medical Center
Southern Maine Health Care
Synernet
Waldo County General Hospital
Western Maine Health

Part of the MaineHealth Family:

MaineHealth Accountable Care
Organization

MaineHealth Affiliates:

MaineGeneral Health
Mid Coast-Parkview Health
New England Rehabilitation
Hospital of Portland
St. Mary's Health System

**Testimony of Katie Fullam Harris
Senior Vice President of Government Affairs
MaineHealth
in Opposition to LD 2110
“An Act to Lower Health Care Costs”
February 25, 2020**

Senator Sanborn, Representative Tepler and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, I am Katie Fullam Harris of MaineHealth, a non-profit integrated health care system that serves the residents of 11 counties in Maine and one in New Hampshire. Every day, MaineHealth’s team of over 19,000 employees works to fulfill our vision of “working together so our communities are the healthiest in America.”

That is why we agree with the goal of this legislation – to improve the affordability of health care for Maine people. We believe that access to health care is a fundamental element to meeting our vision, and access can be hindered if the care is not affordable. But I am here to provide an explanation for why the increased regulation that this bill proposes is not the solution that will meet that goal.

No one disputes that the cost of health care represents a serious problem for many Maine families and businesses. Though Maine’s per capita spending on health care is the lowest in New England, our low per capita earnings still put pressure on Maine families and businesses. As Maine’s largest integrated health care system and also the state’s largest private employer, MaineHealth experiences the pressure of cost from both of those vantage points – as a provider we both experience the anguish of families that struggle to pay for their prescription medications and we experience the rise in bad debt as they can’t pay the cost sharing components of health plans that have increasingly higher deductibles.

As an employer, we are forced to walk the annual tight rope between providing raises for our employees and offsetting the costs of our own health plan increases. It is never an easy task. So we certainly understand the impetus behind this bill.

But as a provider, we also have a fairly good understanding that the drivers behind health care costs will not be easily manipulated by placing an artificial cap on growth. The consequences for doing so could be dire, particularly for rural Maine – and could create greater instability in an already unstable market

Wages– Health care relies on human workers to sustain its delivery. In fact, 63% of MaineHealth’s costs represent the wages and benefits that we provide to our employees. We are in a global employment market for many key positions – particularly physicians, nurses and the increasingly critical IT specialists– and it takes top dollar to attract top talent. On any given day, MaineHealth has 1,200 open positions across the system, and in a recent 12 month period, we recruited workers from 45 states across the country.

As a fiscally conservative organization, MaineHealth benchmarks our salaries to the regional and national medians. But the reality is that the cost of turnover when we lose key positions to our global competitors – including companies such as WEX and UNUM – is high. And regulation and quality standards require that we hire temporary caregivers when many of our positions become vacant – at a cost that is approximately 3 times more than a full time employee. The national labor shortage is having a major impact on health care systems too. Yet regulating our rate of growth will not change these pressures – and, instead, could result in forcing decisions that meet the artificial target in the short term at a significant cost to longer term access to quality care across our state.

Rural Infrastructure – By definition, hospitals must provide care 24 hours per day, 7 days per week, 365 days per year. That is costly in any environment, but it is particularly costly in rural hospitals that have relatively low volume and serve older and poorer communities. Maine’s demographics – we are the oldest median age, we are relatively low income, and particularly in rural areas, we have a high burden of chronic disease – require a level of infrastructure that is not fully supported by the governmental payors that represent an increasingly large portion of rural payer mix.

This has resulted in operating margins that do not support the human nor structural infrastructure necessary to sustain services without supplemental support. Industry experts recommend that health care systems earn an operating margin that exceeds

2.5% to sustain necessary reinvestments. As you can see from the chart, only Maine Medical Center has met that threshold within the MaineHealth system for the last three fiscal years. Our smaller and more rural hospitals have struggled to break even during the same period.

Local Health System	2017	2018	2019
Memorial Hospital (NH)	1.6	1.7	0.2
LincolnHealth	2.2	2.1	1.3
Western Maine Healthcare	2.1	2.2	3.8
Franklin Community Health Network	-6.4	-7.2	-11.8
Coastal Health Alliance	0.1	1.5	2.8
Southern Maine Health Care	.2	-2.0	1.9
Maine Medical Center	4.6	4.6	4.6

In 2019, MaineHealth’s system hospitals unified under a single governance model to allow for a more efficient and effective structure to support these rural providers. We are committed to providing access to care across our footprint, and this governance change allows us to shift resources more nimbly. In fact, in spite of the challenging financial picture of many of our hospitals, we have maintained access to needed care. LD 2110 would look at each local hospital separately – failing to account for the functions of a system. This would stifle the innovative approaches that we develop to share resources across the system to support ongoing access to quality care in rural parts of the state. Additionally, limiting a hospital’s margin may adversely impact other health care activities that are supported by that margin, such as support for community behavioral health services, long-term care, or programs to that invest in the development of local workers to address the current workforce shortage crisis.

Performance Improvement Plans: The bill is extremely prescriptive in its requirements for providers, and the administrative burden associated with PIPs is antithetical to the goals of the legislation; the administrative costs created by in this bill cannot be overstated. We were recently provided with information that the legal and consultant support necessary to secure the approval of a hospital merger through the Massachusetts system, with emphasis on the Massachusetts Health Policy Commission, totaled approximately \$38 million. It is difficult to envision how that is efficient or a cost

reduction strategy – in fact, it will likely discourage providers from attempting to make the health care system more efficient and from responding to changes in the competitive health care market.

In 2001, MaineHealth’s Board of Trustees adopted a goal of maintaining a pricing and expense structure to support affordability for Maine payers while maintaining access to care throughout our region. That voluntary approach was subsequently adopted by the Legislature as part of the Dirigo law in the form of voluntary limits on hospital consolidated operating margins and Cost Per Adjusted Discharge (CPAD). As a health care system, MaineHealth continues to include these limits in its strategic goals by maintaining an operating margin that is 3% or less and our CPAD below 110% of the forecasted hospital market basket index for the coming year. We have been, and remain, committed to doing what we can to address affordability while maintaining access to care for the communities we serve.

The burden of underpayment: The reality is that a large driver of the prices that consumers pay for health care is underpayment by government payers. In our old and poor state, over 61% of the reimbursement rates paid to our local health systems are already set in law by the Medicare and Medicaid programs, which fall well short of covering the cost of care. In fact, Medicare has cut payments to Maine hospitals by \$688 million since 2010. And for local hospital systems paid on the prospective payment system, Medicare pays approximately 77% of cost and Medicaid pays approximately 70% of cost of providing care to patients. That underpayment is reflected in the prices we are forced to charge to those with commercial insurance. That cost shift directly drives affordability of care. No public commission nor PIP will change that.

These represent a few of the serious flaws in the logic associated with this bill. MaineHealth, like all of Maine’s nonprofit health systems, is seriously committed to doing all that it can to improve affordability of health care while maintaining access to the high quality care for which we can be very proud. In fact, our most recent strategic plan expressly includes goals that address cost – including explicit inclusion of the target for Cost Per Adjusted Discharge that we adopted in 2001. Other examples from our local health systems include:

When Maine Medical Center experienced decreases in its uncompensated care due to Medicaid expansion, we passed along those savings in our rate request to commercial carriers, which was 1.7% less than it otherwise would have been.

When we took a system-wide look at prices being charged by our hospitals, we saw that Waldo's prices were high. As a result we did not request a price increase at Waldo for 3 years, a move that has an important impact on the communities of Waldo County.

And the measureable investments we make to improve the health of our communities make a real difference. In just three years of operation, our substance use treatment program is serving nearly 1000 patients every month – and let me assure you that the Medicaid rates do not come close to covering the cost of that program. In fact, in spite of the millions of dollars that have flowed into Maine to support substance use treatment, our system has had little success in accessing additional financial support for our program.

Health care is complex. And, yes, health care is expensive. But increasing regulation on providers is neither good nor effective policy. We have the data. We know what the cost drivers are. Mandatory, artificial growth targets that are based on an equally arbitrary and unproven methodology is dangerous. If Maine's overall economic growth is predicted to be lower than the cost of delivering health care, patients – and particularly rural patients – will pay the price. Only a state with a strong economy would see growth in health care fall below growth of the overall Gross Domestic Product. It would be far more effective to work collaboratively with the Legislature to reduce unnecessary regulatory burden and address cost shifting than to create a new regulatory body that has no authority to address the actual drivers of cost