Office of Affordable Health Care

Advisory Council Meeting, August 7th 2024

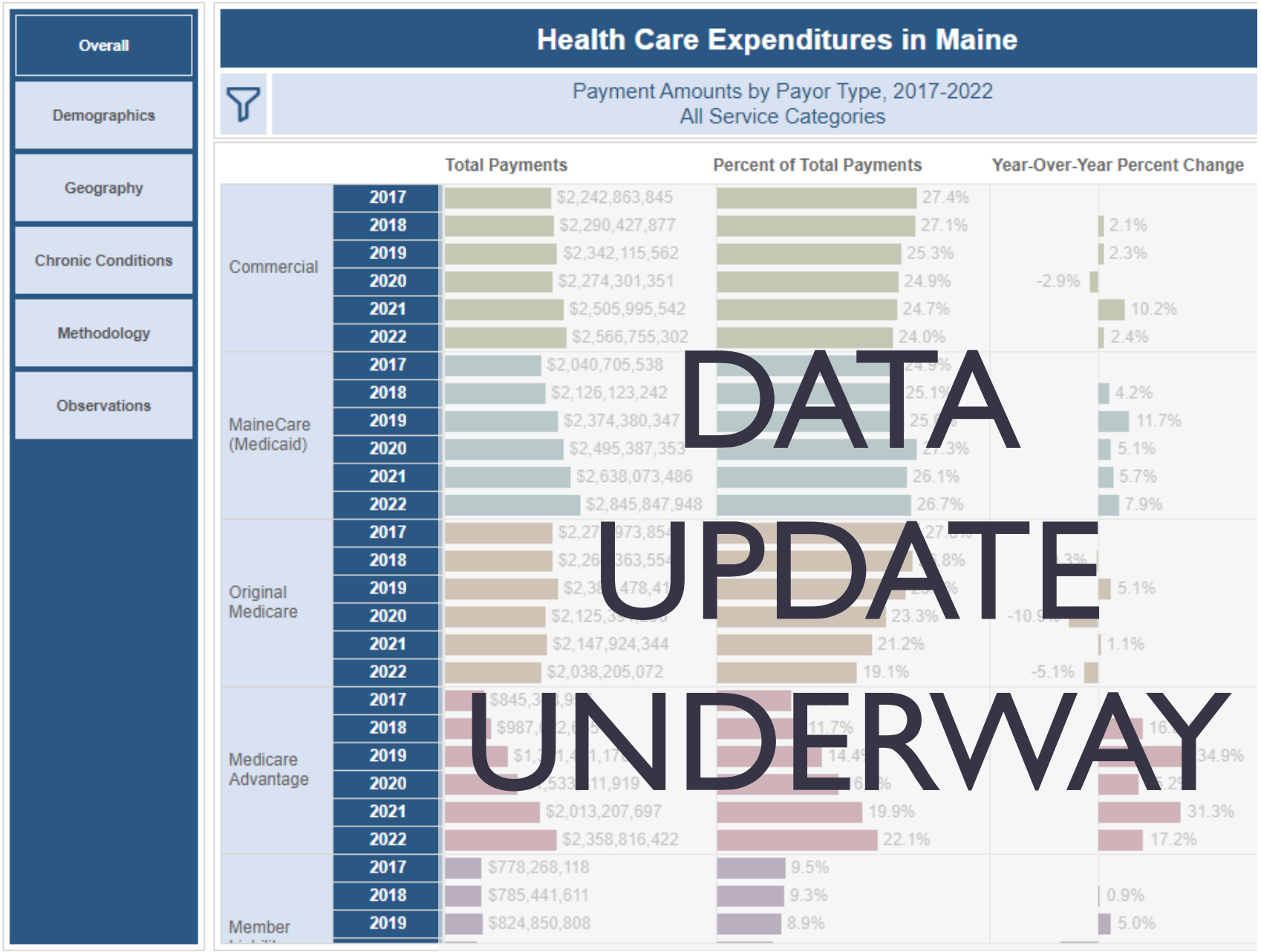
Analytics Update

Background

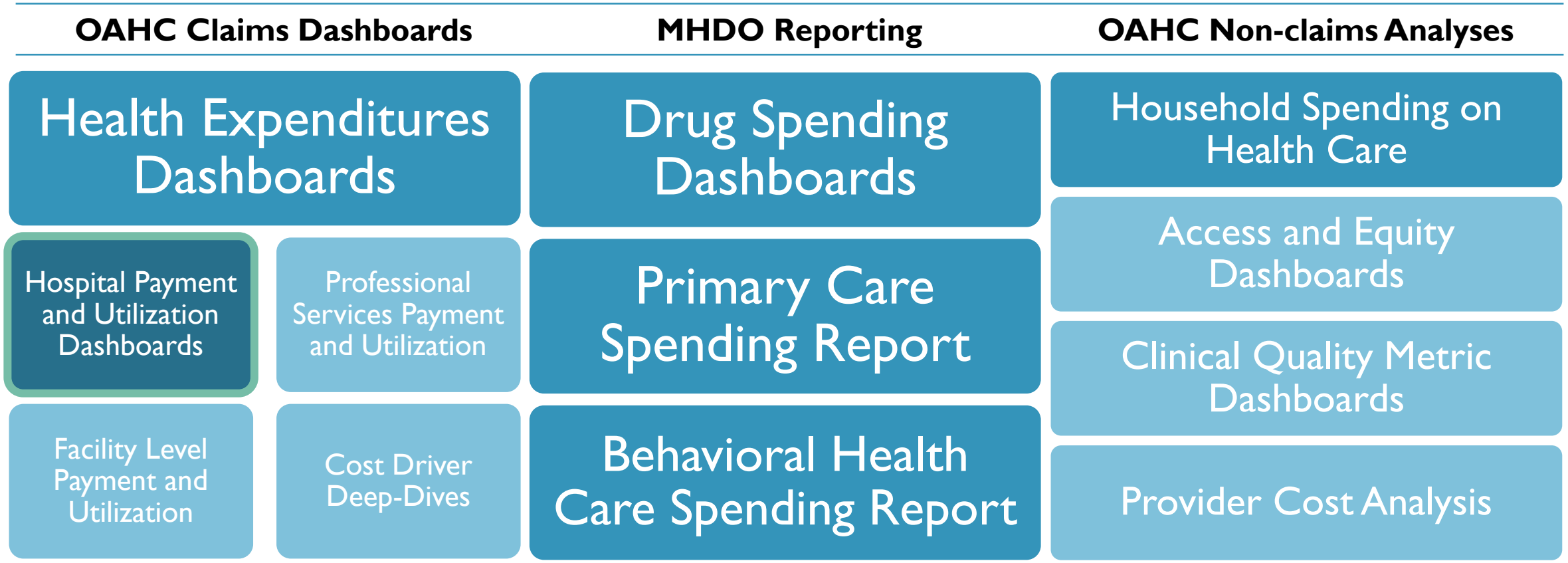
- OAHC is directed to analyze:
  - health care cost growth trends and correlation to the quality of health care
  - health care spending trends by consumer categories, payer type, provider categories or any other measurement that presents available data in a manner that may assist the legislative oversight committee in understanding health care cost drivers, health care quality and utilization trends, the impact of emerging technology in health care treatment, consumer experience with the health care system or any other aspect of the health care system
- MHDO published a first "baseline report" in 2022, prior to OAHC being operational – this product is being updated and will be re-released next month as a set of Health Care Expenditure Dashboards

Health Care Expenditures Dashboards

- These dashboards cover medical spending across providers – hospitals and health systems, independent primary care and specialty practices, other facilities
- Analyses include market segment breakouts, age and gender, geography, and presence of one or more chronic conditions



Analysis Planning



Hospital Services Payments and Utilization

Methods

Methods – All Payor Claims Database

Maine Health Data Organization All Payors Claims Database (APCD)

- Covers 100% of Medicaid and Medicare insured individuals
- Includes 73% of commercially insured individuals
- The data represent **payments -**
  - Defined as the combined payments made by the payor and member liability (inclusive of copay, coinsurance, and deductible) for medical services and procedures.
- The data do not capture uncompensated care

Hospital Analysis

- Goal was to include ***all hospital-related APCD claims*** that are attributable directly to a Maine hospital excluding the affiliated practices.
  - 36 Maine hospitals, excluding psychiatric hospitals operated by the state of Maine
  - Identified hospitals using the National Provider Identifier (NPI) present on the claims record

- The report includes only claims that fall in one of the following broad categories:
  - **Service Category** – The category that the hospital-related medical claim is related to: Inpatient, Outpatient, and Professional, defined as follows:
    - **Hospital Inpatient** – Facility claims related to hospital stays - may include Emergency Room services that resulted in being admitted to the hospital.
    - **Hospital Outpatient** – Facility claims related to hospital visits – includes Emergency Room visits that did not require to be admitted to the hospital.
    - **Professional** – Professional claims related to hospital inpatient, outpatient, or Emergency Room visits.

Payor Categories

- **Commercial** – individuals with only commercial insurance during the month; excludes individuals ages 65 or older
- **Medicaid (MaineCare)** – individuals with only Medicaid insurance during the month; excludes dual eligible Medicare-Medicaid member-months
- **Medicare** – combines Original Medicare and Medicare Advantage, defined as follows:
    - **Original Medicare** – individuals with only commercial insurance during the month; exclusive of dual eligible Medicare-Medicaid; excludes member months with both Commercial and Medicare insurance
    - **Medicare Advantage** – individuals with only commercial insurance during the month; exclusive of dual eligible Medicare-Medicaid; exclusive of commercial-Medicare coverage
- **Dual Eligible Medicare-Medicaid** – individuals with insurance for medical services from both Medicare and Medicaid during the month
- **Commercial and Medicare** – individuals with commercial insurance and either Original Medicare or Medicare Advantage

Measures

- **Total Payments** – The combined payments made by the payor and member liability (inclusive of copay, coinsurance, and deductible) for medical services and procedures.
- **Cost Sharing** – The out-of-pocket amount to be paid by the insured member to the hospital (inclusive of copay, coinsurance, and deductible amounts).
- **Utilization** – Counts of units of service within each service category, as follows:
  - **Hospital Inpatient** – Total number of days of hospitalization.
  - **Hospital Outpatient** – Total number of unique person-date of service-procedure or service code combinations.
  - **Professional** – Total number of unique person-date of service-procedure or service code combinations.
- **Payments Per Unit** – An average payment for services calculated as the total payments divided by the number of inpatient days or number of services and procedures (i.e. total utilization), respectively.
- **Payments Per Capita** – The total payments divided by the sum of member months (regardless of whether the member had any claims during the reporting year), then multiplied by 12 – showing the annual per capita values across individuals assigned to the respective payor type.

Hospital Services Payments and Utilization

Dashboard Review

Dashboard Feedback

- Goal is to finalize dashboards by late August or early September, in advance of the office's annual public hearing
- Welcome initial feedback and comments on the drafts by Friday August 9th 5:00pm
- Working on finalizing methodology documents for sharing this week

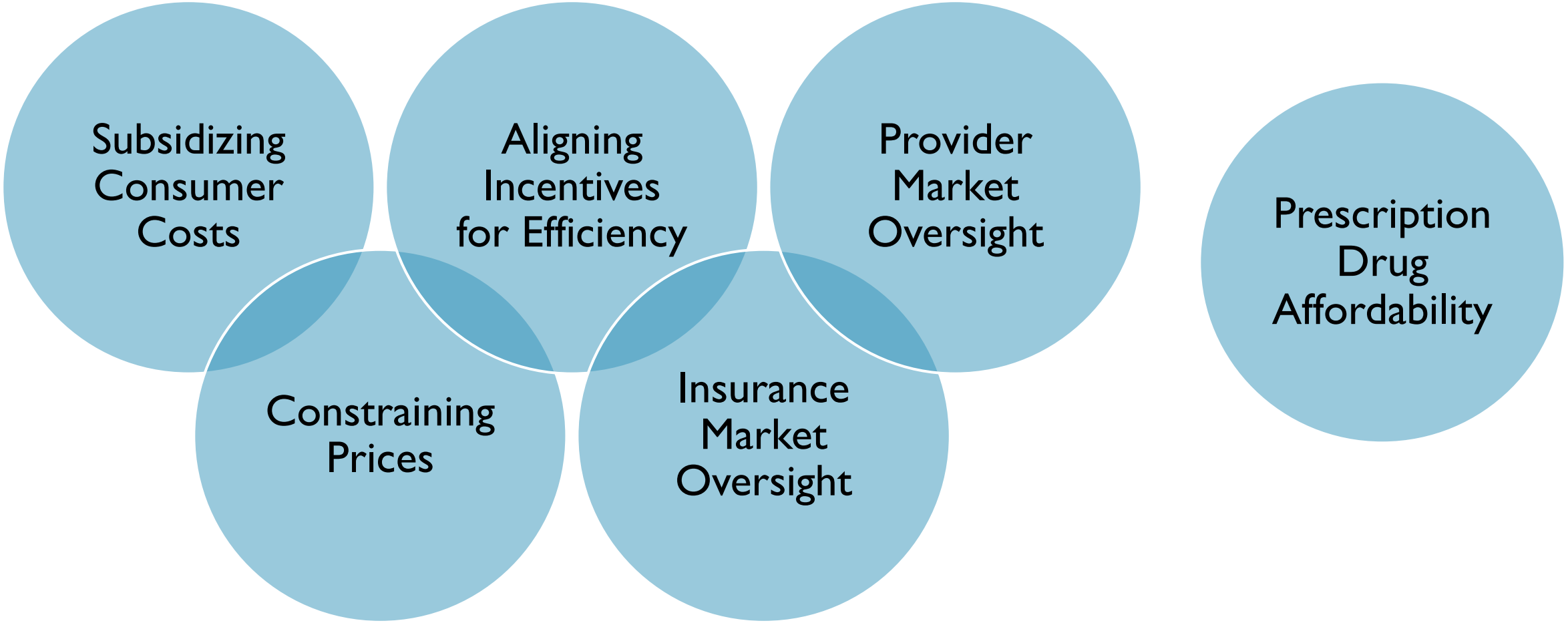
Fall Planning and Policy Development

OAHC Policy Development Charge

The OAHC establishing legislation directs the office to use its analyses to:

- Develop proposals for consideration by the legislative oversight committee on potential methods to **improve the cost-efficient provision of high-quality health care** to the residents of this State;
- Conduct a systemic review of the health care system and develop proposals to **improve coordination, efficiency, and quality of the health care system**;
- Develop proposals for consideration by the legislative oversight committee on potential methods to **improve consumer experience with the health care system**[…];
- Analyze barriers to affordable health care and coverage and develop for consideration by the legislative oversight committee proposals on potential methods to **improve health care affordability and coverage for individuals and small businesses in the State**.

Policy Domains



Subsidizing Consumer Costs

Summary

- Several states offer additional subsidies to Marketplace consumers to lower premiums and/or out of pocket costs, generally on a sliding scale based on income
- These programs require state funding and sources states are using currently include:
  - General revenue
  - Individual mandate penalty revenue
  - A health insurance tax established at the state level following repeal of the federal health insurance tax
- If programs successfully reduce federal spending on premium tax credits, supplemental federal funding may be available through a 1332 waiver

State Examples

- New Mexico's Turquoise plans offer reduced premiums and lower out-of-pocket costs to households up to 400% of FPL
- For 2025, California appropriated $165 million to provide a no-deductible silver plan option to all Marketplace enrollees

Insurance Market Stabilization and Oversight

Summary

- States have authority to regulate fully-insured individual and small group health plans, and take a wide variety of approaches to try to increase affordability by either:
  - Reducing volatility in insurance markets; or
  - Tightening requirements for insurers to maximize efficiency and promote competition
- Within the state regulated market, there may also be opportunities to reduce friction for consumers and providers by ensuring appropriate application of utilization review and prior authorization

State Examples

- Rhode Island's "Affordability Standards" for insurance rate review, which set specific requirements for cost containment and investment in high value care
- Reinsurance programs in Maine and 17 other states, which subsidize insurers whose members have high claims

Provider Market Oversight and Competition

Summary

- Recently there has been an uptick in states exploring changes to market oversight programs to consider how health care entity transactions impact cost and competition as well as access and quality
- Most approaches broaden state authority and the criteria that can be used to assess the impacts of health care transactions, but some also consider reducing barriers to market entry

State Examples

- Oregon's Health Care Market Oversight program, which is empowered to conduct reviews of a wide variety of transactions and can block transactions or impose restrictions to moderate anticipated risks
- Massachusetts and California both considered legislation this year to address the role of private equity in health care

Constraining Prices

Summary

- Recognizing the role that prices paid for health care services contribute to both household health spending and system-wide spending, states are increasingly beginning to consider programs to monitor and exert direct or indirect downward pressure on provider prices:
  - Cost growth target programs
  - Reference-based pricing in state employee programs
  - Price caps used to reduce consumer costs in public option plans

State Examples

- Oregon's state employee health plan is prohibited from paying more than 200% of Medicare prices for in-network hospital services, and 185% of Medicare prices for out-of-network services
- Washington and Colorado's public option plans both include elements of provider price control. Washington's Cascade Care plans must comply with an aggregate price cap of 160% of Medicare for most hospitals, while in Colorado's plan the state's insurance department can cap prices for hospitals in certain cases where insurers fail to meet premium reduction targets

Aligning Incentives to Promote Efficiency and Quality

Summary

- Some states have actively promoted or required participation in delivery system reform efforts intended to better align payment for health care services with outcomes and quality
- These efforts are often administrative, rather than legislative.

State Examples

- North Carolina recently established a Primary Care Investment Task Force directed to establish an investment target for primary care spending
- Three states (VT, PA, MD) worked with CMS to establish multi-payer hospital global budget models to meet state-defined goals for cost containment and provider financial health
- A handful of states actively convene multi-stakeholder delivery system reform workgroups to collaborate on goals and assess participation in new federal payment models

Prescription Drug Affordability

Summary

Most major prescription drug initiatives in states fall into three broad categories:

- Targeting manufacturer prices
- Addressing mark-ups and misaligned incentives along the supply chain
- Reducing acute affordability concerns by shifting consumer costs from out-of-pocket payments to premiums

State Examples

- Colorado and a handful of other states have prescription drug affordability boards empowered to deem drugs as "unaffordable" and set upper payment limits for those drugs
- Maine recently passed a law to increase oversight of PBMs and impose requirements that plan sponsors and members benefit from negotiated rebates