Office of Affordable Health Care

Advisory Council Meeting, October 2nd 2024

Agenda

- Brief Annual Public Hearing Summary
- Facility Fee Report Planning
- Discussion of Policy Domains and Considerations

Annual Public Hearing

Annual Public Hearing

- Hearing was held on Wednesday, September 25th
  - Written testimony is still being accepted through Friday, October 4th
  - Recording and slides, as well as information about how to submit comments is available at maine.gov/oahc/annual-public-hearing
- Planning supplemental listening sessions with consumers in late October in Portland, Lewiston-Auburn, and Machias.

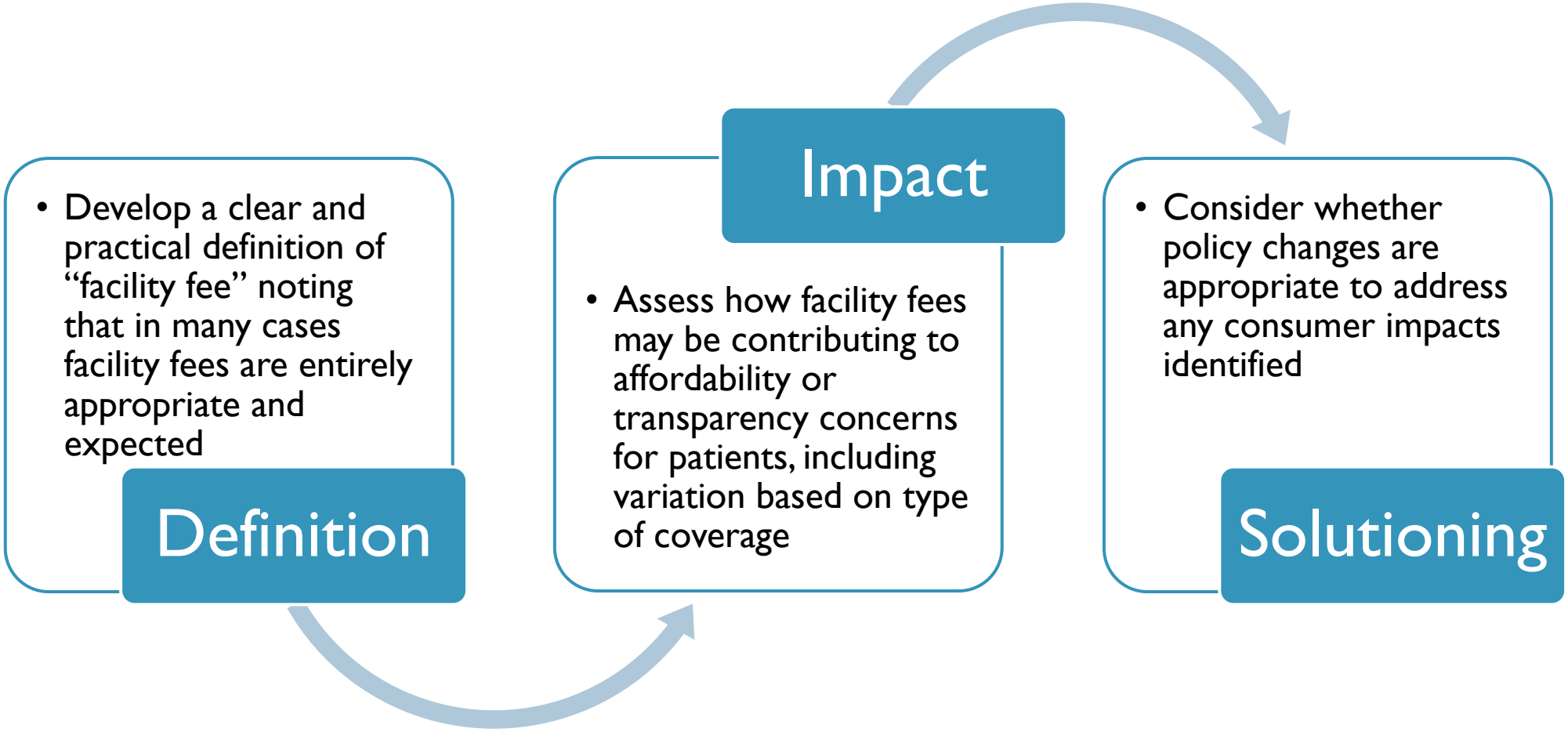
Facility Fee Report Request

Request from the HCIFS Committee

At the end of the legislative session, the HCIFS Committee wrote to OAHC and MHDO with a request to further review facility fee data collection and policy options:

"We ask that you review the current data collection and reporting requirements related to facility fees to determine whether you would recommend any changes to those requirements to improve transparency related to facility fees to educate patients. ***We also ask that you review other state laws and policy options related to facility fees to determine whether statutory changes should be recommended for the protection of patients."***

Report Structure



Defining Facility Fees

OAHC is proposing to define facility fees as any services billed on the UB-04 claim form.

We believe this approach:

- Will capture the billing scenarios that consumer advocates and policymakers have pointed to as being a concern for patients.
- Allows for the translation of the conceptual definition into one that can be used in both data analysis and practical applications.
- Maintains consistency with existing Maine law requiring the use of standardized claims forms.

Existing Maine Law Relevant to Facility Fees

Current Maine law requires:

- Claims for all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers (CMS-1500);
- Insurers may not be required to accept a claim submitted on another form;
- Services in a non-office setting may be billed as negotiated between the insurer and health care practitioner;
- "Office setting" is defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis, whether or not the office is physically located within a facility.

(24-A MRSA §2753; 24-A MRSA §2823-B; 24-A MRSA §4235; 24-A MRSA §1912)

Next Steps

- We have developed questionnaires for hospitals and health insurance carriers to better understand how they have operationalized current law. Hoping to approach MHA and MeAHP for assistance with distribution.
- Consulting with MHDO about methodology for the next round of analysis on facility fees, particularly to better understand cases when both a UB-04 and CMS-1500 are being used to bill for components of a visit.
- Reviewing and summarizing the approaches of other states.

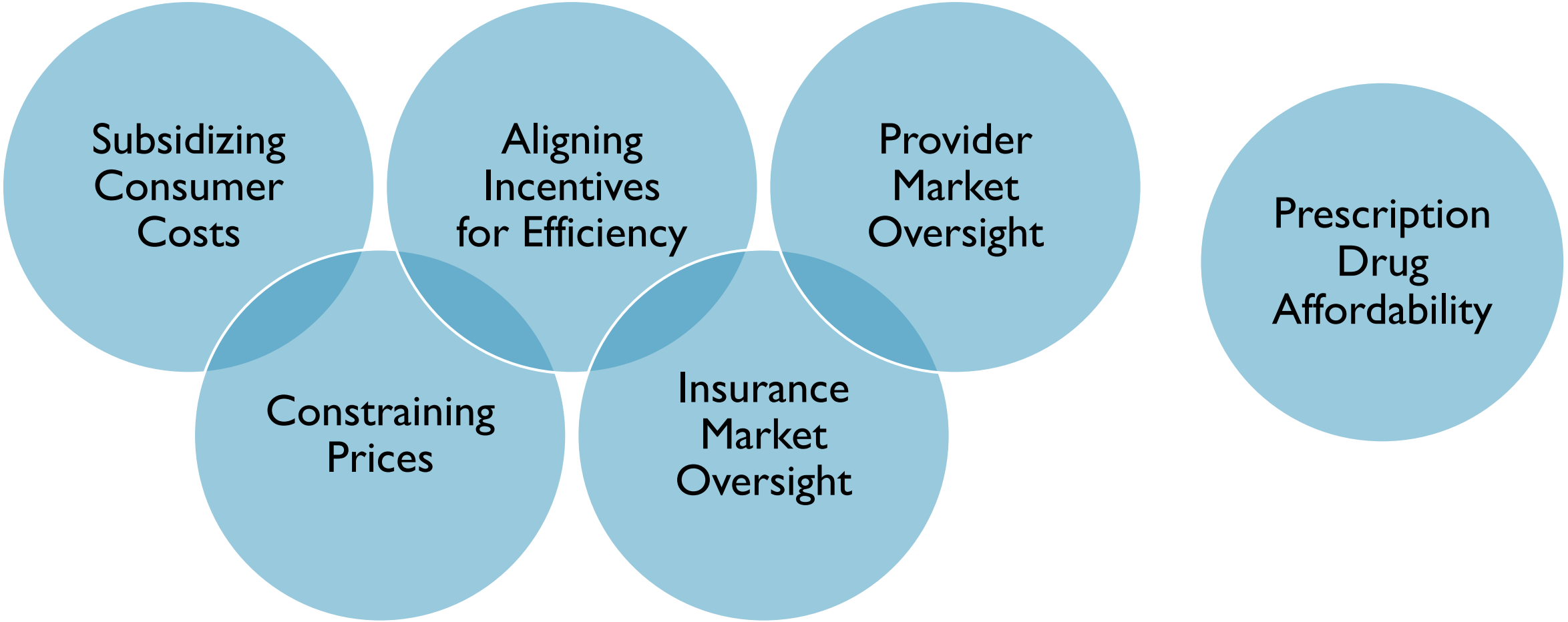
Fall Planning and Policy Development

OAHC Policy Development Charge

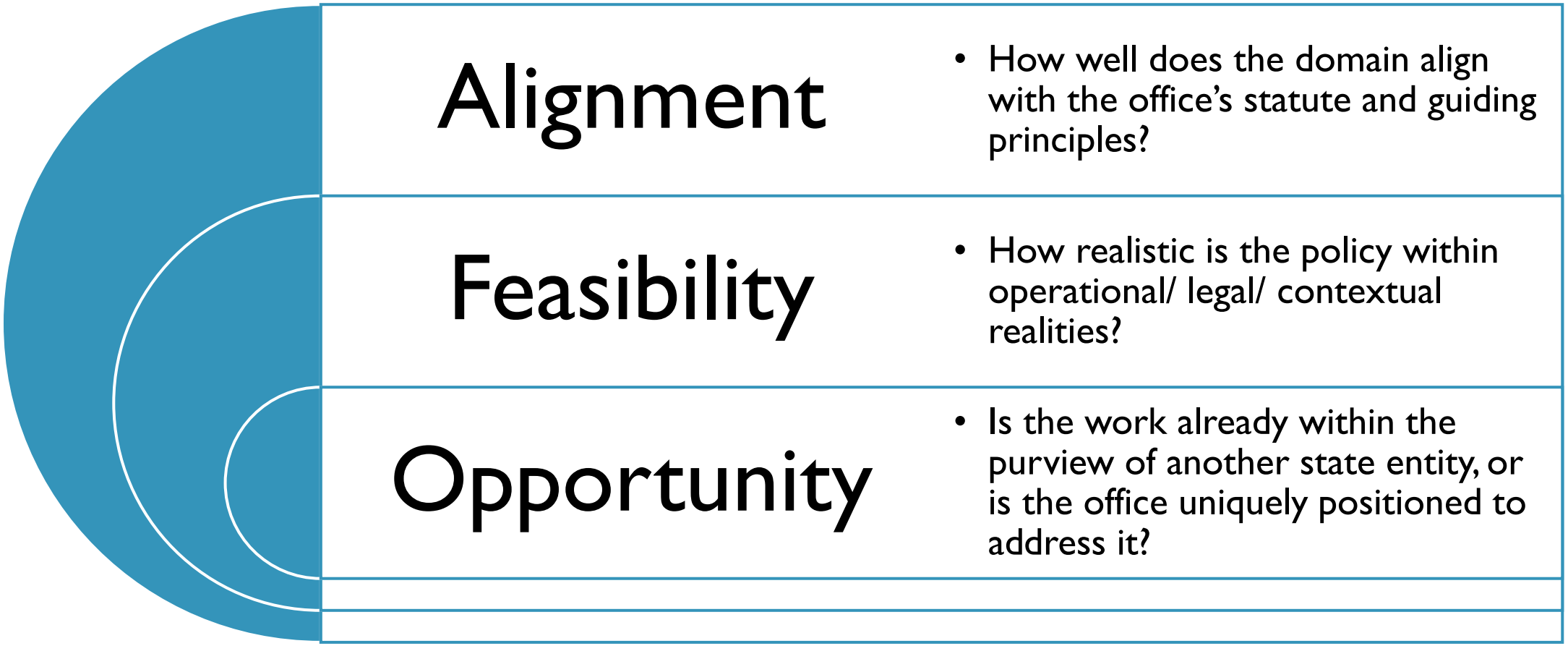
The OAHC establishing legislation directs the office to use its analyses to:

- 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



Assessing Policy Domains



Assessing Policy Domains

Domain	Alignment	Feasibility	Opportunity
Subsidizing Consumer Costs	High opportunity for relief for a segment of consumers, does not address underlying costs	Anticipate identifying new revenue for subsidies or expansion would be a significant challenge	High level of coordination necessary regarding both revenue and coverage options
Constraining Prices	Opportunity for broad impact across markets, potential to redirect resources for greater efficiency	Requires an understanding of where and how savings can be achieved without impacting access or quality	Currently not within the purview of any other state agency
Aligning Incentives for Efficiency	Highly aligned in that initiatives could encompass affordability, quality, and efficiency	Anticipate that there could be alignment with existing stakeholder initiatives and ability to identify shared goals	While other agencies have expertise in this area, believe OAHC is well-positioned to be a broader convener
Insurance Market Oversight	Opportunity for intervention for a segment of the market, but reach is limited by federal preemption	Established structure for state authority, though there have been significant developments in the space recently	Bureau of Insurance has authority and expertise in this area
Provider Market Oversight	See particularly high alignment in considering how to protect against financialization of health care providers	Taking protective measures may be minimally disruptive, although the legal landscape for action is complex	DHHS has authority in this space, but some new market dynamics may not be a focus
Prescription Drug Affordability	Both acute affordability challenges for patients and concerning recent trends in overall spending across payers	Challenging for states to regulate because of the multi-party out-of-state supply chain	Bureau of Insurance has authority over PBMs; relationship to Prescription Drug Affordability Board

Appendix: Policy Domain Summaries

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