Office of Affordable Health Care

Advisory Council Meeting, February 5th, 2025

Agenda

- Administrative
  - Reminder: Meeting date adjustments
  - Vacant seats
- Deep Dive on Market Oversight and Competition Domain
  - Research on Private Equity in Health Care
  - Policy Options
- Legislative Reports
  - MaineCare Eligibility Increases and State-level Subsidies
  - Facility Fees

Private Equity in Health Care

Provider Market Oversight and Competition

Problem Statement:

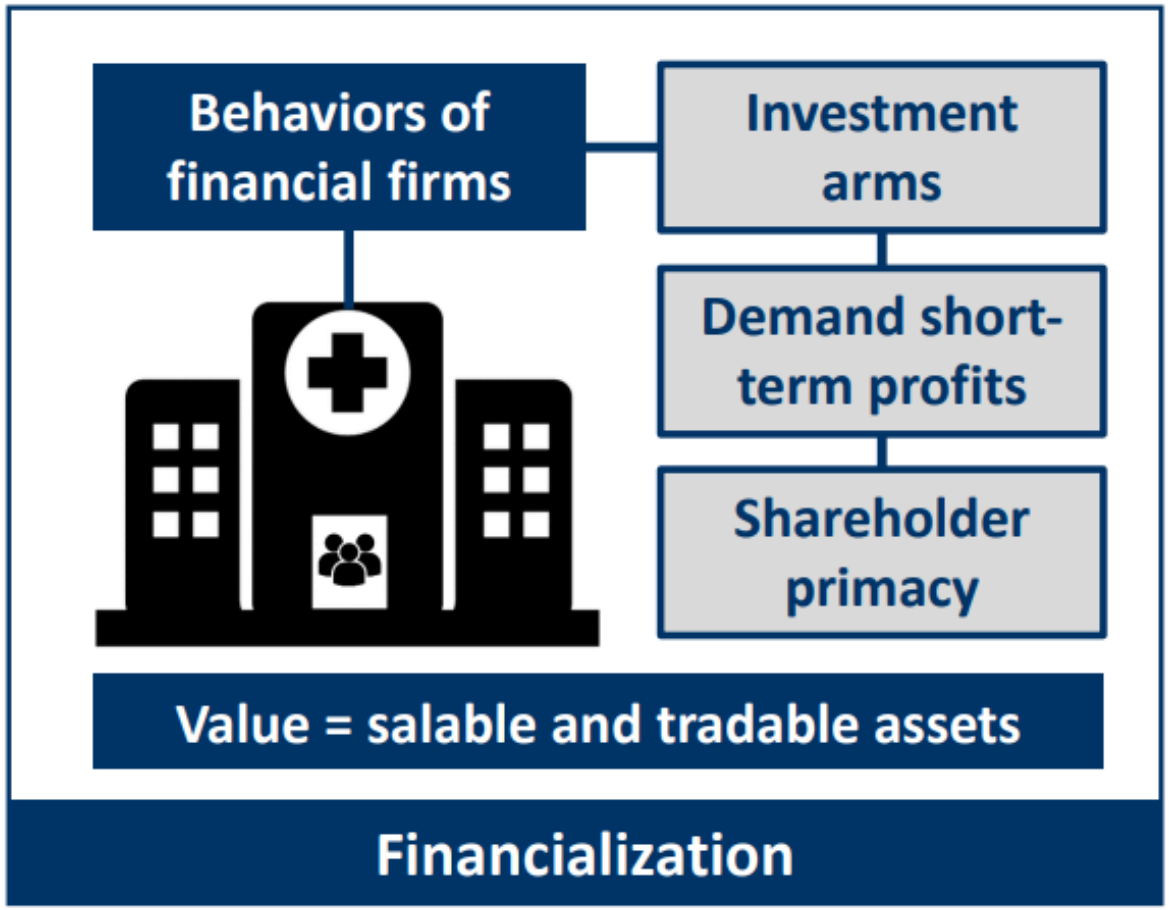
Private equity (PE) investment in health care has grown dramatically in the U.S. over the last 10 years, and early evidence suggests that PE ownership of health care providers can lead to higher prices, staff reductions, and in some cases lower quality of care. While Maine has seen less PE activity in the health care sector than other parts of the country, protective action could be warranted given the significant impacts to access and quality experienced in other states.

Next Steps:

- Review and assess options for mitigating risk from PE acquisition, including recent efforts in other states

Christopher Cai and Zirui Song, "Protecting Patients And Society In An Era Of Private Equity Provider Ownership: Challenges And Opportunities For Policy," Health Affairs, May 2024, https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00942

Financialization in Health Care



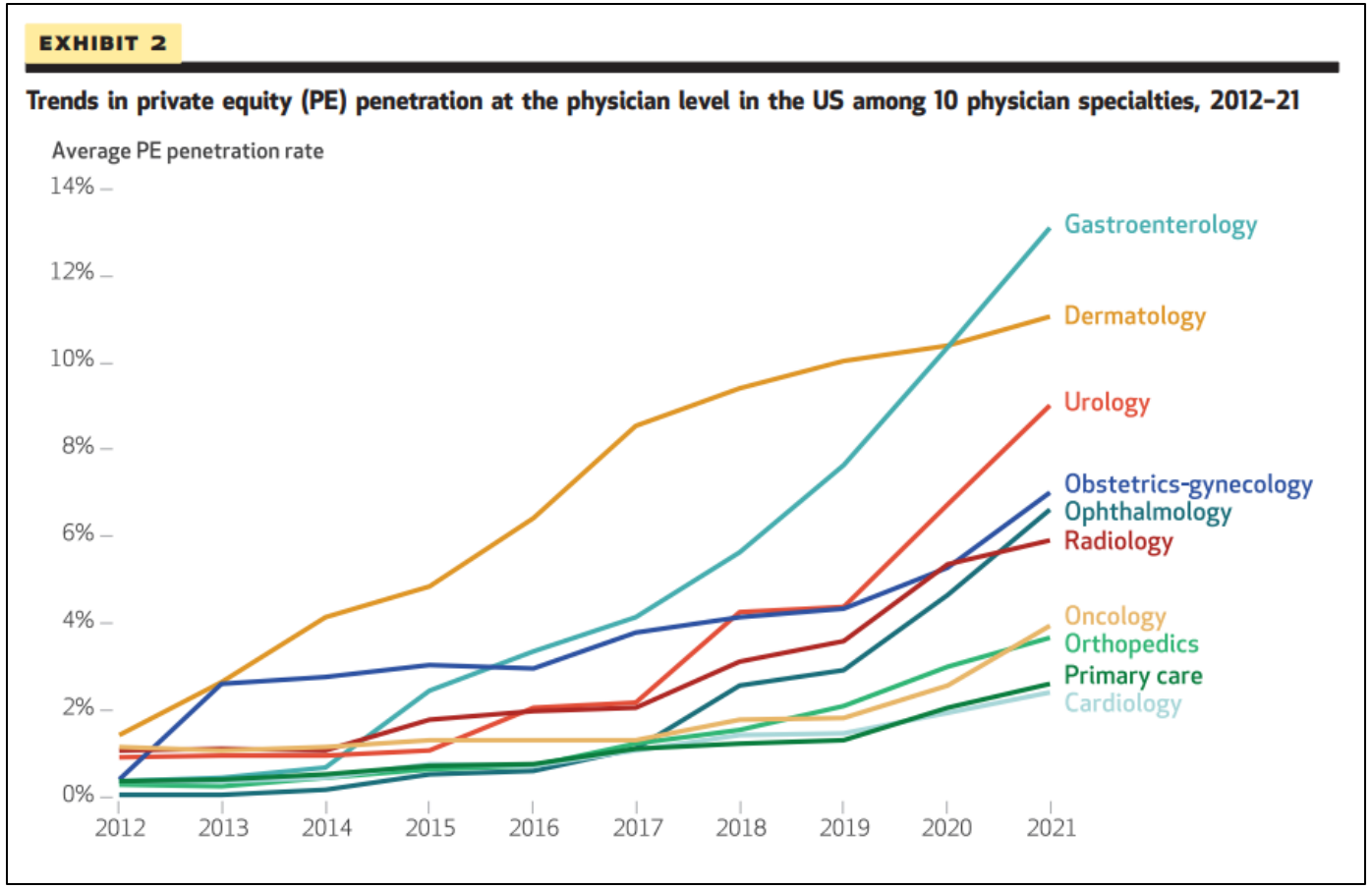
Adapted from Song, Z. (2024) Presentation for the National Academy of State Health Policy 2024 Annual Conference - *Consolidation in the Market and Opportunities to Address It.* September 2024.

Financialization means the transformation of public, private, and corporate health care entities into salable and tradable assets from which the financial sector may accumulate capital.

Private Equity has been identified as particularly problematic since the PE model is predicated on short-term return on investment, and because firms are utilizing third party capital in investments, creating moral hazard and increased risk.

Bruch, Roy, and Grogan, *The Financialization of Health in the United States,* New England Journal of Medicine. January 2024.
U.S. Department of Health and Human Services. (2025). *HHS Consolidation in Health Care Markets RFI Response -Report prepared by the HHS Office of the Secretary (OS), in consultation with the U.S. Department of Justice and the U.S. Federal Trade Commission.*

Private equity ownership in health care has increased



2012: ~ 816 PE physician practices

↓

2021: ~ 5,779 PE physician practices

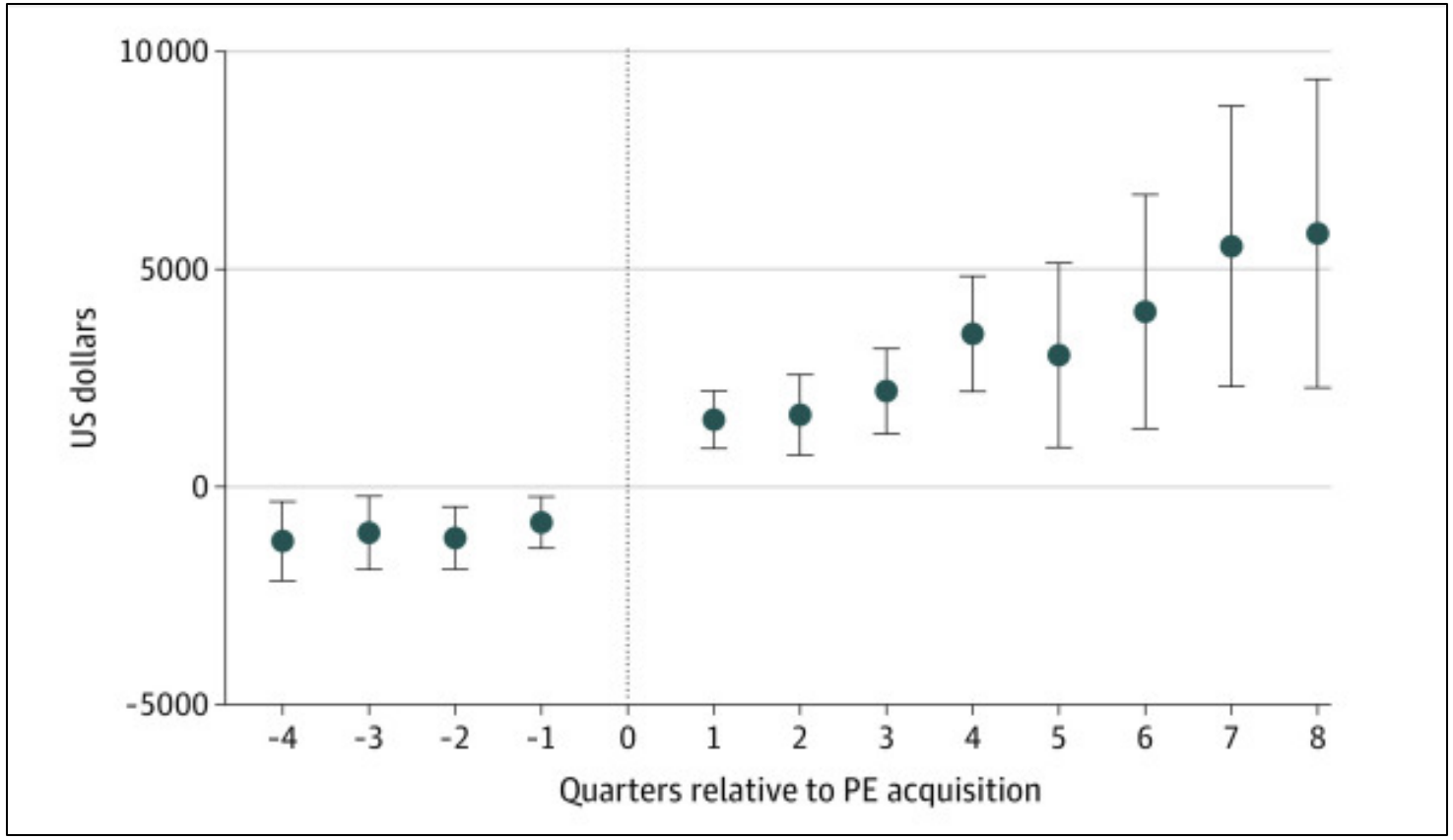
2024: ~ 460 PE hospitals

- 8% of all non-government owned hospitals
- 22% of for-profit hospitals

Abdelhadi, O., Fulton, B. D., Alexander, L., & Scheffler, R. M. (2024). Private Equity–Acquired Physician Practices And Market Penetration Increased Substantially, 2012–21: Study examines private equity-acquired physician practices and market penetration. *Health Affairs*, *43*(3), 354-362.

Private equity ownership is associated with greater spending – prices and utilization

Figure 1. Changes in Total Spending per Practice Associated with Private Equity Acquisition, by Quarter



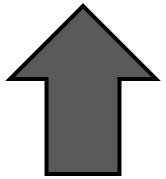
Private equity owned physician practices showed consistent increases in spending after acquisition compared to practices not owned by private equity.

Spending increases among these practices were attributable to higher prices and increased utilization.

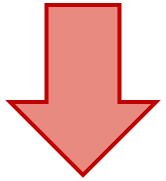
Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. JAMA Health Forum. 2022 Sep 2;3(9):e222886.

Private equity ownership is associated with greater spending – prices and utilization

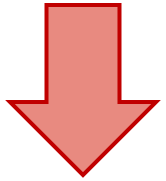
Studies investigating **hospital impacts** of private equity also found:



increased charges and cost to charge ratios



lower Medicare patient admittance



lower salary expenditures for ED and ICU personnel

Bruch JD, Gondi S, Song Z. Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition. JAMA Intern Med. 2020 Nov 1;180(11):1428-1435. doi: 10.1001/jamainternmed.2020.3552. PMID: 32833006; PMCID: PMC7445629

Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. *JAMA.* 2023;330(24):2365–2375. doi:10.1001/jama.2023.23147

Private equity ownership is associated with lower quality of care

Private equity ownership has been shown to have lower quality of care for patients in different settings:

Nursing Homes

- ↑ 10% increase in short-term mortality of Medicare patients.
- ↓ Declines in nursing staff and compliance with care standards.
- ↓ Lower CMS quality star ratings

Hospitals

- ↑ Increased hospital acquired adverse events
- ↓ Declines in patient reported experience measures

Gupta, Atul and Howell, Sabrina T and Yannelis, Constantine and Gupta, Abhinav, Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes (February 13, 2021). University of Chicago, Becker Friedman Institute for Economics Working Paper No. 2021-20, NYU Stern School of Business.

Stevenson, D., Peterson, H., Skinner, R., Ndrianasy, E., Braun, R.T., Unruh, M., & Fernandez, R. Trends in Ownership Structures of U.S. Nursing Homes and the Relationship with Facility Traits and Quality of Care (Research Brief). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. November 13, 2023.

Bhatla A, Bartlett VL, Liu M, Zheng Z, Wadhera RK. 2025. Changes in Patient Care Experience After Private Equity Acquisition of US Hospitals. *JAMA*

Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. JAMA. 2023 Dec 26;330(24):2365-2375.

Case Study: Steward Health Care

PBS NEWS HOUR

Investigation reveals how investors made millions as Steward Health Care system collapsed

Sep 12, 2024 6:25 PM EST

Steward Health Care Crisis Summary

- In 2010, Steward purchased six struggling hospitals in the greater Boston area in a leveraged buyout and converted the hospitals from non-profit to for-profit status. In the purchase, the firm promised to keep the hospitals open for five years, and committed to new investments in infrastructure, improved quality, and expansion of service lines
- From 2010-2016 the firm continued to expand, purchasing hospitals and physicians practices in Massachusetts and other states, eventually growing to include 33 hospitals, 25 urgent care facilities, and 107 skilled nursing facilities.
- Between 2016 and 2020, the system remained unprofitable, and conditions of the purchase of the Boston hospitals had expired. The firm leveraged the system's assets to generate revenue to continue its expansion, notably selling all of its hospital properties to a third party real estate investment trust and leasing the properties back.
- In 2020, ownership of the system was transferred from the private equity firm to a hospital management group led by the system's CEO. The fund made $800 million in the sale, the CEO was paid a $111 million dividend, and the firm existed the investment.
- In 2024, the system filed for bankruptcy, forcing states to step in to try to prevent wide-ranging impacts for residents from hospital closures. In Massachusetts, transfer of ownership was facilitated for five hospitals, while two closed. In Pennsylvania, the state had to provide $4.5 million in additional funding to one regional medical center that was critical to health access in a low-income rural county.

Market Oversight Opportunities

Policy Options for Addressing Financialization in Health Care

- **Transparency**: increasing transparency into transactions by creating or expanding laws requiring notice of transactions, reporting of ownership and financial information, and publication of information collected.
- **Corporate Practice of Medicine**: prohibiting corporations from owning medical practices.
- **Addressing Incentives for Financialization**: reducing the appeal of profit-driven corporate involvement by capping or otherwise regulating prices of health care services.
- **Transaction Review:** empower a state agency to review health care transactions and approve, deny, or impose conditions based on a variety of considerations including access, affordability, and health equity.

Transaction Oversight Laws in Other States

Market Changes in Ownership of Healthcare Related Entities

Activity	Provider:		Insurance Carrier (Payer)	All Other Healthcare Related Entities
	A) Nonprofit	B) For profit		
Notice of Transaction	CA, CO, CT, HI, IL, IN, MA, MN, NV, NH, NM, NY, OR, PA, RI, VT, WA	CA, CO, CT, HI, IL, IN, MA, MN, NV, NH, NM, NY, OR, RI, VT, WA	CA, NV, NH, NY, OR, WA	CA, CO, CT, HI, IL, IN, MA, MN, NV, NH, NY, OR, PA, RI, VT, WA
State Review / Referral of Transaction	CA, CO, CT, HI, IL, IN, MA, MN, NH, NM, NY, OR, PA, RI, VT, WA	CA, CT, HI, IL, IN, MA, MN, NH, NM, NY, OR, RI	CA, NH, OR	CA, CO, CT, HI, IL, IN, MA, MN, NH, NY, OR, PA, RI, VT, WA
Authority to Approve, Approve Conditionally, Deny Transaction	CA, CO, CT, HI, IL, MA, NH, NM, NY, OR, PA, RI, VT, WA	CT, HI, IL, MA, NH, NM, NY, OR, RI	NH, OR	CO, CT, HI, IL, IN, MA, NH, NY, OR, PA, RI, VT
Monitoring and Compliance of Transaction	CA, CO, CT, HI, IL, NM, OR, PA, RI, WA	CT, HI, IL, IN, NM, OR, RI	OR	CO, CT, HI, IL, IN, OR, PA, WA, RI

National Academy of State Health Policy, States' Efforts to Understand and Address Health Care Consolidation, December 2024: https://nashp.org/states-efforts-to-understand-and-address-health-care-consolidation/#state-activity

Massachusetts' Recent Expansion of Oversight

- House Bill 5159 was signed by Governor Healy on January 8th, 2025, and makes changes to the existing Material Change Transaction review process already administered by the Health Policy Commission:
  - Broadens the definition of Material Change Transaction, capturing transactions involving "Significant Equity Investors," non-profit to for-profit conversions, and significant acquisitions, sales, or transfers of assets. The HPC can perform a cost and market impact review if it identifies that a transaction may reduce competition or increase spending, and may refer the results of that review to the Attorney General for action.
  - Requires annual financial reporting by providers which exceed certain thresholds for patient revenue or patient panel size. The law allows for penalties to be assessed for noncompliance.
  - Amends the Massachusetts False Claims Act to expand liability for violations to entities holding an "ownership or investment interest" in a person or entity which violates the law.

Oregon's Health Care Market Oversight Program

- In 2021, the Oregon Legislature passed HB 2362, creating the Health Care Market Oversight (HCMO) program. This law directs the Oregon Health Authority (OHA) to review transactions involving health care entities, such as hospitals, health insurance companies, and provider groups. The HCMO program launched in 2022.
  - OHA reviews each proposed transaction to see how it could affect market consolidation and competition, access to care, quality of care, health care costs, and health equity. If determined necessary, this can include a comprehensive review.
  - For review, entities must meet certain thresholds and transaction types, including revenue thresholds of at least $25 million for one entity in the transaction and $10 million for the other. The law exempts several transaction types, including clinical affiliations, transactions involving FQHCs, and corporate restructures that do not impact control.
  - As of 2024, the OHA has conducted 29 preliminary reviews and five comprehensive reviews. Of the reviews that are complete, none have been blocked and ten were approved with conditions.
  - Six of transactions that HCMO reviewed through 2024 involved a private equity firm.

NASHP Model Legislation

- Part I: Creates a Material Change Transaction review process empowering a designated state entity to receive notice of a broad segment of health entity transactions, identify those that pose risks to consumers and the efficiency of the health care system for comprehensive review, and subsequently approve, deny, or approve with conditions.
- Part II: Proposes refinements to corporate practice of medicine laws to increase effectiveness
- Part III: Increases transparency by requiring annual reporting of organizational structure of health entities as well as certain financial data.

Full model legislation is available at: https://nashp.org/addressing-corporatization-of-health-care-consolidation-and-closures-updated-nashp-market-oversight-model-legislation/

Legislative Report Updates

MaineCare Eligibility Increases and State-level Subsidies

In 2022 the Maine legislature passed LD 1778, *An Act To Improve Health Care Affordability and Increase Options for Comprehensive Coverage for Individuals and Small Businesses in Maine,* which included language charging the Office of Affordable Health Care with studying a variety of policy avenues to increase the affordability of health care coverage. Resolve language included in the bill specifically directed the Office to study and report back to the legislature on four policy approaches:

1. Creating a public option health benefit plan
2. Creating a Medicaid buy-in program;
3. Increasing enrollment in Medicaid and the federal Children's Health Insurance Program (CHIP), including by increasing income eligibility levels
4. Providing state-level subsidies to populations that do not qualify for federal subsidies through the Maine Health Insurance Marketplace, established under Title 22, section 5403

Approaches 1 & 2 were addressed in the office's 2024 public option report, but the office is completing its obligations by providing a report on approaches 3 &4

Increased Eligibility for MaineCare

For this approach, the Office designed three scenarios for increased income eligibility for adults ages 19-64:

- Scenario one expands income eligibility from 138% to 150% of FPL. (11,000 people newly eligible)
- Scenario two expands income eligibility up to 200% of FPL. (73,000 people newly eligible)
- Scenario three expands eligibility to 250% of FPL. (131,000 people newly eligible)

Table 2A. Estimated cost of Medicaid proposed increase in income eligibility to 150% of the federal poverty level.

	MaineCare PMPY Low Cost	MaineCare PMPY Midpoint Cost	MaineCare PMPY High Cost
Annual Cost of Scenario	$61,427,615.01	$92,444,880.72	$123,462,146.43
State Contribution (Assuming 61.29% FMAP[6])	$23,778,629.77	$35,785,413.33	$47,792,196.88

Table 2B. Estimated cost of Medicaid proposed increase in income eligibility to 200% of the federal poverty level.

	MaineCare PMPY Low Cost	MaineCare PMPY Midpoint Cost	MaineCare PMPY High Cost
Annual Cost of Scenario	$387,250,553.75	$582,788,637.52	$778,326,930.80
State Contribution Assuming 61.29% FMAP[6])	$149,904,689.35	$225,597,481.58	$301,290,354.91

Table 2C. Estimated cost of Medicaid proposed increase in income eligibility to 250% of the federal poverty level.

	MaineCare PMPY Low Cost	MaineCare PMPY Midpoint Cost	MaineCare PMPY High Cost
Annual Cost of Scenario	$699,436,798.35	$1,052,610,481.20	$1,405,784,164.05
State Contribution Assuming 61.29% FMAP[6])	$270,751,984.64	$407,465,517.27	$544,179,049.90

State-level Marketplace Subsidies

The Office also developed three scenarios to for the analysis of state-level subsidies:

- Scenario one is the most limited option, focused on improving affordability for lower-income households. It would utilize state funding to increase the generosity of subsidies for households between 150% and 200% FPL, bringing down the required contribution to 0% throughout that range of income, in line with the current contribution level for households below 150% FPL. Scenario one would also cover the portion of premiums attributed to mandated abortion coverage for all subsidized consumers below 200% of FPL, making true $0 plans available to them.
- Scenario two includes the components of scenario one, but also lowers the expected premium contribution amounts for consumers below 400% FPL, providing premium relief for more middle-income households.
- Scenario three includes all components of scenario two, but also lowers the expected contribution amount for households with income above 400% FPL, benefitting higher-middle-income households.

	Scenario 1 11,000-19,000 individuals impacted		Scenario 2 40,000 – 76,000 individuals impacted		Scenario 3 49,000 – 102,000 individuals impacted	
	Marketplace Population	All Eligible Population	Marketplace Population	All Eligible Population	Marketplace Population	All Eligible Population
With ARPA	$2,940,130	$5,288,010.15	$29,658,057	$57,816,368.41	$8,595,041.96	$17,733,615.54
Without ARPA	$81,824,560.93	$169,448,392.25	$108,542,488.09	$221,976,750.51	$87,479,472.54	$181,893,997.64

Facility Fees

- MHDO recently released an updated report on facility fees last week which incorporates feedback and suggestions the Office provided during collaborative discussions with MHDO throughout 2024.
- The updated data is available at: https://mhdo.maine.gov/facilityFeePayments.htm
- OAHC is finalizing a brief report (draft to be shared with Advisory Council this week) to respond to the second request from the legislature analyzing how laws in other states would impact Maine.