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Office of Affordable Health Care

2023 Public Hearing Comment Solicitation – **Payers and Providers**

Written comments are due by midnight on Friday October 6th, 2023.
Comments may be emailed to meg.garratt-reed@maine.gov, and should be attached as a word document or PDF. Please note that comments are not confidential and will be posted publicly.

Submitter Information
Organization: Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield
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Comments

1. ***Please identify and briefly describe the top (2-3) concerns of your organization in reducing health care cost growth and promoting affordability of health care for consumers.***

1.1. Provider Market Consolidation. In concentrated health system markets, despite public representations by health systems that consolidation will result in lower costs and greater efficiencies, costs, and as a result health insurance premiums, have, in fact, increased as a result of consolidation. For example, an FTC Staff Policy Paper issued in August 2022[1] noted that there were substantial increases in commercial inpatient prices at unregulated hospital (Maine Medical Center) during the COPA period (at least 38%) and by 62% after the expiration of the COPA – an average of 50% during the post-merger period. Similarly, SMMC's prices increased by almost 50% after the COPA period ended in 2015, with a decline in SMMC's quality measures.

The FTC Policy Paper referenced a 2020 study[2] that stated:

> The rapid consolidation of Maine health care [*sic*] over the past 15 years makes it difficult to identify the effect of any particular merger or acquisition. Our focus is on the COPA that shielded MaineHealth's acquisition of SMMC, but it is difficult to completely separate the effects of this acquisition from the other transactions. In particular, MaineHealth's acquisition of Goodall Hospital and consolidation with SMMC occurred 17 months before the SMMC COPA expired. MaineHealth's Pen Bay COPA and cardiology consent decree began shortly after the SMMC COPA started and likewise expired shortly after the SMMC COPA. This should be kept in

[1] FTC Policy Perspectives on Certificates of Public Advantage, Staff Policy Paper, August 15, 2022, https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf, p. 10.
[2] Garmon, Christopher and Bhatt, Kishan, Certificates of Public Advantage and Hospital Mergers: Evidence from Maine, Montana and South Carolina (June 24, 2020). Available at SSRN: https://ssrn.com/abstract=3634577 or http://dx.doi.org/10.2139/ssrn.3634577.

> mind when interpreting the results described [in the paper. For instance, the large price increase and worsening of patient outcomes that occurred at SMMC after the COPA expired may be due to unconstrained market power from numerous MaineHealth acquisitions, not just the acquisition of SMMC.

We have seen this play out firsthand in Maine. The health care landscape in Maine is extremely concentrated and dominated by two large hospital systems. There are 36 hospitals in Maine, and 61% of those hospitals in Maine are owned by just two hospital systems. MaineHealth owns 12 of those hospitals, or 33.3% of all hospitals in the state, while Northern Light owns 10 hospitals, or 27.7% of hospitals. These two systems also own a large number of physician practices.

This means these systems are in a position of extreme strength and hold significant leverage when negotiating contracts with health insurers, particularly when combined with network adequacy requirements.

Large health systems are able to leverage their significant market shares by requiring contracts with all affiliated facilities and preventing steering patients to lower-cost, higher-quality care. These anti-competitive contract terms, in the form of "anti-steering," "anti-tiering," "all-or-nothing" and similar contract provisions, protect providers' highly inflated costs – costs that patients and consumers pay through higher premiums and out-of-pocket costs.

Hospital systems can and do use this leverage in their negotiations with health plans in several ways, including:

- Demanding exorbitant rate increases;
- Requiring favorable positions in a carrier's network, such as placement in a higher tier to the exclusion of competitors, regardless of cost or quality;
- Insisting on the same preferential treatment for all owned hospitals; and
- Threatening to terminate all providers in the system when a contract for only one hospital is the subject of negotiations.

1.2. Certificate of Need. Maine's Certificate of Need ("CON") law, while well meaning, has not operated as intended. At Anthem, we are constantly seeking to provide our members with access to high quality health care services at the lowest prices possible. An important element of that effort includes redirecting care, when possible, from high-cost providers to lower cost providers who can provide equally effective care. In Maine, however, we there is a significant lack of affordable alternative providers and sites of care to which we can redirect care. Certificate of Need has hindered the development of alternative sites of care but, at the same time, has not stopped the development of large, monopolistic systems.

For example, a colonoscopy can cost approximately $1,800 at an ambulatory surgical center in the Portland area. At area hospitals in Portland, it can cost as much as $5,000-$6,600. That is a savings of $3,700-$4800, or 64%-73% per procedure. If a

member is paying 20% coinsurance on the procedure, they can save $640-$960 in out-of-pocket costs. That represents a real savings not only for the member, but it also serves to reduce claim costs, which in turn impacts premium.

This also means savings for Maine employers, in addition to their employees. For example, if there are 100 colonoscopy claims covered under an employer's plan in one year, at an average cost of $3,800 (the average cost statewide according to the Maine Health Data Organization's website, CompareMaine.org), the plan could save $40,000 per year by redirecting just 20% of those colonoscopies to an ambulatory surgical center with an average cost of $1,800. And those are the savings associated with redirecting just one procedure—the savings would be significantly higher if other outpatient surgical procedures could also be redirected.

Unfortunately, CON requirements can thwart efforts to establish these alternative sites of care. For example, in 2021, Central Maine Health Systems sought to create an ASC in the Topsham, but the application was denied due, in large part, as a result of significant opposition from a competitor.

1.3. Limits on prior authorization and utilization management. Increasingly, we are seeing efforts to limit the ability of health plans to use tools such as prior authorization to manage utilization. Employers, individuals, and families purchasing health insurance coverage entrust health plans to manage care and ensure that members receive the right care, in the right setting, at the right time. Today, these vital tools used by health plans at the request of insurance purchasers are under attack. Health plans use prior authorization in limited circumstances to protect patients and lower their out-of-pocket costs; by preventing misuse, overuse, and unnecessary or potentially harmful care; and to ensure that care is consistent with evidence-based practices.

According to a Milliman analysis commissioned by the Blue Cross Blue Shield Association in March 2023, the estimated premium impact of removing prior authorization would range from $37.30 to $58.31 Per Member Per Month.[3] In addition, another analysis commissioned by Elevance Health in June 2023, conducted by the consulting actuarial firm Pasco Advisers, estimates that the premium impact of removing prior authorization in the state of Connecticut would be an additional $6.22 to $16.83 PMPM, representing an increase of 1.5% to 3.4% depending on business segment.

Without these important tools, health plans will be left with few, if any, strategies to effectively drive quality and safety, ensure proper utilization, and rein in unnecessary spending. This will result in employers and consumers bearing the brunt of increased costs through higher premiums.

[3] Potential impacts on commercial costs and premiums related to the elimination of prior authorization requirements, Milliman, March 30, 2023, https://www.milliman.com/en/insight/potential-impacts-elimination-of-prior-authorization-requests.

1.4. **Inappropriate hospital billing for professional health care services.** Maine has a long-standing requirement that requires hospitals to bill professional services accurately on professional billing forms; however, there are no provisions for enforcement of this requirement as no state agency has been given the authority to do so. Furthermore, **Anthem** routinely sees systems submit for services rendered at one location but billed under one of their higher cost locations. Currently, there is no clear prohibition of such practice.

1.5. **Lack of transparency around health system finances.** Recent media stories as well as testimony at the OAHC public hearing on September 27, 2023, have indicated that health systems have lost significant amounts of money over the last 2-3 years. Yet that is not consistent with publicly available data from the Maine Health Data Organization

2. Of the concerns described in question one, are there characteristics specific to Maine (geographically, economically, demographically) that contribute to the significance of the issue here?

- Highly consolidated provider systems.
- Lack of alternative sites of care.
- Older, higher cost population with high concentration of cancer and chronic disease.
- Small population spread over a larger geographic area.
- High member cost burden in the form of cost-sharing and high deductibles due to the high cost of care in Maine.

3. Please identify and briefly describe the top strategies your organization is pursuing to address these concerns, as well as metrics for success and any results observed.

Healthcare cost trends for Maine and the country emphasize that changes are needed to achieve our shared goals. Achieving meaningful change takes collaboration with providers, and Anthem is at the forefront of this effort to shift to provider value-based reimbursement.

3.1. Value-based contracting

Our philosophy is deeply rooted in a partnership that empowers care providers in Maine and across the country by:

- **Contracting for value** with reimbursement models and aligned incentives that give care providers autonomy and flexibility, allowing them to focus on traditional preventive care as well as meeting consumers' pharmacy, behavioral health, and social needs; and,
- **Collaborating for success** with tools and resources that make it easier for providers to access the data necessary to help patients make the right care decisions at the right time.

We have made significant progress in Maine where **95% of our Primary Care Providers participate in value-based care arrangements that are driving positive health outcomes.**

These solutions include:

- **Enhanced Personal Health Care (EPHC):** Our flagship value-based solution aims to improve quality outcomes and control cost-of-care trends in local markets. Care providers in EPHC are incentivized for delivering quality, efficient care by focusing on prevention and wellness, offering personalized plans, and coordinating treatment across the spectrum of care.

  With EPHC, a fixed Per-Member-Per-Month (PMPM) clinical coordination payments compensates PCPs for important clinical interventions that occur outside of a face-to-face visit. These services include care planning, enhancing access (such as responding to emails or offering web-based visits) or following up with patients via phone or email to make sure that they fill new prescriptions. This type of proactive clinical coordination improves health and reduces costs. The second part of the payment model are shared savings payments that reward providers when they meet quality measures and the actual costs for their attributed patients are below projected estimates.

- **Oncology Medical Home Plus (OMH+):** OMH+ supports medical oncologists in the shift from volume to value for consumers undergoing active chemotherapy treatment. Oncologists are incentivized to align treatment with patient goals, follow evidence-based care plans, reduce cost of care through comprehensive management of chemotherapy regimens, and support patients through transitions of care and various modalities.

  We support care providers by offering digital resources, population health analytics, and practice transformation tools for improved decision-making. OMH+ care provider partners are encouraged to improve patient outcomes through value-based cancer care pathways rooted in evidence-based medicine, lower cost of care through appropriate use of services, and improve consumer satisfaction through better coordinated cancer care and avoidance of emergent care.

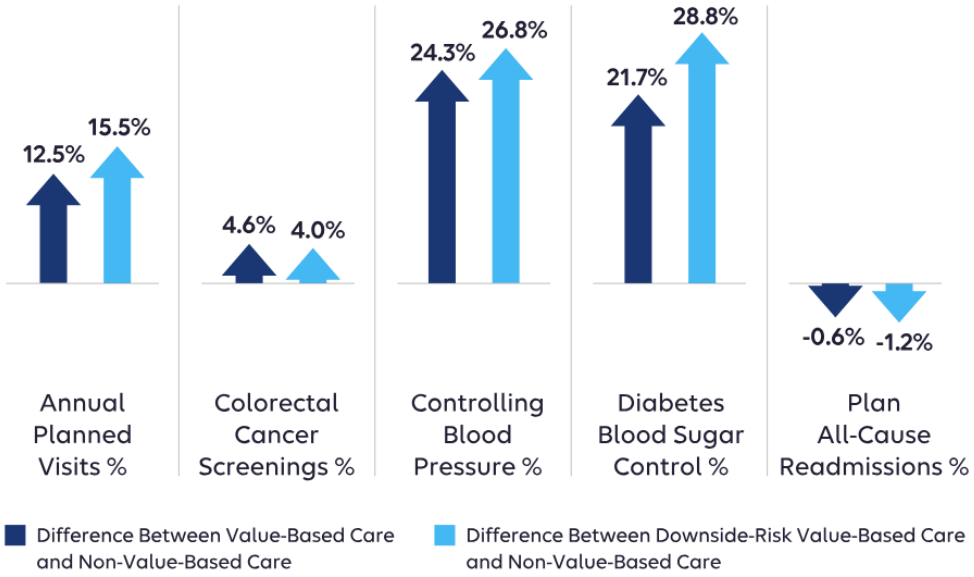
- **Episode-based payments:** These "bundled" payments encourage cost-effective coordination between primary care, specialty care, and ancillary health services by asking specialists to be accountable for cost and quality outcomes for a consumer's entire episode of care. This payment model combines payment for the full continuum of care surrounding a procedure. This drives down care fragmentation and supports improved outcomes for high-volume, high-cost specialty care, such as pregnancy, joint replacement, and colonoscopy.

  Specialists across women's health, gastroenterology, cardiovascular care, and musculoskeletal care are accountable for improving quality and driving affordability. Further, improved collaboration between primary and specialty care providers enhances the consumer experience.

We are seeing meaningful progress when comparing critical health indicators among our commercial consumers in value-based arrangements to those who are not. For example, the following metrics from our EPHC value-based solution highlight the promise and potential value to both improve the health of populations and address costs:[4]

- 5.6% increase in breast cancer screenings;
- 4.0% increase in HbA1c testing for diabetes;
- 3.3% increase in childhood immunization status (MMR);
- 2.9% increase in pediatric well care visits (ages 3-6); and,
- 5.6% increase in pediatric well care visits (ages 12-21).

We see similar results for our Medicare population. Our data shows a stark difference between consumers who are in value-based programs versus those who are not. As shown below, results improve even more when care providers take on downside risk.



Our goal is to collaborate with care providers, bringing together our population health capabilities, analytic insights, artificial intelligence, and clinical "wraparound" strategies to complement providers' patient-specific actions. To that end, we are developing new and truly innovative pathways to bridge the gap between ourselves and care providers and make real progress toward improving the patient experience, improving the health of populations, reducing the overall cost of care, and reducing administrative complexity for clinicians and other care provider partners.

[4] *Health Affairs: The Longitudinal Impact Of A Multistate Commercial Accountable Care Program On Cost, Use, And Quality* (December 2022): https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00279?journalCode=hlthaff

To make administrative pain points a thing of the past, we're focused on sharing data, aligning care management, and automating authorizations. When supported in the transition to value-based care arrangements, care providers are able to focus on patient health and focus less on administrative tasks, like "chart chasing," that are part of fee-for-service arrangements.

3.2. *Diversification of the health care delivery system in Maine.* In addition to the foregoing efforts around value-based care, we have also partnered with innovative providers to expand access to quality, affordable health care in Maine. Examples of these partnerships include:

- ConvenientMD--benefit design for certain plans with no cost shares for primary care and urgent care services received from ConvenientMD when a ConvenientMD PCP Is chosen
- Aware Recovery Care, a 52-week in-home substance use disorder (SUD) treatment program
- We were the first carrier in Maine to contract with Aspire365 for its new in-home SUD and mental health treatment program for teens and adults.
- Free standing infusion centers that provide significant savings on drug costs, in a more comfortable and convenient setting for our members
    - Local Infusion in Augusta and South Portland
    - Novella Infusion in Augusta, Lewiston, and Portland
- LIN Health--a virtual, psychology-based approach to chronic pain management

4. With as much specificity as possible, please identify and describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

The reasons for the rising healthcare cost trends are clear: rising prices for healthcare services and prescription drugs. We recommend the following actions to contain healthcare cost growth:

4.1. Provider Consolidation

- **Address anti-competitive contracting practices:** Anthem recommends prohibiting the following anti-competitive provisions in contracts between carriers and providers: all-or-nothing clauses, anti-tiering clauses, and anti-steering clauses in provider contracts. These reforms will enhance competition among providers and create an opportunity for health plans to engage in access and network innovation.

- **Increase state review of hospital and healthcare provider consolidation:** Consolidation of previously independent provider groups under a single hospital system is driving up the price of healthcare services. These are the same services provided before and after the consolidation with the exception that the consolidation under the hospital system can trigger higher contract prices for payers.

4.2. *Certificate of Need*

- **Reform Certificate of Need (CON) requirements:** Anthem recommends CON reforms to:
    - Reduce barriers to the establishment of alternative sites of care and increase competition;
    - Ensure that hospitals demonstrate a need prior to increasing capacity. Unnecessary expansion results in hospitals needing to cover larger fixed costs and that supply can create its own demand in an environment where charges are paid by third parties.
    - Strengthen oversight of proposed provider mergers and acquisitions.

4.3. ***Require appropriate billing for professional healthcare services:*** Anthem encourages the passage of legislation such as L.D. 1533 that would require hospitals to bill in a manner that accurately reflects not only the service rendered but also the location where the services were rendered to clearly prohibit the practice of systems submitting for services rendered at one of location but billing for those services under one of their higher cost locations. This would enable insurers to apply the correct professional reimbursement rate and the member pays the appropriate cost share.

4.4. ***Recognize the hospital financial data reported to the Maine Health Data Organization as the "source of truth":*** As noted above, there is conflicting information about the financial status of some of Maine's largest hospital systems—one source of truth is needed. As noted in the testimony of the Maine Hospital Association at the hearing on September 27, the OAHC should use consistent data sources in its work. We believe that applies equally to hospital financial data, and that the MHDO information should be the source of truth for hospital financial information, particularly as it relates to the work of the Office of Affordable Health Care. Hospitals are required to submit financial data to the Maine Health Data Organization ("MHDO") pursuant to 22 M.R.S.A. § 8709 and MHDO Rule Chapter 300, and we believe that information provides a consistent, reliable source of information with respect to hospital financial information.

5. Please share any additional comments.

Given that the OAHC is just beginning its work, our comments have focused on several discrete but extremely important issues. This should not be considered an all-inclusive list. There are many other issues that must also be addressed, such as the cost of prescription drugs, mandated benefits, and other laws that contribute to higher costs in Maine and we look forward to future discussions around these important issues.