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: Community Health Options
Individual submitter's name: Kevin Lewis
Title: President & CEO

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.

   Among the many contributing factors to the high costs of health care are the following:

   - Specialty pharmacy and pharmacy delivered in the medical setting. The cost of specialty drugs continues to be the leading trend factor impacting the commercial market.
   - State-imposed headwinds.
     - In Maine's predominantly fee for service market, the government's curtailment of management controls hampers our ability to influence Triple Aim achievement.
     - The merging of the individual and small group markets and its impact on MGARA as well as the further reduction in the value of MGARA through the curbing of reinsurance recoveries on "high priced items and services".
   - Provider consolidation. The rise of system consolidation and collapse of independent practices have coincided with changes in utilization and practice patterns and imposition of facility fees across a broader expanse of system controlled provider practices.

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?

   Maine's rural nature with a dispersed population across its large expanse has amplified the challenges that confront the whole of our country.

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.

   Over the past decade, Community Health Options has made considerable investments through our benefit design to advance improved health outcomes while reducing the total costs of care in achieving those outcomes. We pioneered a value-based benefit design that dramatically reduced cost sharing for routine care necessary for chronic disease

management. We led the way in making the first three behavioral health visits free to members in all non-HSA plans. We pay Members to receive infusions at lower cost infusion centers that have resulted in millions of dollars of reduced costs which in turn gets plowed back into lower premiums for all. And we work specifically to aid Members access lower cost prescription drugs through coordinated efforts with their providers which has reduced out of pocket spending and increased access to medications.

In addition to cost savings, these and other related efforts at Community Health Options have led to significant quality outcomes: our all-cause readmission rates are lower than the industry benchmark, our adherence rates for chronic care medications are higher than our peers nationally, and we are exceeding NCQA standards for our rate of follow-up following an inpatient behavioral health stay.

Health Options is committed to improving health outcomes while reducing the total costs of care. We do this through the tools that are available to us which include care coordination and utilization management, prior authorization, partnering with providers, and member outreach. We do this by investing in our infrastructure and in our service model. Our entire service center is here in Maine. And the results are in: NCQA recently awarded Community Health Options four stars for clinical quality (the care provided by the network of providers), five stars for enrollee experience and five stars for plan efficiency, affordability, and 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 following list identifies the top state health policy changes that we recommend to ameliorate the high costs of coverage in Maine:

1. **De-couple the individual and small group markets.** The single biggest factor driving up individual and small group premiums for 2024 is the effect that the merging of the markets has had on Maine's reinsurance program, MGARA. By vastly increasing the pool covered by MGARA without increasing the funding, the results of the merger were quite predictable: a dramatic decrease in the value of MGARA on a per participant basis. This then drives down the value of MGARA to insurers which correspondingly depresses the amount of section 1332 waiver funds flowing to Maine, triggering a death spiral for the program. Rather than raising taxes on insureds throughout Maine, we should decouple the markets and directly address small group mechanics.
2. **Increase the small group pool.** By changing the definition of small group from up to 50 employees to up to 100 employees, Maine's small group pool would substantially increase and benefit from a larger, more sustainable block of insureds.

3. **Increase the health of the small group pool.** The small group community rated pool faces the potential of gradually turning into a high-risk pool due to the increasing numbers of its healthiest groups leaving for self-insurance arrangements. Placing appropriate guardrails around self-insured arrangements for small groups will still allow for self-insurance but also take into account the costs to the small group community-rated market lest it gradually become the de facto high-risk pool.
4. **Make HealthInfoNet available to payer participation.** HealthInfoNet (HIN) is arguably the most successful health information exchange in the country. It serves an extremely valuable purpose by making critical health information available to reduce waste and increase timely access. While abiding by the patient protections of HIPAA, payer access to HIN would aid in care coordination, reduce administrative burden and generally root out wasted spending due to inefficiencies.
5. **Eliminate the HPIS tax on premium payers.** The cap on reinsurance recoveries to 200% of Medicare payments serves to further limit the value of MGARA without doing what was intended with the policy, i.e., reduce the total costs of care.
6. **Do not place further curbs on prior authorization and utilization management.** Until we reach widespread adoption of value-based care contracting with downside risk arrangements, prior authorization and utilization management are necessary tools that help with stewardship of premium dollars and steer towards "right care, right time, right place."
7. **Do not mandate particular drugs or drug classes.** Forcing coverage of a particular brand only further strengthens the manufacturers at the expense of premium payers.
8. **Adhere to mandate studies prior to final consideration of any mandates.** Calls for mandates are frequent but each should be considered carefully in terms of its value and relative impact to premiums for all rate payers.
9. **Encourage value-based arrangements without increasing health care costs.** The move to value-based payment systems should benefit the clinicians providing the care and the patients receiving the care, and without layering on additional costs to an already beleaguered market. The entry point to value-based care cannot be the imposition of additional charges. There should be adequate resources within existing funding to move towards both gain sharing and risk bearing, and applied in ways that allow clinicians to move from volume-based to value-based.
10. **Establish seamless enrollment pathways between Medicaid and the Marketplace.** Despite the Unwinding, the Urban Institute estimates that only 5% of those losing Medicaid will find their way into Marketplace coverage, while over 20% are estimated to go uninsured.[1] Improving the seamlessness in coverage and greater

[1] https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage

access to preventive care and good management of chronic conditions will lessen more expensive costs downstream.