October 6, 2024

Attn: Meg Garrat-Reed

Office of Affordable Health Care
Meg.garratt-reed@maine.gov

**Re: Comments on the Office of Affordable Health Care 2023 Public Hearing**

Dear Ms. Garrat-Reed,

Thank you for the opportunity to submit these comments regardingaffordability barriers Mainers face in accessing the health care and coverage they need.

Consumers for Affordable Health Care (CAHC) is designated by Maine’s Attorney General as Maine’s Health Insurance Consumer Assistance Program (CAP). The CAP program provides toll-free and in-person access to certified application counselors and trained individuals who help Mainers understand their health coverage options and apply and enroll in private health insurance. The CAP program also provides Mainers assistance with appealing inappropriate health insurance denials, and it also helps connect people with available non-insurance safety net programs, to meet their health care and other basic needs. CAHC also serves as the Ombudsman program for Maine’s Medicaid program, MaineCare, and helps people with applying for and navigate the enrollment process for MaineCare coverage. It is from our experience assisting Mainers in navigating health coverage programs, along with information from a survey of Maine people regarding their experiences accessing and paying for health care and coverage in Maine, that we offer the following comments.[[1]](#footnote-2)

First, we would like to acknowledge the many steps that Governor Mills and Maine policy makers have taken in recent years to improve access to coverage and care in our state. Medicaid expansion has helped more than 109,000 Mainers access comprehensive health coverage, and children under 21 years of age and pregnant people now have access to MaineCare regardless of their immigration status. Maine successfully launched its own State-based Exchange, CoverME.gov, lowered out-of-pocket costs for primary and behavioral health care, and took steps to improve stability within the fully insured market, including by limiting the availability of short-term, limited duration health plans and merging the individual and small group markets.

While these and other initiatives have helped improve access to quality and affordable health care and coverage, Maine people and small businesses continue to face many challenges affording the health care and coverage they, their families, or their employees, need.

1. **Affordability Barriers Facing Mainers**

**Gaps in Eligibility for Coverage:** Maine policymakers took a significant step in improving health care affordability and access by expanding eligibility for MaineCare to all income-eligible children under the age of 21 and pregnant people, regardless of their immigration status. However, many adults are continuing to fall through the cracks. Nobody living in Maine should have to choose between going to the doctor or getting the medicine they need and being able to feed their families, pay rent, or meet their basic needs. Yet, these are the choices many New Mainers are forced to make, because they are not able to qualify for MaineCare, due to discriminatory eligibility exclusions based on immigration status.

Studies of the effect of cost-sharing requirements within Medicaid populations have shown that cost is a significant barrier to accessing care in a timely manner.[[2]](#footnote-3) Excluding people from coverage discourages those people from accessing preventive care which could obviate the need for other more expensive necessary health care. People without access to health coverage are more likely to delay receiving care until their health has deteriorated and their condition has worsened, and they will likely wind-up seeking care in a hospital emergency room that is more invasive and more expensive than if they had been able to access the appropriate services earlier on. Our healthcare system is most cost efficient when everyone has coverage and can access the appropriate level of medical care when they need it, which would reduce the burden on hospital emergency departments, which are currently the only point of access to care for many. It is also worth noting that hospital free care and other financial assistance programs often do not cover the costs of emergency ambulance rides, medical specialists not employed by a hospital, or prescription drugs needed to treat and manage serious and chronic health conditions. While Maine’s patchwork of financial assistance programs can help provide many important services, it is not a substitute for comprehensive coverage.

**Rising Medical and Rx Costs:** Too often we hear from Mainers though our HelpLine who are struggling to afford the cost of the prescription drugs they need, some of whom are forced to make difficult choices between paying for medicine and being able to provide for their families and put food on the table or gas in their tank. Recent polling of Maine voters found:

* More than half of Mainers are concerned about not being able to afford a prescription drug or medicine they need.
* One in four Mainers, cut pills in half, skipped doses of medication, or delayed or did not fill a prescription, due to cost.
* Four out of ten Mainers with medical debt say prescription drug costs contributed to their debt. [[3]](#footnote-4)

Data published by the Maine Health Data Organization (MHDO) shows that, over a twelve-month period ending on June 30, 2022, **more than $757 million dollars were spent in Maine on just 25 of the costliest prescription drugs**, which is nearly $72 million **more** than was spent on the 25 costliest drugs in Maine the previous year.[[4]](#footnote-5) The amount spent in Maine for just one of these drugs, Eliquis, exceeded $93 million dollars, which is nearly $17 million **more** than was spent on Eliquis in Maine during the previous 12-month period.[[5]](#footnote-6)

High drug costs are forcing many Mainers to make difficult choices, including between buying the medicine they need or being able to put food on the table or fuel in their tank. It is clear these high and still rising prices are unsustainable for Maine people and payors to continue paying.

However, prescription drugs are not the only thing Mainers are struggling to afford when accessing health care. Survey results show:

* Two out of three Mainers believe a major medical event would be a financial disaster for them.
* More than four out of ten Mainers reported experiencing discomfort or pain for longer than they needed to, due to high healthcare costs and more than one third of Mainers reported that they delayed or skipped going to the doctor when they were sick, due to high healthcare costs.

Additionally, when Mainers do access care, many struggle to pay their medical bills, and often end up in debt.

* One in three Mainers struggled to pay for basic necessities, such as food, heat, or housing, within the past two years as a result of a medical bill. Among those who struggled to pay for basic necessities, nearly three quarters reported they experienced this as the result of a hospital bill.
* Nearly one in three Mainers have been contacted by a collection agency about a medical bill within the past two years, of which more than 80% said the medical bill that was sent to collections was from a hospital. [[6]](#footnote-7)

It is clear Mainers are struggling to afford the health care services they need, particularly hospital services.

Facility fees often represent a significant portion of many hospital bills. The types of services and settings subject to facility fees have increased over the years and now are often charged for routine services and outpatient care, which has led to higher costs and confusion for patients. For example, through our HelpLine, we have heard from people who received multiple facility fees for a single visit, were charged facility fees for visiting a freestanding urgent care clinic, and who have even been charged a hospital facility fee for a telehealth visit. People typically do not expect to receive facility fees for outpatient services, especially for routine care or when the provider office isn’t located on a hospital campus.

While many people may qualify for Free Care or other hospital financial assistance programs, not everyone who is eligible is aware of these programs or people may also face barriers when applying for or accessing financial assistance. In fact, survey data shows that roughly half of Mainers who have hospital-related medical debt are not aware that Maine hospitals are required to provide medically necessary care for free to Mainers who meet certain income guidelines.[[7]](#footnote-8) Unfortunately, by the time some people become aware of hospital free care programs, they may have already missed their application window to apply. Additionally, many people face other challenges in obtaining free care, including language barriers, as well as onerous information or documentation requests, such as requiring applicants to get documents notarized or physically come to the hospital to sign their application in-person in front of hospital staff.

Even people who are approved for free care still face affordability challenges and many receive unexpected bills for services or providers not covered by the program, even when care was provided at the hospital or in a hospital-based facility. These exclusions create significant confusion and patients are often left on the hook for bills they thought would be covered by free care. The lack of transparency around which specific services and providers are or are not covered under a hospital’s free care program often result in people avoiding or delaying care, even after they are approved for free care, due to the uncertainty and fear that they may receive a bill that they would not be able to afford.

Furthermore, there are many people who are over the income limits for free care programs, but who also are unable to afford their hospital bills. While most hospitals offer payment plans, many only allow payments to be made under these plans over a six-month period. This often results in very high monthly payment amounts that people cannot afford to pay. Through our HelpLine, we often hear from Mainers who are struggling to afford a monthly payment plan for hospital debt, or who have been sent to collections or have had to take on credit card debt to pay for their hospital bills.

**Unaffordable Insurance Premiums & Out-of-Pocket Costs:** Too often we hear from people through our HelpLine who can’t afford to pay for their health coverage or medically necessary care, or who have gone into debt or experienced financial hardships, in order to pay for necessary medical treatment, even when they have had health insurance.

Survey results demonstrate that these affordability barriers among Mainers with private insurance are widespread in Maine:

* More than half of people with commercial insurance would be much more likely to get medical services or prescription drugs if their health plan didn’t have such high deductibles or out-of-pocket costs.
* Almost six out of ten Mainers with commercial insurance are concerned they will lose their coverage because they cannot afford it.
* More than half of Mainers with commercial insurance face difficulty paying for medical expenses not covered by their health plan.[[8]](#footnote-9)
1. **Characteristics Specific to Maine**

There are several characteristics specific to Maine that impact access to affordable health care and coverage, including the rural makeup of our state. Maine is considered the most rural state in the country, with forty percent of the state’s population living in one of Maine’s 11 rural counties. Living in rural areas is often associated with increased barriers to accessing care – due to lack of transportation, a need to travel farther distances to reach a primary care provider, or a complete lack of availability of providers. Rural communities represent nearly two-thirds of primary care health professional shortage areas in the country, and Maine is no exception to this pattern. A 2022 Maine Shared Community Health Needs Assessment Report found that access to care was identified as the second highest priority in Piscataquis County, one of Maine’s most rural counties. A lack of availability of primary care providers in the country was the most frequently mentioned health concern related to access to care. It was also identified as the largest barrier to care by community forum participants. In addition to provider shortages, carriers typically charge higher premiums in rural counties, further exacerbating affordability challenges for people and small businesses in rural areas.

Another characteristic impacting affordability is the level of concentration within Maine’s health care market. Research shows that health care prices are higher in areas with less competitive markets.[[9]](#footnote-10) An analysis of hospital market concentration in metro areas across the United States found that the market in Portland, ME was highly concentrated. In 2021, Portland scored a 4,716 on the Herfindahl-Hirschman Index (HHI), which was higher than 162 of the 183 metro areas included in the analysis.[[10]](#footnote-11) The higher the market concentration score, the less competitive the market is.

1. **Policy Changes**

**Close Coverage Gap for Immigrants:** More than two out of three Mainers support ensuring that all Mainers qualify for health coverage - regardless of immigration status.[[11]](#footnote-12) Governor Mills and the Maine Legislature tooka significant step in improving health care affordability and advancing health care equity by restoring eligibility for MaineCare to children and pregnant people regardless of their immigration status. However, the coverage gap still exists for adults, and many immigrants living and working in Maine who are ineligible for MaineCare due to their immigration status. Removing this discriminatory exclusion so that all income-eligible people living in Maine can have access to coverage for the same scope of services through MaineCare, regardless of their immigration status, is crucial to addressing health care affordability in Maine.

**Provide Extended Continuous Eligibility for Children**: Having access to regular preventive care starting in childhood is crucial to growing into a healthy adult later in life. [[12]](#footnote-13) However, our healthcare system includes a patchwork of many different types of coverage all with unique eligibility criteria and oftentimes gaps in coverage can be difficult to avoid. Maine should explore federal innovation waivers to provide extended continuous coverage to children for multiple years, such as waivers approved in Oregon and Washington.[[13]](#footnote-14) This can have the concomitant effect of lowering MaineCare administrative costs relating to those under such waivers.

**Expand and Improve Access to Hospital Financial Assistance Programs:**  We hear from consumers on our HelpLine and from partner organizations who work with low-income populations about the difficulties people with low-income accessing the hospital Free Care for which they are income eligible. Requiring non-profit hospitals to do the following would ensure there is greater accessibility to the free care program for those who need it most:

* Strengthen and enforce requirements to widely publicize information about the availability of financial assistance and how to apply, and require the screening of individuals for financial assistance, prior to initiating collection actions.
* Remove application deadlines for Free Care applications.
* Prohibit free care applications from asking for unnecessary information, such as information about assets, or from imposing other unnecessary application requirements, such as requirements for documents to be notarized or signed in-person at specified locations.
* Require hospitals to provide medically necessary free care to people with income up to at least 200% FPL.
* Eliminate “surprise billing” by ensuring hospital free care programs cover all medically necessary services provided in a hospital or hospital-based setting, regardless of which individual provider performed the service.
* Require hospitals to offer patients who do not qualify for free care affordable payment plans with terms of at least 2 years and with monthly payments that do not exceed 3% of the patient's monthly gross income.
* Strengthen guardrails related to extraordinary collection activities taken by hospitals.
* Require hospitals use a single streamlined application for all financial assistance programs.

**Strengthen Consumer Protections Related to Medical Credit Cards:** Medical credit cards are sometimes pushed on patients to pay for routine or other medical care. The cards are often promoted as interest free, but may actually charge interest in certain situations, such as if a payment is late, etc. This drives up health care costs and medical debt. This practice aggravates existing issues in health care billing and collections for patients who are unable to afford care. Many times, enrollment in advertised medical credit cards results in the loss of medical bill negotiating power, increased barriers to accessing Hospital Free Care or other financial assistance programs, aggressive debt collection practices, or loss of credit reporting protections.

Nearly one in three Mainers report their family incurred new or additional credit card debit within the past two years, as a result of medical bills. We encourage the Office to consider policies to strengthen consumer protections related to medical credit cards. Specific policies may include those highlighted by Consumer Reports, including:

* Prohibit deferred interest on medical credit cards.
* Bar medical credit card providers from placing a charge on an account or issuing funds before a medical procedure is completed or the medical product is delivered (with limited exceptions)
* Reminding credit card companies that patients are entitled to withhold payment based on claims or defenses due to problematic practices by medical providers related to medical credit cards, and that they must conduct a reasonable investigation of such disputes.
* Adopting the requirements of the 2013 Consumer Financial Protection Bureau Administrative Proceeding Consent Order against CareCredit as regulations, such as requiring patients to apply directly with the credit card company for credit limits over $1,000; requiring training of provider staff; and prohibiting providers from charging for services not yet rendered, with limited exceptions. [[14]](#footnote-15)

**Utilize Medicare Reference Pricing:** The Inflation Reduction Act, passed in 2022, contained several provisions aimed at reducing the costs of prescription drugs, including requiring the Secretary of Health and Human Services (HHS) to negotiate prices for some of the costliest prescription drugs covered by Medicare. CMS recently selected ten drugs for negotiation for 2026. The total number of negotiated drugs will increase each year, with 15 additional Part D drugs selected for negotiation for 2027, up to 15 additional Part B or Part D drugs for 2028, and up to 20 additional 20 Part B or Part D drugs for 2029 and subsequent years.[[15]](#footnote-16) CMS will select drugs from among the 50 drugs with the highest total Medicare Part D spending and the 50 drugs with the highest total Medicare Part B spending.

Seven of the ten drugs that will be part of the first round of negotiations are also in the top 25 most costly drugs in Maine, according to data from the Maine Health Data Organization.[[16]](#footnote-17)

In its most recent annual report, the Maine Prescription Drug Board (MPDAB) identified the new Medicare maximum fair prices “as an opportunity for Maine to leverage the work of the federal government,” and recommended Maine adopt maximum fair prices as reference rates to set upper payment limits for selected drugs sold in Maine.[[17]](#footnote-18) This would ensure that Mainers who are not enrolled in Medicare will still be able to benefit from the maximum fair prices for selected drugs negotiated for Medicare. It is also worth noting that, due to the limited number of drugs that will be selected for negotiation for Medicare, the MPDAB also recommends that Maine “institute Medicare reference rates supplemented by Canadian reference rates where domestic MFPs are not available, to maximize savings.”[[18]](#footnote-19) Due to the large number of drugs that have price tags too high for Mainers to afford, CAHC also supports using Canadian reference rates to supplement Medicare-based reference rates, when a Medicare MFP is not available for a drug.

In addition to prescription drugs, we also urge the Office to consider policies that promote the use of Medicare referenced-based pricing (RBP) for health care services. To address high hospital prices, some state health purchasers are using Medicare RBP as a reference-point when setting hospital reimbursement rates, which can help lower costs and ensure rates more accurately reflect actual costs of providing services.

For example, Montana’s state employee health plan uses a Medicare-based reference point to pay hospitals and other medical facilities.[[19]](#footnote-20) The reference-based pricing agreements set the price range paid by the health plan from 220% to 225% for inpatient services and 230% to 250% for outpatient services.[[20]](#footnote-21) An independent study of publicly available data estimated the Montana state employee plan saved $47.8 million from state fiscal years 2017 to 2019 using reference-based pricing.[[21]](#footnote-22), [[22]](#footnote-23)

**Prohibit Anti-Competitive Practices:** Nationally, some dominant health systems have used anticompetitive contract provisions to keep high-cost, low-value providers in preferred plan networks and to raise hospital prices, including anti-tiering, anti-steering, and all-or-nothing clauses.[[23]](#footnote-24) [[24]](#footnote-25)

Since carriers are required to maintain adequate provider networks, there are some providers or facilities, particularly in rural areas, that they likely must contract with in order to maintain an adequate network. If these facilities are part of a larger health care system, anti-steering, anti-tiering, and all-or-nothing clauses can dramatically diminish a carrier’s leverage when negotiating rates and contract terms for other facilities or hospitals within the health system, even when those facilities or hospitals are not necessary to meet network adequacy requirements. This often leads to higher prices and may also result in consumers being steered away from other independent smaller practices or higher-value providers.

Prohibiting anti-steering, anti-teering, and all-or-nothing clauses in contracts can help level the playing field for negotiations between insurers and large health systems, which helps insurers to better negotiate lower in-network prices, which should ultimately lead to lower costs for their members. Prohibiting anti-competitive contracting terms will also help to ensure carriers are able to design networks with the highest-quality, lowest-cost providers available.

Massachusetts, California, and Nevada already have laws that restrict these types of clauses.[[25]](#footnote-26) Maine would benefit from following their lead, especially given the highly consolidated nature of our health care market.

**Limit Facility Fees for Certain Services and Settings:** The types of services and settings subject to facility fees have increased over the years and are now often charged for routine services and outpatient care, which has led to higher costs and confusion for patients. We encourage the Office to consider policies to increase transparency of facility fees, as well as limit the types of services and settings for which patients may be billed a facility fee.

**Ensure Alignment of Silver Premiums:** The Affordable Care Act requires carriers to set premiums that reflect the characteristics of a particular plan, not the characteristics of the population expected to enroll in that plan. This means plans with more generous coverage should have higher premiums than plans that offer less generous coverage. However, in many states, including Maine, variations in metal-level premiums do not always correspond appropriately to differences in coverage generosity.[[26]](#footnote-27) This can increase, sometimes significantly, premium costs for consumers, both among subsidy-eligible and ineligible populations. An analysis published by Families USA estimated the impacts of realigning metal-tier premiums based on coverage generosity in 2020 Marketplace plans. The analysis found metal-tier premium realignment would have saved Marketplace enrollees in Maine an average of $739, amounting to $46 million of total projected premium savings on 2020 Marketplace plans in Maine.[[27]](#footnote-28)

Adopting the following policies would help to prevent premium misalignment in Maine:

* Require induced demand assumptions used by carriers to project higher utilization when plans have lower overall cost sharing.
* Prohibit carriers from varying metal-level premiums based on their past utilization in a particular metal tier. Carriers should rely instead on the utilization patterns experienced by all enrollees pooled together, without distinguishing between silver, gold, and bronze utilization patterns.
* Establish standardized metal level and CSR variant enrollment projections.

**Limit Cost-sharing Requirements:** If consumers can afford their premium but cannot afford to use their coverage, the overall value of their insurance is minimal. We appreciate all of the steps Maine policymakers have taken to reduce out-of-pocket costs for consumers, including caping insulin copays at $35, eliminating cost-sharing for the first visits, and requiring first-dollar coverage for the second and third visits, to primary care and behavioral health providers, as well the Bureau’s continuous work on developing and improving Clear Choice plan designs. However, even a $50 copay is significant enough to cause many Mainers to avoid or delay care, including at times when health conditions can be treated more easily and with lower overall costs than if left unaddressed or treated at a later stage. We encourage the Office to explore additional strategies to lower out-of-pocket costs in order to reduce affordability barriers to accessing needed medical care. Strategies should maximize pre-deductible coverage, as well as utilize copays over coinsurance, to the greatest extent possible without exceeding AV limits. A 2016 study found that standardized silver plans that provided pre-deductible coverage for primary and specialty care visits, **all** drugs, mental health visits, and urgent care would have comparable premiums to other non-standardized silver plans.[[28]](#footnote-29)

**Increase Standardization of Clear Choice Plans:** The purpose of Clear Choice designs is to standardize benefits between plans, in order to simplify the plan selection experience and to allow consumers to make apples-to-apples comparisons when shopping for health plans. However, the current variation permitted between plans within a single clear choice benefit structure undermines the ability for consumers to make a true apples-to-apples comparison between plans. Furthermore, these benefit variations frequently lead to higher out-of-pocket costs for consumers. This issue is particularly relevant to plans with tiered benefit designs, which in our experiences working with patients and consumers, are particularly confusing for individuals to understand. For example, in Kennebec County, currently half of the six Silver $4,200 clear choice plans offered on the Marketplace utilize tiered networks, all of which offer different levels of cost-sharing and include cost-sharing amounts that are higher than the cost-sharing levels specified in the Silver $4,200 clear choice design developed by the Bureau of Insurance. In addition to higher deductible and copay amounts, one plan subjects a tier 2 specialist visit to a $130 copay **after** meeting a $7,000 deductible, even though this service should have pre-deductible coverage, and a much smaller copay, based on the cost-sharing designated in the applicable Clear Choice benefit design.

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| **2023 Tiered Clear Choice Silver $4,200 Plans Offered On-Marketplace in Kennebec County** |
| **Clear Choice Silver $4,200****Benefit Design** | **Deductible** | **Max OOP** | **PCP** | **Specialist** |
| $4,200  | $9,100  | $50 | $80 |
| **Tiered Plans** | **T1** | **T2** | **T1** | **T2** | **T1** | **T2** | **T1** | **T2** |
| CHO | Health Options Clear Choice Silver $4200 HMO Tiered NE | $4,200 | $5,040\* | $9,100 | $9,100 | $50 | $70\* | $80 | $95\* |
| Anthem | Anthem Clear Choice Silver X Tiered 4200 | $4,200 | $6,300\* | $9,100 | $9,100 | $35 | $70\* | $80 | $130 **after deductible\*** |
| Harvard Pilgrim | Clear Choice Maine's Choice Plus HMO Silver 4200 | $4,200 | $7,000\* | $9,100 | $9,100 | $50 | $80\* | $80 | $110\* |

\*Cost-sharing is higher than the amount specified in the base Clear Choice plan design.

Tiered network designs should only be permitted in Clear Choice Plans if the tier that provides the lowest level of coverage under the plan utilizes the standardized Clear Choice cost-sharing structure established by the Bureau of Insurance for that particular plan design. We do not object to carriers attempting to steer consumers to high-value providers by offering a preferred network with reduced cost-sharing amounts. However, any reduction in cost-sharing should be a reduction from whatever the designated cost-sharing amount for that particular service would be under the Clear Choice design developed by the Bureau. When shopping for plans, consumers should be able to enroll in a Clear Choice plan with the assurance that they will not have to pay any more for a covered in-network service or prescription drug, than the cost-sharing amounts specified in the Clear Choice benefit design for that plan. The benefit structure established in a Clear Choice benefit design should set the floor for the level of benefits offered in any Clear Choice plan utilizing that benefit design. Otherwise, labeling these plans as “Clear Choice” is highly misleading to consumers, who may be left on the hook for medical bills that far exceed how much they expected to owe for a covered service or prescription drug.

**Strengthen Actuarial Value Requirements for Clear Choice plans:** In addition to creating confusion, and potentially resulting in unexpected medical bills, tiered benefit structures as are currently utilized in silver-level Clear Choice plans offered on the Marketplace, also make it more expensive for consumers to obtain the levels of coverage provided in the Clear Choice benefit designs established by the Bureau. For example, in Kennebec County, the five lowest-cost silver Marketplace plans currently available all utilize tiered networks. All five of these plans have AV amounts that are lower than the AVs for their corresponding Clear Choice benefit designs, as created by the Bureau.

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| **2023 Lowest-premium Silver Plans Available On-Marketplace in Kennebec County** |
| **Carrier** | **Plan Name** | **Plan AV** | **BOI Clear Choice Design AV** | **Difference in AV** |
| CHO | Health Options Clear Choice Silver $4200 HMO Tiered NE | 70.21% | 70.26% | **-0.05%** |
| CHO | Health Options Clear Choice Silver $3500 HMO Tiered NE | 71.07% | 71.18% | **-0.11%** |
| Anthem | Anthem Clear Choice Silver X Tiered 6000 | 70.04% | 70.44% | **-0.40%** |
| Anthem | Anthem Clear Choice Silver X Tiered 5500 | 70.05% | 70.69% | **-0.64%** |
| Anthem | Anthem Clear Choice Silver X Tiered 4200 | 70.03% | 70.26% | **-0.23%** |

The projected AV amount for a Clear Choice benefit structure, as developed by the Bureau, should serve as a floor for the minimum value that a plan utilizing the Clear Choice design must provide.

**Reduce Market Segmentation:** Given the relatively small size of Maine’s market, it is especially important to protect against market segmentation. As an analysis prepared by Gorman Actuarial, Inc. explains, “Generally, as markets get smaller, the enrollees who remain in the market are less healthy and require more health care resources, which drives up premiums.”[[29]](#footnote-30) While merging the individual and small group markets into a pooled market has helped to expand the size of the risk pool, we encourage the Office to explore additional policies to further reduce market segmentation and promote the health of the fully insured pooled market, including strengthening guardrails for non-ACA compliant plans, such as health care cost sharing ministries; and as well as products that enable small groups to self-insure, rather than participate in the community-rated pooled market.

**Strengthen Rate Review:** While the Bureau of Insurance reviews proposed individual and small group rates submitted by carriers each year, several other states have granted their state regulatory agencies greater latitude and authority to disapprove rates on the basis of affordability. For example, Rhode Island requires rates to be consistent “with the interest of the public,” and has adopted affordability standards carriers must abide by that target underlying cost drivers. [[30]](#footnote-31) Rhode Island’s affordability standards have succeeded in curbing rising hospital prices, reducing enrollee spending, and lowering cost-sharing without reducing quality or utilization.[[31]](#footnote-32)

We urge the Office to consider policies to establish prior approval authority, as opposed to the file-and-use process currently permitted, as well as establish an affordability mandate that broadens the Superintendent’s authority to reject proposed rates on the basis of affordability. Maine’s rate review process would be further strengthened by providing Maine’s Superintendent with authority to review *all* proposed rates, regardless of whether a proposed increase meets a specific threshold, such as California and Oregon have done.[[32]](#footnote-33)

**Provide State-Level Subsidies:** Other states have succeeded in both increasing enrollment and improving their risk pools through providing state financial assistance in addition to the federal APTCs, to further lower coverage costs for populations likely to face financial barriers to enrolling in coverage.[[33]](#footnote-34) Massachusetts, for example, which has the highest state rate of enrollment among potentially eligible populations, provides financial assistance in addition to federal premium and cost-sharing subsides for people with incomes up to 300% FPL. An analysis of enrollment data from Massachusetts found that lowering premium costs by just $40 led to a 14-24% increase in Marketplace enrollment among eligible individuals.[[34]](#footnote-35) A Families USA report estimates that if Maine were able to achieve Massachusetts’ level of Marketplace enrollment among its potential APTC-eligible populations with income below 300% FPL, enrollment would increase by 21,000 people. Not only would affordability barriers improve for those individuals who gained coverage, but the increase in Marketplace enrollment among this population would likely improve the combined risk pool as well as bring in an estimated additional $152 million in APTC subsidies to Maine, which would increase available funding for Maine’s reinsurance program, which cumulatively would also help lower premiums for individuals and small businesses who aren’t eligible for subsidies.[[35]](#footnote-36)

**Establish a Public Option Health Plan:** We encourage the Office to explore public option models that increase consumer choice and strengthen market competition for comprehensive, affordable health coverage, and aim to lower health care costs. Several states have established or enacted legislation to establish or are currently considering some form of a public option. Colorado’s public option requires insurers to offer gold, silver, and bronze tier public option plans in all counties where they offer individual or small-employer plans. Colorado Option plans must meet certain premium rate reduction targets and health equity network requirements.[[36]](#footnote-37) Washington and Nevada have also begun planning for or implementing public option plans.

Thank you very much for the opportunity to submit these comments and for your consideration of the issues and policy solutions raised. If you have further questions, please don’t hesitate to contact me at kende@mainecahc.org or 207-480-2136**.**

Sincerely,

Kate Ende
Policy Director
Consumers for Affordable Health Care

1. <https://www.mainecahc.org/wp-content/uploads/2023/05/Polling-Views-of-Maine-Voters-On-Health-Care-Affordability.pdf> [↑](#footnote-ref-2)
2. <https://www.clasp.org/publications/fact-sheet/evidence-builds-access-medicaid-helps-people-work/> [↑](#footnote-ref-3)
3. <https://www.mainecahc.org/wp-content/uploads/2023/05/Polling-Views-of-Maine-Voters-On-Health-Care-Affordability.pdf> [↑](#footnote-ref-4)
4. <https://mhdo.maine.gov/tableau/prescriptionReports.html> [↑](#footnote-ref-5)
5. Ibid. [↑](#footnote-ref-6)
6. <https://www.mainecahc.org/wp-content/uploads/2023/05/Polling-Views-of-Maine-Voters-On-Health-Care-Affordability.pdf> [↑](#footnote-ref-7)
7. Ibid. [↑](#footnote-ref-8)
8. Ibid. [↑](#footnote-ref-9)
9. <https://academic.oup.com/qje/article-abstract/134/1/51/5090426?login=false> [↑](#footnote-ref-10)
10. <https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Current-Spending> [↑](#footnote-ref-11)
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