**Testimony of Trevor Putnoky**

**to the Office of Affordable Health Care**

**September 27, 2023**

My name is Trevor Putnoky and I’m the President and CEO of the Healthcare Purchaser Alliance of Maine (HPA). While I serve as the Chair of the Advisory Council on Affordable Health Care, my testimony today is solely in my capacity as the President and CEO of the HPA.

The HPA is a nonprofit that represents the purchasers of healthcare in Maine. Our mission is to advance healthcare value and to support and incentivize high-quality, affordable care. We have over 60 members, including some of the largest public and private employers and health trusts in Maine. Collectively, our members spend over a billion dollars annually providing health care for nearly one quarter of the commercially insured population in the state.

***Concerns regarding healthcare cost growth and affordability***

The HPA believes there are a number of factors contributing to the rising costs of health care in Maine, and the increasing challenges that Maine people and businesses face trying to afford that care.

* Market consolidation. Maine has a highly consolidated healthcare market, with nearly half of the state’s hospitals owned by two large health systems, and many primary care and specialty practices system owned as well. And while mergers and acquisitions of healthcare entities are often touted as ways to improve efficiencies, lower costs, and enhance quality and access, studies have found that prices in consolidated markets are actually higher than in competitive markets, with one study estimating average prices are 12 percent higher at monopoly hospitals, compared to markets with robust competition.[[1]](#footnote-1) Results from that same study suggest that bargaining leverage is an important component in price variation.[[2]](#footnote-2)

When this sort of market imbalance exists, dominant healthcare systems can insist on higher rates, as well as contract provisions with carriers and plan sponsors that limit competition and ultimately increase costs to consumers. They also control patient referral pathways. Such consolidation makes it extremely difficult for healthcare purchasers to implement benefit design and other network strategies designed to better manage costs and improve affordability, as these “must have” providers’ have near monopolistic negotiating power—e.g., they can threaten to leave networks and implement anti-competitive contract practices.

* Opaque price information. Prices for healthcare services vary substantially across Maine, depending on where patients go to receive care. For instance, patients can pay as little as $15 for lab work at an independent lab but get charged more than five times that amount to have the exact same labs drawn at a hospital in Maine. Unfortunately, consumers often lack access to pricing information that could help them identify and utilize more affordable providers. While the federal government has mandated hospitals to post pricing data online, hospital-posted transparency data is extremely difficult to use. The files are in different formats, there are missing CPT modifier codes, and there are missing data points. This makes it very difficult for consumers—as well as employers and payers—to address the wide variation in price across providers in Maine and to utilize affordable care.
* Hospital financial transparency. Despite steadily rising reimbursement rates, many Maine hospitals state that they are operating in the red. Without a better understanding of the financial health of the state’s hospitals, it is difficult for policy makers and the purchasers of health care to know which strategies are appropriate for reducing the costs of care and improving affordability for Maine consumers.
* MGARA. Since its inception, the MGARA program has helped to reduce premiums—and improve affordability—in the individual market through reinsurance of high-risk claims. Following the merger of Maine’s individual and small group markets, however, MGARA funds are now used to reinsure high-risk claimants in both the individual ***and*** small group markets. This reduces the program’s impact on individual premiums, which will in turn reduce federal funding for MGARA, which is based on the extent to which MGARA reduces ***individual*** premiums through reinsurance of high-risk claims. And with less federal funds available, MGARA will have even less of an impact on the individual market moving forward, which will further reduce federal funding in the future and potentially create a downward funding spiral.

  While we understand the argument that the small group market is shrinking and that combining it with the individual market into a larger, merged market can create more stability, we are concerned that an unintended consequence of the merger will be reduced MGARA resources, which will limit the program’s ability to improve affordability through reinsurance of high-risk claims.

***Issues specific to Maine***

While most of the concerns identified above (other than the MGARA issue) are not unique to Maine, we believe that they are particularly acute here, particularly the highly consolidated nature of Maine’s healthcare market. Further, the rural nature of the state can discourage provider competition in some parts of Maine, as providers wishing to invest in infrastructure often look for locations with sufficient volume to support that investment. In addition, the high cost of care in Maine is exacerbated by the state’s lower per capita income: Maine has the 10th highest healthcare expenditures per capita in the nation,[[3]](#footnote-3) but comes in 30th for per capita income.[[4]](#footnote-4)

***HPA strategies***

There is no silver bullet to solving the problem of healthcare affordability. Both market interventions and policy reforms will be critical to reining in costs while preserving access to high-quality care and superior outcomes. As an alliance of healthcare purchasers, we undertake a range of strategies to leverage commercial purchasers’ marketing power to improve affordability. For example,

* We work with Maine businesses to eliminate terms in their vendor contracts that restrict their ability to access data and implement effective programs, including benefit designs to utilize more affordable sites of care.
* We offer employers group purchasing arrangements of impactful, high-value healthcare services like Carrum Health, which offers a centers of excellence program that pays providers on a prospective, bundled basis. Carrum eliminates price variation and provides access to the highest quality providers at below-average market rates. Another program addresses the crisis over accessibility to behavioral health services in Maine: WellSpace Maine partners with employers to offer employees and dependents virtual and in-person behavioral health services, with guaranteed access to a provider within five days.
* We provide data analytics to purchasers to help them to identify and address cost drivers in their health plan.
* We provide numerous opportunities for healthcare purchasers to learn more about—and utilize—strategies that can control healthcare costs and improve affordability for their members.

***Health policy priorities***

As the office explores policies and strategies to improve affordability, we urge you to consider the following suggestions:

* Eliminate anticompetitive contract terms—such as all-or-nothing and anti-tiering/steering clauses—from provider contracts with carriers, as proposed in *LD 1708, An Act to Address Anticompetitive Terms in Health Insurance Carrier and Health Care Provider Contracts*.
* Cap out-of-network reimbursement rates at a percent of Medicare or at a percent of the average reimbursement rate for in-network providers.
* Mandate a universal reporting standard for hospitals to comply with federal price transparency requirements and institute meaningful penalties for noncompliance, such as prohibiting noncompliant hospitals from collecting medical debt, as proposed in *LD 953, An Act to Protect Maine Patients Regarding Hospital Price Transparency.*
* Ensure hospitals inform patients about free/charity care programs and screen patients for eligibility. Also ensure that the application process is frictionless for patients to enroll, as envisioned in *LD 1955, An Act to Require Hospitals and Hospital-affiliated Providers to Provide Financial Assistance for Medical Care.*
* Require that the tax benefits associated with a hospital’s nonprofit status do not exceed the value of the hospital’s community benefit, with community benefit clearly defined.
* Ensure the public has access to—and understanding of—hospital finance information, including data on investment income and losses.
* Create a division within the Bureau of Insurance to handle consumer, purchaser, and payer complaints regarding providers.
* Create a more robust review process of any future healthcare mergers or acquisitions and also evaluate the effectiveness of Maine’s CON program—including an assessment of whether the CON process preserves highly consolidated regional markets—and the higher prices that may go along with those concentrated markets—by blocking new providers from entering a region.
1. Zack Cooper, Stuart Craig, Martin Gaynor & John Van Reenen, *The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51 (2019). Available at: <https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf>. [↑](#footnote-ref-1)
2. Ibid. [↑](#footnote-ref-2)
3. Kaiser Family Foundation, “Health Care Expenditures per Capita by State of Resident,” *State Health Fact.* Available at: <https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Health%20Spending%20per%20Capita%22,%22sort%22:%22desc%22%7D>. [↑](#footnote-ref-3)
4. St. Louis Fed, “Release Tables: Per Capita Personal Income by State, Annual,” *FRED Economic Data*. Available at: <https://fred.stlouisfed.org/release/tables?eid=257197&rid=110>. [↑](#footnote-ref-4)