ADVISORY COUNCIL ON AFFORDABLE HEALTH CARE

First Meeting
June 20th, 2023
1:00pm-3:00pm

AGENDA

- 1:00-1:10 – Introductions
- 1:10-1:30 – OAHC and Advisory Council Structure and Duties
- 1:30-2:00 – Landscape of Health Care Costs: What the Data Tells Us
- 2:00-2:30 – Vision for the OAHC
- 2:30-3:00 – Next Steps and Closing Feedback

THE OFFICE OF AFFORDABLE HEALTH CARE

Statutory Structure and Duties

AUTHORIZING STATUTE AND STRUCTURE

The Office of Affordable Health Care (OAHC) was authorized in PL 2021 Ch. 518, codified at 5 MRSA Part 8, Ch. 310-A.

- The office is established as an independent state agency, it is not part of an existing executive branch department or division
- The office works under the "general policy direction" of the Advisory Council and the Committee of Jurisdiction (Joint Standing Committee on Health Coverage, Insurance, and Financial Services (HCIFS))

DUTIES OF THE OFFICE - SUMMARY

- The Office is directed to:
  - Analyze health care cost growth trends and health care spending trends, and monitor the adoption of alternative payment methods in Maine and nationally
  - Develop proposals to:
    - Improve the cost-efficient provision of high-quality health care
    - Improve coordination, efficiency and quality of the health care system
    - Improve consumer experience with the health care system
    - Improve health care affordability and coverage for individuals and small businesses in the State
  - Provide staffing assistance to the Maine Prescription Drug Affordability Board

DELIVERABLES OF THE OFFICE

- Must hold an annual public meeting by October 1st each year
- Must report annually to the Governor and the legislative oversight committee
- One time requirement due by January 1, 2024 to: "*study the effects of policies aimed at improving health care affordability and coverage, including effects on the affordability of premiums and cost-sharing in the individual and small group health insurance markets, and the effects of the policies on enrollment in comprehensive health coverage. The office shall consider, but is not limited to considering: 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, 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 […]; and 5. Other policies as identified by the office and the Advisory Council on Affordable Health Care […]. The office shall provide a report of its findings to the joint standing committee of the Legislature having jurisdiction over health coverage and insurance matters no later than January 1, 2024.*"

UPDATE ON ADMINISTRATIVE ITEMS

- Office “start up”
  - Currently set up in a suite of office space at 221 State Street, Augusta
  - Website creation underway, should be ready to go live in July
- Hiring
  - FJA in process for Public Service Coordinator II to serve in a senior analyst role
  - Pursuing a reclassification of the second authorized position from Secretary Specialist to Policy Analyst
  - Delivery Order process underway to be able to hire fellows/interns through temporary staffing
- Budget
  - Budget revisions included in the change package to better reflect operating expenses, and to add funding for contracted analytics support and to offer paid internships

131ST LEGISLATURE ACTIVITY

Several bills impacting OAHC moved through the HCIFS Committee this session (*status included as of 6/16*):

- LD 914 – Added a reference to considering the cost of new and emerging technologies in the office's work. *(passed to be enacted)*
- LD 1856 – A resolution which clarifies the office's policy option study requirement. It would prioritize a study of public options models for delivery in January of 2024, and provide flexibility on the timeline of delivery of a report on other policy models, which would be required by January 2025. *(passed - final)*
- LD 1792 – established a rural health task force which would be convened and staffed by OAHC. Required to provide a report by December 3, 2023. *(not yet considered)*
- OAHC was also included as an ex officio member of two other task forces, and would be required to provide staff support upon request:
  - LD 1795 – Facility Fee Task Force *(passed to be engrossed)*
  - LD 329 - Blue Ribbon Commission on Guaranteed Health Care *(passed House)*

OVERVIEW OF THE ADVISORY COUNCIL

- The Council is directed to "advise the office on matters affecting the cost of health care in this State."
- The group should elect a Chair and Vice-Chair from among its members
- Must meet at least every two months, though meetings may be added or cancelled by the Chair
- A quorum (7 votes) is required for action by the Council. Representatives of DAFS and DHHS are non-voting members.
- There are recusal requirements for conflict of interest

THE LANDSCAPE OF HEALTH CARE COSTS

What Data Tells Us

THE PROBLEM

The United States spends the most money (per capita) on health care of any developed country, nearly twice the average of OECD countries, yet has the shortest life expectancy. [1]

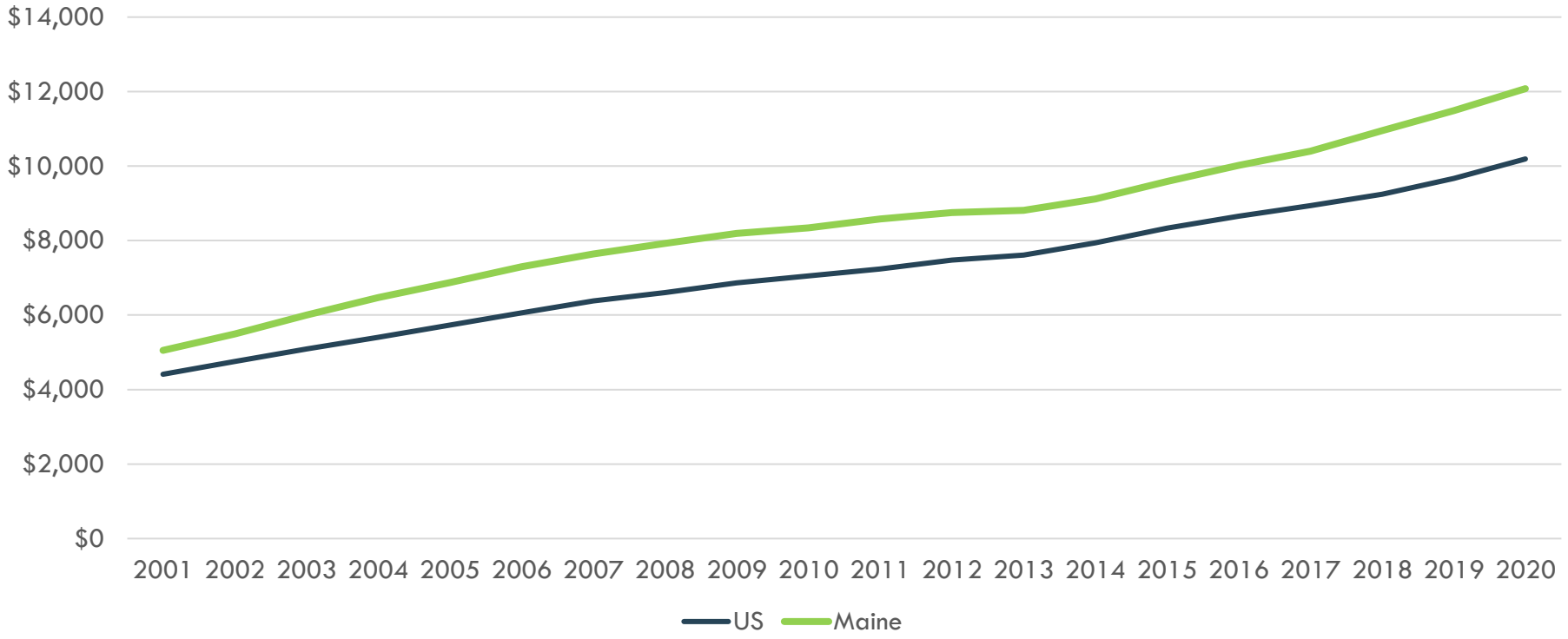
More than a third of Mainers recently surveyed had delayed visiting a doctor because of concern about cost, and nearly 70% believe that just one major medical event or illness could cause a financial disaster for them.[2]

In a 2021 national survey of large employers, nearly 90% of said they believe the cost of providing health benefits will become unsustainable in the next 5-10 years, and 85% expect the government will be required to intervene to provide coverage and contain costs.[3]

1. "U.S. HEALTH CARE FROM A GLOBAL PERSPECTIVE, 2022: ACCELERATING SPENDING, WORSENING OUTCOMES," THE COMMONWEALTH FUND. JANUARY 31, 2023.
2. CONSUMERS FOR AFFORDABLE HEALTH CARE SURVEY, ADMINISTERED BY DIGITAL RESEARCH INC. MAY 2023.
3. "VAST MAJORITY OF LARGE EMPLOYERS SURVEYED SAY BROADER GOVERNMENT ROLE WILL BE NECESSARY TO CONTROL HEALTH COSTS AND PROVIDE COVERAGE, SURVEY FINDS," KFF. APRIL 19, 2021.

HEALTH CARE SPENDING IN MAINE

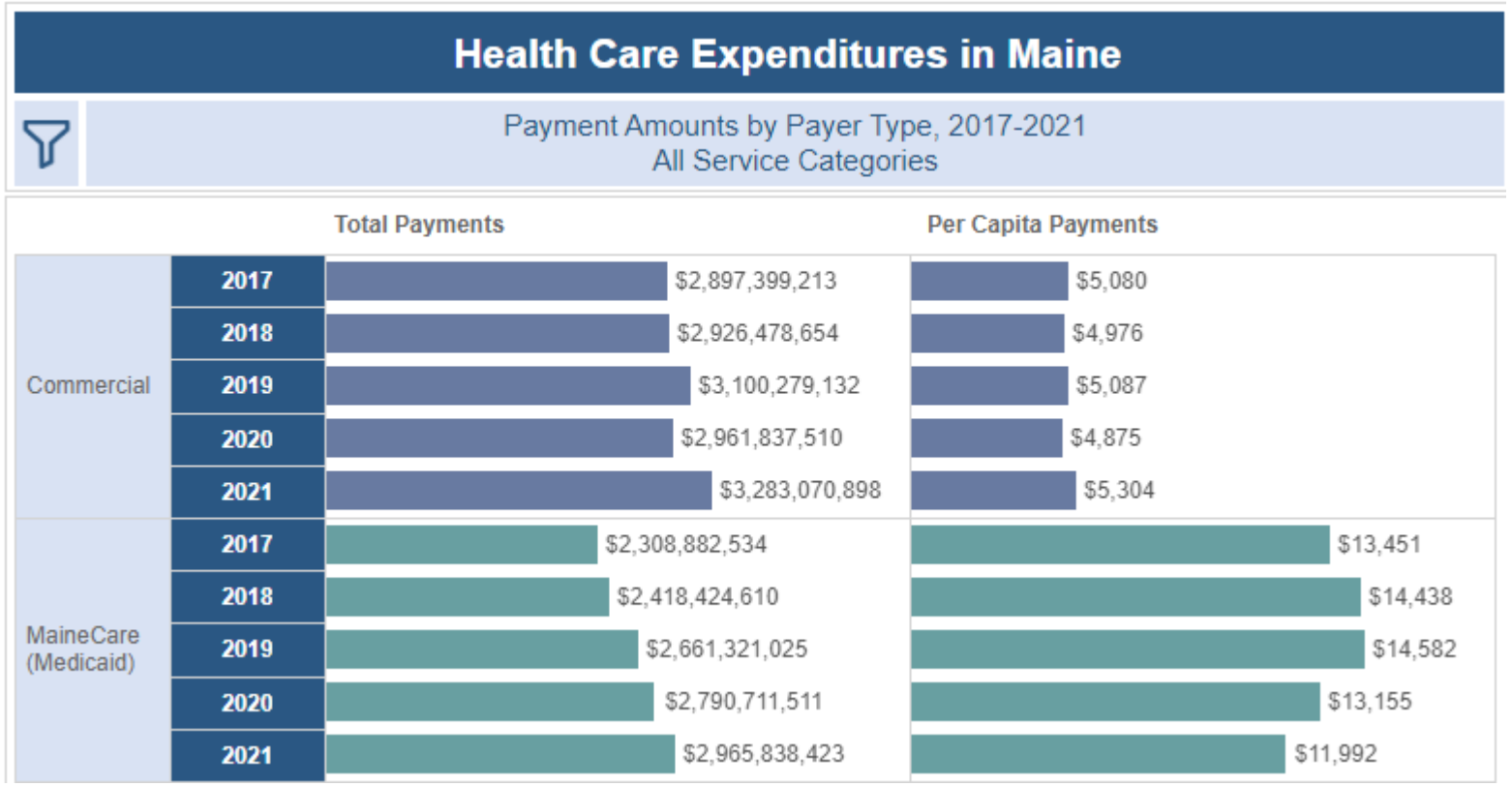
HEALTH EXPENDITURES PER CAPITA



Maine's per capita spending on health care is higher than the U.S. average, and has grown at a faster rate in recent decades. Maine currently has the 10th highest per capita health expenditures in the country.

SOURCE: CENTERS FOR MEDICARE & MEDICAID SERVICES, OFFICE OF THE ACTUARY, NATIONAL HEALTH STATISTICS GROUP. NATIONAL HEALTH EXPENDITURE DATA: HEALTH EXPENDITURES BY STATE OF RESIDENCE, AUGUST 2022.

MHDO ANALYSIS OF HEALTH CARE EXPENDITURES

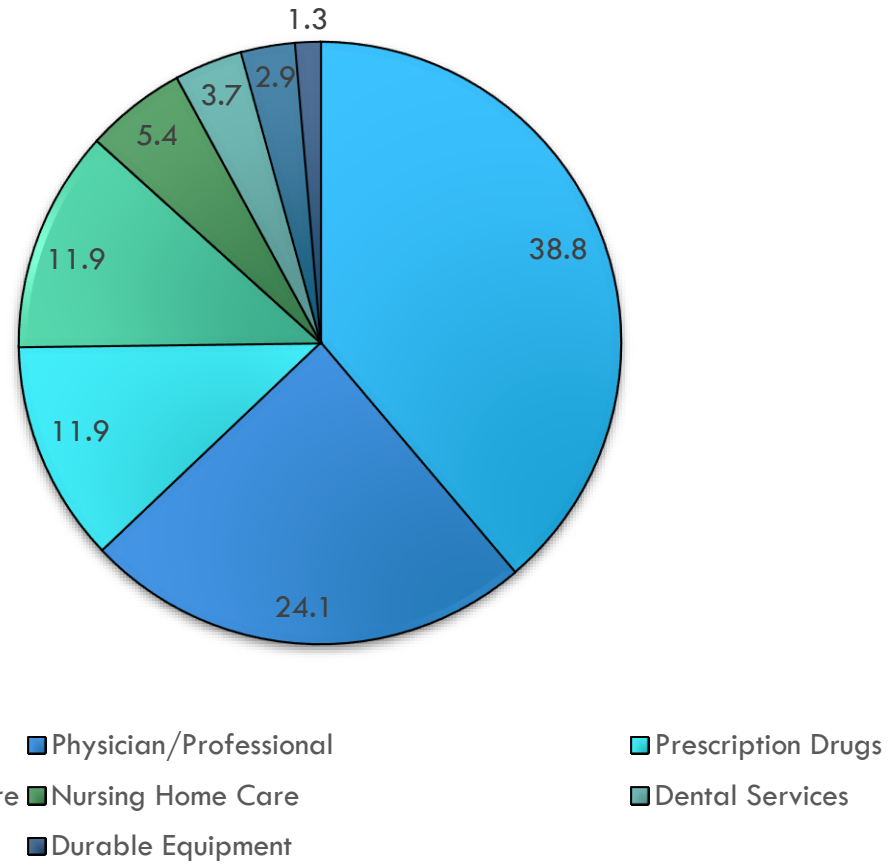


Maine Health Data Organization's analysis of claims data also shows fairly consistent growth in total commercial spending, with the exception of a reduction in 2020 associated with the deferral of care at the outset of the COVID-19 pandemic.

MAINE HEALTH DATA ORGANIZATION, HEALTH CARE EXPENDITURES AND HEALTH CARE QUALITY IN MAINE: BASELINE REPORT, JANUARY 2023

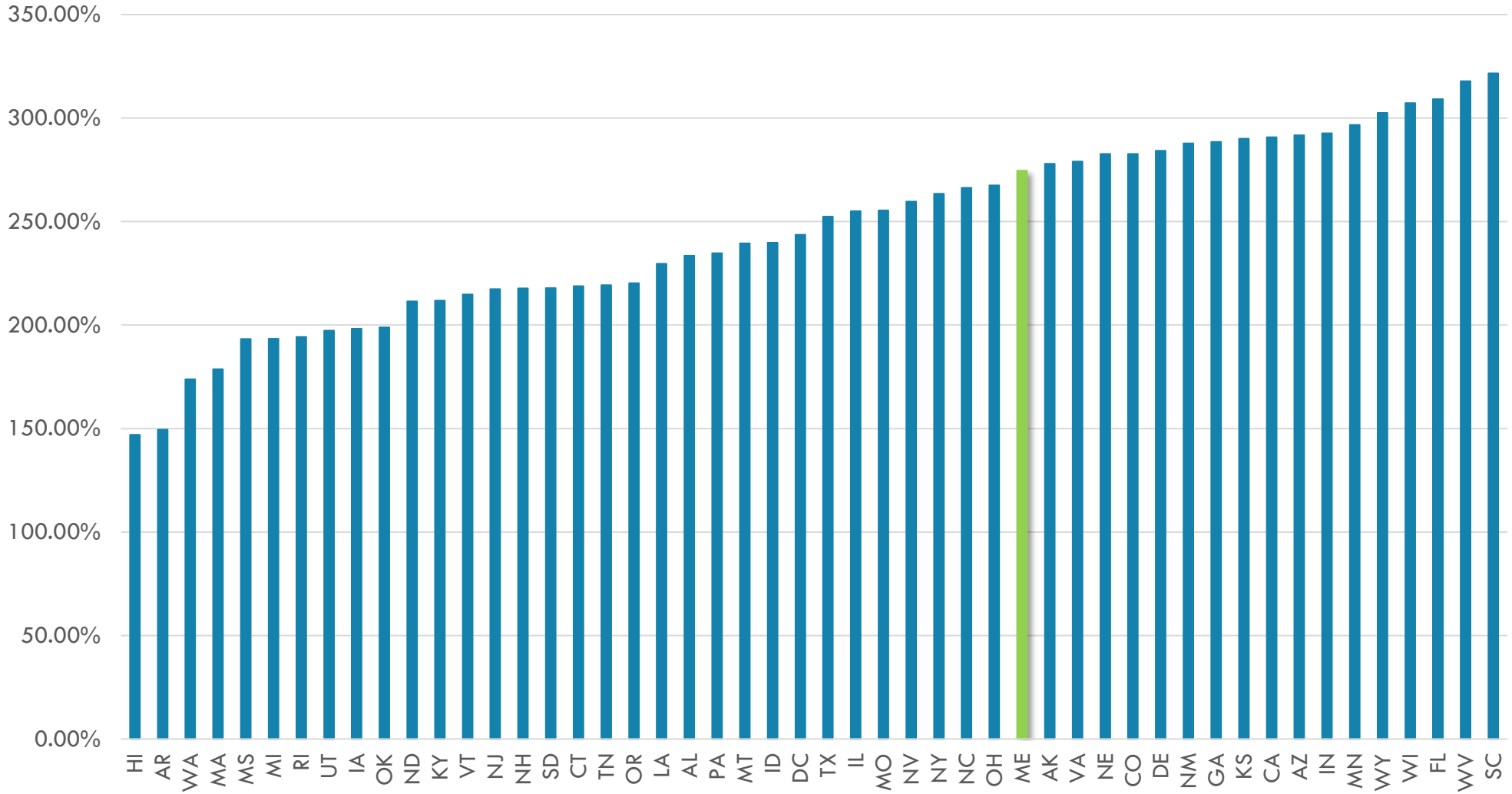
DISTRIBUTION OF HEALTH SPENDING IN MAINE (2020)

Spending on hospital care makes up the largest percentage of Maine's total health spending, followed by physician and professional services, then prescription drugs



SOURCE: CENTERS FOR MEDICARE & MEDICAID SERVICES, OFFICE OF THE ACTUARY, NATIONAL HEALTH STATISTICS GROUP. NATIONAL HEALTH EXPENDITURE DATA: HEALTH EXPENDITURES BY STATE OF RESIDENCE, AUGUST 2022.

PRICES PAID TO HOSPITALS BY PRIVATE PAYERS AS A PERCENT OF MEDICARE PRICE



While Maine's aging population is likely a factor in higher per capita spending, prices are as well. Maine's average hospital prices are 275% of Medicare prices, the 18th highest in the country.

SOURCE: RAND CORPORATION, PRICES PAID TO HOSPITALS BY PRIVATE HEALTH PLANS FINDINGS FROM ROUND 4 OF AN EMPLOYER-LED TRANSPARENCY INITIATIVE, JULY 2022.

IMPACT OF RISING COSTS ON MAINE PEOPLE

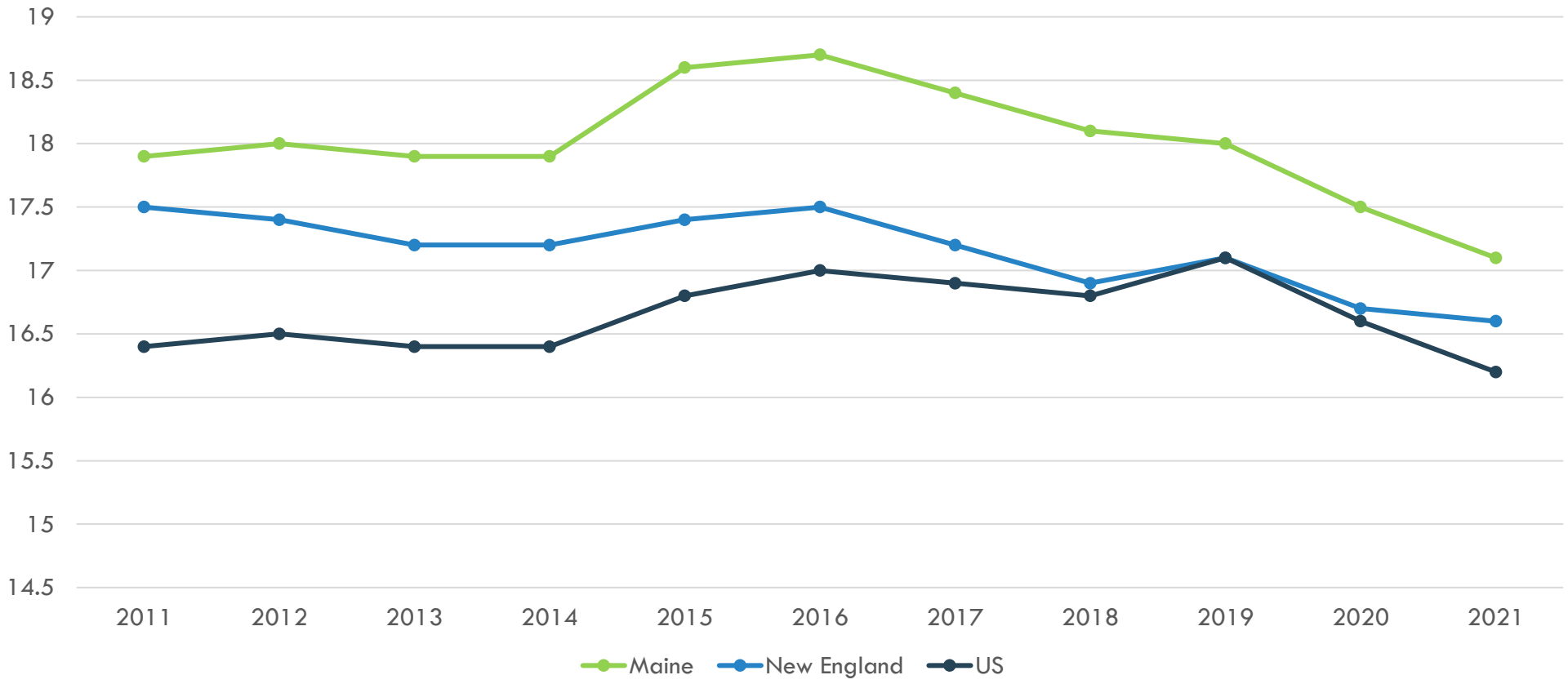
AFFORDABILITY FROM A CONSUMER PERSPECTIVE

Consumers primarily experience health care costs through their insurance expenses, though increasingly high deductibles create more exposure to direct costs from health expenses.

A recent Forbes analysis ranked Maine the 7th most expensive state for health care, based on 11 metrics for cost and access.

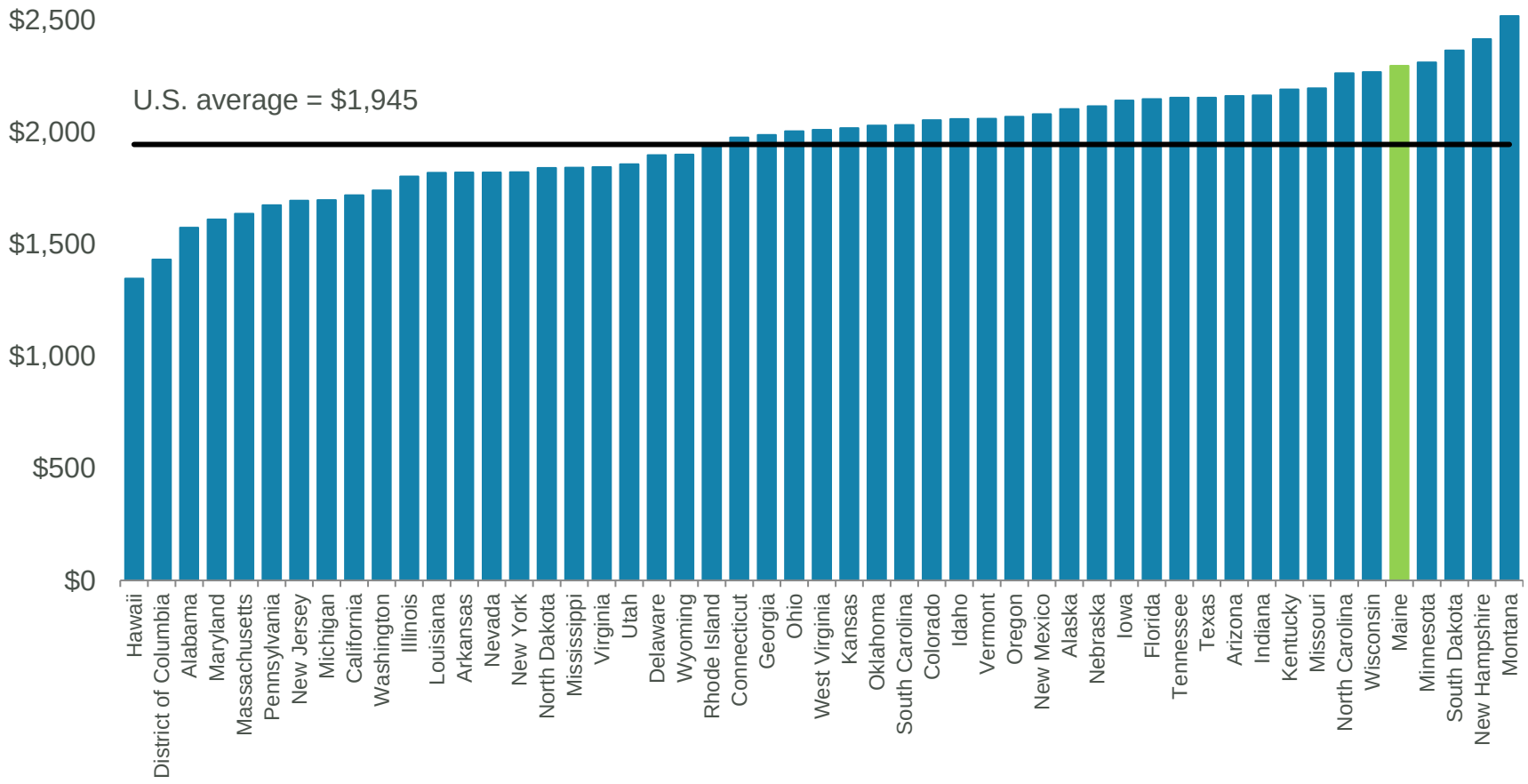
Rank	State	Total Score Out of 100	Health Care Spending Per Capita[1]	% of Adults Who Did Not See a Doctor Due to Cost[2]
1	South Dakota	100.00	$11,736	9.13%
2	Louisiana	86.69	$9,796	13.13%
3	West Virginia	82.31	$12,019	12.97%
4	Florida	79.51	$9,501	14.87%
5	Wyoming	78.63	$10,296	12.30%
6	Nebraska	75.13	$9,974	10.90%
7	Maine	74.08	$11,505	10.60%
8	Delaware	73.91	$12,294	10.10%
9	New Hampshire	69.53	$11,359	9.93%
10	Oklahoma	69.35	$8,997	14.70%

HEALTH EXPENDITURES AS A PERCENTAGE OF TOTAL PERSONAL EXPENDITURES



SOURCE: MAINE DEVELOPMENT FOUNDATION, 2022 MEASURES OF GROWTH REPORT, NOVEMBER 2022.

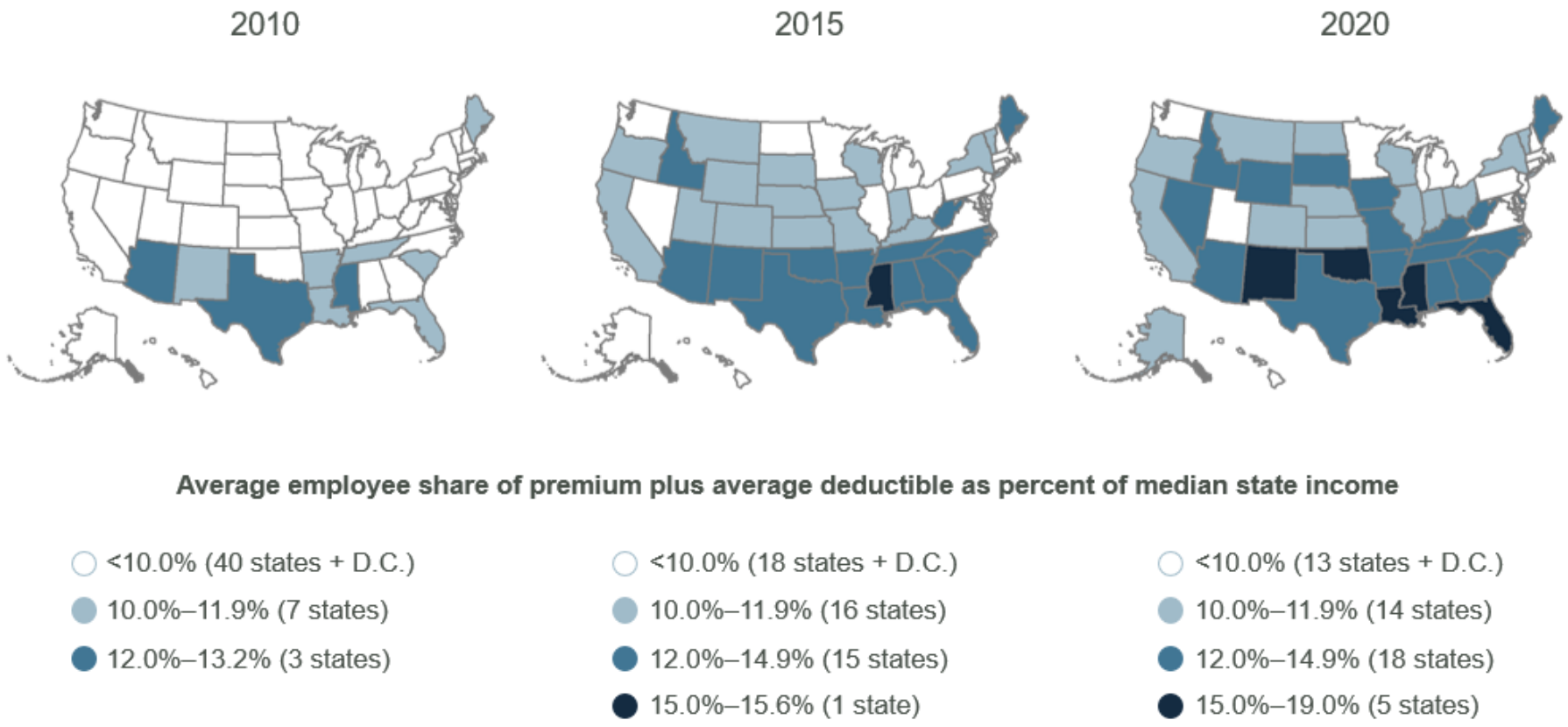
AVERAGE DEDUCTIBLE FOR SINGLE COVERAGE



Employer sponsored insurance premiums in Maine are slightly above the national average, but our state has among the highest average deductible for employer-sponsored health insurance plans

SOURCE: SARA R. COLLINS, DAVID C. RADLEY, AND JESSE C. BAUMGARTNER, STATE TRENDS IN EMPLOYER PREMIUMS AND DEDUCTIBLES, 2010-2020 (COMMONWEALTH FUND, JANUARY 2022).

PREMIUMS AND DEDUCTIBLES AS A PERCENT OF INCOME



Note: Combined estimates of single and family premium contributions and deductibles are weighted for the distribution of single-person and family households in the state.

Data: Premium contributions and deductibles — Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2010–2020; Median household income and household distribution type — analysis of Current Population Survey (CPS), 2010–2021, by Mikaela Springsteen and Sherry Glied of New York University for the Commonwealth Fund.

HOW MAINE PEOPLE EXPERIENCE HEALTH CARE COSTS

A survey of more than 920 Maine adults, conducted from Oct. 18, 2021 to Oct. 28, 2021, found that:

- More than 3 in 5 (63%) experienced one or more healthcare affordability burdens in the past year
- Half (51%) of uninsured adults cited "too expensive" as the major reason for not having coverage, far exceeding other reasons like "don't need it" and "don't know how to get it."
- 14% reported being unable to pay for basic necessities like food, heat, or housing because of medical bills
- 4 in 5 (80%) report being "worried" or "very worried" about affording some aspect of healthcare in the future

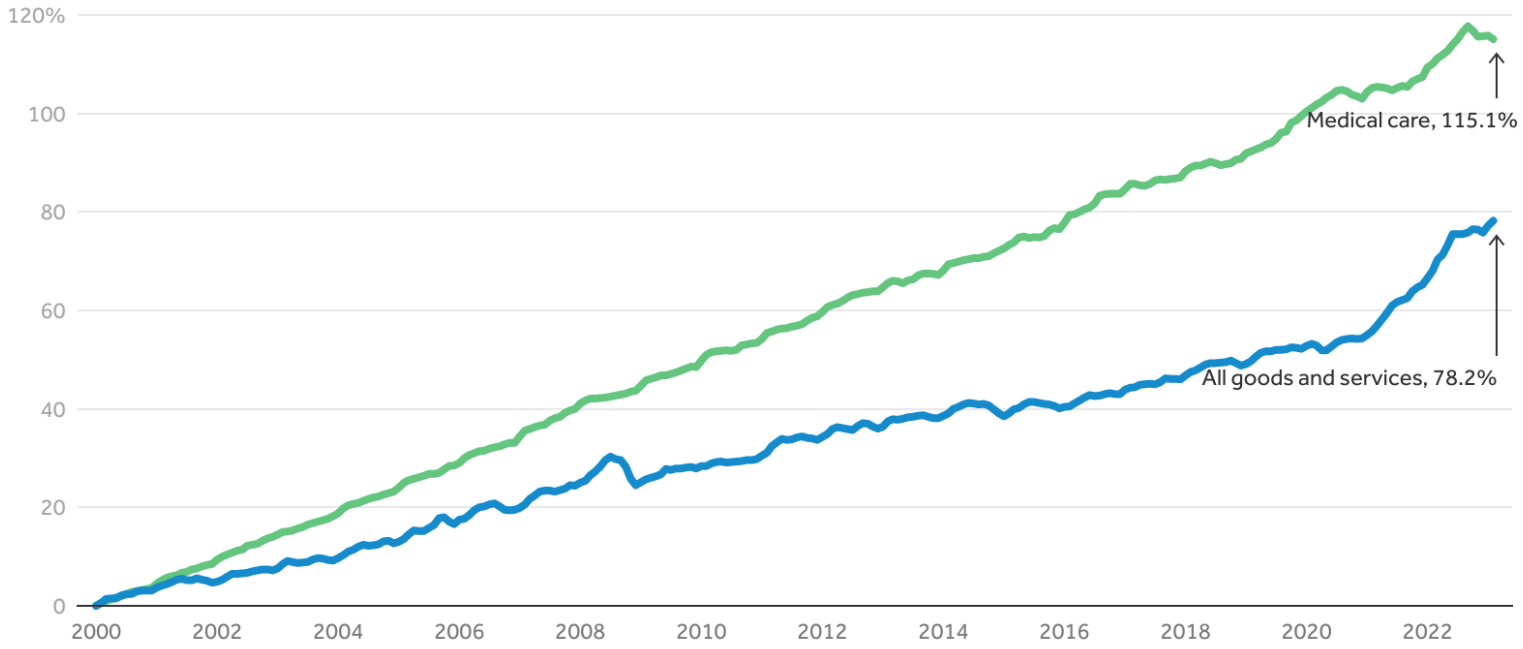
SOURCE: ALTARUM DATA BRIEF #111: "MAINE RESIDENTS STRUGGLE TO AFFORD HIGH HEALTHCARE COSTS," JANUARY 2022

WHAT DRIVES HIGH AND RISING SPENDING? REVIEWING NATIONAL DATA

HOW DOES MEDICAL SPENDING COMPARE TO OTHER GOODS AND SERVICES?

Spending on medical services (by individuals, commercial payers, businesses, and government) has grown at a faster rate than other goods and services in the past 20 years. This suggests that factors unique to the health care sector are driving spending increases, rather than input costs shared across industries (e.g., labor or facility operation costs).

Cumulative percent change in Consumer Price Index for All Urban Consumers (CPI-U) for medical care and for all goods and services, January 2000 - February 2023

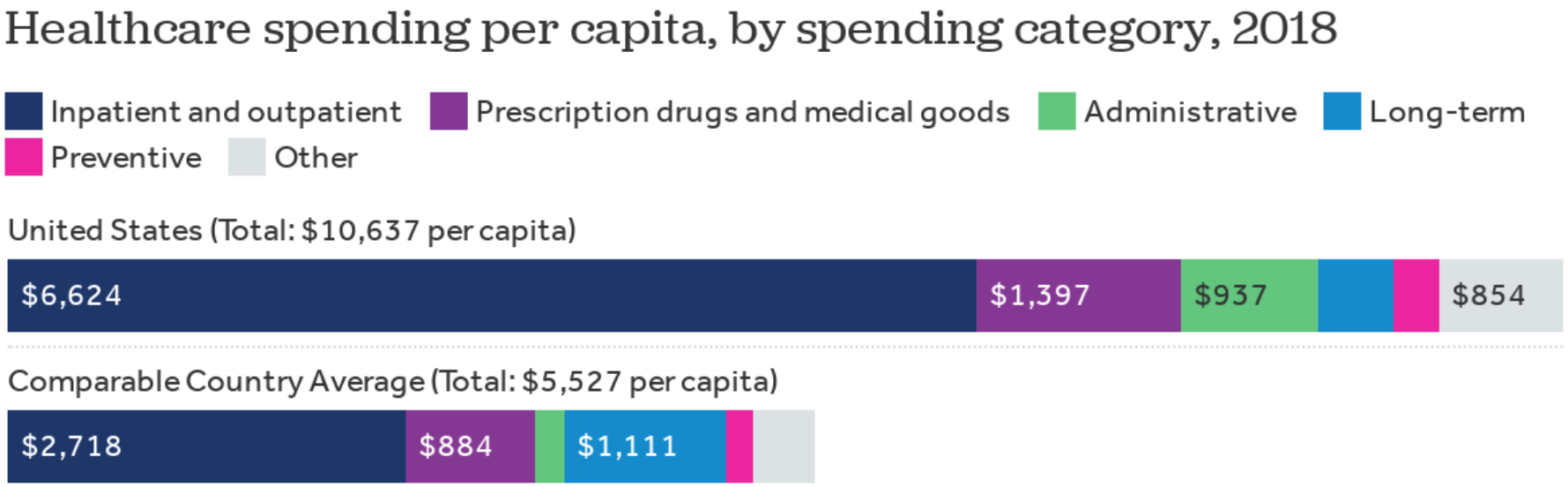


Note: Medical care includes medical services as well as commodities such as equipment and drugs.

Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data

Peterson-KFF Health System Tracker

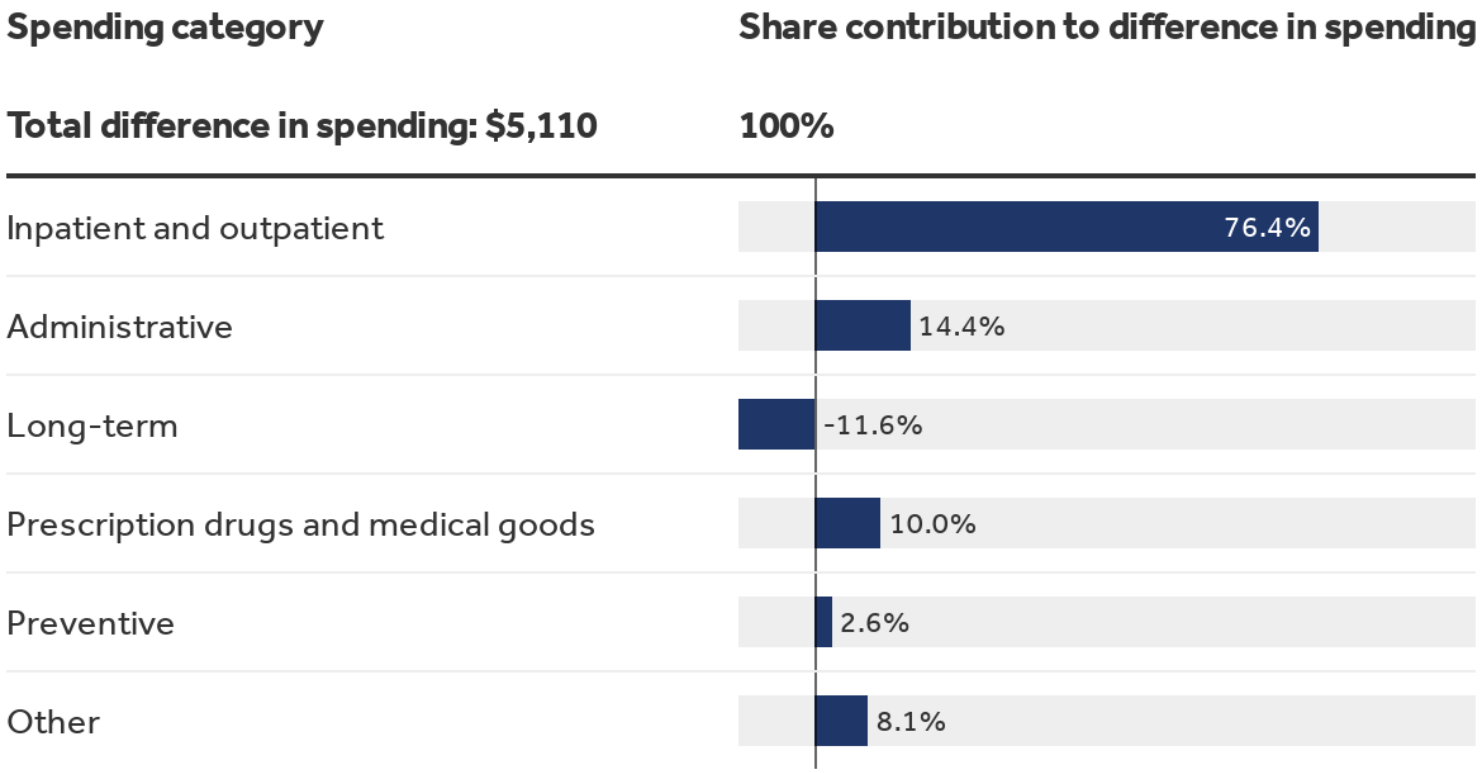
HOW DOES PER CAPITA SPENDING IN THE U.S. COMPARE TO COMPARABLE COUNTRIES?



Source: KFF analysis of OECD Health Statistics

Peterson-KFF Health System Tracker

Distribution of difference in per capita health spending between the U.S. and comparable countries, by spending category, 2018



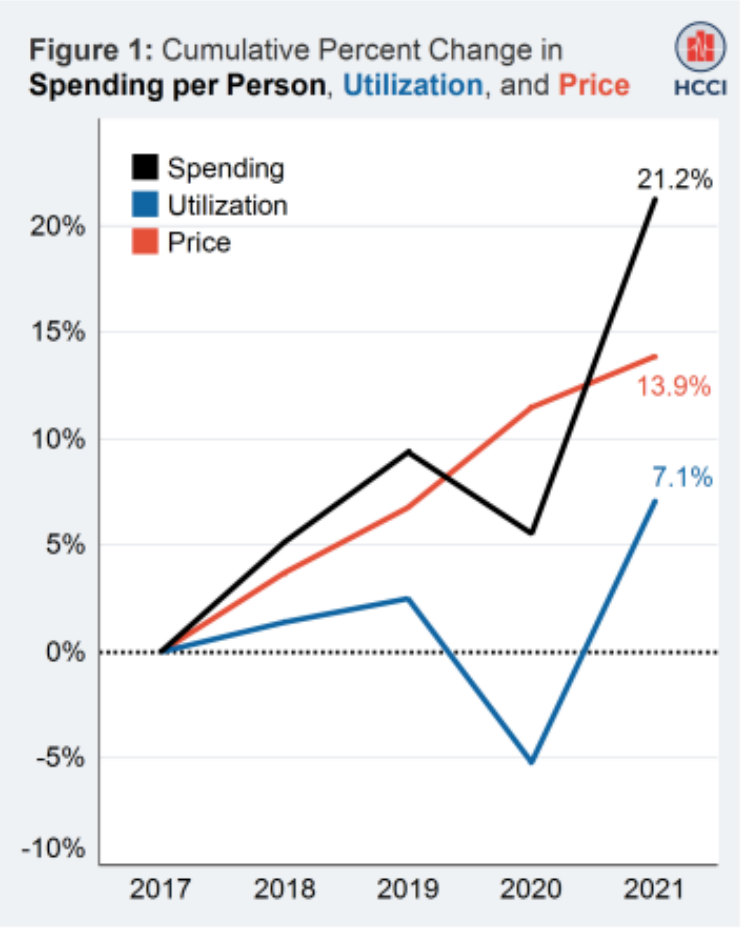
Comparable countries include Austria, Belgium, Canada, France, Germany, Netherlands, Sweden, Switzerland, and the United Kingdom.

Source: KFF analysis of OECD Health Statistics.

Peterson-KFF Health System Tracker

While spending on administration and prescription drugs are higher in the U.S., the main driver of relatively high health expenditures in the U.S. is spending on inpatient and outpatient care.

HOW DO CHANGES IN PRICE AND UTILIZATION CONTRIBUTE TO INCREASED SPENDING?



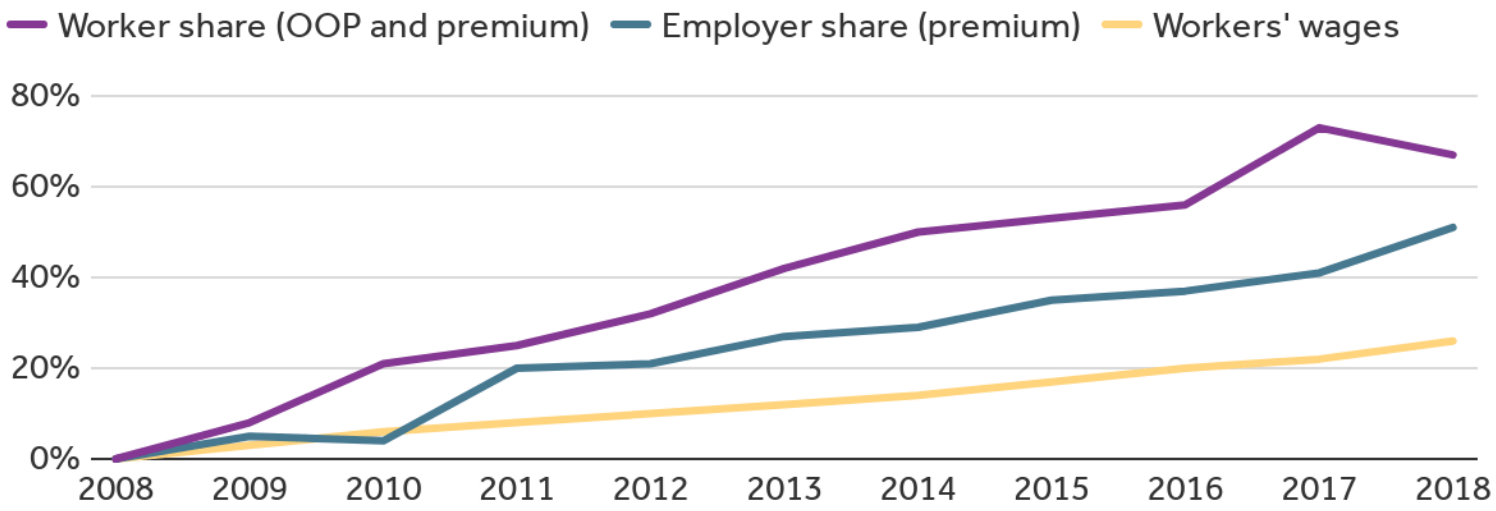
Annual spending is influenced by utilization, as illustrated by corresponding decreases due to delayed and deferred care in 2020 resulting from COVID-19. Over time, however, increasing prices are the more significant driver of increased spending for the commercially-insured population nationally.

SOURCE: HEALTH CARE COST INSTITUTE. 2021 HEALTH CARE COST AND UTILIZATION REPORT. APRIL 2023.

HOW IS RISING SPENDING REFLECTED IN PREMIUMS?

Health care spending by both employers and employees is significantly outpacing wage growth.

Cumulative growth in premiums and out-of-pocket spending for families with large employer coverage, 2008-2018



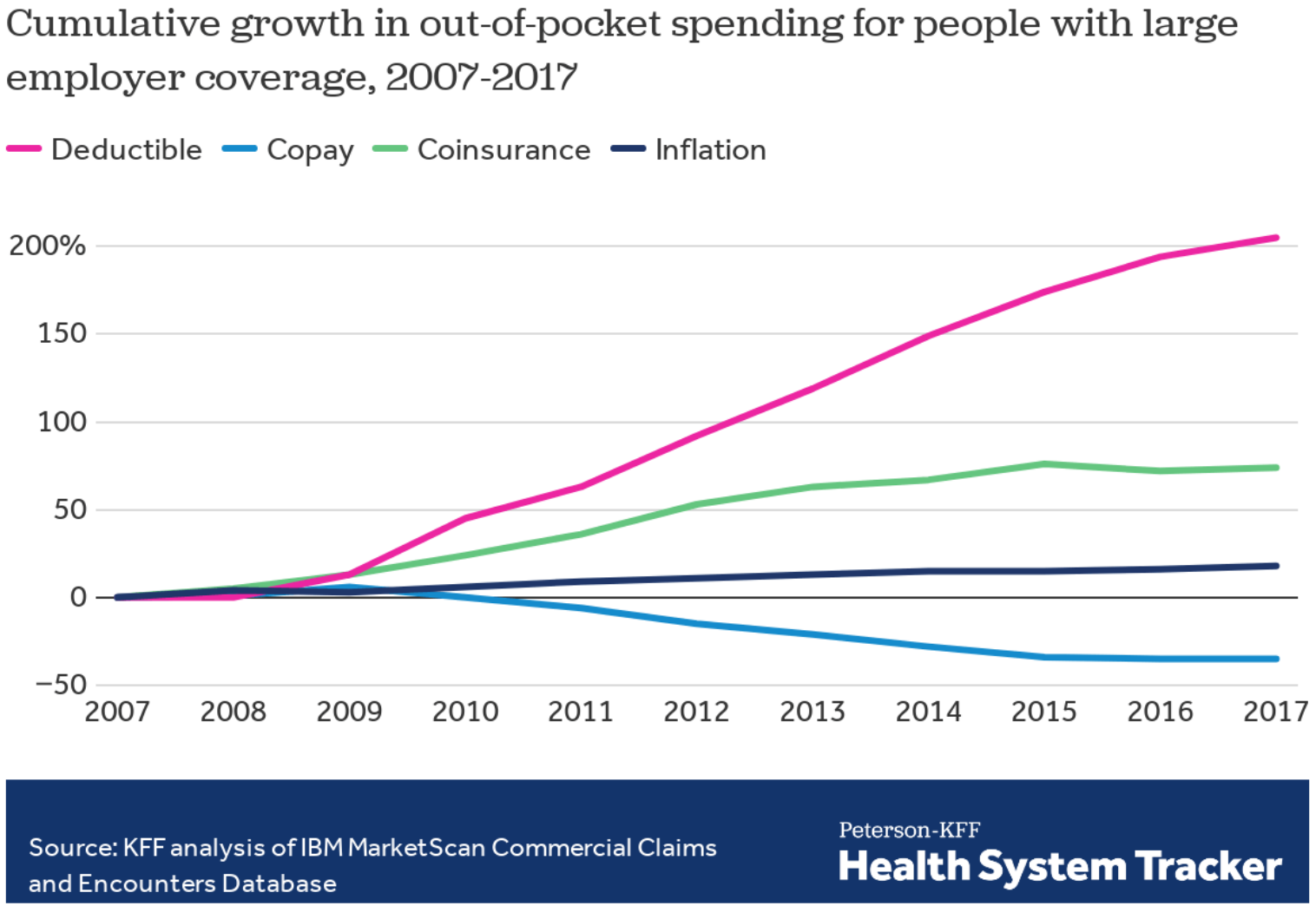
Note: Out-of-pocket (OOP) costs are inflated from 2017 to 2018 because data are not yet available. Large employers are those with one thousand or more employees.

Source: KFF analysis of IBM MarketScan Commercial Claims and Encounters Database and KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Peterson-KFF Health System Tracker

HOW IS RISING SPENDING REFLECTED IN OUT OF POCKET COSTS?

Growth in deductibles is significantly outpacing overall health care spending trend, leaving the segment of consumers with health needs more exposed and therefore more cognizant of prices.



FUTURE RESEARCH QUESTIONS

- How has Maine's per capita spending changed when adjusted for age?
- To what extent is shifting to non-claims expenses (e.g., incentive payments, capitated payments) a factor in spending trend? How can this spending be incorporated into analyses?
- What services/ geographies/ input costs are the most significant drivers of increasing spending?
- How do trends in Maine's insurance market compare to national trend? How do increases in member liability compare to growth in total spending?

VISION FOR THE OFFICE OF AFFORDABLE HEALTH CARE

GUIDING PRINCIPLES

Focus on the "big picture"

- Prioritize opportunities with the most significant opportunity for impact
- Recognize the complexity of interdependent systems and actors in health care

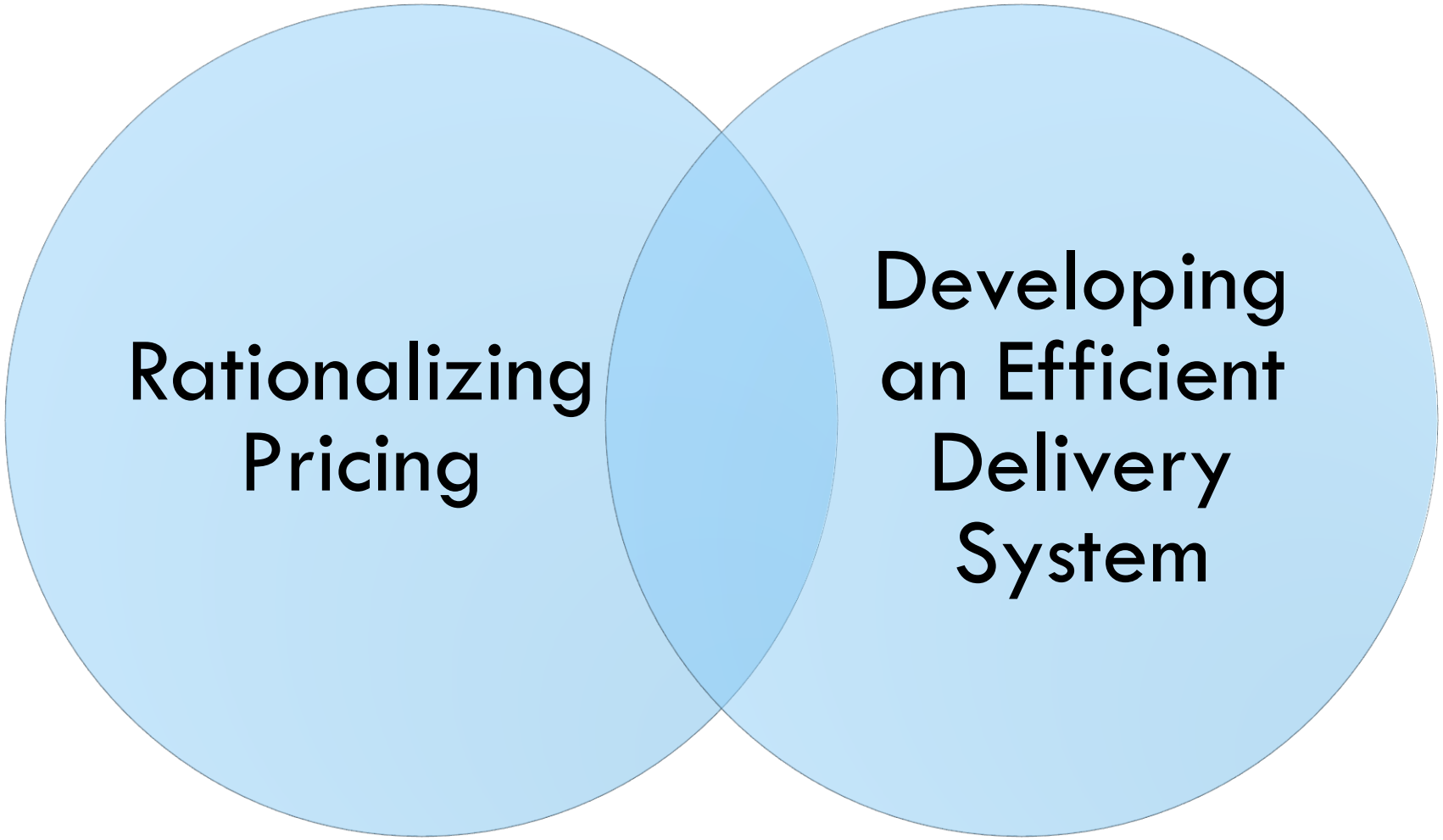
Define affordability from a consumer perspective

- Focus on cost relief for end-payers (individuals and families, businesses, government), with a particular emphasis on consumer cost burden that may result in delayed or deferred care
- Avoid policies that simply shift costs, unless cost-shifting is undertaken intentionally to promote better outcomes

Deliver results

- Take into account whether proposals are achievable, and other implementation considerations
- Recognize that continuing the status quo is not sustainable

MAJOR THEMES IN STAKEHOLDER INPUT



RATIONALIZING PRICING

- Maine's prices are high relative to national average, despite costs being comparable to national average
- There is significant variation in prices for services across providers in the state, with little discernable pattern or explanation
- The trajectory of premiums and cost-sharing in the commercial market is a major risk to access to health care for consumers and businesses in the state

DEVELOPING AN EFFICIENT DELIVERY SYSTEM

- Robust, accessible, low-barrier preventative, primary, and behavioral health care can limit unnecessary progression of disease or utilization of high-cost care settings
- There is a need for additional mapping of services and needs across systems and stakeholders
  - E.g., appropriate urgent care/ emergency services in rural areas, availability of psychiatric and long term care beds to avoid extended unnecessary hospital stays
- Opportunity exists in aligning across payers to maximize adoption of value-based delivery models, which could generate savings and/or improve care

NEXT STEPS

UPCOMING MILESTONES

- September – first public meeting
  - Statute described this as a hearing on "cost trends and barriers to health care affordability"
- October/November – Advisory Council "retreat"
  - To discuss policy options, to include speakers from other states and national thought leaders
  - Propose inviting members of the HCIFS and HHS Committees to join
- January 2024 – deliver first reports to HCIFS Committee
  - One report on the office's activities and updated analysis of spending trends
  - Separately provide a report responsive to specific policy areas in the 2022 amendment to the office's duties – likely an overview report focusing on goals and design considerations, no formal modeling

COUNCIL BUSINESS

- Setting a regular cadence for meetings
  - Second or third Tuesday of each month, early afternoon?
  - In-person, virtual, or hybrid?

- Electing a Chair & Vice Chair
  - Vote during August meeting
  - Chair and Vice Chair will work with the ED to set agendas for meetings, facilitate portions of Council meetings, and provide leadership in determining when and how the Council should take formal actions
  - Members interested in serving can self-nominate, or be nominated by another member
    - Please send an email to the group with nomination in advance of the meeting
  - Thoughts on process and any input on qualifications/expectations?

AUGUST MEETING AGENDA ITEMS

- Review September public hearing planning and agenda
- Discuss plans for fall "retreat" – policy topics, invited speakers, format
- Administrative business: votes on Chair/Vice Chair, bylaws and remote meeting policy, and signing of conflict of interest agreements
- Any other items?

APPENDIX: REVIEW OF OTHER STATE COUNTERPARTS

Structure and Activities

State & Office Name	General Structure	Activities
California - Office of Health Care Affordability	Office within the Department of Health Care Access and Information	Establishing a cost growth benchmark effective in 2025.
Colorado – Office of Saving People Money on Health Care	Executive office under the oversight of the Lieutenant Governor. Seems to coordinate activities across other department, especially DOI.	State requires Marketplace carriers to meet premium reductions for a set of standardized plans the state defines. If they are unable to, DOI steps in and caps prices for certain hospitals/services. Also implementing a hospital assessment fee for hospitals with outlier prices.
Connecticut – Office of Health Strategy	Executive branch agency	Created a consumer affordability index, coordinates data analysis and operations of the HIE and APCD, involved in health system planning processes, has implemented a cost growth benchmark program without penalties.
Delaware – Health Care Commission	Division of Department of Health and Social Services.	Tracking and monitoring performance for a cost growth benchmark program. Also involved in reinsurance waiver program, APM promotion work, and workforce/medical education.
Massachusetts – Health Policy Commission	Stand-alone state agency of significant size. Overseen by a Board of Commissioners.	Has an explicit mandate to oversee the cost growth benchmark program, which has been operational for several years and includes ability to require PIPs.
New Jersey – Office of Health Care Affordability and Strategy	A division of the Governor's Office.	Planning a health care cost growth benchmark.

State & Office Name	General Structure	Activities
Nevada – Patient Protection Commission	Commission staffed/supported by Department of Health and Human Services.	Working on implementing a health care cost growth benchmark established via executive order. Supporting legislative initiatives to prevent hospitals and freestanding EDs from "employing physicians" and a mandate related to interoperability.
Oregon – Health Policy Board	The Health Policy Board is the policy-making and oversight Board of the Oregon Health Authority.	Responsible, with other Departments, for implementation of a cost growth benchmark set by a legislatively created committee. Also has subcommittees/initiatives on primary care payment reform, health equity, and workforce.
Washington – Health Care Cost Transparency Board	Board staffed/facilitated by the Washington State Health Authority.	Has set a cost growth benchmark for 2022-2026. Currently collecting data on first year performance.