Consumers for Affordable Health Care
Advocating the right to quality, affordable health care for all Mainers.

mainecahc.org
PO Box 2490
Augusta ME 04338
1-800-965-7476

Testimony Neither For Nor Against LD 1878,
An Act to Establish a Managed Care Program for MaineCare Services
May 12, 2025

Senator Ingwersen, Representative Meyer, and honorable members of the Joint Standing Committee on Health and Human Services. I am Ann Woloson, Executive Director at Consumers for Affordable Health Care. I am here today to testify neither for nor against LD 1878, An Act to Establish a Managed Care Program for MaineCare Services.

Consumers for Affordable Health Care, a nonpartisan, nonprofit organization that advocates the right to quality, affordable health care for every person in Maine. As designated by Maine's Attorney General, CAHC serves as Maine's Health Insurance Consumer Assistance Program (CAP), which operates a toll-free HelpLine. Our HelpLine fielded nearly 7,300 calls and emails last year from people across Maine who needed help obtaining, keeping, using, or fixing problems with private health insurance or with accessing or affording health care services. CAHC also serves as the Ombudsman for Maine's Medicaid program, MaineCare, and helps people apply for and navigate the enrollment process for MaineCare. It is with that background that we provide these comments.

We respectfully submit this testimony, neither for nor against, LD 1878. The bill proposes to require the Department of Health and Human Services to establish a managed care program for MaineCare. It mandates a number of requirements: seeking approval from the federal government, developing the request for proposals and the procurement process, and establishing deadlines for enrolling specific categories of eligible enrollees in managed care.

While we understand the instinct and desire to reign in healthcare costs, we have some reservations about moving MaineCare to a managed care system in general, at this time and at the pace proposed by this bill.

A 2023 Kaiser Family Foundation study reported that five for-profit, publicly traded companies account for 50% of Medicaid Managed Care Organizations (MCOs) enrollment nationally. All five were ranked in the Fortune 500, and four were ranked in the top 100, with total revenues ranging from $32 billion to $324 billion in 2022.[1] While the profit margins may be changing some due to a decrease in Medicaid enrollment resulting from the end of "continuous eligibility" under Medicaid after the pandemic,[2] we believe that scarce resources, (public funding),allocated

[1] Experience of the Five Largest Publicly Traded Companies Operating Medicaid Managed Care Plans During Unwinding | KFF, April 2024.
[2] A Look at Medicaid Enrollment and Finances of the Five Largest Medicaid Managed Care Plans | KFF, Feb. 2025.

to support our health care providers and fund health care services for those who would otherwise be without coverage, should be used to do so, rather than for generating huge profits for the companies that "manage care" and their stock holders.

Again, while we understand the desire to reign in health care cost and improve service delivery, the ability of Managed Care to do so is mixed. In its 2023 Medicaid Managed Care and Outcomes Report, the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission asserts that "there is no definitive conclusion as to whether managed care improves or worsens access to or quality of care for beneficiaries."[3] The report details how Managed Care works compared to a traditional fee-for-service model where the state pays providers directly for covered services provided:. Under Managed Care:

- The state pays a managed care plan a capitation rate—a fixed dollar amount per member per month—to cover a defined set of services for each person enrolled in the plan.
- The plan pays providers for the Medicaid services an enrollee may require that are included in the plan's contract with the state.
- MCOs are at financial risk if spending on services and administration exceeds payments; conversely, they are permitted to retain any portion of payments not expended for covered services and other contractually required activities.

The report provides other interesting perspectives regarding the capitated payment MCO model suggesting that a set amount per enrollee, and not on how much treatment is provided, may create incentives to undertreat patients to minimize treatment costs and that capitated plans may also seek to enroll as many healthy patients as possible and discourage participation of disabled or high utilizing enrollees.[4]

Finally, the report describes how Incentives can be influenced by capitation payment rates. For example, adequate payments should be able to provide access to coordinated and effective care while generating savings that can support additional medically necessary services. On the other hand, if capitation rates are set too low, they may create incentives to restrict services through use of gatekeepers, preauthorization policies, or limits on benefits.[5]

We also want to highlight that there has been concern at the federal level about the accountability and transparency of Medicaid managed care organizations. A 2022 report by the Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS) indicated that states are failing to require essential reporting by MCOs and that consequently, the Centers for Medicare and Medicaid Services (CMS) does not know how hundreds of billions of Medicaid

---

[3] Managed care's effect on outcomes - MACPAC,9/12/23.

[4] Ibid

[5] Ibid

money is being spent by insurers nor how much value recipients and taxpayers are getting for the massive amount of spending through Medicaid (managed care).[6]

The concern by the OIG came two years after the Health Care Finance Administration released its guidelines to be used by State Medicaid Agencies, Fraud Control Units, and managed care organizations in preventing, identifying, investigating, reporting, and prosecuting fraud and abuse in a Medicaid managed care environment, and to better equip States with new measures and initiatives to protect against fraud and abuse in Medicaid managed care programs.[7]

Again, we are testifying neither for nor against this bill. We do understand the desire to create savings and seek efficiencies in our publicly funded health programs. The reality is, however, Medicaid's costs per beneficiary are substantially lower than for private insurance and have been growing more slowly than per-beneficiary costs under private employer coverage.[8] Historically, Medicaid has shown to be a much more efficient and cost effective than private insurance with administrative costs totaling less than about seven percent, less than half the private sector rate.[9]

We would urge the committee to think about the issues raised in our testimony along with other payment models shown to be successful in improving access to services that address costs, some of which Maine's Office of MaineCare Services have already explored, including Accountable Care Organization models, Primary Care Incentive Payments, bundled payment models, etc.

Given the uncertainty at the federal level and limited resources at the state level, we believe that managed care might be something worth considering. We believe however, that more time and effort should be given to exploring how MaineCare might benefit from various payment models that utilize its scarce resources more effectively, in the effort to become as efficient as possible, while adequately supporting Maine's health care providers and improving patient health outcomes. Should the committee decide to move forward with exploring managed care for MaineCare, we suggest that some consideration be put into utilizing nonprofit organizations to do so or to somehow create a proposal scoring preference for such entities.

Also, it is worth mentioning that the Department, several years ago, put much effort into working with various stakeholders in developing a patient-focused Medicaid managed care planning document that included a process for creating and monitoring quality measurements A review of that planning process and its results could be helpful to policy makers when contemplating moving forward with such an initiative again.

Thank you.

---

[6] U.S. Department of Health and Human Services, Office of Inspector General, "CMS Has Opportunities To Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios," September 22, 2022.

[7] https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/guidelinesaddressingfraudabusemedmngdcare.pdf

[8] https://www.cbpp.org/research/correcting-seven-myths-about-medicaid

[9] https://kffhealthnews.org/news/medicaid-true-or-false/