HEALTHCARE PURCHASER ALLIANCE OF MAINE

April 14, 2020

Senator Heather Sanborn, Co-Chair
Representative Denise Tepler, Co-Chair
Joint Standing Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333

Dear Senator Sanborn, Representative Tepler, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services,

I am writing to share with you some feedback from the Healthcare Purchaser Alliance (HPA) of Maine on ***LD 1196, An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health.***

The HPA is a purchaser-led organization whose mission is to advance healthcare value in Maine and support and incentivize the use of high-quality, affordable care. We have over 50 members, including some of the largest public and private employers and health trusts in Maine. Collectively, our members spend over $1 billion annually purchasing health coverage for nearly a quarter of the commercially insured people in the state.

We agree with Representative Zager that high-quality primary care can improve health and health outcomes—particularly through improved integration of behavioral health services. To that end, the HPA has a long track record of supporting increased investment in primary care over our organization's 25+ year history. At the same time, we believe it is essential that further investments in primary care be carefully deployed in ways proven to improve healthcare outcomes and value, and not increase downstream costs. And while we applaud the inclusion of language in Representative Zager's bill requiring that the increased primary care funding not raise total healthcare expenditures, we believe that, as currently drafted, the bill would likely increase total healthcare spend for Maine employers and consumers.

We understand from Representative Zager that LD 1196 is based on a similar program to increase primary care spending in Rhode Island. An analysis of that program—published in *Health Affairs* in 2019—found that increased primary care spending did not reduce total healthcare expenditures. We believe the results from Rhode Island can inform discussions about LD 1196.

As the *Health Affairs* authors note, after the new policy was implemented in Rhode Island, overall healthcare spending per enrollee in the state declined by 5.8 percent (net of increased primary care spending). While such savings are impressive, the authors did not attribute the reduction in spending to the increased investment in primary care. Instead, they conclude that the spending reduction was due to the price controls that were also implemented as part of Rhode Island's program:

> The decline in spending growth was driven by lower prices, rather than reduced utilization. There were no differential reductions in outpatient or inpatient utilization, nor in specialty visits or ambulatory care-sensitive hospitalizations, suggesting that increased non-FFS primary care coordination spending did not drive the reduction in spending growth. Rather, the timing of the decline and reduction in prices rather than utilization was concordant with the adoption of the

> price inflation caps and DRG-based payments in 2012 and 2013.[1] Thus, while a redistribution of funding towards primary care was achieved without net losses to payers, the reduction in FFS spending growth appears to be mostly attributable to the price controls in the Affordability Standards, rather than to the increased spending on non-FFS primary care.[2]

The authors do note that some types of primary care investments—such as those involving capitated or risk-based payments to providers—have been associated with lower utilization and spending. However, there were no such design constraints placed on the increased dollars provided to primary care practices in Rhode Island, and ultimately, the additional investment had no impact on utilization of inpatient, outpatient, or specialty care.

We are concerned that—as currently drafted—LD 1196 would not achieve the sponsor's objectives of increasing primary care investment without increasing total healthcare spend. The bill does not include any price control mechanism, which was essential to the overall spending reductions achieved in the Rhode Island program. Nor does it require that the additional primary care dollars be invested in a value-based manner that would reward quality outcomes and potentially lower total cost. Without those components, it is likely that LD 1196 will increase costs and reduce affordability for both Maine businesses and their employees. Maine employers and consumers are already facing unsustainable increases in healthcare costs that crowd out spending on other priorities, such as wages, and leave Maine consumers increasingly unable to afford care.

As noted above, we share Representative Zager's commitment to a state where every resident has affordable access to high-quality primary care that effectively manages patient care and results in superior health outcomes. But simply increasing primary care spending will not achieve those results. Additional investments must be designed to reward—and hold providers accountable for—high-value care and improved outcomes.

As LD 1196 moves through the legislative process, we hope that the committee, Representative Zager, and other stakeholders will consider the lessons from Rhode Island and explore ways to invest in primary care that meaningfully improve health care and health outcome and do not further increase already unsustainable healthcare costs.

Thank you for the opportunity to share our feedback on LD 1196. Please let me know if you have any questions or if I can be of further assistance. I can be reached at phayes@purchaseralliance.org or 844-8106.

Best,

Peter Hayes
President and CEO

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[1] Bailit Health Purchasing, LLC. *Assessment of the Rhode Island Office of the Health Insurance Commissioner's Affordability Standards* Providence, 2013, August. As referenced in Aaron Baum, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton, and Sanjay Basu, "Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers," *Health Affairs,* Vol. 38, No 2, 2019.

[2] Baum, Song, et al.