

**TASK FORCE ON
HEALTH CARE COVERAGE FOR ALL OF MAINE**

Meeting Agenda

May 23, 2018

1:00 pm to 4:30 pm

Room 220, Cross State Office Building

- ❖ Welcome and Introduction of Chairs and Members
- ❖ Review summary of April 2nd meeting
- ❖ Review Maine's Federal 1332 Waiver Application
- ❖ Update from the Structure of the Health Insurance Market Study Group
- ❖ Update from the Controlling Costs Study Group
- ❖ Update from the Public Options Study Group
- ❖ Discussion of Next Steps/Plans for Study Groups
- ❖ Public Comment (if time permits)
Comments should be responsive to updates from study groups and task force discussion

Task Force on Health Care Coverage for All of Maine

April 2, 2018

Draft Meeting Summary

Task Force Members Present:

Sen. Rodney Whittemore, Senate Chair; Rep. Heather Sanborn, House Chair; Sen. Brownie Carson; Sen. Geoff Gratwick; Rep. Anne Perry; Joel Allumbaugh; Jeff Austin; Mark Hovey; Dan Kleban; Kevin Lewis; Frank McGinty; Kris Ossenfort; and Trish Riley.

Task Force Members Absent: Sen. Eric Brakey; Rep. Paul Chace; Rep. Robert Foley

Staff: Colleen McCarthy Reid

Welcome and Introductions

The chairs of the task force, Sen. Whittemore and Rep. Sanborn, convened the meeting; members introduced themselves.

Summary of March 2nd Meeting

The task force briefly reviewed the summary of the March 2nd meeting.

Review of Survey

Staff reviewed the updated survey results with the task force. Thirteen of the 16 members have now responded to the survey. A summary of the survey responses is included with the meeting materials at: <http://legislature.maine.gov/doc/2235>

Members recognized that there is some common ground among the members, particularly with regard to reducing the cost of health care services and prescription drugs. The survey responses can be used by the study groups as a framework for discussion.

Study Groups

At the March 2nd meeting, the task force agreed and decided to form 3 study groups organized around the following topics: Controlling Costs; the Structure of the Health Insurance Market; and Public Options. The chairs considered preferences expressed by members and named the following members to each study group:

Structure of the Health Insurance Market Study Group: Rep. Anne Perry, Sen. Eric Brakey, Joel Allumbaugh, Kristine Ossenfort, Frank McGinty

Controlling Costs Study Group: Sen. Brownie Carson, Rep. Paul Chace, Jeff Austin, Trish Riley, Mark Hovey

Public Options Study Group: Sen. Geoff Gratwick, Rep. Bob Foley, Dan Kleban, Kevin Lewis

All of the study groups had the chance to meet by phone or in person before the task force meeting and provided these updates.

Update from the Structure of the Health Insurance Market Study Group

Joel Allumbaugh described the initial discussion of the Structure of the Health Insurance Market Study Group. The study group was able to meet once on March 26th and developed the following draft framework after their initial discussion.

The study group intends to focus on policy solutions that will target those populations within the existing market that are experiencing the most dysfunction and are most sensitive to premium increases. The study group acknowledged that current federal law and uncertainty related to the action/inaction of the federal government are significant barriers to any possible policy solutions. The underlying cost of health care also has an impact on the health insurance market so there will be overlap with the efforts of the Controlling Costs Study Group.

Some of the potential policy options that have been suggested, include:

- ❖ Development of a Section 1332 Waiver to resume operations of the Maine Guaranteed Reinsurance Association (MGARA);
- ❖ Statutory changes to MGARA, such as adding the ability to reinsure small group claims;
- ❖ Amend the definition of small group;
- ❖ Merge the individual and small group market;
- ❖ Segregate the individual market risk pool;
- ❖ Require an individual mandate to have health insurance coverage or consider other measures to incentivize the purchase of health insurance coverage;
- ❖ Consider state-level limits/restrictions on short-term health insurance policies;
- ❖ Consider impact of loss of federal funding to insurers for cost-sharing reductions.

The study group needs more time for brainstorming and to identify the pros and cons of each policy option, the barriers to implementation, the avenues for implementation and the group's position on each option before sharing with larger group.

Update from the Controlling Costs Study Group

Mark Hovey reported on the March 28th discussion of the Controlling Costs Study Group. The study group had a lively discussion and will learn a lot from each other; the group's goal is to develop a concrete outline for both long-term and short-term approaches to controlling costs.

The study group initially identified four areas of interest for further discussion:

1. Reduction of administrative costs in the billing/claim processes
2. Reimbursement/rate reform-- reasonable reimbursement to providers for services
3. Reduction of prescription drug costs/growth rate
4. Incentives to change behavior to avoid medical care cost--prevention

The study group intends to discuss these areas further to develop specific policy proposals. The task force acknowledged that reducing costs is needed, but a healthier population is the "silver bullet" for addressing costs in the long-term.

Update from the Public Options Study Group

Sen. Gratwick described the discussions of the Public Options Study Group; the group had the opportunity to meet twice before this meeting. Based on these initial discussions, the study group needs significant time to develop a concept for a new model of models for providing health care coverage to residents of Maine.

The study group has identified several important principles that must be incorporated into any model moving forward, including:

- ❖ System must be simpler and predictable
- ❖ Funded through contributions from all residents, including those receiving public benefits
- ❖ Coverage for all residents—everybody in
- ❖ Oversight through a centralized government trust or authority
- ❖ Coverage provided through existing carriers---retain competition among carriers on service and consumer engagement in health and wellness
- ❖ Provide agreed-upon “basic health plan” or uniform benefits package with supplemental coverage and benefits available
- ❖ Changes in reimbursement/payment model for health care providers to eliminate/reduce cost-shifting
- ❖ Reinsurance and risk adjustment for carriers
- ❖ Cost containment measures needed to bring down costs, including administrative costs and prescription drug costs
- ❖ Implement system for electronic sharing of individual health care data among carriers and providers---facilitate access to medical records/coverage information through single ID card

The study group acknowledged that any model would need careful actuarial analysis and study. The group also recognizes the difficult politics surrounding the enactment and implementation of such a model. Despite those challenges, the study group believes the system needs large scale and long-term reform.

Next Meeting

The next meeting will be scheduled sometime in May after further discussion by the chairs. Subsequently, the meeting was scheduled for May 23, 2018 at 1:00 pm.

The meeting adjourned at 3:25 pm.

Task Force on Health Care Coverage for All of Maine

On May 9, 2018, the State of Maine, through the Bureau of Insurance, applied for a Section 1332 State Innovation waiver to the United States Department of Treasury and the Centers for Medicare and Medicaid Services (CMS) within the federal Department of Health and Human Services. The request permitted under Section 1332 of the federal Affordable Care Act seeks a waiver of certain provisions of the ACA to permit reinstatement of the Maine Guaranteed Access Reinsurance Association (MGARA) for the 2019 plan year. If granted, the application would be effective January 1, 2019 for a period of 5 years, with an option for an additional 5-year renewal.

A copy of the executive summary and waiver application is attached. Also attached (green) is a copy of the laws governing MGARA.

The anticipated timeline for the waiver application process included in the application is excerpted below.

- 6/24/18: CMS determines application complete
- 8/1/18: CMS approves Sec. 1332 waiver
- 8/5/18: MGARA submits amended plan of operation to BOI for approval
- 8/22/18: Deadline for final determination of 2019 plan year rates
- 9/1/18: MGARA assessment notice sent to carriers for 2019 (quarterly)
- 12/31/18: First quarterly assessment due to MGARA
- 1/1/19: MGARA resumes operations
- 4/1/19: Federal government provides pass-through funding for 2019

**STATE OF MAINE
EXECUTIVE SUMMARY AND
APPLICATION FOR WAIVER
UNDER SECTION 1332 OF THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT**

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List of Exhibits

- A. Section 1332 State Innovation Waiver Actuarial Analyses and Certification and Economic Analyses, Milliman, Inc., March 20, 2018**
- B. Maine Guaranteed Access Reinsurance Association Plan of Operation**
- C. Maine Guaranteed Access Reinsurance Association Mandatory Ceding Conditions**
- D. Maine Bureau of Insurance Cost Report of Public Law Chapter 488, “An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program,” January 2018**
- E. 2017 Public Law Chapter 124, “An Act To Amend the Maine Guaranteed Access Reinsurance Act”**
- F. Notice of Public Comment Period**
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State of Maine
Executive Summary and
Application for Waiver under Section 1332
of the Patient Protection and Affordable Care Act

I. Executive Summary

A. Request. The State of Maine, through its Bureau of Insurance, Department of Professional and Financial Regulation (“State”) submits this Section 1332 State Innovation Waiver request to the United States Department of the Treasury and to the Centers for Medicare and Medicaid Services (“CMS”), a division of the United States Department of Health and Human Services (“HHS”). This request seeks waiver of Section 1312(c)(1) under Section 1332 of the Patient Protection and Affordable Care Act (“ACA”) for a period of five years beginning in the 2019 plan year to permit the reinstatement of Maine Guaranteed Access Reinsurance Association (“MGARA”), the State’s existing reinsurance program (described in the following section). This waiver will not affect any other provision of the ACA, but will result in lowering premiums and reducing federal payment of premium tax credits (“PTC”)

B. Background. Prior to the implementation of the ACA, Maine was a leader in state-level innovation designed to reduce Mainers’ healthcare costs and increase their access to affordable health coverage. The State’s flagship innovation was MGARA, a legislatively established private nonprofit organization operating a reinsurance program for the higher-risk segment of the State’s individual health insurance market. In 2013, MGARA’s presence limited what otherwise would have been a 22 percent rate increase to only a 2 percent increase. That highly successful program was placed in suspension with the advent of the ACA, to avoid the imposition of redundant costs on the Maine market through parallel federal and state reinsurance programs. The State now seeks a State Innovation Waiver under Section 1332 of the ACA (a “1332 Waiver”) to permit the reinstatement of this program and to build upon the State’s past health reform successes.

Under the proposed 1332 Waiver, Maine would restart the MGARA reinsurance program (the “State Program”) and receive federal pass-through funding in the amount of the savings that would be generated from the resulting reduction in PTC subsidies. The proposed 1332 Waiver would be effective January 1, 2019 for an initial period of five years, with an option to renew for an additional five years.

C. Basis for Request and Goal of Reinsurance Program. During the past few years, Maine’s individual health insurance market has undergone significant change. Community Health Options (“CHO”), the State’s Consumer Operated and Oriented Plan (CO-OP), has emerged as the State’s largest carrier serving the individual market. Anthem, formerly the State’s largest carrier serving the individual market, announced on September 27, 2017, that it would not be writing ACA plans in Maine for 2018. Premiums have increased significantly throughout the market, and we have seen the implementation of narrower provider networks by health carriers.

The restart of the State Program through the 1332 Waiver will bring increased certainty and stability to Maine’s individual health insurance market through a positive effect on premium

levels. By reinsuring high-cost claims, the State Program will spread risk across the broader Maine health insurance market, thereby lowering premiums. The program also spreads the most volatile component of the risk within the individual market, thereby providing stability. The program is also expected to encourage participation (or continued participation) by insurers in that market.

D. Impact of the State Program. Title 24-A M.R.S. §3953(1)(C) authorizes the Superintendent of Insurance (“Superintendent”) to develop a proposal for a 1332 Waiver to facilitate resumption of the State Program, and, upon approval by the Governor, to apply for the waiver and implement it upon federal approval. The Legislation conditions resumption of the State Program on the granting of a 1332 Waiver. Total funding for the State Program for 2019 is estimated to be approximately \$93 million (see funding model described in Section III below). The State estimates that the State Program will result in a net premium decrease of nine percent (9%) in 2019. Through this waiver request, Maine seeks federal pass-through funds – provided from the proceeds of net premium tax credit savings, estimated to be in excess of \$33 million per year through 2027 – to partially recoup expenditures made from assessments collected under state law.

E. Compliance with Section 1332. Granting the 1332 Waiver will not impact the comprehensiveness of coverage in the Maine insurance markets. As noted above, the waiver will reduce premiums and increase affordability. As a result, the State estimates enrollment in the individual market will increase by approximately 1.1 percent in 2019, 0.9 percent in 2020, and 0.3-0.8 percent in the eight years remaining in the ten-year budget cycle over what enrollment would be without MGARA¹ (see Exhibit A, Figure 1). Due to the resulting reduction in individual health insurance premiums, including premiums for the second-lowest-cost silver plan, the federal government will see a net reduction in spending of more than \$33 million for each year the five-year waiver and the State Program are in place.

II. Assurances of Compliance with Section 1332 Guardrails

The State anticipates that its proposal will meet the parameters set forth in Section 1332 of the ACA and provides the following assurances:

A. Comprehensive Coverage – 1332(b)(1)(A). The proposed waiver makes no alterations to the required scope of benefits offered in the insurance market in Maine and will not result in a decrease in the number of individuals with coverage that meets the ACA’s Essential Health Benefits requirements.

B. Affordability – 1332(b)(1)(B). The proposed waiver will not decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending. The waiver will not result in any decrease in affordability for individuals; on the contrary, the purpose of the waiver is to revive the State Program’s favorable effect on insurance rates in Maine’s individual market.

¹ Exhibit A, pp. 11-17.

C. Scope of Coverage – 1332(b)(1)(C). The proposed waiver will facilitate the provision of coverage to at least a comparable number of Maine residents as would be provided absent the waiver. The total estimated non-group enrollment increase resulting from the waiver is 1.1% in 2019 and ranges from 0.3% to 0.9% each year through 2028. Percentage enrollment increases are greatest for those persons not eligible for premium tax credits.

D. Federal Deficit Neutrality – 1332(b)(1)(D). The proposed waiver will not result in increased spending, administrative, or other expenses to the federal government. It requests pass-through payments that mirror the State Program’s reduction in federal PTC subsidies for which the federal government would otherwise be responsible, net of reductions in premium-based Exchange user fees.

E. Pass-Through Funding. Under the proposed waiver, the federal government would pass through to the State, as contemplated by Section 1332(a)(3) of the ACA, its cost savings resulting from the State Program’s positive effect on premium rates and corresponding reduction in the amount of PTC that would otherwise be claimed by many individual market participants in Maine in a given calendar year.

F. Effect on Federal Operational Considerations. The proposed waiver requests no changes to Maine’s federally-facilitated exchange (the “Exchange”) or treatment by the Internal Revenue Service.

G. Public Notice. The proposed waiver has been publicly posted, public information and comment hearings were held, and public comments were solicited in compliance with 31 CFR 33.112 and 45 CFR 155.1312. Postings on-line met national standards to assure access to individuals with disabilities.

III. Background and Description of Maine’s Health Insurance Market

A. Background: Maine’s Individual Market Reinsurance Program. MGARA is a key component of the reforms originally instituted in May 2011, when the Maine State Legislature passed 2011 Public Law Chapter 90, “An Act To Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services” (“PL90”). During its period of active operation (prior to suspension of operations due to the transitional reinsurance provided under the ACA), MGARA reduced insurance costs in Maine’s individual health insurance market by providing reinsurance for a significant portion of the coverage provided through individual health insurance policies. If the 1332 Waiver request is granted, MGARA’s re-activation is intended to again reduce insurance costs in Maine’s individual health insurance market through operation of its reinsurance program.

Over MGARA’s period of active operation (2012 and 2013), MGARA paid approximately \$66 million in claims and generated a positive fund balance of approximately \$5 million. Based on rate filings submitted by insurance carriers operating in Maine’s individual market, the State Program generated an approximate **20% reduction in requested rates**. By way of example, Anthem Health Plans of Maine, Inc.’s (“Anthem”) 2013 rate filing sought a rate increase of 1.7%. Anthem projected that without the State Program, its 2013 rate increase would have been 21.6%.

Despite this success, the State Program was rendered redundant during the pendency of the federal transitional reinsurance program (the “Federal Program”) established by HHS under the ACA. Both programs offered reinsurance for the individual health insurance market in Maine, subsidized by broad-based assessments on the entire health benefit market. Although there were differences between the structures of the two programs, the Federal Program served essentially the same functions as MGARA and there was substantial overlap in the benefits that would have been paid to ceding insurers. Accordingly, MGARA suspended all but limited administrative operations effective January 1, 2014, to avoid imposing redundant costs on the Maine market through parallel federal and state individual market reinsurance programs.

The Federal Program ended as scheduled on December 31, 2016. Cognizant of the success of its pre-ACA health reform efforts and the unfavorable rate effects associated with the absence of any individual market reinsurance program in the State, Maine seeks to reinstate the State Program. By this Application, Maine seeks a 1332 Waiver pursuant to the provisions of Section 1332 of the Act, as discussed below.

PL90 established a four-part funding mechanism to spread the costs associated with the MGARA reinsurance program across the individual, group, and self-insurance markets. Under the proposed waiver, pass-through funds received by the State would be contributed to MGARA as a fifth revenue source, further enhancing its ability to make insurance more affordable for Maine residents and increase market stability for insurers. The funding sources are described in the following table.

Table 1

<u>Funding Mechanism</u>	<u>Description</u>
Organizational Assessment	One-time nominal \$500 fee for each insurer licensed in 2012 for medical insurance, whether or not active in that market (not applicable prospectively)
Base Market Assessment	Assessment to health insurers and third-party administrators based on the number of insured lives covered by each in the Individual, Small Group, Large Group, and Self-insured Markets (excluding State and Federal employees), at a rate of up to \$4 per covered person per month (“PMPM”)
Reinsurance Premium	Insurers ceding covered persons to MGARA pay a ceding premium, currently set at 90% of the premium received from the enrollee
Deficit Assessment	Optional Assessments to cover any Net Losses — up to a maximum of \$2 PMPM

	assessed to health insurers based on the number of insured lives covered by each
Pass-Through Funding	Under the proposed waiver, all pass-through funds will be contributed to MGARA to enhance its capabilities.

The definition of “insurer” includes any insurance company, nonprofit hospital and medical service organization, fraternal benefit society, health maintenance organization, non-ERISA self-insured employer, third-party administrator, multiple employer welfare arrangement, health reinsurer, health insurance captive, and any other State-sponsored health benefit program, whether fully insured or self-funded.

The MGARA Board of Directors retained Milliman, Inc. (“Milliman”) to perform the economic and actuarial modeling contained in this Application. Milliman’s Report to the Board is Exhibit A to this Application.

The current MGARA Plan of Operation is attached hereto as Exhibit B. A revised Plan of Operation will be finalized by the Board following approval of the 1332 Waiver. The revised Plan will incorporate updated payment parameters and coverage ceding processes as described below, and will be consistent with the existing Plan of Operation in most other material respects.

The State Program provides reinsurance for policies covering high-risk individuals, as identified by medical diagnosis or by the insurance carrier’s underwriting judgment. When the carrier cedes a policy to MGARA, it operates like a traditional reinsurance program: the ceding carrier pays MGARA a premium, and in return, MGARA pays a portion of the carrier’s claims if they exceed the specified attachment point. When reactivated in 2019, MGARA will collect a reinsurance premium for each ceded policy that is equal to 90% of the underlying insurance premium, and reimburse the ceding carrier for eligible claims incurred during the year under the policy, at the following levels:

- 90 percent of claims paid between \$47,000 and \$77,000; and
- 100 percent of claims paid in excess of \$77,000, net of amounts recoverable from a federal high cost risk pool (60% of claims over \$1 million in 2019).

The Board determines the reinsurance premium, the attachment points, and the list of medical conditions for which ceding is mandatory.² The ceding carrier has the responsibility, under both the statute and the Plan of Operation, to manage reinsured claims in the same manner as it manages claims that are paid from the carrier’s own funds.

² 24-A Me. Rev. Stat. §§ 3958 & 3959(2). MGARA’s enabling legislation specifies the attachment points to be used in 2012, but grants the Board the power to adjust the attachment points annually to reflect increases in costs and utilization.

Eligible claims are only those amounts that are actually paid by a ceding carrier for benefits provided to the individual. Eligible claims do not include such things as administrative expenses, attorneys' fees, or non-medical benefits. The ceding carrier's maximum exposure for any reinsured individual in a single calendar year is \$50,000 (100% of the first \$47,000 plus 10% of the next \$30,000).

MGARA has unlimited exposure to \$1 million per calendar year for all eligible claims on ceded policies in excess of the exposure retained by the ceding carrier. In its 2018 Notice of Benefit and Payment Parameters, CMS made changes to the ACA risk adjustment program to include a high-cost risk pooling mechanism, under which carriers are reimbursed 60% of claim costs above \$1,000,000 for members whose claims exceed that threshold. The current claim threshold of \$1,000,000, set for the 2019 benefit year via recently finalized regulations, is subject to adjustment through rulemaking. Although the MGARA Board of Directors has not yet formally adopted a change in response to this development, based on conversations with MGARA's General Counsel, the Bureau of Insurance anticipates the MGARA program will coordinate with the federal risk adjustment program; for example, with respect to claims that exceed the federal pooling threshold (currently \$1,000,000), the federal risk adjustment program could pay 60% and the MGARA program could pay 40%.

Under the MGARA program, there are currently eight designated medical conditions which require ceding of coverage. A list of the eight conditions is attached as Exhibit C. Carriers may voluntarily cede other coverage to MGARA. The 90% ceding premium was actuarially determined to be sufficient to support anticipated levels of mandatory and voluntary ceding. Together with the ceding carrier's retained risk, it has operated as a sufficient deterrent to excessive voluntary ceding.

During MGARA's operations in 2012–13, it had reinsured 90% of claims paid on ceded policies from \$7,500 to \$32,500 and 100% of claims in excess of \$32,500. When setting the revised payment parameters for 2019, Milliman and the Board considered the significant differences in the Maine insurance market between 2013 and present, including lower deductibles, mandatory prescription drug benefits, increases in medical trend, changes in benefit design, and a significantly larger individual market. They modeled potential adjustments in attachment points, ceding premiums, and mandatory ceding conditions to determine the optimal way to provide premium relief and market stability while assuring the solvency of the program. Other factors, in particular the maximum assessment of \$4 per member per month, are fixed by MGARA's enabling legislation. Based on the Milliman modeling and Board's consideration of alternatives, it was determined that the original eight ceding conditions remained optimal, that increasing ceding premiums above 90% was not necessary, and that the proposed increases in the attachment points will be sufficient to address MGARA's financial needs.

During MGARA's 2012-13 operations, carriers were able to evaluate coverage eligible or suitable for ceding to MGARA on the basis of a health statement collected at the time of application for insurance. Because the large majority of Maine's individual insurance market is now enrolled through the federally-facilitated Exchange (also known as "the Marketplace") and no health information is collected there, MGARA's reliance on health statements is no longer feasible. MGARA will be replacing reliance on the health statement with mandatory ceding

based on carriers identifying policies with ICD 10 codes associated with the mandatory ceding conditions. Mandatory ceding will be able to occur at any point in the year with reinsurance retroactive to the beginning of the policy year with respect to both coverage and premium. Discretionary ceding will remain subject to procedures set forth in MGARA's Plan of Operation. Discretionary ceding will be allowed only during the first 60 days following the effective date of the underlying primary coverage, thereby minimizing the opportunity for carriers to cede mid-term policies on which adverse claims experience has developed.

The changes in ceding procedures described above will require changes in MGARA's Plan of Operation prior to its January 1, 2019 reactivation. Proposed changes in the Plan of Operation must be filed with and approved by the Superintendent of Insurance.

B. Characteristics of Maine's Health Insurance Market.

Maine's individual market has grown significantly in the last several years, from approximately 28,500 individuals in 2013 to over 85,000 in 2017 and 78,000 as of February, 2018. Approximately 90% of the individual market is insured through the Exchange. A very high percentage of the individual market (estimated at 78%) qualifies for federal Premium Tax Credit (PTC) subsidy, with 51% of the individual market at less than 250% of the federal poverty level (FPL) and 27% between 250% FPL and 400% FPL. Approximately 73% of the Exchange individual market is enrolled in Silver Plans. Maine's individual coverage rates were increased by approximately 23% in 2017 (the first year following the cessation of the Federal Program), and again by approximately 32% in 2018. This reflects, among other things, the continued absence of an individual market reinsurance program in Maine following the cessation of the Federal Program. Granting of the 1332 Waiver is required in order to restart the State Program.³

Maine's small employer health insurance market has declined over the years from approximately 94,000 insured lives in 2013 just before implementation of the Affordable Care Act to approximately 60,000 in 2018. This is partly due to self-employed individuals becoming ineligible for small group coverage, but most of the market attrition is due to other structural factors, including large premium increases in the small group market, the availability of subsidized alternatives in the individual market, and changes in the age rating methodology. Both small and large employers expressed concern during the public comment period about the cost of reinstating MGARA's \$4 per member per month assessment. However, Milliman's modeling estimates this cost to be less than 1% of the total cost of employer-sponsored insurance in Maine.⁴

Maine has been active in seeking to control health care costs. The Maine Health Data Organization maintains "Compare Maine" (www.comparemaine.org), a website which provides the public with comparative health care cost and quality information for a wide variety of medical procedures. Recent legislation addressing costs includes 2017 Public Law

³ 24-A Me. Rev. Stat. § 3953(1)(A)(1).

⁴ Exhibit A, p. 19

Ch. 232, “An Act To Encourage Maine Consumers to Comparison-shop for Certain Health Care Procedures and to Lower Health Care Costs,”⁵ which when fully implemented in 2019 will encourage group insurance enrollees to use lower-cost health care providers by requiring carriers to return a portion of the savings to consumers when the actual cost of the service is less than the average cost. Another recent law, 2015 Public Law Ch. 488, “An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Monitoring Program,”⁶ enacted stringent limitations on the ability of health care practitioners to write opioid prescriptions. Although this law was enacted as an opioid abuse measure rather than a cost control measure, a January 2018 Maine Bureau of Insurance study of initial results found that insurance carriers spent \$2.4 million (46.7%) less on opioid and opioid derivative claims in the first half of 2017 than in the first half of 2016. Health plan members spent nearly \$580,000 (36.9%) less in out-of-pocket costs during the same time periods. A copy of the study is attached as Exhibit D.

IV. Description of Proposed 1332 Waiver

As described above, during its period of operation, the State Program brought a rapid and dramatic improvement in individual market premiums in the State. A 1332 Waiver will permit the resumption of the State Program and apply its ameliorative effect to the high rates that have characterized the ACA market.

A. Overview. As contemplated by Section 1332, the State proposes to apply the federal funding that would have been paid to Maine Exchange participants absent the State Program, as pass-through payments under Section 1332(a)(3) of the ACA (“Pass-Through Payments”). This funding would be combined with MGARA’s existing funding mechanism to support and enhance the State Program’s continued ameliorative impacts on Maine’s individual market insurance rates. Without a reinsurance program, individual health insurance premiums will continue to rise at an unsustainable rate. Consequently, more Mainers will choose or be forced to go without health insurance, further driving up rates due to adverse selection and provider cost shifting. By re-implementing the State Program, Maine will reduce the potential for further market disruption, lower the cost of individual premiums, and decrease federal government PTC obligations.

Exhibit A, Figure I-5D(ii) shows that, after factoring in the 1332 Waiver and the re-implementation of the State Program, average 2019 federal PTC payments are estimated to be \$500 per member per month. Exhibit A, Figure I-5D(iii) also shows that without the 1332 Waiver and the State Program, 2019 federal PTC payments will be an estimated \$65 per member per month higher.

In order to reestablish the State Program, Maine seeks federal pass-through funds in the amount the federal government would have otherwise paid in PTC absent consideration of the reinsurance payments in the premiums paid by insureds in the individual market. By mitigating high-cost individual health insurance claims, the State Program will help to stabilize Maine’s

⁵ 2017 Public Law of Maine Chapter 232.

⁶ 2015 Public Law of Maine Chapter 488 (enacted in 2016).

individual market and make premiums more affordable. With the 1332 Waiver in place and State Program in operation, Maine anticipates that individual premiums, including premiums for the second-lowest-cost silver plan, will be lower, net of the premium assessment, by 9% in 2019, 9.4% in 2020, and in the 8–9% range for 2021 through 2028 than they would have been without the 1332 Waiver and re-implementation of the State Program.

The following snapshot illustrates the projected benefits of resumption of the State Program under the proposed 1332 Waiver:

Table 2

Source	Baseline	Waiver/State Program
2019 Premium	\$683 PMPM	\$618 PMPM
2019 Enrollment	61,000	62,100

B. Need for the Waiver

The proposed 1332 Waiver would resolve an unintended consequence of the interface between the ACA and the State Program. The State Program, by reducing premiums in the individual market, will decrease the PTC amount that Maine’s Exchange participants have the right to receive. Section 1332 of the ACA was enacted to recognize the federal government’s continuing obligation to provide equivalent funding in such situations. The reduced PTC amount represents a measurable loss of federal support to Maine’s insurance market, compared to the amount that would otherwise be received by Exchange participants in Maine in a given calendar year absent the State Program.

C. Impact if Waiver is Not Granted

Absent a Section 1332 Waiver, even if the law had permitted the resumption of the State Program, it would almost certainly remain in suspension. This is because, if operated without a 1332 Waiver, the State Program would impose costs on the Maine insurance market without the materialization of a corresponding market benefit, as outlined above. Maine has already experienced average annual individual market rate increases of 23% in 2017 and 32% in 2018 since the suspension of MGARA and the cessation of the federal transitional reinsurance. These increases are expected to continue and, indeed, intensify. If a 1332 Waiver is granted and the State Program resumes, it is anticipated that approximately 300 to 1,100 additional individuals will have access to affordable coverage due to the lower cost of health insurance through MGARA’s ameliorative effect on rates.

D. Legislation

2017 Public Law Chapter 124, “An Act To Amend the Maine Guaranteed Access Reinsurance Act,” authorizes the State Superintendent of Insurance to develop a proposal for a 1332 Waiver to facilitate resumption of the State Program, to apply for the proposed waiver upon approval by the Governor, and to implement the waiver if it receives federal approval. Consistent with

the rationale articulated above, the Legislation conditions resumption of the State Program on the granting of a 1332 Waiver. A copy of the Legislation is attached as Exhibit E hereto.

E. Pass-Through Funding and Tax Credit Proposal; Section Impacted by Waiver

Consistent with Section 1332(a)(3) of the ACA, the State requests that the aggregate amount of credits and reductions that would have been paid on behalf of Maine Exchange participants absent the resumption of the State Program, be paid to the State for the purposes of implementing the State Program under the 1332 Waiver. Table II-1 of the actuarial analysis (Exhibit A) projects a net reduction in federal expenditures of approximately \$33 million in 2019 under a resumption of the State Program, and accordingly this amount is requested in the form of federal Pass-Through Payments. These funds will be leveraged by the State Program to further augment its beneficial effects on Maine's individual health insurance rates. The implementation of the State Program directly affects the cost of the baseline plan as defined in Section 36B(b)(3)(B) of the Internal Revenue Code, and it alters the rating calculations mandated under the regulations implementing Section 1312(c)(1) of the ACA, which requires "all enrollees in all health plans ... offered by [an] issuer in the individual market ... to be members of a single risk pool." In order to allow the benefits of MGARA to be fully realized through the rate-setting process, Maine seeks a waiver of Section 1312(c)(1) to the extent that it would otherwise require excluding expected reinsurance payments, ceding premiums, or assessments when establishing the marketwide index rate. Consideration of these payments will lower the marketwide index rate. A lower index rate will lower premiums for Maine's second lowest-cost silver plan, which will reduce the overall PTC that the federal government is obligated to pay to subsidy-eligible consumers.

F. Effect on ACA Sections that are Not Proposed to be Waived

No other section of the ACA would be affected by the proposed 1332 Waiver.

V. Actuarial Analyses and Certifications

A. Coverage Comparability

Actuarial analysis modeling included in this Application estimates that MGARA will result in a lower number of uninsured Mainers each year than in the baseline scenario in which MGARA is not reactivated. The analysis estimates that MGARA will not have any material impacts on the number of Mainers covered under employer-sponsored plans, traditional Medicaid, Medicare, or other public programs. For the duration of the projection period, the analysis estimates approximately 300 to 1,100 additional annual enrollees in the non-group market relative to the non-MGARA scenario.

B. Affordability of Coverage

MGARA is not estimated to impact premium rates materially for employer-sponsored insurance. A state-based assessment of \$4 per member per month on commercial insurers and

group health plans administered by third party administrators will be reimplemented as partial funding for MGARA. The modeling estimates this assessment will be less than 1% of an average employer's premium rate. There will be no impact on public programs such as Medicare and Medicaid. For the non-group market, there is an estimated 9% aggregate premium reduction relative to what rates would be without the waiver. Similar premium reductions are projected for each year through 2028. Net impact on any individual insured will vary greatly depending on his or her household income and interaction with the ACA's premium assistance program.

C. Scope and Comprehensiveness of Coverage

Because MGARA makes no change to insurer benefit requirements for plans offered in Maine's health insurance markets, MGARA meets the comprehensiveness requirements required for a Section 1332 waiver.

VI. Implementation Plan and Timeline

The State Program will be re-implemented by MGARA under the supervision of the Superintendent and the Maine Bureau of Insurance ("MBOI") in accordance with an amended Plan of Operation to be filed with the Superintendent for approval at the time the waiver is granted.⁷

- 06/02/17: Legislation enacted.
- 4/2/18: The public comment period begins.
- 4/13/18: Second public comment hearing is held.
- 5/2/18: The public comment period ends.
- 5/4/18 Tribal consultation period ends
- 5/9/18: The 1332 waiver application is submitted to the federal government.
- 6/24/18: The federal government determines that the waiver application is complete.
- 8/1/18: CMS approves 1332 Waiver for State Program.
- 8/5/18: Amended MGARA Plan of Operation approved by Superintendent of Insurance.
- 8/22/18 Deadline for final determination of 2019 rates.
- 9/1/18: MGARA assessment notice to insurers for 2019 operations, to be paid quarterly.
- 12/31/18: Insurers pay first quarterly assessment to fund the State Program.
- 1/1/19: MGARA commences operation, including reporting to CMS or other federal agency or authority.
- 4/1/19: The federal government funds the pass-through payments to the State Program for 2019.

⁷ MGARA's current Plan of Operation is attached as Exhibit B. Proposed amendments to the Plan are described in this Application.

VII. Additional Information

A. Administrative Burden. The 1332 Waiver will cause minimal administrative burden and expense for Maine and for the federal government. The waiver will cause no additional administrative burden to employers and individual consumers because the State Program does not relate to the administrative functions or requirements typically undertaken by employers or individuals. Individual health insurers will see no additional administrative burden associated directly with the 1332 Waiver. Individual health insurers will experience additional administrative burden and associated expense as a result of the operation of the State Program resulting from ceding of policies and submission of reinsurance claims; however, the 1332 Waiver itself will not result in any additional administrative burden or cost, and the monetary benefit from the State Program's reinsurance will far exceed any resulting administrative expense.

MGARA and the MBOI, collectively, have the resources and staff necessary to absorb the following administrative tasks that the 1332 Waiver will require the state to perform:

- Administer the State Program
- Collect and apply federal pass-through funds
- Monitor compliance with federal law
- Collect and analyze data related to the 1332 Waiver
- Perform reviews of the implementation of the 1332 Waiver
- Submit annual reports (and quarterly reports, if ultimately required) to the federal government

The 1332 Waiver will require the federal government to perform the following administrative tasks:

- Review documented complaints, if any, related to the 1332 Waiver.
- Review state reports.
- Periodically evaluate the state's 1332 Waiver program.
- Calculate and facilitate the transfer of pass-through funds to the State.

Maine believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government, so that their effect should be insignificant. The 1332 Waiver does not necessitate any changes to the Federally-Facilitated Marketplace and will not affect how PTC or cost-sharing reduction payments are calculated or paid.

B. Impact on Residents Who Need to Obtain Health Care Services Out-of-State. The vast majority of Maine residents receive healthcare services from Maine-based providers. Maine does share a border with New Hampshire, and is not far from Boston, which is a center for advanced health care facilities; however, insurer service areas and networks that cover border areas generally are serviced through Maine-based providers and insurers' networks make adequate provision for any service required in New Hampshire or Massachusetts. Granting the 1332 Waiver request will not

affect insurer networks or service areas that provide coverage for services performed by out-of-state providers.

C. Ensuring Compliance; Preventing Waste, Fraud, and Abuse. MGARA is required under its enabling legislation to annually prepare comprehensive financial accounting statements audited by an independent certified public accountant and file the audited statements with the Superintendent and the Joint Standing Committee on Insurance and Financial Services of the Maine Legislature. The independent certified public accountant is required to make an annual review of MGARA's solvency, and submit that review to the Superintendent. The Superintendent has authority to order MGARA to charge additional assessments, as necessary to maintain solvency. MGARA is also required to report annually to the Joint Standing Committee on Insurance and Financial Services of the Maine Legislature regarding its operations and financial condition. MGARA and the Maine Bureau of Insurance will administer the State Program in accordance with its existing accounting, auditing, and reporting procedures. Auditing and reporting obligations of participating insurers are governed by MGARA's Plan of Operation and State rules and regulations.

The Maine Bureau of Insurance is responsible for regulating and ensuring regulatory compliance and monitoring the solvency of MGARA and all insurers; performing market conduct analysis, examinations, and investigations; and providing consumer outreach and protection. The Maine Bureau of Insurance investigates all complaints that fall within its regulatory authority.

The federal government is responsible for calculating the savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

D. State Reporting Requirements and Targets. The Maine Bureau of Insurance will submit the required quarterly, annual, and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive requirement, and the federal deficit requirement, in accordance with 45 CFR 155.1308(f)(4).

As required, the State will hold public meetings six months after the proposed 1332 Waiver is granted and annually thereafter. The date, time and location of each forum will be posted on the MGARA website and the Bureau of Insurance website. The division will also notify consumer and business advocacy organizations. Each meeting will be conducted at a site that allows both in-person and telephonic attendance to accommodate residents across the State.

The Maine Bureau of Insurance will assume responsibility for the reporting requirements of 45 CFR 155.1324, including the following:

- Quarterly reports [45 CFR 155.1324(a)]: To the extent required, the Maine Bureau of Insurance will submit quarterly reports, including reports of ongoing operational challenges, if any, and plans for, and results of, associated corrective actions.

- Annual reports [45 CFR 155.1324(b)]: MBOI will submit annual reports documenting the following:
 - (1) The progress of the waiver.
 - (2) Data on compliance with Section 1332(b)(1)(B) through (D) of the ACA.
 - (3) Modifications, if any, to the essential health benefits for compliance with Section 1332(b)(1)(A) of the ACA.
 - (4) The premium for the second lowest-cost silver plan under the waiver and an estimate of the premium as it would have been without the waiver for a representative consumer in each rating area.
 - (5) A summary of the annual post-award public forum required by 45 CFR 155.1320(c) together with a summary of action taken in response to public input.
 - (6) Any additional information required by the terms of the Section 1332 Waiver.

MBOI will submit and publish annual reports by the deadlines established in 45 CFR 155.1324(c) or the deadlines established by the terms of the 1332 Waiver.

VIII. Public Comment and Tribal Consultation

A. Public Comment. On March 30, 2018, MBOI opened public comment on this 1332 Waiver request and posted notice of the opportunity to comment on the MBOI website and the MGARA website. On the same day, MBOI sent notice via govdelivery to its list of interested parties and stakeholders. The Notice issued is attached as Exhibit F. The list comprises more than 1500 individuals and organizations with an expressed interest in insurance-related matters.

On April 12 and 13, 2018 MBOI held public comment and information sessions in Bangor and Portland, Maine. These sessions were lightly attended and nearly all attendees were representatives of various stakeholders. Attendees included a representative of the Maine Chamber of Commerce, a representative of the Eastern Maine Health Care system, several representatives of health plans, a representative of a consumer group, an insurance producer, a legislator, and one unaffiliated member of the general public. Two members of the MGARA Board of Directors and its General Counsel attended the Portland meeting. The Superintendent of Insurance utilized a PowerPoint presentation to present the proposal and facilitate discussion during each meeting. The PowerPoint is attached as Exhibit G to this Application. Two major points were raised by attendees during the sessions: (1) reinsurance programs such as the one proposed, like any other insurance affordability initiative, redistribute the funding resources within the health care cost payment system but do not address underlying high health care costs; and (2) reinstatement of the \$4 per member per month assessment is of concern to the employer representatives who spoke, though they acknowledged that similar assessments were levied by

MGARA in 2012–13 and by the federal transitional reinsurance program from 2014–16.

A thirty-day public comment period was held from April 2, 2018 through May 2, 2018. Written comments were received from the following nine interests:

- American Lung Association;
- American Cancer Society Cancer Action Network
- American Heart Association & American Stroke Association
- Anthem Blue Cross/Blue Shield
- Epilepsy Foundation & Epilepsy Foundation New England
- Maine Association of Health Plans
- Maine Hospital Association
- Maine State Chamber of Commerce, and
- National Multiple Sclerosis Society

These comments are set forth as Exhibits H-1 to H-9 to this Application.

B. Tribal Consultation

Maine has four federally-recognized tribes, the Aroostook Band of Micmacs, the Houlton Band of Maliseets, the Passamaquoddy Tribe and the Penobscot Nation. Representatives of each of these tribes were contacted, information about the proposal was provided and consultation with or comments from the tribes were solicited. No comments were received from any of the tribes. Communications with each tribe are set forth as Exhibit I-1 to I-4 of this Application.

Maine Revised Statutes
Title 24-A: MAINE INSURANCE CODE
Chapter 54-A: MAINE GUARANTEED
ACCESS REINSURANCE ASSOCIATION ACT

§3953. MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

1. Guaranteed access reinsurance mechanism established. The Maine Guaranteed Access Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business in the State, an insurer that has issued or administered medical insurance within the previous 12 months or is actively marketing a medical insurance policy or medical insurance administrative services in this State must participate in the association. The Dirigo Health Program established in chapter 87 and any other state-sponsored health benefit program shall also participate in the association. Unless an earlier resumption of operations is ordered by the superintendent in accordance with paragraph A, operations of the association are suspended until December 31, 2023 except to the extent provided in section 3962 and the association may not collect assessments as provided in section 3957, provide reinsurance for member insurers under section 3958 or provide reimbursement for member insurers under section 3961 as of the date on which a transitional reinsurance program established under the authority of Section 1341 of the federal Affordable Care Act commences operations in this State.

A. If the board proposes a revised plan of operation that calls for the resumption of operations earlier than December 31, 2023 and the superintendent determines that the revised plan is likely to provide significant benefit to the State's health insurance market, the superintendent may order the association to resume operations in accordance with the revised plan. This paragraph applies only if:

- (1) An innovation waiver under Section 1332 of the federal Affordable Care Act as contemplated by paragraphs B and C is granted; or
- (2) The federal Affordable Care Act is repealed or amended in a manner that makes the granting of an innovation waiver unnecessary or inapplicable. [2017, c. 124, §1 (NEW) .]

B. After consulting with the board and receiving public comment, the superintendent may develop a proposal for an innovation waiver under Section 1332 of the federal Affordable Care Act that facilitates the resumption of operations of the association in a manner that prevents or minimizes the loss of federal funding to support the affordability of health insurance in the State. [2017, c. 124, §1 (NEW) .]

C. With the approval of the Governor, the superintendent may submit an application on behalf of the State in accordance with the proposal developed under paragraph B for the purposes of resuming operations of the association to the United States Department of Health and Human Services and to the United States Secretary of the Treasury to waive certain provisions of the federal Affordable Care Act as provided in Section 1332. The superintendent may implement any federally approved waiver. [2017, c. 124, §1 (NEW) .]

[2017, c. 124, §1 (AMD) .]

2. Board of directors. The association is governed by the Board of Directors of the Maine Guaranteed Access Reinsurance Association established under Title 5, section 12004-G, subsection 14-H.

A. The board consists of 12 members appointed as described in this paragraph:

- (1) Seven members appointed by the superintendent: 2 members chosen from the general public and who are not associated with the medical profession, a hospital, an insurer or a producer; 2 members who represent medical providers; one member who represents individual health insurance consumers who is not associated or formerly associated with the medical profession, a hospital,

an insurer or a producer; one member who represents a statewide organization that represents small businesses; and one member who represents producers. A board member appointed by the superintendent may not be removed without cause; and

(2) Five members appointed by the member insurers, at least one of whom is a domestic insurer and at least one of whom is a 3rd-party administrator. [2013, c. 273, §2 (AMD) .]

B. Members of the board serve for 3-year terms. Members of the board may serve up to 3 consecutive terms. [2011, c. 90, Pt. B, §8 (NEW) .]

C. The board shall elect one of its members as chair. [2011, c. 90, Pt. B, §8 (NEW) .]

D. Board members may be reimbursed from funds of the association for actual and necessary expenses incurred by them as members but may not otherwise be compensated for their services. [2011, c. 90, Pt. B, §8 (NEW) .]

E. The board shall establish regular places and times for meetings and may meet at other times at the call of the chair. The board shall post notice of scheduled meetings, meeting agendas and minutes of meetings on a publicly accessible website maintained by the association. [2013, c. 273, §3 (NEW) .]

F. The board shall establish a mechanism on its publicly accessible website for the public to submit comments on matters related to the operations of the association. [2013, c. 273, §3 (NEW) .]

G. The board shall establish a process for taking public comment at selected board meetings to be held at such time and place as the board may determine. The opportunity for public comment must be made available not less often than quarterly. Except as specified in this paragraph, meetings of the board are not open to the public. [2013, c. 273, §3 (NEW) .]

[2013, c. 273, §§2, 3 (AMD) .]

3. Plan of operation; rules. The board shall adopt a plan of operation in accordance with the requirements of this chapter and submit its articles, bylaws and operating rules to the superintendent for approval. If the board fails to adopt the plan of operation and suitable articles and bylaws within 90 days after the appointment of the board, the superintendent shall adopt rules to effectuate the requirements of this chapter and those rules remain in effect until superseded by a plan of operation and articles and bylaws submitted by the board and approved by the superintendent. Rules adopted by the superintendent pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 90, Pt. B, §8 (NEW) .]

4. Immunity. A board member is not liable and is immune from suit at law or equity for any conduct performed in good faith that is within the scope of the board's jurisdiction.

[2011, c. 90, Pt. B, §8 (NEW) .]

SECTION HISTORY

2011, c. 90, Pt. B, §8 (NEW). 2013, c. 273, §§1-3 (AMD). 2015, c. 404, §1 (AMD). 2017, c. 124, §1 (AMD).

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**Task Force on Health Care Coverage for All of Maine
Public Options Study Group
Meeting Notes**

The following are members of the Study Group: Rep. Robert Foley, Sen. Geoffrey Gratwick, Dan Kleban and Kevin Lewis.

March 23 and March 30 Meetings. The Public Options Study Group met twice on March 23 and March 30. Based on these initial discussions, the Study Group would like to spend more time developing a concept for a new model for providing health care coverage to residents of Maine. The broad outlines of such a model would include:

- ❖ Sec. 1332 waiver through ACA
- ❖ Coverage for all residents—everybody in
- ❖ Provide agreed-upon “basic health plan” or uniform benefits package with supplemental coverage and benefits available
- ❖ Coverage provided through existing carriers—focus competition among carriers on service and consumer engagement in health and wellness
- ❖ Oversight through a centralized government trust or authority
- ❖ Funded through contributions from all residents, including those receiving public benefits
- ❖ Changes in reimbursement/payment model for health care providers to eliminate/reduce cost-shifting
- ❖ Reinsurance and risk adjustment for carriers
- ❖ Cost containment measures needed to bring down costs, including administrative costs and prescription drug costs
- ❖ Implement system for electronic sharing of individual health care data among carriers and providers—facilitate access to medical records/coverage information through single ID card

May 8 Meeting. The Study Group held a conference call on May 8th with all members participating. Sen. Gratwick prepared an outline of issues for discussion; the group focused on the following issues during their discussion.

Coverage for all Mainers: everyone in, no one out. The Study Group reiterated their agreement that any model for universal coverage should require the participation of everyone. The group acknowledged that there may be a need to consider exceptions for “opting out” under some circumstances. The group determined that mandatory participation should be recommended to full task force, but that the members should be open to feedback to consider exceptions. The group discussed the importance of mandatory participation for the stability of the coverage model and what types of incentives or penalties could be used to encourage compliance, including financial penalties, restrictions on ability to receive “free care” or charity care and increased premium/coverage payments when individuals that “opted out” seek to re-enroll (similar to Medicare Part D model).

Funding. The Study Group discussed the various options to provide funding for the coverage model. Dan Kleban expressed his continued support for using the payroll tax as a mechanism as it would rely on a current method already familiar to employers; additional methods for collection would be needed for those who are unemployed or receiving public benefits. Rep. Foley suggested that the income tax could also be used and contributions could be collected through income tax returns. Because not all Mainers are subject to payroll taxes or income taxes, Sen. Gratwick thought some sort of sales or use tax must also be considered. Members expressed the belief that any proposals to the full task force should include a combination of funding mechanisms to encourage feedback and further discussion.

Budget/ rate-setting. The Study Group discussed the need for any coverage model to control overall costs. The group is interested in learning more about the rate-setting methods used by Maine's Workers' Compensation Board. The group is also interested in learning more about Maryland's rate-setting system and whether evidence shows that it worked to control or reduce costs in comparison to other models. The group agreed to gather more information and have more discussion on this topic.

Oversight entity/organizational structure. The Study Group discussed what type of oversight entity/organizational structure should be recommended for the coverage model. The group agreed that any oversight entity should be independent or quasi-independent from State government, but acknowledged that legislative oversight over appointments and funding is necessary. Members appointed to an oversight entity must have broad representation from all stakeholders. The group noted that politics would be hard to ignore. Potential models include MEMIC and the Maine Turnpike Authority.

Other discussion. The Study Group acknowledged that the development of a public/private universal coverage model is a long-term endeavor; the group also touched on the potential for incremental policy changes that may have a positive impact on the current system. Kevin Lewis expressed his continued concern about the individual health insurance market and suggested that risk adjustment mechanisms should be considered. He also said carriers were concerned about the impact of short-term health insurance policies and association health plans on the individual market. Rep. Foley suggested that it may be worthwhile to take another look at PL 90 and its provisions to see if more could be done to assist carriers and keep premiums affordable. Rep. Foley also suggested that targeting prescription drugs could make an impact on costs and that the issue has bipartisan support among task force members and the Legislature. Sen. Gratwick reported that the Cost Containment Group was looking at various proposals related to prescription drug costs, including a proposal for a State entity to act as wholesaler for importation of certain drugs from Canada at lower costs.

Task Force on Health Care Coverage for All of Maine
Controlling Costs Study Group
May 23rd Update

The Controlling Costs Study Group met by conference call on May 21. The following are members of the Study Group: Sen. Brownie Carson, Rep. Paul Chace, Jeff Austin, Mark Hovey and Trish Riley. All members participated in the call.

The outline below summarizes the group's agenda and discussion.

1. Importation of prescription drugs from Canada.

The group continued to discuss the potential for creating a state-sponsored wholesale importation program for certain high cost prescription drugs from Canada. Vermont recently became the first state to authorize such a program. Ms. Riley noted that federal approval for such a program is required and Vermont will be developing an application for federal authorization/waiver (to be submitted in January 2019). Federal law can authorize wholesale importation in this manner if a state can demonstrate that the program can ensure safety and cost savings. Ms. Riley noted that safety is harder to demonstrate, but that wholesale importation can provide an intact supply chain to maintain compliance with FDA requirements. Rep. Chace concurred that there are greater checks and balances with wholesale importation; there are significant concerns about safety with personal importation of prescription drugs.

The group agreed it would be worthwhile to bring this suggested proposal to the task force for further discussion; there must be a willingness to suggest several different approaches. There will be numerous administrative and business challenges to be considered if wholesale importation is to be implemented, including rebates and the 340B drug pricing program. However, the structure for importation can be designed in different ways, perhaps even initially exempting the 340B program and/or MaineCare.

2. Capping what consumers pay for certain high cost prescription drugs.

The study group discussed model legislation considered in Maryland that would establish a public utility-like entity to oversee and regulate what payers would be required to pay for certain high cost drugs. The creation of such a review board/commission does not require federal approval to implement. It would develop standards for determining unconscionable price increases and cap the payments for all payers. The commission does not set prices but would cap what payers pay for drugs.

The group also discussed other efforts undertaken by states to control prescription drug spending. Examples include:

- New York's Medicaid budget mechanism which allows the renegotiation of additional supplemental rebates for high cost drugs with penalties for public disclosure to manufacturers that refuse to honor negotiated rebates; and
- Texas legislation to authorize the Legislature's Appropriations Committee to access and review confidential drug rebate agreements negotiated by government programs.

In addition, the group talked about the Drug Utilization Review (DUR) Committee, which is comprised of stakeholders to monitor prescription drug use and spending within the MaineCare program. It was

suggested that the existing structure and scope of the DUR Committee could be broadened to include the review functions proposed in the Maryland legislation.

Another suggestion was to consider the establishment of a purchasing alliance requiring the use of a single formulary for all public purchasers. This approach could leverage the buying power of large governmental payers, including State employees, University system and municipalities.

The study group agreed on the following elements of cost containment related to prescription drugs:

- ❖ Use one formulary/leverage purchasing power
 - Which drugs are included?
 - How broad is the scope?
- ❖ Create an entity with authority to review and cap payments for certain high-cost prescription drugs
 - Use model from proposed MD legislation---PUC-type entity
 - Expand scope of existing Medicaid DUR (Drug Utilization Review) Committee
- ❖ Inclusion of Medicaid
- ❖ Pursue approaches used in other states/learn from other states and collaborate when possible

The group acknowledged that these approaches may be contentious, but that there appears to be bipartisan interest in seeking policy solutions. The group believes many different options should be considered by the task force.

3. Reducing administrative costs and reporting burden by standardizing billing for medical services.

The group discussed the possibilities for reducing administrative costs through standardization of the billing and claims process. This issue was the focus for a 1998 legislative study by The Task Force to Study the Feasibility of a Single Claims Processing System for 3rd-Party Payors of Health Care Benefits. At that time, the task force declined to make recommendations for legislation and decided to defer to national efforts and private sector efforts to encourage electronic claims processing and simplify administrative claims processes. Many of the same issues raised years ago continue to exist today. Despite the use of the same form, government and commercial payers have different requirements for submitting claims. While Maine has enacted laws requiring the use of standardized claim forms, electronic transmission of claims and prompt payment of “clean claims”, the group determined that it may be useful to gather more information and suggestions from providers and payers relating to streamlining the claims process. Members are also interested in whether any claims are submitted on paper and under what circumstances. Members will also reach out to the Maine Health Data Organization related to the development of national uniform standards for reporting of claims data.

Task Force on Health Care Coverage for All of Maine
Structure of the Health Insurance Market Study Group
May 23rd Update **DRAFT**

The Structure of the Health Insurance Market Study Group has met three times to date: March 26, April 23 and May 21. The following members of the Study Group were present: Rep. Anne Perry, Kristine Ossenfort, Joel Allumbaugh and Frank McGinty. Sen. Gratwick attended the April 23rd and May 21st meetings; Frank McGinty was absent.

The Study Group developed the following draft framework for their discussions.

Intended Approach: The Study Group intends to focus on policy solutions that will target certain populations experiencing problems related to health insurance coverage in the existing market. The following examples were discussed:

- Individuals who have incomes below 100% of the federal poverty level who do not qualify for the APTC (advanced premium tax credit);
- Individuals who are “lightly subsidized” and particularly sensitive to health insurance premium increases; and
- Individuals who have incomes above 400% of the federal poverty level who do not qualify for the APTC (advanced premium tax credit).

Principles: The Study Group preliminary determined that any policy solutions should be organized around certain agreed-upon principles. One of the principles discussed in the initial meeting was the importance of elasticity in the health insurance market.

Barriers: Current federal law and uncertainty related to the action/inaction of the federal government are significant barriers to the possible policy solutions outlined below. The underlying cost of health care also has an impact on the health insurance market so there will be overlap with the efforts of the Cost Containment Study Group.

Possible policy options: The Study Group outlined several possible policy options, including, but not limited to *{suggested that group identify the pro’s and con’s of each policy option, the barriers to implementation, the avenues for implementation and the group’s position on each option before sharing with larger group}*:

- ❖ Development of a Section 1332 Waiver to resume operations of the Maine Guaranteed Reinsurance Association (MGARA);
- ❖ Statutory changes to MGARA, such as adding the ability to reinsure small group claims;
- ❖ Amend the definition of small group;
- ❖ Merge the individual and small group market;
- ❖ Segregate the individual market risk pool;
- ❖ Require an individual mandate to have health insurance coverage or consider other measures to incentivize the purchase of health insurance coverage;
- ❖ Consider state-level limits/restrictions on short-term health insurance policies;
- ❖ Consider impact of loss of federal funding to insurers for cost-sharing reductions; and

Task Force on Health Care Coverage for All of Maine
Structure of the Health Insurance Market Study Group
May 23rd Update **DRAFT**

- ❖ Consider expansion of services eligible for “right to shop” program.

Data and Analysis:

On April 23rd, the Study Group discussed the importance of having data to inform its policy recommendations. The group talked about the Maine Health Data Organization and whether its claims database could be more rigorously utilized to determine cost drivers, cost variations, trends and quality. The group decided to invite the Maine Health Data Organization to its next meeting to discuss these issues further. Staff will also ask the members to develop a list of questions/data requests for MHDO.

On May 21st, the Study Group met with Karynlee Harrington of the Maine Health Data Organization. Ms. Harrington talked about the all payer claims database maintained by MHDO and highlighted the organization’s current and planned efforts to increase consumer awareness of health care costs and quality throughout the State. Ms. Harrington also provided information about MHDO’s role in providing information and further analysis related to prescription drug prices as a result of the enactment of LD 1406, An Act to Promote Prescription Drug Price Transparency.

Before the meeting, the group forwarded to Ms. Harrington several questions indicating the types of information that might help the group evaluate potential policy options and recommendations. As a starting point, the group identified the following questions:

1. *What are the top 25 cost drivers for medical procedures? Maybe inpatient versus outpatient?*
2. *What are the top 25 cost drivers for drugs?*
3. *Can we trend this over a period of years to see how cost drivers have and are changing?*
4. *When there is significant cost variation between sites of service, can we identify what % of patients are going to different locations? In other words, what % are going to lower cost, average cost, higher cost options?*
5. *What can we learn about quality differences?*
6. *What can we learn about outcomes? More specifically- if we see higher spending/investment on certain conditions, can we determine if we are getting results?*
7. *Can these data points be broken out by insurance markets such as individual commercial market, small group, large group, Medicare, Mainecare?*

Ms. Harrington reported that she believed that MHDO’s claims database has the capacity to answer these type of questions, but she stressed that MHDO has limited resources. If the questions are focused on the specific information needed, MHDO will be able to provide more useful data. The group agreed

Task Force on Health Care Coverage for All of Maine
Structure of the Health Insurance Market Study Group
May 23rd Update **DRAFT**

to think further about each of the suggested policy options that have been discussed to develop a list of more focused questions and information requests relevant to each policy option.

The group also discussed whether MHDO's current statutes can be amended in any manner to improve the cost and quality information available to the public. Ms. Harrington pointed to Section 8712 of MHDO's governing statutes—this provision guides MHDO in its reporting on the website. It was suggested that the statute could be strengthened to integrate the reporting of cost and quality measures. The group is interested in talking about these issues further.

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