# Options and Opportunities for Implementing the Affordable Care Act in Maine


The Advisory Council on Health Systems Development

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## Executive Summary

The Patient Protection and Affordable Care Act of 2010 (ACA) – the national health care reform law – gives Maine opportunities to increase the number of people with health insurance, reshape the health care delivery system, improve health care quality and control costs for Maine's people and businesses. Maine is well positioned to take advantage of these opportunities to enhance and extend initiatives, both inside and out of state government, that are already underway in the state. The 2010-2012 State Health Plan recognized this in the detailed workplan it includes to guide Maine's implementation of the ACA. Over the past eight months, the Advisory Committee on Health System Development (ACHSD) has held public meetings and discussed key elements of the ACA and how Governor-elect LePage and the Maine Legislature can implement them to the state's best advantage. The ACHSD was established in Maine law to guide the development of the State Health Plan, analyze and report on factors driving health care costs and make reports to the Legislature regarding payment reform. The ACHSD comprises 20 members; 15 appointed by the Governor and reviewed by the Joint Committee on Health and Human Services prior to appointment, and 5 appointed by the Legislature. The ACHSD's recommendations are the subject of this report.

### *Maine is well positioned to implement national reform*

In passing national health reform, Congress and the Administration focused on three key goals:

- Providing near-universal access to health insurance
- Improving quality of care
- Improving affordability to employers and individuals

To meet the **first goal**, the ACA supports employer sponsored health coverage and relies primarily on the private health insurance market, requiring health insurers to offer coverage to all, prohibiting discrimination in pricing health insurance, and requiring individuals to have coverage. Federal premium tax credits for low and moderate income wage earners will make premiums and cost sharing more affordable. To support individuals' access to coverage, the ACA includes a new requirement for employers with 50 or more full-time employees to offer health coverage or pay a penalty. The ACA expands Medicaid eligibility to all citizens with incomes at or below 133% of the federal poverty level (FPL); the expansion is largely federally funded. The ACA also makes a number of changes in Medicaid aimed at simplifying the eligibility and enrollment process, improving access to primary care and preventive services, and easing barriers to home and community-based services for those in need of long-term care.

Because Maine has historically been an innovative state, committed to providing affordable health coverage for its citizens, the leap to cover individuals in the ACA is not as great in Maine as it is in much of the nation. In implementing the ACA, Maine will also need to develop a plan to transition individuals from the Dirigo programs to opportunities available under the ACA. Mainers currently eligible for Dirigo programs will qualify for federal tax credits to subsidize coverage available through a newly created Exchange beginning in 2014, freeing up dollars now assessed for use as Dirigo subsidies for other uses, or for repeal. Current Maine efforts to

improve public health and the health care delivery system may also benefit from ACA provisions, including federal funds for grants and demonstration projects. Maine has already received over $24 million in federal funds available through the ACA.

To meet its **second goal**, the ACA sharpens the federal focus on quality measurement and requires the development of national standards. Dedicating federal resources to developing measures that focus on health outcomes across populations in a standard manner will allow for a better understanding of what care is being provided. At the same time, studying evidence-based practices in a systematic way will allow for increased information about what medical interventions improve health outcomes and which ones do not. Maine has a well-developed infrastructure for studying and improving health care quality, including private and public organizations that collaborate on statewide initiatives. The ACA brings an increased national focus on quality that creates opportunities for the state to build on these partnerships.

The majority of health coverage in Maine, as in most states, comes through employment. As the costs of coverage continue to increase, they have a significant impact on the economic well-being of Maine businesses. As a **third goal**, the ACA begins to tackle the difficult job of containing health care costs. In addition to significant investment in prevention and early detection, the ACA seeks to increase access, which decreases the cost-shift from uncompensated care to private health coverage, and to improve quality, which reduces health care expenditures for overused or misused treatment. Among other approaches, the ACA aims to increase the affordability of health care by reforming insurance rules to reduce premium growth, increase transparency, fund payment reform demonstration projects, and tackle administrative costs. And the law funds state-based demonstrations in malpractice reform and worksite wellness.

The ACA also establishes Health Benefit Exchanges, to operate in each state and promote competition among insurers. The ACA provides the parameters for an Exchange but leaves a great deal of flexibility for each state to determine its final design. The ACA calls for two nation-wide, private health plans to be sold in every state through the Exchange, provides repayable loans and seed funding for development of a new private health insurance option called a Consumer Operated and Oriented Plan ("COOP") in each state, and allows for interstate health insurance compacts to form. In Maine, many of the necessary functions of an Exchange are already performed by the Dirigo Health Agency and other state agencies. Because of this existing capacity, Maine's task in establishing an Exchange is not as complex as in most other states.

## ***Issues and recommendations for Maine in implementing the ACA***

The ACHSD, in collaboration with Governor Baldacci's Health Reform Steering Committee, began in April 2010 to assess Maine's readiness to implement the ACA. Through a series of 14 public meetings, conducted by both the ACHSD and the Steering Committee and using a process that allowed for public input and feedback, the ACHSD considered the following key topics in the ACA and their possible impact on Maine. The ACHSD identified the need or potential for policy actions, providing recommendations where appropriate. The topics included:

- Impact of the ACA on employers and the insurance market, including from the requirement on individuals to purchase health insurance the requirement on larger businesses to contribute toward health insurance coverage or pay an assessment, and changes to insurance market rules;
- Health Benefit Exchanges, including key functions of an Exchange and basic design recommendations for a Maine Exchange;
- Impact of the ACA on Medicaid, including eligibility and benefits changes, opportunities to coordinate with the Exchange and long term care initiatives;
- Opportunities for payment reform, including demonstration projects focused on system reform through development of Accountable Care Organizations (ACOs) and innovative payment models;
- The future of the Dirigo Assessment;
- Impact of the ACA on health programs for members of Indian tribes; and
- Impact of the ACA on quality and public health.

The Table below outlines the ACHSD's recommendations for actions to be taken in Maine as part of the state's efforts to review and implement the ACA. This table is meant only to provide a summary of the work of the Steering Committee and ACHSD to date. Detailed descriptions of these topics and analysis of potential options and next steps are included in the full report.

| Issue | Recommendation |
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| **Employers and Insurance Market** | |
| Essential Benefit Plan: The ACA creates an Essential Benefit Plan that details required benefits to be included in health plans offered through the Exchange. These benefits are likely to differ from those required by Maine through its state mandated benefits. | Once federal regulations are issued, Maine should conduct an analysis that compares its mandated benefits to those included in the Essential Benefit Plan to determine the difference in required benefits and the costs associated with those differences. The analysis should further consider the potential for adverse selection, the impact on potential for regional participation and how the provision of the services impacts the overall health of Maine citizens. If the state chooses to continue the additional benefits, the state must also evaluate whether and how much the existence of a mandate adds net costs to the system and, if so, find state or other funds to pay for the premium cost of those benefits in plans offered in the Exchange, as well as ways to address adverse selection. |
| Medical Loss Ratio: The MLR measures the amount an insurer spends on health care. The ACA requires that insurers meet MLR requirements which limit what is spent on administrative profit, marketing and non-care related activities. The MLR requirements in | Maine should consider the pros and cons of amending its statute to conform the MLR ratios included in the ACA or holding insurers in Maine to both Maine and national standards. As part of this analysis, Maine could also consider a hybrid in model in |

| Issue | Recommendation |
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| the ACA differ from those imposed by Maine on insurers in the small and non-group market today, both in amount and definition. In addition, the ACA places an MLR requirement on insurers in the large group market. | which for some markets it conforms to the federal standard and others it follows the current Maine standard, based on what is best for consumers and businesses. |
| Community Rating Changes: The ACA includes a community rating requirement that is different than Maine's: no group size rating, age rating limit of 3:1; Maine's current rating limit is 1.5: 1 and includes geography; in addition, the ACA allows tobacco use to be considered with rating limit of 1.5:1; Maine's current tobacco adjustment is not limited but has to be actuarially justified. | Maine should consider whether to retain its current community rating standards, or whether to amend its community rating standards to meet the federal minimum, and if so, whether to offset any premium increase for older Mainers through reinsurance or other methods. The elimination of group size variation will also have an impact. Maine should consider whether subsidies should be available to offset any potential increase. |
| Multi-State Insurance Compacts: The ACA allows states to enter into such compacts beginning in 2016. HHS is charged with providing guidance on which rules must be met on a state-by-state basis and which rules will be waived through compact. | Maine should consider whether joining a multi-state insurance compact in or after 2016 is in its best interest and if so, what states would it like to join with. |
| **Exchange** | |
| Confirm Policy Goals of the Maine Exchange: The Steering Committee and ACHSD defined goals for the Exchange including:<br>• Improve Health of Mainers;<br>• Insure more people;<br>• Improve overall quality & satisfaction through payment reform, benefit design & quality incentives;<br>• Standardize, simplify and increase transparency in insurance purchase;<br>• Create a more robust market for health insurance;<br>• Increase portability &choice;<br>• Reduce the rate of health care cost growth | The LePage Administration and the Legislature should determine whether they are in agreement with these policy goals. If not, a new goal setting exercise should occur to provide policy direction for the Exchange planning process. |
| Establishing an Exchange: The ACA provides states with the option of creating its own Exchange or having the federal government establish one for it. | Maine should pursue the establishment of a state-based Exchange and take advantage of the existing infrastructure and capacity in state agencies to perform many of the functions of an Exchange. |
| Who the Exchange Serves: The ACA provides states with the option of creating separate Exchanges for individuals and businesses or | Maine should establish a single Exchange serving both individuals and businesses |

| Issue | Recommendation |
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| just one Exchange serving both individuals and businesses. | |
| How Many Exchanges: The ACA provides states with the option of having one or more Exchanges to serve geographically distinct regions of the state. | Maine should have one Exchange serving the entire state. |
| Collaborating with New England States: The ACA allows states to create regional Exchanges. | Maine should pursue establishment of its own Exchange while concurrently working with other New England States to collaborate as much as possible on certain Exchange functions. |
| Location and Governance of the Exchange: The ACA allows the Exchange to be housed in a non-profit or governmental entity and provides flexibility in governance of the Exchange. | Maine's Exchange should be housed in an independent or quasi-governmental agency. |
| **Medicaid** | |
| Financing: The ACA provides a significant infusion of federal funds in the long-term but requires maintenance of effort for current eligibility and benefits. | Maine should continue to analyze the financial impact of the ACA on Medicaid, and consider in its analysis the impacts of managed care, medical home and other Medicaid initiatives. |
| Coordination with the Exchange: The ACA requires coordination between Medicaid and the Exchange for eligibility and enrollment and presents opportunities for coordination across managed care plans, payment reform and quality. | DHHS should work closely with the entity chosen to serve as the Exchange to streamline eligibility and enrollment across Medicaid and the Exchange. Further DHHS should participate in the Exchange design to allow for joint planning for the Medicaid Managed Care Initiative, whether to elect to offer a Basic Health Plan, and to leverage covered lives for payment reform initiatives. |
| Long Term Care: The ACA includes a number of changes to Medicaid law, as well as financial incentives for states, aimed at improving access to use of long-term care services in the community (such as personal care attendants, home health aides, and other supports that help people meet their daily needs over an extended period). | DHHS should analyze the potential the ACA provisions have to improve access to and delivery of long-term care and, to the extent state financing permits, take advantage of opportunities in the ACA to increase the use of home and community based care, improve the long-term care information and referral network, and upgrade the workforce. |
| **Payment Reform** | |
| Payment Reform Opportunities: The ACA includes several demonstration projects and program changes aimed at implementing payment reform initiatives. | The ACHSD should continue to monitor multi-payer payment reform initiatives and regulatory barriers in Maine.<br><br>Maine should consider providing infrastructure support for developing and |

| Issue | Recommendation |
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| | ongoing payment reform initiatives.<br><br>Maine should continue efforts to develop a robust Exchange that will include payment and system delivery reform as part of its ongoing strategy. |
| **Dirigo Assessment** | |
| Use of Dirigo Assessment beginning in 2014: The federal premium tax credits the ACA provides to subsidize the cost of individual coverage will overlap with the subsidies provided through the Dirigo Assessment, creating an opportunity to reconsider the need for and use of that assessment going forward. | Use resources from Maine's Exchange Planning grant to perform further analysis of policy options for the Dirigo Assessment including repeal or maintaining all or part of the assessment to subsidize small business' share of their employees' health premiums or to subsidize coverage for small businesses; to supplement ACA premium tax credits and further reduce premium costs; to cover administrative costs of the Exchange and quality initiatives; to establish a reinsurance program; to wrap coverage of state mandated benefits, or repeal the assessment. More analysis will be needed to determine the cost estimates and potential effects on coverage for each option. |
| **Quality** | |
| Increased focus on Quality: The ACA brings an increased national focus on Quality and opportunities to improve quality measurement and outcomes in Maine. | Maine should utilize the opportunities in the ACA to continue to provide leadership in measuring and reporting on health care quality and build on ongoing public/private partnerships.<br><br>Dirigo's Maine Quality Forum should continue to pursue ACA funding for quality initiatives that meet Maine's strategic goals and build on existing state infrastructure. |
| **Indian Health** | |
| The ACA provides numerous opportunities to address health and health care needs among members of Indian tribes and tribal organizations. Most significantly, it reauthorizes the Indian Health Improvement Act, which enacts a broad range of improvements to health care for Indians. | The State should collaborate with Maine's Indian tribes to take advantage of all appropriate programmatic and funding opportunities in the ACA, and Maine's tribes should be encouraged to apply for appropriate grants. |
| **Public Health** | |
| Increased focus on Public Health: As with Quality, the ACA brings an increased national focus on public health and provides | Maine should develop a strategic plan, as part of its 2012-2014 State Health Plan that focuses on opportunities to leverage quality |

| Issue | Recommendation |
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| opportunities to leverage that focus in Maine. | and public health opportunities in the ACA for the benefit of Maine.<br><br>DHHS should continue to pursue ACA funding for public health initiatives that meet Maine's strategic goals and to build on existing state public health infrastructure.<br><br>DHHS should collaborate with local business communities to promote employee wellness. |

The ACA as enacted is a work in progress, to be clarified by forthcoming regulation and potentially modified by Congressional and court action, as its major provisions take effect over the years until full implementation in 2014. States have responsibilities under the law as written and Maine is well situated to meet those responsibilities quickly and in a way that benefits the state. The Timetable included below provides a listing of key tasks by year and topic necessary to implement the ACA in Maine. With the analysis and recommendations in this report, the ACHSD hopes to make an early positive contribution to those activities.

| Timetable by Key Tasks to Implement ACA in Maine |
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| **2011** |
| **Organization of the ACA** |
| Assign Executive Branch lead to ACA implementation |
| Determine process and workplan to continue ACA planning effort |
| Provide staff support to the ACHSD to provide guidance in the implementation of the ACA |
| **Insurance Reforms** |
| Determine whether to merge the individual and small group market based on BOI study |
| Determine whether Maine should conform to MLR requirements or retain its own standard for the individual or small group market |
| Determine extent of interest in Maine in CO-OP plans |
| **Exchange** |
| Review Exchange Planning Grant Award and current workplan |
| Determine whether to continue contract with Bailit Health Purchasing for Exchange planning effort |
| Determine whether to continue with current workplan or amend planning effort with OCIIO |
| Submit quarterly Exchange planning grant reports to OCIIO |
| Confirm policy goals for the Exchange; if not in agreement revisit and determine policy goals |
| Review recommendations on Exchange design to date; if not in agreement, revisit direction |
| Participate in ongoing New England region discussions of Exchange collaboration |
| Determine number of 500,000 Mainers income eligible for some form of assistance will meet other requirements and obtain health insurance through the Exchange |
| Draft and submit legislation to establish a Health Insurance Exchange |
| Consider whether to implement a Basic Health Plan within the Exchange |

| Timetable by Key Tasks to Implement ACA in Maine |
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| Develop key functions of the Exchange (call center, eligibility and enrollment procedures, qualifying health plans, navigators, reporting requirements, etc) either Maine specific, or in collaboration with other states, if appropriate |
| Apply for Exchange Implementation grant funding when available |
| **Medicaid** |
| Conduct ongoing financial analysis of impact of ACA on Medicaid and CHIP, as new federal guidance is release |
| Consider whether Maine qualifies for hardship waiver of maintenance of effort requirement based on state's budget deficit; and consider potential reduction of expansion populations and short and long-term impact of such change |
| Coordinate program planning between Medicaid and the Exchange, including Medicaid Managed Care Initiative |
| Consider implementation of the health home option |
| Consider potential to move some MaineCare caseload to Basic Health Plan |
| Consider demonstration projects as they become available (bundled payments, global payments, Pediatric Cos, IMD payments for emergency stabilization) |
| Consider optional eligibility expansions (presumptive eligibility; family planning) and cost impact |
| Consider implementation of optional PCA and 1915(i) (allowing provision of home and community based services under Medicaid plan rather than waiver) |
| Determine whether Maine can and should apply for state re-balancing incentive program |
| **Payment Reform** |
| Continue to utilize ACHSD to monitor multi-stakeholder payment reform initiatives |
| Monitor market trends to assess impact of application of different models |
| Measure progress of different initiatives on quarterly basis, using set milestones focused on measures of quality and cost |
| Monitor Medicare activities on payment reform and consider if and how to leverage those activities and any other Federal demonstrations |
| **Dirigo Assessment** |
| Utilize resources from Exchange Planning grant to analyze potential impact of repeal of assessment and/or potential for use of assessment beginning in 2014 |
| **Quality** |
| Utilize the opportunities in the ACA to continue to provide leadership in measuring and reporting on health care quality and build on ongoing public/private initiatives. |
| Pursue ACA funding for quality initiatives that meet Maine's strategic goals and build on existing state infrastructure. |
| **Indian Health** |
| Collaborate with Maine's Indian tribes to take advantage of all appropriate programmatic and funding opportunities in the ACA. |
| **Public Health** |
| DHHS should continue to pursue ACA funding for public health initiatives that meet Maine's strategic goals and to build on existing state public health infrastructure. |
| DHHS should collaborate with local business communities to promote employee wellness. |

| Timetable by Key Tasks to Implement ACA in Maine |
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| **2012** |
| **Insurance Reforms** |
| Review Essential Health Benefit plan requirements when federal guidance released, consider whether any Maine state mandated benefits are not included; whether Maine would consider changing state requirements to conform, and if not, how Maine would fund coverage for state mandated benefits in the Exchange. |
| Analyze impact of community rating requirements in Maine on premiums, based on Maine's current community rating requirements |
| Review NAIC recommendations regarding interstate insurance compacts |
| **Exchange** |
| Continue implementation efforts through Implementation Planning grant |
| Develop sustainability model for Exchange beginning in 2015 |
| Assess competitiveness and price impact of two nation-wide plans operating in Maine through Exchange. |
| **Medicaid** |
| Conduct ongoing financial analysis of impact of ACA on Medicaid and CHIP, as new federal guidance is release |
| Determine necessary eligibility system changes to implement required use of Modified Adjusted Gross Income (MAGI) in determining eligibility. |
| Determine how Medicaid and Exchange will coordinate on eligibility and "no wrong door" approach |
| Consider demonstration projects as they become available (bundled payments, global payments, Pediatric Accountable Care Organizations, payments to Institutes for Mental Disease (IMDs) for emergency stabilization) |
| **Payment Reform** |
| Continue to utilize ACHSD to monitor multi-stakeholder payment reform initiatives |
| Monitor market trends to assess impact of different models does not create market chaos |
| Measure progress of different initiatives on quarterly basis, using set milestones focused on measures of quality and cost |
| Monitor Medicare activities on payment reform and consider if and how to leverage those activities |
| **Quality** |
| Utilize the opportunities in the ACA to continue to provide leadership in measuring and reporting on health care quality and build on ongoing public/private partnerships. |
| Pursue ACA funding for quality initiatives that meet Maine's strategic goals and build on existing state infrastructure. |
| **Indian Health** |
| Collaborate with Maine's Indian tribes to take advantage of all appropriate programmatic and funding opportunities in the ACA. |
| **Public Health** |
| Develop the 2012-2014 State Health Plan and include a strategic plan that focuses on opportunities to leverage quality and public health in the ACA for the benefit of Maine. |

| Timetable by Key Tasks to Implement ACA in Maine |
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| **2013** |
| **Insurance Reforms** |
| Consider potential for moving to federal community rating requirements, including impact on premium costs. |
| Consider Maine's interest in participation in interstate insurance compact and effect of rules Maine would need to accept from partnering states |
| **Exchange** |
| Show readiness for Exchange implementation to federal government |
| Extensive testing before Exchange goes live |
| Consider implementation activities |
| **Medicaid** |
| Conduct ongoing financial analysis of impact of ACA on Medicaid and CHIP, as new federal guidance is release |
| Determine how to meet ACA outreach requirements |
| Plan for Federally funded Medicaid eligibility expansion (childless adults; foster care children to 26)and impact for savings/costs |
| |
| Coordinate Medicaid Managed Care initiative with Exchange health plan procurement to allow for coordination of contract requirements and payment reform activities |
| Increase Medicaid fees for primary care physicians to Medicare rates (funded 100% by Federal government and plan for sustainability |
| **Payment Reform** |
| Continue to utilize ACHSD to monitor multi-stakeholder payment reform initiatives |
| Monitor market trends to assess impact of different models does not create market chaos |
| Measure progress of different initiatives on quarterly basis, using set milestones focused on measures of quality and cost |
| Monitor Medicare activities on payment reform and consider if and how to leverage those activities |
| **2014** |
| **Insurance Reforms** |
| If interested in joining an interstate insurance compact, determine which state may be interested in partnering with and develop such partnership |
| **Exchange** |
| Implement the Exchange including 2 nationwide private plans |
| **Medicaid** |
| Conform Medicaid eligibility with ACA (childless adults; foster care children to 26) |
| If interested, implement optional eligibility expansions (presumptive eligibility; family planning) |
| Implement community spousal support requirement |

## I. Introduction

The Patient Protection and Affordable Care Act of 2010 and Health Care and Education Reconciliation Act of 2010 (collectively referred to as the ACA) dramatically change the health coverage and health insurance landscape in the United States.[1] The new law will impact government, individuals and businesses on many fronts. The ACA recognizes the role of the states and allows states to implement the federal law. Should a state decide not to implement federal law, the federal government will implement and enforce the ACA. Court challenges and pending regulations will further shape the future of the law.

This report is supported by a grant from the Health Services Resources Administration (HRSA) and reflects the work of Governor Baldacci's Health Reform Steering Committee[2] and the Advisory Committee on Health System Design (ACHSD)[3] beginning in April 2010 to understand the ACA and its implications for Maine and to recommend next steps in implementation for Maine for Governor-elect LePage and the Maine Legislature.

As a first step, in April 2010, the ACHSD received an overview presentation of the ACA. The presentation formed the basis for a chapter in the 2010-2012 State Health Plan that is focused on the ACA which spells out a process to implement reform in Maine. Based on that implementation plan, both the Steering Committee and ACHSD met monthly from June through November and received presentations on different aspects of the ACA from a team of consultants led by Bailit Health Purchasing, LLC. All meetings of the Steering Committee and the ACHSD were streamed live, were held in accessible meeting spaces and provided an opportunity for public comment. The presentations[4] focused on the following topics:

- Considerations in applying for federal grants and development of prioritization criteria (June);
- Exchange 101 (July);
- Impact of the ACA on Business (August);
- Basic Design Questions for a Maine Exchange (September);
- Impact and Opportunities of the ACA on Medicaid (October);
- Opportunities for Payment Reform in the ACA (November); and,
- Consideration of the Dirigo Assessment given the ACA; and the ACA's Impact on Public Health and Quality (November).

[1] The Patient Protection and Affordable Care Act is referred to herein as the ACA and is H.R. 3590.
[2] The Steering Committee is chaired by Trish Riley, Director of the Governor's Office of Health Policy and Finance; and includes Mila Kaufman, Superintendent of the Bureau of Insurance, Brenda Harvey, Commissioner of the Department of Health and Human Services, Karynlee Harrington, Executive Director of the Dirigo Health Agency, Ellen Schneiter, Commissioner of the Department of Administrative and Financial Services; and Anne Head; Commissioner of the Department of Professional and Financial Regulation.
[3] The ACHSD was established in Maine law to guide the development of the State Health Plan, analyze and report on factors driving health care costs and make reports to the Legislature regarding payment reform. The ACHSD comprises 20 members; 15 appointed by the Governor and reviewed by the Joint Committee on Health and Human Services prior to appointment, and 5 appointed by the Legislature. ACHSD membership is included as Appendix A. By Executive Order, Governor Baldacci appointed the ACHSD to guide the implementation of the ACA in Maine.
[4] Each presentation is available on Maine's healthcare reform website at www.maine.gov/healthreform.

This report includes a description of the major aspects of the ACA and considers potential policy options and recommendations for next steps for the implementation of the ACA in Maine. The report was released as a draft for public review on December 8, 2010 and public comment was accepted through December 14, 2010 at 9:00 AM. Further, the Steering Committee and the ACHSD jointly accepted public comment at a public hearing of the report on December 14, 2010. Following public comment, the Steering Committee and ACHSD reviewed the public comments received orally at the public hearing or in written form and made revisions to the report to address those comments.

## II. Overarching Goals of Health Reform

For many years, the United States has lagged behind its peer nations in both access to coverage and quality of care provided to its residents.[5] Despite that, the United States per capita spending on health care has steadily increased and now exceeds 15% of the GDP.[6] At the local level, Maine residents and businesses have struggled to keep pace with increasing health care costs.[7]

In passing national health reform, Congress and the Administration focused on three key goals:[8]

- Providing near universal access
- Improving quality of care
- Improving affordability to employers and individuals

To meet the first goal, the ACA provides for an expansion of mandatory Medicaid eligibility[9] to all citizens with incomes at or below 133% of the federal poverty level (FPL), funded in large part with federal funds, and provides subsidies[10] for individuals with incomes to 400% of the FPL beginning in 2014.[11] Because Maine has historically been an innovative leader among states when it comes to providing public health coverage for its citizens, the leap to cover individuals in the ACA is not as great in Maine as it is in much of the nation.[12] In 2010, Maine ranks 6th in the nation, up from 19th in 2003, in percent of population with insurance. Nearly fifty percent (500,000) of individuals under age 65 in Maine have incomes below 400% of the FPL, making them potentially eligible for premium tax credits if they are not offered health insurance coverage through an employer or if that coverage is too expensive for them to afford (over 9.8%

[5] K. Davis, C. Schoen, S. Schoenbaum et al., *Mirror, mirror on the wall: An international update on the comparative performance of American health care*. Vol. 50 (New York: The Commonwealth Fund, 2007).
[6] Kaiser Family Foundation, *Health care spending in the United States and OECD countries* (January 2007).
[7] Per capita health care expenditures in Maine are 24% higher than the national average. See Health Expenditures by State of Residence, 1991-2004; accessed at http://www.cms.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccountsResidence.asp.
[8] President Obama, National Radio Address, June 6, 2009, accessed on September 14, 2010 at http://usgovinfo.about.com/od/healthcare/a/obama060609.htm.
[9] Section 2001 of the ACA (H.R. 3590).
[10] Section 1401 of the ACA.
[11] A chart detailing the federal poverty level and the maximum annual cost of health insurance is attached as Appendix B.
[12] State based reforms instituted in 2003 have improved Maine's uninsured rate to the sixth best in the nation. Together, Medicaid, CHIP provide coverage for Maine's pregnant women and children to 200% of the FPL and to parents to 206% FPL. See Maine State Medicaid Fact Sheet, Kaiser Family Foundation. Maine also covers childless adults in MaineCare to 100% of the FPL and provides for additional coverage for low-income workers through Dirigo.

of family income.) Further Maine-specific modeling is planned under the Exchange planning grant to determine accurate estimates of number of lives who will receive coverage in Maine through the Exchange. A recent national study from the Lewin Group[13] estimated that 125,300 Mainers may be eligible for premium tax credits in 2014.

To meet the second goal, the ACA increases the federal focus on quality measurement and requires the development of national standards, with particular attention to identifying and reducing racial and ethnic disparities in health care delivery and outcomes. Dedicating federal resources to developing measures that focus on health outcomes across populations in a standard manner will allow for a better understanding of the care that is being delivered and insight into variations in practices and their relationship to outcomes of care. At the same time, studying evidence-based practices in a systematic way will allow for increased understanding of what medical interventions improve health outcomes and which ones do not. This knowledge will affect costs by supporting what works and avoiding what doesn't.

The majority of health coverage in Maine, as in most states, is obtained through the workplace. As health care costs continue to increase unabated, they have had a significant impact on the economic well-being of Maine businesses. As a final goal, the ACA begins to tackle the difficult job of containing health care costs. In addition to significant investment in prevention and early detection, the ACA begins to address costs, in part, by increasing access, thereby decreasing the cost-shift from uncompensated care to private health coverage, and by improving quality, to assure that health spending is appropriate and reduce health care expenditures that are due to the overuse or misuse of treatment. An important factor will be ensuring that there is an adequate workforce that balances provider and insurer choice with cost, quality and access. In addition, the ACA aims to increase the affordability of health care by increasing transparency, tackling administrative costs, establishing exchanges that promote competition, and the funding of a number of demonstration programs aimed at containing costs, including health system redesign and payment reform strategies as well as a medical malpractice demonstration.

In moving toward these three major goals, the ACA provides opportunities for both individuals and businesses. First, increased access to coverage is likely to keep individuals healthier; requiring reduced use of sick time and improved worker productivity. Second, transparency under the ACA will require insurers, and the providers within their networks, to clearly justify the rate increases they are seeking. This transparency may lead to reduced rates of premium growth for employers and their employees, as well as individuals who purchase coverage outside of employment. The standardization of coverage and ability to clearly view the differences in plans through the Exchange will facilitate informed purchased decisions.

## III. Implementing the ACA

While many provisions of the ACA do not take effect until January of 2014, a number of provisions – specifically those related to health plan offerings and insurance reforms, became effective in 2010 or will become effective in 2011. The ACA amends a number of different federal laws, including the Public Health Service Act, the Employee Retirement Income Security Act, the Social Security Act, and the Internal Revenue Code. Many ACA provisions require rulemaking, and to date, several federal Departments, including HHS, DOL and the IRS, have

[13] *Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit in Maine*, Families USA, September 2010.

issued interim final regulations on 2010 and some 2011 requirements. Input to federal rulemaking is done both through formal comments and many meetings with stakeholders, including states. The ACA specifically directs the federal government to consult with certain stakeholders, most notably the National Association of Insurance Commissioners (NAIC) who was charged with develop standards for medical loss ratios, for certification by HHS. Various interest groups continue to lobby the Administration and Congress to impact the pending regulations.

## IV. Impact of the ACA on Businesses

This section details the major changes within the ACA that impact business, either directly or because of their impacts on individuals. Specifically, this section provides a detailed description of the following aspects of the ACA and implementing regulations, to the extent they've been promulgated or proposed:

- individual and employer mandates;
- employer tax rules;
- health plan offerings;
- required benefits and insurance reforms; and,
- employer wellness opportunities and incentives

It also explores some policy options and provides general recommendations for how Maine should proceed during the implementation process.

### a. The Insurance Requirement

For the first time, the ACA places requirements on individuals to obtain health coverage and also places requirements on larger employers to provide coverage.

*The Individual Mandate*

The ACA requires all citizens to have health insurance beginning in 2014, with limited exceptions. The joint policy goals of the individual mandate are to improve access to preventive and other health care and to reduce uncompensated care to health care providers who serve the uninsured. An individual who does not have health insurance will be subject to a phased-in tax penalty, unless an exemption applies.[14] During the first year, 2014, the maximum penalty is $95 or 1% of household income; the penalty grows to $695 per person with a family maximum of $2,085 or 2.5% of household income by 2016. After 2016, the penalty will increase annually using cost-of-living adjustments.

To make coverage affordable, the ACA also provides premium tax credits toward the cost of coverage (both the cost of premiums and the cost of deductibles and other out-of-pocket costs) for health insurance purchased through a new entity known as a Health Insurance Exchange, described in detail in Section 1412 of the ACA and in Section V of this report. In addition, state Exchanges will also provide a special low cost plan for individuals under the age of 30. As

[14] Exemptions from the tax penalty include financial hardship, religious objections, American Indians, those without coverage for less than 3 months within the year, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan is more than 8% of individual income, and those with incomes below the tax filing threshold.

described above, approximately 500,000 Mainers are expected to be income eligible for subsidies under the ACA, and the Lewin Group estimates that, of those, 123,500 will access insurance through the Exchange. Further analysis will be conducted through the Exchange planning grant to determine how many work in firms that offer health coverage, how many are eligible for but unenrolled in Medicaid and CHIP, and how many will obtain coverage through the Exchange. Individuals who are not eligible for a public program or a subsidy may increase their uptake of employer-sponsored coverage.[15] On the other hand, some individuals who currently purchase coverage through their employer may drop that coverage that is considered unaffordable under the ACA, in order to obtain a premium tax credit through the Exchange. Outside of the employer market, the individual mandate will likely create an increased uptake of individual coverage, either through the Exchange or otherwise in the Maine insurance marketplace by individuals who do not have access to insurance through employment and who do not qualify for a premium tax credit.

*Employer Coverage Requirements*

To ensure that larger employers continue to provide health coverage to their employees, the ACA includes employer coverage requirements. Beginning in 2014, employers with 50 or more full time equivalent employees are required to offer health insurance or pay an assessment. The ACA considers a full-time employee to be any individual who works 30 or more hours per week.[16] To determine the number of full-time equivalents among part-time workers, the ACA divides the number of hours worked per month by a firm's part-time employees by 120 hours. Seasonal employees are not included in this initial threshold calculation.[17]

1. Employers that Do Not Offer Coverage

An employer that does not offer health insurance coverage will be assessed a penalty only if any of its employees receives a premium tax credit through the Exchange. Once a penalty is triggered, the employer will be assessed a penalty of $2,000 for each full-time employee in excess of 30.[18] Part-time employees are not included in the assessment calculation, but seasonal employees are.

2. Employers that Do Offer Coverage

An employer that does offer health coverage may also be assessed a penalty. An employee is eligible to decline employer coverage and apply for subsidized coverage through the Exchange if the cost of the employee's share of the premium exceeds 9.8% of total family income. If an employer that offers coverage has one or more employees that receives a subsidy through the Exchange, the employer may be assessed a penalty equal to $3,000 for each employee that

[15] The ACA includes a requirement that employers with more than 200 employees must automatically enroll eligible employees into health coverage. Employees may opt out of the coverage. Nothing within the ACA requires that employers offer the same plan to all employees, but there are specific non-discrimination requirements that prohibit an employer from providing greater coverage to highly compensated employees than to lower compensated employees.

[16] For an example of the employer size calculation, see slide 15 of the PowerPoint presentation, The Impact of the ACA on Business, presented to the ACHSD in August 2010, accessible at www.maine.gov/healthreform.

[17] Under the ACA, a seasonal employee is an employee that works fewer than 120 days in the year.

[18] For an example, see slide 17 of the Impact of the ACA on Business presentation, accessible at www.maine.gov/healthreform.

obtains a subsidy in the Exchange. In no case can the employer's penalty be greater than if it had not offered coverage at all.[19]

The ACA requires that employers of all sizes that offer coverage participate in the free choice voucher program. Under this program, certain employees with incomes less than 400% of the FPL may receive a voucher from their employer toward the purchase of coverage in the Exchange. The voucher would be in an amount equal to what an employer would have paid for the individual under its own plan. This only applies to a small percentage of employees however, as to be eligible, the employee's share of the premium must be between 8% and 9.8% of total family income. Employers that provide vouchers will not be subject to a penalty for any employee who receives one.[20]

*Employer Wellness Opportunities*
The ACA provides for small businesses to receive government grants for up to five years to establish wellness programs. Under the law, these grants were supposed to begin in October 2010 but few details about the grants have been released to date.

In addition to the grants, the ACA provides greater flexibility for employers to offer employee rewards related to wellness, such as premium discounts, cost-sharing waivers, and new benefits, effective January 2014. Under this program, incentives can be valued at up to 50% of the cost of participating in wellness programs, where previously the incentive could not be more than 30% of the participation cost. Such programs may include a wellness program or meeting individual health goals (e.g., stop smoking). If an employer offers an incentive attached to a wellness program that not everyone can participate in based on current health or disability, the employer must offer an alternative wellness program.

**b. Tax Changes in the ACA**
The ACA includes a number of tax changes, including small employer tax credits; increased taxes for some businesses and individuals; and tax incentives for targeted industries.

*Small Employer Tax Credits*
The ACA provides immediate help to small businesses and small tax-exempt organizations to afford the cost of health insurance for their employees. These tax credits are available beginning in tax year 2010, whether or not an employer has previously offered coverage. HHS estimates that 22,000 businesses in Maine are potentially eligible based on employer size.

To be eligible for the tax credit, small businesses must offer health coverage to their employees, have no more than 25 full-time equivalent employees, and have average annual wages of less than $50,000. Tax credits can be applied either to income taxes or taxes withheld for their employees. If an employer does not have a tax liability in the year that the credit is earned, the tax credit will remain available for a future filing year.

[19] For an example, see slide 19 of the Impact of the ACA on Business presentation, accessible at www.maine.gov/healthreform.
[20] Maine will need to determine how the use of a free choice voucher impacts the state's 75% take up requirement in the small group market.

Under Phase One, which is currently underway and runs through 2013, a small business that offers health insurance coverage to its employees may be eligible for a tax credit equal to up to 35% of the employer's premium contribution for for-profit businesses and up to 25% for non-profits, provided that the employer pays a minimum of 50% of the premium cost.[21] Very small businesses whose employees have very low wages may get the full credit; the amount of the credit decreases as the employer size and average employee salary increases.[22]

In Phase Two, which begins in 2014, a small business may be eligible to receive a tax credit for a two year period if the business meets all of the requirements described above and purchases health coverage for employees through the Exchange. In this phase, businesses may receive a credit of up to 50% of the premium cost for for-profits and up to 35% for non-profits. Similar to the first phase, businesses with the smallest numbers of employees and lowest average wages may get the full credit; other small businesses may receive a partial credit.[23]

As part of its outreach to individuals and businesses on health reform, Maine may want to consider what information it can provide to small businesses to educate them on the availability of credits and analysis of potential value of the credit. In addition, as an incentive for small businesses to offer coverage through the Exchange and maintain small business health coverage, Maine may want to consider providing subsidies to sole proprietors and employers and their employees that are otherwise ineligible for a premium tax credit through the Exchange.[24]

*Tax Changes that Impact Individuals*

Several tax changes in the ACA impact individuals. First, as described above, individuals who do not meet the individual mandate requirements will be subject to a tax penalty. In addition, the ACA makes a number of tax changes related to currently allowed medical deductions. Specifically, the ACA places limitations on Flexible Spending Arrangements (FSAs), Medical Savings Accounts (MSAs), and Health Savings Accounts (HSAs) that reduce an individual's ability to use pre-tax dollars to pay for medical expenses that are not otherwise paid for by their insurance coverage. First, the ACA places a $2,500 contribution limit on FSAs beginning in 2013.[25] Beginning on January 1, 2011, over-the-counter drugs not prescribed by a physician cannot be reimbursed through a FSA, MSA or HSA. Effective January 1, 2013, the ACA also increases the threshold from itemizing deductions related to medical expenses on an individual's annual tax return from 7.5% of family income to 10% of family income.[26]

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[21]To meet the 50% contribution requirement, the employer must provide 50% to the premium cost of individual coverage. If the employee obtains a family plan through the employer, the employer will satisfy the 50% contribution as long as the employer pays 50% of what individual coverage costs, even if that is less than 50% of the premium for the coverage that the employee is actually receiving.

[22]Specifically, employers with 10 or fewer employees and average wages less than $25,000 may qualify for a tax credit that equals between 25% and 35% of the employer's cost. Those with more than 10 employees and/or wages between $25,000 and $50,000 will qualify for a credit of up to 25% of the employer cost.

[23]Full credit (between 35-50% of the premium cost) is available to small employers with 10 or fewer employees and annual wages of less than $25,000. See slides 27-28 in the Impact of the ACA on Business presentation, accessible at www.maine.gov/healthreform.

[24]This question may be analyzed as part of the Exchange Planning Grant, and may also consider how the current Dirigo assessment could fund such subsidies, as described in Section VII.

[25]There is currently no limit on FSA contributions in the law, but most employers limit an employee's contribution to $5,000 annually.

[26]This provision is waived, between 2013 through 2016, for individuals 65 and older.

In addition, the ACA imposed a 3.8% tax on unearned income for higher-income tax payers (individuals with incomes above $200,000 and couples with incomes above $250,000), effective January 1, 2013. This will have limited impact in Maine; it is expected to apply to only 1.5% of Maine taxpayers.

*Tax Changes that Impact Employers*

Similarly to the change in allowable tax reductions for health care for individuals, the ACA limits some tax advantages related to health care for employers. Specifically, effective January 1, 2013, there will be an increase in Medicare Part A tax rates on wages by .9% for individuals with incomes over $200,000 and couples with incomes over $250,000. Also effective January 1, 2013, the ACA eliminates the employer tax deduction for employers which provide drug coverage to retirees and receive Medicare Part D retiree drug subsidy payments. Another tax change, which took effect in April 2010, clarifies the economic substance doctrine and increases penalties for underpayment of taxes.[27]

The tax change attracting the most media attention is the so-called "Cadillac tax." This provision of the ACA, which is not scheduled to go into effect until January 1, 2018, imposes an excise tax on insurers of employer-sponsored health plans with an aggregate cost[28] over $10,200 for individual coverage and over $27,500 for family coverage.[29] Beginning in 2020, the threshold for the excise tax will be indexed to the Consumer Price Index for All Urban Consumers (CPI-U). The excise tax will be equal to 40% of the value of the plan in excess of the threshold amount. As noted, it is technically a tax on the insurer. In the case of the self-insured employer, the employer will be taxed as the insurer for this purpose. While fully-insured employers will not be taxed themselves for offering these plans, it is likely that the insurer will pass this cost on to the employer in some manner.[30] Likewise, individuals that purchase high-cost insurance plans outside of the employer market may see this cost reflected in their premium.

*Taxes and Tax Incentives Focused on Specific Industries*

The ACA includes tax changes that increase taxes and fees on specific industries, as well as providing tax incentives for targeted industries. To help in the law's financing, the ACA places fees on specific industries: pharmaceutical manufacturers, health insurance companies, and medical device manufacturers. In addition, the ACA also imposed a 10% tax on tanning services which began in July 2010. This fee, though it may marginally assist in financing the expansion of health coverage under the ACA, is more like a "sin tax, designed to lower consumer consumption" Likewise, retroactive to January 2010, to discourage unprocessed fuels, the ACA excludes unprocessed fuels in determining eligibility for a biofuel producer credit.

[27]The economic substance doctrine denies tax benefits that arise from transactions that do not result in a meaningful change in a taxpayer's economic position.

[28]The aggregate cost includes reimbursements under an HSA.

[29]The ACA provides for an increased threshold for individuals over the age of 55 who are retired and not eligible for Medicare, and for individuals in high-risk professions. The threshold increases by $1,650 for individual coverage to $11,700 and by $3450 to $30,950 for family coverage.

[30]The insurer's ability to pass this cost on to the employer may be limited by Medical Loss Ratio requirements as this cost is likely considered an administrative expense, not a medical expense.

To encourage certain activities that may lead to medical advances, the ACA includes two incentives for businesses in this space. First, the ACA provides for a 12-year patent protection for biologics. The ACA also includes a therapeutic discovery tax credit for drug development by small to medium life sciences companies.

### c. Employer Requirements

The ACA introduces a number of new requirements on employers, focused on: (1) reporting information about the health coverage offered to and accepted by employees and (2) providing information to employees about coverage offered through the employer, as well as the opportunity to obtain coverage through the Exchange.

*Employer Reporting Requirements*

The ACA introduces two new reporting requirements for employers. First, beginning in January 2012, employers must include the value of the employee's health insurance coverage on the W-2 form. This does not, however, affect taxable income. The ACA requires that employers include the following in determining the value of coverage:

- Major medical coverage;
- Executive physicals;
- HSA contributions;
- On-site medical clinics;
- Employee Assistance Programs;
- Medicare supplement policies; and,
- Employer contributions to FSAs.

Collecting this information on the W-2 will increase transparency and will also prepare the IRS to determine whether an individual meets the individual mandate. In addition, collecting this information will allow the IRS to analyze the true impact of the tax on high-value plans described above. To date, the IRS has not released any guidance on this requirement.

Beginning in 2014, employers must file a report to the Secretary of the Treasury each January 31st that details the employer's coverage policies. The ACA specifies the following information be included:

- Employer demographic information, including name, address and Federal ID number; and
- Certification of whether the employer offers insurance to full-time employees and/or dependents and, if so:
    - Opportunity to enroll in minimum essential coverage;
    - Length of any waiting period;
    - Months in the preceding year in which coverage was available;
    - Monthly premiums for lowest-cost option;
    - Employer's plan share of covered health expenses; and,
    - Number of FTEs that are covered
        - Must include employee names and SSN.

*Employer Information Requirements*
The ACA places two new information requirements on businesses of all sizes. First, effective March 23, 2012, the ACA requires that businesses provide clear information to their employees on the type of coverage that is being offered, if any, through employment. Specifically, the ACA requires that businesses provide a summary of benefits and coverage both before enrollment and when existing enrollees re-enroll with the plan. The summary must meet specific standards under the statute. The ACA requires standardized definitions of key terms and includes specific requirements around the length, language and font used in the summary. A statutory workgroup established by the National Association of Insurance Commissioners (NAIC) – to-date has completed an initial set of detailed recommendations to the federal government. [31] Exchange plans will also provide similar summaries of coverage.

Second, the ACA requires that businesses provide information to their employees on the potential for employees to obtain a premium tax credit through the Exchange beginning on March 1, 2013. The information must include services available through the Exchange and its contact information. It must also include information on an employee's potential eligibility to receive a subsidy for coverage through the Exchange if the employer's plan has an actuarial value below 60% or if the employer's plan may be unaffordable to an employee based on income. If the employer does not offer coverage, it must also share this information with its employees.

**d. Health Plan Offerings**
The ACA makes a number of significant changes to the type of insurance that may be offered in the market, including the development of an "essential health benefits package." The ACA also establishes standards for insurance plans offered in the Exchange and provides opportunities for the development of new health plans. A key goal of the Exchange is to provide simple one-stop shopping and comparisons for consumers.

*What Insurance Plans May Be Purchased*
The ACA requires that insurance meet minimum coverage requirements, and establishes additional requirements for "qualified health plans" offered through the Exchange, which are the only plans eligible for premium tax credits for individuals.[32] In addition, the ACA requires an 80% medical loss ratio (MLR) for all individual and small group health insurance, and an 85% MLR for all large group health insurance.[33]

1. Essential Health Benefits
The ACA specifies minimum coverage within health insurance plans and requires implementation of this provision by HHS regulation. Specifically, the ACA requires the U.S. Department of HHS to establish minimum benefit standards for the following services, which are to be "equal to the scope of benefits provided under a typical employer plan":[34]

[31]The initial definitions and summary of coverage document was tested via consumer focus groups by AHIP and Consumers Union.
[32]For a detailed description of plans to be offered through the Exchange, see Section V.
[33]The ACA's Medical Loss Ratio requirements are detailed below.
[34] The ACA expressly requires the Essential Health Benefits Package to be included in all qualified health plans offered through the Exchange and in non-grandfathered individual and small group health insurance both inside and

- Ambulatory and emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health;
- Prescription drugs;
- Rehabilitation and devices;
- Laboratory;
- Preventive and wellness; and,
- Oral and vision (for pediatrics).

While many health plans offer most of these benefits today, there are several potential expansions depending on the regulatory implementation of this provision. Specifically, today not all health plans include prescription drugs, oral and vision services. In addition, until the regulations are released, it is difficult to know whether the majority of health plans today are meeting the other benefit requirements, particularly in terms of limits on mental health services and durable medical equipment. As those regulations are released, it will be important for the State of Maine, its insurers and its employers to understand the differences between what is required in the Essential Health Benefits Package and what is currently offered in Maine.

Because Maine, like all states, has specific benefit requirements for health insurance, it will be important for the state to compare the Essential Health Benefits Package with the state's mandated benefits. This analysis should determine which of the state's mandated benefits are not included in the Essential Benefits, how often those services are utilized, what the net cost of providing those services are, the potential for adverse selection, the impact on potential for regional participation, and how the provision of the service affects the overall health of Maine's citizens. The state will then need to determine whether to maintain some or all of the mandated benefits that are not included in the Essential Health Benefits Package. Importantly the ACA requires states that elect to have additional mandated benefits to pay for them with state, not federal, or premium resources; therefore Maine would need to determine how it would pay the cost of those mandates deemed necessary for Maine residents purchasing through the Exchange. Federal subsidies cannot be used to cover the cost of a benefit that is not included in the Essential Benefits Package.

2. Cost Sharing Standards

The ACA also places limits on the share of the cost of covered services that must be paid by the enrollees through deductibles, copayments, and coinsurance. With the exception of a catastrophic plan that is only available to individuals under 30 or who have demonstrated financial hardship, all plans offered through the Exchange will be required to have an actuarial value of at least 60%. This means that on average, the insurer must pay at least 60% of the costs of covered services for individuals enrolled in the plan. This is measured across the entire population, and the actual share of the cost will vary from individual to individual. The insurer will pay the entire cost after someone who needs extensive health care services exceeds the plan's out-of-pocket maximum, while those whose health care needs are within the plan's

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outside the Exchange. At this time, federal agencies have not provided guidance on the applicability of these coverage standards to large group insurance or to self-insured group health plans.

deductible will pay the full cost, except for those preventive services that the ACA exempts from deductibles and copayments. Plans offered through the Exchange are classified as Bronze, Silver, Gold, or Platinum, with actuarial values of 60%, 70%, 80%, and 90% respectively. For individuals with incomes up to 250% of FPL who buy Silver plans, subsidies are provided to reduce the cost sharing they would otherwise be required to pay.

In addition, deductibles for all small group health insurance, whether or not offered through the Exchange, must not exceed $2,000 per individual or $4,000 per family. Also, if an employer's health plan has an actuarial value of less than 60%, then its employees with family income below 400% of FPL will be eligible to buy coverage in the Exchange, with the assistance of premium tax credits, potentially triggering employer tax penalties.

3. Medical Loss Ratio

The ACA places a national minimum medical loss ratio (MLR) standard on insurers. MLR measures the amount of the total health insurance premium that is utilized to pay for medical expenses versus administrative expenses and profit. Specifically, the ACA requires a MLR of 80% for individual[35] and small group plans, and a MLR of 85% for large group coverage. Further, the ACA requires that if the insurer fails to meet the MLR requirement it must provide rebates to consumers in amounts equal to the dollar value of the difference between the actual and the required MLR.

Unlike many states that will be applying an MLR requirement for the first time, Maine currently has MLR requirements in place in the individual and small group market. The minimum MLRs are as follows:

- 65% for individuals
- 75% for small groups (78% without prior rate review)

Maine does not currently require a minimum MLR for large group coverage.

For purposes of the ACA, an insurer's MLR includes total incurred claims plus total expenses incurred for improving health care quality, divided by premium net of taxes and fees. This is different from existing state law and insurance accounting definitions of MLR, and the ACA required the National Association of Insurance Commissioners (NAIC) to make recommendations on standards, including a definition of expenses incurred for improving health care quality. The Secretary of Health and Human Services recently adopted the NAIC's MLR recommendations, which designate activities that have a direct patient benefit and improves health care quality and desired health outcomes in a measurable way. This can include care management, care coordination and disease management. It also includes wellness and health promotion activities, including public health marketing campaigns.

[35]The Secretary of HHS is authorized to adjust the MLR threshold in the individual market in states where an 80% threshold may destabilize the individual market. Criteria for the waiver were established in regulations promulgated in November 2010. The State of Maine, through its Superintendent of Insurance, has requested a waiver from the individual MLR requirement, citing concerns over instability in the market if one of the two insurers currently offering individual coverage in Maine should leave the market based on the MLR requirement.

The definition does not include initiatives that are primarily focused on controlling or containing costs. In addition, generally marketing, accreditation fees, fraud prevention efforts, utilization review, medical underwriting, executive salaries and bonuses are excluded.

4. Community Rating Changes and Reinsurance Provisions

The ACA includes requirements on insurers in both the individual and group markets, in and out of the Exchange, in developing premiums that allow premiums to vary within a community by no more than 3 to 1 based on age and 1.5 to 1 based on tobacco use. Mathematically, this translates to a premium band that can be 50% above or below the average premium based on an individual's age, and plus/minus 20% based on tobacco use.

Maine has a community rating requirement today that combines both age and geography and limits the community variation to plus/minus 20% based on age and geography. This means the highest and lowest premiums may not differ by more than 1.5 to 1 (or 20%) for age and geography for individual market rates.[36]

The ACA allows states with narrower rating bands to maintain their rules. Maine will need to evaluate whether or not to modify its community rating standard based on the federally required minimum. In theory, moving to a 3 to 1 rating standard would result in lower health insurance costs for younger adults and higher costs for older adults. To determine how this change would impact made, significant analysis is needed, particularly in a state with a population with a higher proportion of older residents. Maine has the flexibility within its Exchange planning grant to conduct this actuarial analysis.

In addition to introducing a federal minimum for community rating standards, the ACA creates a temporary reinsurance mechanism, available between 2014 and 2016, to equalize risk across patients. One of the two temporary mechanisms requires states to establish or contract with a non-profit reinsurance entity that collects payments from insurers and third-party administrators for self-insured plans and pays out funds to insurers providing individual coverage and those selling plans in the Exchange that cover high-risk individuals. The ACA also requires the HHS Secretary to establish a risk-corridor program for qualified health plans offered in the individual and small group market for 2014 through 2016. To the extent costs in those plans are higher than 103% of target costs, plans will receive payment from HHS. However, if costs are lower than 97% of target costs, plans will be required to reimburse the Secretary of HHS.

5. Benefit Changes

The ACA includes significant changes to benefits that plans can offer and provides some limited-time benefits that remain in place until Exchanges become operational in 2014. As described below, some health plans that are considered "grandfathered plans" will not need to incorporate all of these changes.

Effective June 23, 2010, the ACA provided an early retiree reinsurance grant program that provides relief for employers who apply and qualify for a federally funded temporary

[36]Federal law limits the variation between the highest and lowest premiums, while Maine law limits the variation of all premiums above or below the base rate. For purposes of comparison, each method is shown alongside its mathematically equivalent counterpart.

reinsurance program for employers covering retirees who are over age 55 but not yet eligible for Medicare. Participating employers will receive coverage for 80% of claims between $15,000 and $90,000 for retirees and their dependents. The ACA appropriated a maximum of $5 billion for this program. Many employers in the State of Maine are receiving this funding.[37]

The ACA made the following changes that became effective September 23, 2010:

- Dependent coverage to age 26
- No lifetime limits allowed on policy coverage
- No pre-existing condition exclusions for children
- No discrimination in insurance offerings based on salary[38]
- Appeals and Reviews
- Coverage of preventive care without cost-sharing

Nationally, these changes are expected to have less than a 5% impact on total premium costs. Prior to the enactment of the ACA, Maine gave fully insured employers the option of offering coverage of dependents to age 25. The ACA expanded this requirement in that it requires all health plans and groups to offer to a family and extends the age to 26. This change applies to all plans, including grandfathered plans.[39] Further, Maine law does not include a married dependent or a dependent with children as eligible for coverage while the federal law applies to all dependents regardless of marital status. This change is expected to have a small impact on premiums. Plans that were in effect before Sept. 23, 2010, can wait to extend coverage to dependents until their next enrollment period, however, most of Maine's insurers began extending the coverage beginning in summer of 2010.

Effective January 1, 2011, health plans cannot require member cost-sharing for preventive services, unless the plan meets the requirements of a grandfathered plan as described below. The goal of this change is to improve access to preventive services through the elimination of cost-sharing and to improve health by preventing disease and finding treatable diseases early. The administration issued regulations in July 2010 that specify the preventive services for which cost-sharing is prohibited.

Additional benefit changes go into effect in January 2014. Specifically, health insurance may not:

- Exclude pre-existing conditions for adults
- Place an annual limit on policy coverage
- Have deductibles above limits within the ACA for small group plans
- Exceed standards on out of pocket costs
- Be subject to an employee waiting period of longer than 90 days

[37] Maine employers that are participating in this program are listed on the state's health reform website: www.maine.gov/healthreform.
[38] This requirement existed in Maine prior to the passage of the ACA.
[39] While grandfathered plans must comply, the rules are slightly different in that if the dependent has other employer-sponsored coverage available, he or she is not eligible for the parent's coverage.

*Grandfathered Plans*

The ACA also provides that employers can continue to offer certain plans that are considered "grandfathered."[40] Grandfathered plans are considered protected and are not required to implement all of the consumer protections included within the ACA. To be a grandfathered plan, the plan must have been an existing group health plan or health insurance coverage with enrolled members as of March 23, 2010. The Administration has issued a series of regulations in which they attempt to balance the dual goals of allowing individuals to keep their current plans while ensuring that individuals receive consumer protection provisions of the ACA. To retain a plan's grandfathered status, employers may only make minimal changes. Specifically, employers:

- Must not lower their contribution to health care premiums by more than 5% below the rate of contribution in March 2010;
- Must not raise coinsurance percentages;
- Must not raise copayments or deductibles by more than 15% plus medical inflation;[41]
- Must not eliminate current benefits; and,
- Must not reduce annual limits.

Employers may make some limited changes to their current plans and remain grandfathered, including:

- Increasing the number and types of benefits;
- Changing provisions to comply with state or federal regulations;
- Changing plan administrators, if self-funded;
- Voluntarily adopting provisions within the ACA that are not required of grandfathered plans; and,
- Modest adjustment to benefits, cost-sharing and premiums.

As noted above, some changes in the ACA apply to all plans regardless of grandfathered status. In addition to providing dependent coverage to age 26, other changes that apply to all plans include prohibitions on lifetime limits, MLR requirements, limiting employee waiting periods to 90 days and only allowing plan rescissions for fraud or intentional misrepresentation of material fact.

Grandfathered plans are exempt from complying with the following provisions of the ACA[42]:

- Prohibition on pre-existing condition exclusions;
- Essential benefit package requirements;
- Rules on deductible maximums and out-of-pocket maximums;
- Required coverage of preventive services with no cost-sharing;
- Internal and external appeal process rules;
- Prohibition on prior authorization for OB-GYN visits;
- Requirement for same emergency care payment in and out of network; and,
- Nondiscrimination based upon salary.

[40] Section 1251 of the ACA (H.R. 3590)

[41] An additional $5 increase is allowed for copayments, which are typically set as round dollar amounts.

[42] To the extent the ACA includes provisions that already exist in Maine's state laws, grandfathered plans will still be held to Maine's state law requirements if they are fully insured plans.

*Additional Requirements on Health Plans under the ACA*
In addition to the changes described above, the ACA includes a number of additional requirements on health plans. Specifically, health plans must:

- Develop administrative simplification requirements; rules to be adopted by July 2011, and health plans to implement by January 2013.
- Develop uniform explanation of coverage documents and standardized definitions, effective 2012.
- Submit annual reports of quality improvement benefits and reimbursement structures, effective 2012.
- Provide coverage for routine costs associated with clinical trials, effective January 2014.

*Potential for New Plans to Enter the Maine Insurance Market*
The ACA presents a number of opportunities for new plans to enter the Maine insurance market. The potential for new entrants will depend greatly on policy decisions made by Maine, particularly around the structuring of the Exchange and whether to change some state based policies (e.g., community rating) that are tighter than national standards. In addition, the ACA provides repayable loans and seed funding for the development in each state of CO-OP Programs, which are private, non-profit, member-run health insurers that must reinvest any profits in lowering premiums and/or improving quality, and whose presence in the individual and small group market is designed to provide more choice to individuals and small businesses and to spur competition among other private insurers in the Exchange. The Exchange is also required to offer a minimum of two private, nation-wide plans that are administered through the Federal Office of Personnel Management.

Finally, the ACA allows states to enter into multi-state compacts that would allow insurers to offer products across state lines beginning in January 2016. The Secretary of HHS is charged with developing standards for voluntary interstate compacts that will permit sales of insurance products across state lines, working in consultation with the NAIC. The federal regulations will provide specific guidance on which state rules will be waived due to the compact, and which state rules must still be met by an insurer licensed in another state in the compact. At a minimum, the insurance company will still be required to be licensed to do business in each state in which it offers an insurance product. Regulations are due to be released by July 1, 2013.

The State of Maine will need to make a policy decision on whether it would want to join a compact and, if so, with what other states. Legislative approval would be required to enter into a compact. In determining whether to join a compact, the State consider the following questions:

- Who are the current insurers in the Maine marketplace?
- Is there a need for additional insurers in the state?
- If yes, why would additional insurers be helpful?
- Is it possible to engage additional insurers without a multi-state compact?
- What rules would likely be waived if the state were to consider joining a compact and what is the impact on consumers and the market place if those rules are waived?

**e. Medicare Payments**

The ACA makes several changes to the Medicare program, including updating the payment methodology for hospitals through reductions to the market basket update. This methodological change will result in reduced growth in Medicare reimbursement for many providers, including Maine's hospitals.

Medicare payment changes became effective in 2010 and will impact hospital margins and may lead to more costs being shifted to commercial payers. In addition, because MaineCare ties its payment methodology to Medicare, any reduction may also impact growth in Medicaid rates, further exacerbating this problem. It will be important to monitor this impact once the other components of ACA and Medicare payment reform, including provider incentives and potential revenue increases through expanded coverage of the uninsured, become effective in 2014.

**Recommendations**

- Once federal regulations are issued, Maine should compare that list of benefits to its state mandated benefits and consider whether to amend its state mandated benefits to remove any that are not included; or, whether to continue to require such benefits and find state or other funds to pay for the premium cost of those benefits in plans offered in the Exchange.
- Maine should consider the pros and cons of amending its statute to conform the MLR ratios included in the ACA or holding insurers in Maine to both Maine and national standards. As part of this analysis, Maine could also consider a hybrid in model in which for some markets it conforms to the federal standard and others it follows the current Maine standard, based on what is best for consumers and businesses.
- Maine should consider whether to retain its current community rating standards, or whether to amend its community rating standards to meet the federal minimum, and if so, whether to offset any premium increase for older Mainers through reinsurance or other methods. The elimination of group size variation will also have an impact. Maine should consider whether subsidies should be available to offset any potential increase.
- Maine should consider whether joining a multi-state insurance compact in or after 2016 is in its best interest and if so, what states would it like to join with.
- Maine should continue to advocate for a change to the Medicare hospital rate methodology as it applies to Maine.

## V. The Health Insurance Exchange – Options for Maine

One of the innovative aspects of the ACA is the requirement for the establishment of state-level Exchanges. Exchanges have been conceptualized and developed as platforms to improve access to insurance for small businesses and individuals. Exchanges can be attractive alternative distribution channels for small-to-medium sized employers, part-time employees that work for large employers, temporary and seasonal employees, and people purchasing in the individual market. Exchanges can also help facilitate access to premium tax credits and employer tax credits in an efficient, transparent marketplace.

This section presents an overview of the provisions contained in the ACA regarding Exchanges and of the process Maine employed in 2010 to develop options and recommendations for its Exchange. This process included engagement of both a Health Reform Steering Committee (Steering Committee) established by Executive Order and comprising key state officials[43], and the Advisory Council on Health Systems Development (ACHSD), established by the Legislature (members listed in Appendix A) to provide oversight and stakeholder input to develop a state health plan, including its provisions regarding the implementation of the ACA in Maine. These groups participated in facilitated, public discussions regarding the structure and functions the ACA requires of an Exchange and Maine's goals and priorities for an Exchange. This section reviews these discussions and the preliminary direction for a number of high-level policy options. In addition, it lays out a number of operational and implementation decisions that Maine must make in establishing its Exchange.

### a. Overview of Exchange Provisions in ACA

The ACA requires the establishment of an American Health Benefit Exchange (AHBE) in each state by January 1, 2014, which must provide both an insurance marketplace for individuals and a Small Business Health Options Program (SHOP) for businesses with 100 or fewer employees. The federal government will step in and create Exchanges in states that have not made significant progress toward the development of an exchange by 1/1/2013. Planning grant funds were made available to states for up to $1 million per state in September 2010 and additional federal implementation grants will also be available beginning in the spring of 2011. Maine received such a planning grant in the fall of 2010. Technical assistance will also be available for establishing the Exchanges, including model legislation from both the National Association of Insurance Commissioners (NAIC) and the National Association of Social Insurance (NASI). The ACA requires that states consult stakeholders in the planning and development process. Further guidance from the federal government is expected on many of the issues described in this section.

<u>Eligibility for the Exchange</u>

The ACA makes available premium and cost-sharing tax credits for individuals with incomes greater than 133% and not more than 400% of the Federal Poverty Level (FPL) on a sliding-scale

[43]The Steering Committee is chaired by Trish Riley, Director of the Governor's Office of Health Policy and Finance; and includes Mila Kaufman, Superintendent of the Bureau of Insurance, Brenda Harvey, Commissioner of the Department of Health and Human Services, Karynlee Harrington, Executive Director of the Dirigo Health Agency, Ellen Schneiter, Commissioner of the Department of Administrative and Financial Services; and Anne Head; Commissioner of the Department of Professional and Financial Regulation.

basis. Individuals can access these subsidies only via purchase of an insurance product through the AHBE. In addition to subsidized individuals, the AHBE may sell insurance to other individuals as long as they are legal US citizens and legal immigrants who are not incarcerated. However, unsubsidized individuals are not required to purchase insurance through the Exchange.

The ACA makes available tax credits for certain small businesses with 25 or fewer employees with average wages of $50,000 or less. Beginning in 2014, employers taking advantage of these credits must purchase health insurance via the SHOP Exchange. Employers can take advantage of the tax credits outside the Exchange before 2014. Small businesses that are not eligible for the tax credit (up to 100 employees) may also purchase group health insurance for their employees through the Exchange but are not required to do so.

States have some flexibility regarding which employers they permit to purchase insurance via the SHOP Exchange. For example, states can limit the SHOP Exchange to employers with 50 or fewer employees until 2016. Beginning in 2016, employers of up to 100 employees must have the option of purchasing through the state's SHOP Exchange. States can also expand access to the SHOP Exchange to employers with more than 100 employees beginning in 2017.

Insurance offerings inside and outside of the Exchange

The ACA permits both an individual and group health insurance market to continue to exist outside the Exchange. The ACA also provides for the renewal of grandfathered plans outside the Exchange. States can determine how much they want to limit the number and type of product offerings inside the Exchange. Historically, there have been problems with adverse selection in similar programs. This has occurred primarily when products offered outside the exchange have attracted healthier subscribers, or when unhealthy businesses have been attracted to exchanges. The ACA included a number of provisions to mitigate such adverse selection in the Exchange including:

1) An individual mandate to hold "minimum essential coverage," requiring most people to purchase something more than a "skinny benefit plan."
2) Essential health benefits requirements apply to plans inside and outside of the Exchange, thereby standardizing to a certain extent what constitutes insurance.
3) Insurance reforms such as modified community rating, guaranteed issue and renewal, and limits on waiting periods and preexisting conditions apply both inside and outside the Exchange.
4) Individuals (and small groups) inside the Exchange are pooled with non-grandfathered plans outside the Exchange (together if individual and small group markets are merged[44]).
5) Risk-adjustment programs are established, including special transitional programs during the early phases of reform when there is more uncertainty in assessing risk due to changes in the market.
6) Premium subsidies (to 400% FPL), cost-sharing subsidies, and employer tax credits are only available within the Exchange, which should result in a good-sized risk pool in most states.

[44] The Bureau of Insurance is currently studying the impact of a market-merger.

Insurers are not required to participate in the Exchange, and they can remain outside the Exchange offering lower-cost plans unless a state legislates otherwise. If they offer through the Exchange they must offer Gold- and Silver-level coverage before they can sell other levels of coverage to limit "cherry-picking" healthy lives who may gravitate towards less comprehensive plans.

Key functions

Table 1 below provides an outline of the various functions of an Exchange and describes any activities that are specific to the individual and/or SHOP Exchange. The ACA provides varying levels of detail for each of the following functional areas: 1) determine and coordinate eligibility, including management of subsidy and tax credits; 2) create benefit categories of health insurance plans and certify, decertify and recertify qualified health plans; 3) maintain a call center for customer service and establish procedures for enrolling individuals and businesses; 4) establish a website for comparison shopping, 5) assign quality ratings and reward quality; and 6) set up a Navigator program, including delineating the roles of Navigators and brokers.

Table 1: Exchange Functions

| | *Individual Exchange* | *SHOP Exchange* |
|---|---|---|
| Determine and Coordinate eligibility | - Coordinate eligibility determinations for Medicaid, CHIP and other state-level programs<br>- Process exemptions to individual mandate<br>- Facilitate premium credits<br>- Facilitate cost-sharing credits<br>- Facilitate voucher eligibility<br>- Verify if individuals have access to affordable and quality employer-sponsored insurance. | - Facilitate small employer tax credits |
| Create benefit categories of health insurance plans and certify qualified health plans | - Four benefit levels + separate catastrophic plan: Bronze, Silver, Gold, Platinum, Catastrophic<br>- Certify qualified health plans and approve insurers to offer them | - Four benefit levels: Bronze, Silver, Gold, Platinum<br>- Certify qualified health plans and approve insurers to offer them |
| Contract with qualified health plans, and co-ops to offer health insurance | Solicit and negotiate bids, contract for coverage | Solicit and negotiate bids, contract for coverage |
| Maintain a call center for customer service and establish procedures for enrolling individuals and businesses | - Assist consumers in selecting plan<br>- Maintain call center | - Assist businesses in selecting a plan for their employees<br>- Assist employees of enrolled employers in selecting a plan<br>- Establish a process for enrolling employees from single employer into multiple plans<br>- Assume aggregator role |
| Establish a website for comparison shopping | For individuals, subsidized and not | For small employers and their employees |

| | | |
|---|---|---|
| Assign quality ratings and reward quality | Developed by HHS | Developed by HHS |
| Set up Navigator Program | Grants to organizations that assist individuals in enrolling | Grants to organizations that assist employers and employees in enrolling |

**b. Planning Process for Maine's Exchange**

Maine began its overall reform planning process soon after the ACA was enacted. Maine was able to use funding provided by a planning grant from Health Resources and Services Administration to begin an education and planning process with stakeholders, which included identifying high-level policy options for the Exchange. Those efforts are conducted through a partnership with consultants from Bailit Health Purchasing (Bailit), whose team includes former state officials responsible for including language in Massachusetts' reform bill regarding the establishment of an Exchange--now called the Massachusetts Health Insurance Connector Authority. Maine established significant infrastructure to support the planning for the Exchange, including:

- The Governor convened, by Executive Order, a Health Reform Steering Committee that comprised key state officials and has charged a legislatively established group; the Advisory Council on Health Systems Development (ACHSD), to provide oversight and stakeholder input. These groups are working with the Legislature as well, including the Joint Select Committee on Health Reform.
- Prior state-level reforms place Maine ahead of the coverage curve and align the state's insurance market regulations with the new federal rules making it easier to move forward on establishing an Exchange.
- Maine's 2010-2012 State Health Plan commits the state to implementing the ACA, including considering the establishment of an Exchange.
- The state already administers, through the Dirigo Health Agency (DHA), health care tax credits; insurance subsidies on a sliding scale for individuals, self-employed and employees in small businesses under 300% FPL; an insurance voucher program; and the Pre-Existing Condition Insurance Plan. DHA has also developed a consumer-focused call center and a website that it is in the process of enhancing.
- DHS has already established a Medicaid eligibility portal to streamline eligibility
- Maine's commitment to quality measurement and data reporting through the DHA's Maine Quality Forum and private sector groups like Maine Health Management Coalition and QualityCounts give the state a head start on federal reforms and provides a good foundation on which to build payment reform within an Exchange environment.

Before attempting to answer the key policy questions, it was important for stakeholders to identify the problems Maine is hoping to address by establishing an Exchange. Too often, solutions are proposed before a thorough understanding of the problem and consideration of all potential solutions is contemplated.

Maine used its format of public meetings to discuss the problems it hoped to address with the establishment of an Exchange. For each issue, the steering committee first identified the problem and then the ACHSD provided input and confirmation regarding each problem:

- High insurance costs
  - Small to medium firms dropping coverage
  - Part-time and seasonal workers have difficulty affording coverage
- Limited transparency in insurance purchase and healthcare system
  - Difficult to compare products
  - Confusing for consumers
  - Limited Information available on quality and cost of plans and providers
- Lack of continuity for individuals moving between health insurance coverage types
- Current payment structures do not provide incentives for primary care and prevention
- Limited choice of carrier in individual and small group markets

The Steering Committee and ACHSD did not attempt to prioritize these problems but rising health care costs resonated the most with members of both groups. Next, it was important to describe and fully understand the elements and/or policies contributing to the problems identified above. Some of these issues may be very familiar to state policymakers, but questions involving Maine's insurance markets and the employer-based health insurance system may require additional data gathering and analyses during the implementation phase.

The next step in the discussion of policy options for Maine's Exchange was to identify and prioritize the core goals for the Exchange, linking these goals to the identified problems. The same process was followed; that is, the steering committee identified the goals for Maine's Exchange and then the ACHSD reviewed the goals. There was a lively discussion about the goals and whether the Exchange was necessary and/or sufficient to accomplish them.

**The ACHSD recommends the following goals**:

*1.* **Improve Health of Mainers:** The overarching goal of the ACA is to improve the health of residents of the United States. Members from both the Steering Committee and ACHSD reminded us that this should be the overall goal of Maine's Exchange as well.

*2.* **Insure more people:** The primary role of an Exchange is to increase the number of people with health insurance. The Exchange can help to facilitate this by simplifying the purchase of insurance for individuals and businesses, streamlining the eligibility process for public programs, coordinating among programs, facilitating premium and cost-sharing credits for individuals and tax credits for employers making health insurance more affordable, and by allowing premium aggregation for people with multiple part-time jobs, and two-worker households. The Exchange can also be the primary source for information and education in the state on health care reform thereby helping individuals and employers to understand their responsibilities regarding the purchase of health insurance.

*3.* **Improve overall quality and satisfaction through payment reform, benefit design and quality incentives:** The Exchange **can be** a primary platform for integrating payment reform and quality incentives into the health care delivery system. This may be possible because the

Exchange will likely have significant market share and the Exchange could either require these activities as a condition of participation or reward plans that include features that improve the delivery of health care services. These improvements in care should result in high levels of satisfaction for Mainers.

*4.* **Standardize, simplify and increase transparency in insurance purchase:** The Exchange is required to standardize insurance products and to simplify the process of purchasing insurance for consumers. One goal for Maine's Exchange is to establish a process that reflects Maine's population needs and one that works with its diverse residents. It will be important to understand the amount and type of choice that consumers desire and to provide the level of standardization that allows for easy comparisons among the products and enrollment in products that best meet consumers' needs. The Exchange must also integrate information regarding the quality and cost of health care providers into the information system so a consumer purchasing a product with a particular provider network will be able to make informed decisions.

*5.* **Create a more robust market for health insurance**: This goal is directly linked to several of the problems identified earlier. In addition to a perceived need for greater choice overall, it is believed that with greater competition will come lower costs. Since Maine has a limited number of carriers in the small group and individual markets, some stakeholders believe that increasing carrier choice for consumers in these markets is an important element to improving the competitiveness of Maine's insurance markets. Availability of subsidies will bring a new market and possibly attract more competition. Maine has several choices to consider in making the market more competitive. For example, options could include other carriers, a "public" plan, multistate plans offered by the federal Office of Personnel Management, interstate plans, and plans offered by non-profit insurers under the CO-OP program, or qualified direct primary care medical home plans.

*6.* **Increase portability and choice:** An Exchange can increase portability for consumers in several ways. First, the ACA requires that the state Exchanges coordinate eligibility for both Medicaid and the tax subsidies through a single, streamlined eligibility system. Second, a state could choose to offer similar plans offered by the same carriers in their Medicaid and Exchange programs. Third, if a state decides to merge its individual and small group markets, the same plans available to individuals could be available to employees of small firms. The tasks involved in making this type of portability possible would not be easy, and therefore Maine needs to fully evaluate the benefits and challenges of increased portability.

Increasing choice is an important goal for Maine's Exchange. Through the Exchange alternative products will become available to Mainers, including national private plans and, potentially, plans offered through the CO-OP program and through multi-state compacts. In addition, greater choice of insurance products for employees of Maine's smaller businesses is also likely.

*7.* **Reduce the rate of health care cost growth:** Escalating health care costs in Maine are one of the major problems stakeholders identified. One goal for the Exchange is to reduce administrative costs associated with health insurance, thus lowering premiums. An Exchange can help facilitate a reduction in administrative costs through centralized enrollment and marketing for individuals and small businesses. The Exchange can also help to facilitate lower

health care costs by increasing portability so that an individual can remain with an insurance plan longer, offering the plan the possibility to better manage the beneficiary's health in partnership with providers and consumers,. In addition, the Exchange may help improve value through the power of consolidated purchasing and/or the competitive effects of improved transparency of cost and quality information for purchasing decisions.

These goals should help to shape the first-order policy decisions that need to occur before Maine can begin to contemplate the myriad smaller policy and implementation decisions involved in getting its Exchange up and running.

### c. High-level Policy Options for Maine's Exchange

This section presents several high-level policy questions and includes highlights from the discussions among Steering Committee and ACHSD members. Following the description of each set of options is a tentative direction based on the steering committee and stakeholder discussions.

These discussions are useful in providing direction to the planning team as it moves towards developing a "strawman" proposal for the Exchange, and they are consistent with the recommendations of the Legislature's Joint Select Committee on Health Reform.

i. *Should Maine create its own Exchange or wait for the federal government to establish one for it?*
States accepting responsibility for the Exchange must establish an American Health Benefit Exchange (AHBE) to serve individuals who receive tax credits as well as others who are purchasing insurance on their own. The law also requires the AHBE to establish a Small Business Health Option Programs (SHOP) for employers with 100 or fewer employees. States can opt to operate both of these pooling entities under a single Exchange. Unless state policymakers choose to have the federal government regulate insurance in Maine, the Bureau of Insurance would be responsible for reviewing and approving the policy terms and premium rates for the insurance products and regulating the market conduct and financial condition of the insurers offering coverage through the Exchange, as it does for other insurance products.

In considering whether to operate a state-based Exchange or to default to the federal government, there are a number of issues to consider, including:

- Coordination with other health coverage programs
- Amount of desired flexibility
- Uniqueness of market characteristics of Maine
- Capacity and infrastructure within the state to operate an Exchange
- Implementation timeline
- Efficiency of running a state-based Exchange

There are many benefits to Maine establishing its own Exchange but there are also challenges. The benefits and challenges are described below.

**Coordination with other health coverage programs**
It would likely be less complex to coordinate benefits and eligibility across all of Maine's programs if the Exchange operates in the state as opposed to the coordination being done by the federal government or across multiple states. If Maine allows the federal government to manage its Exchange, the state would not have as much flexibility in the operation of its Exchange. This could create gaps in regulation, uncertainty as to which standards apply, and problems in coordination between Maine's Bureau of Insurance and the federal government. Moreover, if rating rules or other regulatory provisions are different for plans operating in the Exchange from those operating in the outside market, these differences could cause selection problems. While it is possible that a multi-state or regional Exchange could coordinate with its state programs and, at the same time, coordinate with other states, it would be more complicated to design and implement such a structure.

**Amount of desired flexibility**
Although there will be federal standards for the state-level Exchanges, it may be desirable to customize Maine's Exchange to best meet the needs of Maine's residents. Relinquishing this responsibility to the federal government would likely create more work for agencies required to coordinate with the Exchange and may not provide enough flexibility regarding implementation issues that arise. There is greater likelihood that Maine can have an Exchange that meets its priorities if it establishes its own Exchange.

**Uniqueness of Market Characteristics**
Maine has unique market characteristics, including a larger than average proportion of small businesses, a large seasonal and part-time workforce, and a large middle-income population, many of whom will be eligible for subsidies through the Exchange. Maine's rating laws are different from the national standards established by the ACA but are similar to other New England states. While Maine will need to consider whether to adopt all of the national standards, thoughtful consideration should be given to what impact such changes will have on the insurance markets and on individuals and businesses purchasing insurance in these markets.

**Capacity and Infrastructure**
Maine has significant existing capacity to operate an Exchange as many of the necessary functions are already performed by the Dirigo Health Agency and other state agencies. The table below shows the functions of the Exchange that the state currently performs. Maine is ahead of many other states in having managed many of these activities in some capacity. However, not all of the functions are currently handled by a state agency. Moreover, some activities will require Maine to augment its current infrastructure to meet all of the demands of the Exchange. Because of these existing internal resources, the task before Maine is not as complex as it would otherwise be. Policymakers should be careful to avoid creating duplicative rules or structures and should take advantage of this existing capacity.

**Table 2: Current State Infrastructure**

| | Dirigo | Maine DHHS | Maine BOI | Maine State Employee Health Insurance Plan | Exists in State |
|---|---|---|---|---|---|
| Eligibility | | | | | |
| Determine public program | | X | | | X |
| Determine subsidies for private insurance | X | | | | X |
| Determine employer vouchers | | | | | |
| Determine employee vouchers | X | | | | X |
| Determine affordability waiver | | | | | |
| Determine affordability exemption | | | | | |
| Determine employer access | X | | X | | X |
| Refer applicants to other programs | X | X | X | | X |
| Benefit and Plan Interaction | | | | | |
| Contract with carriers | X | X | | X | X |
| Standardize benefit categories | | | X | | X |
| Classify plans by actuarial value | | | | | |
| Certify qualified health plans | X | | X | | X |
| Reward quality through market-based incentives | | | | X | X |
| Assign quality ratings to plans | | | | X | X |
| Conduct risk adjustment[45] | X | | | | X |
| Customer Service | | | | | |
| Establish and run call center | X | X | X | | X |
| Enroll individuals | X | | | X | X |
| Enroll businesses | X | | | | X |
| Maintain website with cost and quality information | X | | X | X | X |
| Provide cost calculator | X | | | | X |
| Premium Payment and Collection | | | | | |
| Pay brokers | X | | | | X |
| Manage Navigator program | X | | | | X |
| Pay premiums to carriers | X | | | X | X |
| Aggregate premium from multiple sources | X | | | | X |

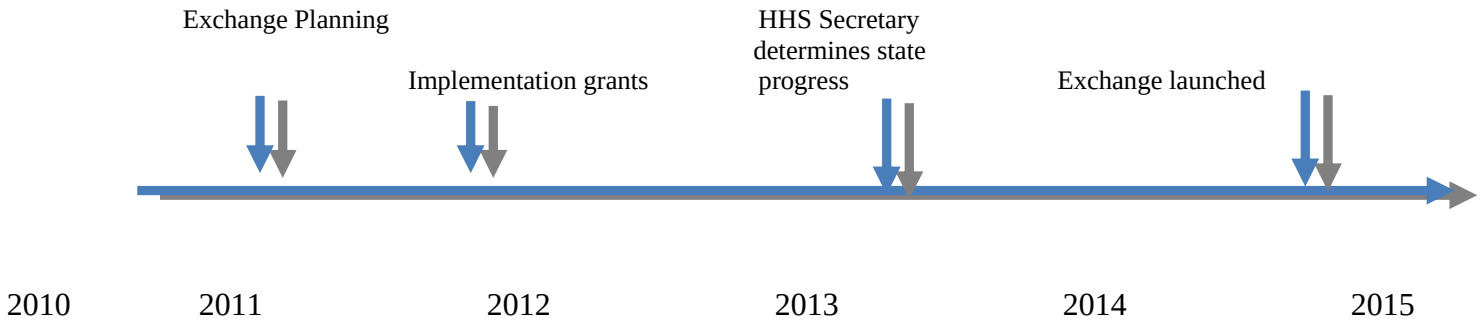
## Implementation Timeline

Figure 1 provides a high-level implementation timeline for the Exchange. Because this timeline is very ambitious, it leaves little time for an initial planning process. In addition to the higher-level decisions being discussed here, there are numerous smaller policy and operational decisions that must be made prior to the establishment of the Exchange. It is a simpler process for Maine to manage these decisions if it is creating its own Exchange. There is a level of complexity

[45] The Dirigo Health Agency established an Experience Modification Program (EMP) program a form of experience underwriting not uncommon in start-up association like plans where the risk of the population is unknown for the first two years of the DirigoChoice Program. The EMP protected the DirigoChoice pool from adverse selection in the early days of the program.

added to the decision-making process if Maine needs to coordinate its implementation with the federal government.

**Figure 1: Implementation Timeline**




**Efficiency of Running a State-based Exchange**

Maine's population is about 1.3 million. Experts have suggested that about 100,000 lives are necessary in order to establish an Exchange that is financially self-sustaining. Nearly fifty percent (500,000) of Mainers are eligible for premium tax credits based on income alone. However, many of these individuals may continue to receive health insurance from their employers and will not be eligible for tax subsidies. Recent estimates from the Lewin Group[46] found that an estimated 125,300 Mainers will be eligible for the premium tax credits in 2014. Further Maine-specific modeling will need to be conducted to determine accurate estimates of the number of lives who will be receiving coverage through the Exchange. In addition to subsidizing coverage for some Mainers, the Exchange may also attract others who are purchasing insurance without a subsidy as well as businesses purchasing on behalf of their employees. Although it may not be efficient to run a state Exchange in every state, it seems fairly clear that Maine's unique characteristics, combined with its capacity to operate an Exchange, position the state to take on this responsibility.

**Summary**

The advantages of Maine operating its own Exchange instead of defaulting to the federal government include ease of coordinating the Exchange with other state-level programs and ensuring a maximum amount of flexibility in implementing an Exchange that adds value for Mainers, especially given the uniqueness of Maine's market characteristics. The State already has significant infrastructure within its state agencies that it can build upon during the planning and implementation phase.

[46] Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit in Maine, September 2010 by Families USA.

The primary challenge to Maine in implementing its own Exchange is the long-term requirement to make the Exchange self-sustaining. As part of its Exchange planning grant, Maine will develop a plan for sustainability for the Exchange once federal start up money ends.

**Recommendation: Pursue the establishment of a state-based Exchange in Maine.**

*ii. Should Maine create separate Exchanges for individuals and businesses or just one Exchange serving both individuals and businesses?*

If Maine decides to implement its own Exchange, subsequent questions arise. The first question posed to the steering committee and ACHSD was whether Maine should establish one Exchange for individuals and a separate one for businesses, or merge the two under one Exchange. The question was *not* whether the two insurance markets should be merged; the Bureau of Insurance is now studying that question. In considering whether to operate two Exchanges or one Exchange each for individuals and businesses, a number of issues were considered, including:

- Coordination between individual and small group Exchanges
- Resource requirements
- Impact on the market
- Ability to cater to specific needs of individuals and/or businesses

**Coordination between individual and small group Exchanges**

Individuals move between employer coverage and individual coverage as their employment status changes. Having one Exchange that serves both individuals and businesses makes it easier for people to know where to go to purchase insurance. In addition, if there is one Exchange, decisions that affect either individuals or employers can be more thoughtfully considered to ensure coordination of policies. Should a decision be made to merge the markets, having one Exchange would also promote continuity and portability in coverage as the same products would be available both to individuals and small businesses in the Exchange.

**Resource requirements**

The resource requirements for establishing and operating an Exchange are not insignificant. The federal government is planning to provide funds to states for implementing Exchanges but beginning in 2015, state exchanges must be self-sustaining. If two Exchanges are established, the resource requirements would not be doubled since some of the infrastructure could be shared. However, capital requirements and staffing needs would be greater if two separate entities are established. There would certainly be economies of scale achieved if only one Exchange were established with two "product lines," one catering to the needs of businesses and one to the needs of individuals.

**Impact on the market**
As mentioned earlier, recent estimates from the Lewin Group[47] found that an estimated 125,300 Mainers will be eligible for the tax credits in 2014. Further Maine-specific modeling will need to be conducted to determine accurate estimates of the number of lives who will be receiving coverage through the Exchange. Since all subsidized individuals are required to purchase insurance through the Exchange, this number represents the low end of Maine's estimated Exchange participation. At the high end, there are 500,000 individuals in Maine who would be income eligible for a subsidy. In addition to subsidized individuals, beginning in 2014, small businesses seeking a tax credit will also be required to purchase through the Exchange. It is unclear how many small businesses in Maine will take advantage of these tax credits. It is also difficult to estimate how many individuals and businesses who are not subsidized will choose to purchase through the Exchange. Experts have noted that in order for an Exchange to function efficiently at least 100,000 members are needed. It seems that Maine's AHBE will meet this requirement but is unclear whether a SHOP Exchange operating in Maine could meet this level of membership.

**Ability to cater to specific needs of individuals and/or businesses**
The Steering Committee and ACHSD discussed the different customers who would be served by the individual and SHOP Exchanges. The ACHSD recognizes that individuals and small businesses obtain insurance in different ways. They noted that it might be difficult for one entity to balance the differing priorities of these two groups. The roles of the Exchange as put forth in the ACA are quite broad. Moreover, there is greater specification in the ACA regarding the individual Exchange than the SHOP. Some ACHSD members worried that the priorities of small businesses could get lost in the effort to launch the AHBE for subsidized individuals. In addition, the AHBE could be perceived as more of a "government program" and businesses may not view the entity that is managing the subsidized program as a place where they can purchase private insurance for their employees. Today the Dirigo Health Agency provides access to coverage for both individuals and small businesses.

If the two entities are merged into one Exchange, it is clear that significant marketing and promotion of the SHOP functions will be needed. In addition, efforts will need to focus on separate on-line and customer service needs of individuals and businesses.

**Summary**
There was consensus from both the steering committee and ACHSD that the advantages to Maine of operating a single Exchange that served both individuals and businesses outweighed the disadvantages. There was interest voiced that the Exchange establish separate lines of business within the Exchange to ensure viability of both programs and that the priorities of each group be met. Moreover it was stressed that marketing, outreach, and customer service activities be designed to meet each group's particular needs.

[47] Ibid.

**Recommendation: Establish a single Exchange serving both individuals and businesses that supports the unique needs of each market**

*iii. Should Maine have one or more Exchanges to serve geographically distinct regions of the State?*

The ACA allows for states to operate more than one Exchange if the regions of the state are distinct enough to warrant multiple Exchanges. This issue did not require extensive discussion within either the steering committee or ACHSD as many of the issues discussed above were reiterated here, and members of the two committees generally felt that Maine's population of just over 1.3 million people could be covered by one Exchange. Moreover, the insurance carriers licensed to operate within the state are available statewide. It seemed obvious to everyone that administrative efficiencies could be realized if just one state-wide Exchange were established but it was noted that there would need to be special outreach to individuals and businesses in the rural areas of Maine. In addition, there are certain geographic areas of the state that do not have access to broadband or WIFI and therefore, other strategies would be necessary for reaching individuals and businesses in those areas. Finally, it was noted that the governance structure of the Exchange should reflect the geographic diversity of the state.

**Recommendation: Maine should have one Exchange serving the entire state.**

*iv. Should Maine collaborate with New England states on some or all Exchange functions?*

Another important decision is whether Maine should establish or join a regional exchange. As with the initial question of whether Maine should administer an Exchange at all, considerations include coordination, capacity, flexibility, efficiency and similarity of market characteristics (including demographics of those who will be purchasing through the Exchange, number and type of carriers and plans, employer offer rates, etc.).

**Coordination with other health coverage programs**

It would likely be less complex to coordinate benefits and eligibility across all of Maine's programs if the Exchange operates in the state as opposed to multiple states performing this coordination role. If Maine establishes or joins a regional Exchange, it is also unclear who would have oversight over the insurance products offered through the Exchange. This could create problems in coordination between Maine's Bureau of Insurance and other states' insurance regulators. Moreover, although a full examination is not yet complete, rating rules and other regulatory provisions differ on a number of factors within the New England states. In a multi-state Exchange it would be important to synchronize these rules within the Exchange. In practice, that would also mean synchronizing the entire insurance market, because different rules for products sold inside the Exchange from those sold outside the Exchange would invite market distortions such as adverse selection. Also, Medicaid programs across the New England states differ and this will also make it difficult to coordinate seamless eligibility requirements.

**Amount of flexibility desired**
Although federal standards for the state-level exchanges are not yet fully specified, it seems clear that the federal government wants to provide states with a fair amount of flexibility in implementing their Exchanges. It may be desirable to customize Maine's Exchange to best meet the needs of Maine's residents. If Maine establishes or joins a multi-state Exchange, it would need to ensure that the goals and priorities for the other states are more or less in line with Maine's priorities and goals. There is greater likelihood that Maine can establish an Exchange that meets its priorities if it has the maximum amount of flexibility which means establishing its own Exchange.

**Uniqueness of Market Characteristics**
Maine has unique market characteristics, including a larger than average proportion of small businesses, a large seasonal and part-time workforce, and a large middle-income population, many of whom will be eligible for subsidies through the Exchange. As mentioned above, Maine also has unique rating rules that are different from the other New England states on a number of counts. While Maine (and other New England states) will need to consider whether to move towards the national standards on a number of these issues, it could be problematic to move these standards without thoughtful consideration regarding the impact it will have on the markets in Maine.

**Capacity and Infrastructure**
Another important consideration is determining what capacity currently exists (both public and private) to operate a state-level Exchange. The start-up costs of an Exchange would be lower if it were built upon an existing infrastructure. Maine has already considered the functionality that exists in state agencies (see Table 2). Maine has significant experience working with vendors to facilitate premium assistance and subsidy/voucher programs for eligible individuals and employers.

Maine should also assess existing private infrastructure, such as distribution channels for small employers purchasing insurance for their employees. These entities sometimes go unnoticed by policymakers, but such private-sector intermediaries may provide small groups, and in some instances individual consumers, with a central point of access to compare health benefits and select a health plan from among a number of carriers. This is much of the infrastructure needed to launch a broader Exchange.

Maine has significant existing capacity to operate an Exchange. Maine is ahead of many of the New England states (Massachusetts may be the exception, but it is unlikely to join a multi-state Exchange). It seems prudent for the state to take stock of these resources as opposed to creating an entirely new multi-state Exchange.

**Implementation Timeline**
The federal implementation timeline for establishing state-level Exchanges is extremely ambitious. It will be difficult for many states to meet these deadlines. Coordinating an effort this large across other states will increase the complexity of implementing an Exchange and will likely slow down the process. In addition to the higher-level decisions being discussed here, there are numerous smaller policy and operational decisions that must be made prior to the

establishment of the Exchange. Although difficult, it is a simpler process for Maine to manage these decisions if it is creating its own Exchange.

**Efficiency of Running a State-based Exchange**
Although it may not be efficient to run a state Exchange in every state, it seems fairly clear that Maine's unique characteristics, combined with its capacity to operate an Exchange, position the state to take on this responsibility. There was interest and discussion among the steering committee and ACHSD around multi-state Exchanges and whether the benefits of economies of scale and increased portability would outweigh the costs. It was agreed that the state should work with the other New England states to collaborate on administrative "back office" functions considered feasible and beneficial and that such collaboration might extend to various aspects of Maine's state-based Exchange.

**Summary**
The advantages of a regional Exchange include some economies of scale, in addition to some added portability that could result from having product availability across contiguous states. However, given the ambitious federal timelines, challenges of working across states with multiple state agencies and Maine's differing provider and insurance carrier profiles compared with neighboring states (NH, VT and MA) it is unlikely that a regional Exchange would be initially desirable. In addition, federal start-up funds will be available to states soon and Maine should take advantage of this opportunity initially to build the needed infrastructure – including effective and seamless eligibility systems – for the overall reform activities. This option would not preclude some regionalization of certain aspects of the Exchange, such as data sharing and opportunities for regional demonstration projects or grants and the potential to share some functionality with neighboring states.

**Recommendation: Maine should pursue establishment of its own Exchange while concurrently working with other New England states to collaborate as much as possible on certain Exchange functions.**

*v. Where should Maine's Exchange be located and what governance structure should it have?*
The Exchange needs the capacity to accomplish an extensive list of tasks—including (but not limited to) processing applications, determining eligibility for premium tax credits and cost-sharing subsidies, developing and maintaining a website, paying commissions, ongoing marketing and outreach, and developing and maintaining an electronic interface. Important questions about location and governance structure for the Exchange were presented to the steering committee and ACHSD. They discussed the following issues:

- Coordination with other state programs and agencies
- Amount of desired flexibility
- Amount of desired accountability and transparency
- Degree of state authority preferred
- Desired amount of political influence

- Perception by individuals and businesses

**Coordination with other state programs and agencies**
The ACA requires coordination of eligibility determination for Medicaid, CHIP and premium tax credits. In addition, a state may desire enhanced coordination with other public programs, with benefits and health insurance plans, and for transitions from public-to-private and individual-to-employer coverage. Overall coordination may be less complex if the Exchange is located within a state or quasi-state entity.

Whether a non-profit administers the Exchange or the responsibilities are located in a state or quasi-state authority, the Exchange will require some interface with other state operations including the HHS department and the Bureau of Insurance. Data sharing between the Exchange and the federal government, and between the Exchange and other state agencies is easier to facilitate if the Exchange is within the state's infrastructure. Moving outside that realm to a quasi-state agency, or to a non-profit organization, these arrangements, although not impossible, become much more complex not only due to technical issues such as differing computing standards, but also significant privacy concerns.

**Amount of desired flexibility**
If the Exchange is housed in a state agency, state procurement rules, staffing levels and hiring procedures may not be as flexible as what is desired for an entity that will oversee functions that contain both public and private aspects. In Massachusetts, the quasi-state agency structure provided the right balance of flexibility from state agency rules while maintaining the level of accountability important in overseeing the public aspects of the Exchange.

**Amount of desired accountability and transparency**
The ACA contains a host of requirements on plans participating in Exchanges that should significantly improve the transparency of insurance products. Such provisions include: information on claims-payment policies and practices, financial information, data on enrollment and disenrollment, data on claims denials and rating practices, information on cost-sharing and out-of-network coverage and data on enrollees' rights. A fully governmental organization is subject to the greatest level of accountability and transparency although enabling legislation could include provisions to ensure greater transparency should Maine prefer that the Exchange be housed in a quasi-state agency or non-profit.

**Degree of state authority preferred**
The ACA provides significant flexibility in this area. The ACA requires that the Exchange be housed either within a state organization or a non-profit but provides no guidance on how the governing boards are constituted and appointed, nor on how state Exchanges are expected to relate to and interact with other state entities.

Maine could operate its Exchange within an executive branch agency. Under this model, an advisory board might be established to provide input and advice on Exchange policies and procedures but the ultimate decision-making authority and responsibility would rest with the administration. A government agency model would provide the greatest degree of state authority but would be significantly influenced by changes in administration and politics. As there does

not appear to be an environment to create a new agency, the Exchange may be housed in an existing agency. However, if it is not a distinct entity, it may get lost within other responsibilities of an existing agency. Further, at least one existing entity – the Bureau of Insurance – has noted a potential conflict in taking on responsibility for the Exchange given its primary regulatory role.

Housing the Exchange in a non-profit organization would put the state at an arm's distance from necessary and time-sensitive decision-making. In addition, states are ultimately responsible for implementing many of the provisions in the ACA and it seems the benefits gained from placing the Exchange in the hands of a non-profit may not be worth this significant trade-off in oversight and authority.

A quasi-public-private structure could provide the proper balance between decision-making and responsibility. The Legislature will define accountability for the quasi-state entity and establish a board governance structure of the entity that allows the state to have some say in how policy decisions are made. Under this model, a balance would need to be struck between policy-setting responsibilities of the Legislature, the Administration and the board, and the administrative responsibilities of Exchange staff. In general, boards can provide oversight for broad policies such as approving major contracts with vendors, and setting carrier selection criteria and standards for transparency.

If a quasi-state entity is used, decisions remain about the responsibilities of the board and how the governing board is constituted and appointed. Questions include who can serve on the boards, how many members will make up the board and for what length of term. It may be important that members be chosen for their professional and community leadership and experience. In addition, members with backgrounds in business, consumer advocacy, health care, insurance and community service or other skills may be important assets to the Exchange. Whether or not to include ex-officio members, potential conflicts of interest for certain members, and the ideal number of board members are important considerations. The ACHSD recommends that, at a minimum, the board should operate in the public interest and no board member should realize personal financial gain.

One governmental place to house the Exchange is to convert the Dirigo Health Agency to an Exchange since it already performs many of the required functions of an Exchange (see Table 2 above). Many of the skills and expertise in managing a subsidy program that interfaces with both individuals and employers already exist within this agency. There is no other existing state agency that has the breadth and depth of skills needed to accomplish the myriad tasks charged to the Exchange. Creating an entirely new state or quasi-state agency to house the Exchange may be viewed as excessive since so much of the functionality already exists within the Dirigo Health Agency.

**Perception by individuals and businesses**

There was some discussion in both the Steering Committee and ACHSD regarding how the Exchange would be perceived by businesses and individuals if it were housed in a governmental agency versus a non-profit organization. There was a mixed sentiment among both Steering Committee and ACHSD members. On the one hand, some members felt that housing the

Exchange in a non-profit organization could be perceived by some to be more agile and business-friendly, particularly for the SHOP Exchange, and it would not be dependent upon state politics. Other members felt that many Mainers would feel that accountability was the most important consideration and that trust would be highest for a governmental agency.

**Summary**

Regardless of where it sits, the Exchange will require significant interface with other state agencies including, at a minimum, the Medicaid agency, the Bureau of Insurance and Maine Revenue Services. Balancing the need for coordination with other state programs and agencies and the amount of desired flexibility, accountability, and transparency will be important. Ultimately, the degree of state authority preferred by the new Administration and Legislature will drive the governance structure and location of the Exchange in Maine. Moving quickly on this decision is essential in order to move forward on the planning and implementation of the Exchange. It was agreed that the state should build on its current infrastructure in establishing the Exchange. The Steering Committee and ACHSD did not come to a final decision regarding where to house the Exchange but the following recommendation provides some guidance in this regard.

**Recommendation: Maine's Exchange should be housed in a quasi-governmental agency, accountable to a board of directors and the Legislature, which operates in the public interest and whose board does not realize personal financial gain.**

## VI. Impact and Opportunities of the ACA on Medicaid and CHIP

While much of the discussion surrounding the ACA has focused on the development of exchanges, the ACA makes significant shifts to the Medicaid program, particularly in terms of mandatory coverage groups. The ACA finally de-links Medicaid from welfare and allows for low-income individuals to continue receiving support as their income increases.

This section will describe the major changes to the Medicaid program[48] and present opportunities to improve MaineCare and to coordinate with the Exchange.

### a. Eligibility Changes Under the ACA and Enhanced Federal Funds

*Eligibility Changes*

Today, Maine provides individuals with access to health coverage through a combination of MaineCare, CubCare and Dirigo.[49] The ACA expands mandatory coverage under the Medicaid program to cover all individuals to 133% of the FPL.[50] Benefits provided to this population do not need to equal full Medicaid benefits required for other mandatory populations, but need to meet benchmark or benchmark equivalent coverage. At a minimum, the benefits must include all federal mandatory benefits plus prescription drugs and mental health services. Premiums and cost-sharing are allowed based on an individual's income. States can begin to provide this coverage now, but will be required to do so beginning in January 2014.

The ACA also requires that, beginning in 2014, states provide Medicaid coverage to former foster children up to the age of 26. These young adults must be provided the full Medicaid benefit package, including Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits.

Under the ACA, states may choose to use presumptive eligibility[51] for all Medicaid populations. Currently federal law only allows states to use presumptive eligibility for children, pregnant women and women with breast and cervical cancer. The ACA also expands who can conduct presumptive eligibility determinations to include hospitals that are designated as qualified entities.

Another optional expansion in the ACA allows for a family planning category within the Medicaid state plan, rather than the traditional family planning waiver that exists today. This provision allows states to cover women of child bearing age to the same level of income as pregnant women and covers family planning services, and related medical diagnosis and

[48]For a complete description of changes to the Medicaid program in the ACA, see the Impact of the ACA on Maine's Medicaid & CHIP Programs: Provisions and Policy Considerations, October 2010, accessible at www.maine.gov/healthreform.

[49]Children and their parents are covered to 200% of the FPL; pregnant women are covered to 185% of the FPL, persons with disabilities are served at varying incomes based on disregards, and childless adults are covered to 100% FPL. Through Dirigo, individuals and families may receive subsidized coverage to 300% of the FPL.

[50]Because the ACA also requires that states use a standardized process to determine income through a Modified Adjusted Gross Income (MAGI) calculation, coverage will be to 138% of the FPL (133% plus a 5% disregard).

[51]Presumptive eligibility allows an individual to declare income and other information and receive benefits immediately, but for a limited amount of time, while submitting the required verifications.

treatment services. All family planning services will be matched at 90%; all related services will be matched at a state's regular match rate.[52]

*Federal Funding*

The federal government will pay for virtually all of the expansion population, beginning in 2014, including paying an enhanced match for states like Maine that already covered much of this population through a Medicaid waiver. Specifically, Maine is considered a transition state and will receive an increasing level of federal match toward coverage of childless adults to 133% of the FPL. The enhanced match is based on the gap between the state's base FMAP and 100% match. Maine will receive full federal funding for individuals between 100-133% of the FPL who were not previously covered and for any individuals who have not received coverage due to Maine's waitlist for its childless adult population. To receive any federal match for the Medicaid program, states are required to maintain eligibility standards that were in place in July 2008, though a hardship waiver is available where states can show budget deficits. The waiver would allow for a state to reduce coverage to optional populations (e.g., childless adults, parents at higher income levels) or optional services (e.g., adult dental benefits) but such reduction in coverage may increase the number of uninsured and shift costs to other payers.

The ACA shifts additional funding responsibilities to the federal government for the Children's Health Insurance Program (CHIP) from 2015 through 2019, by enhancing the current federal match for the CHIP program by 23%. Maine's current CHIP match is 74.66%, bringing its match for the program beginning in 2015 to 97.66%. In addition to providing enhanced funding for CHIP, the ACA formally reauthorized the program through 2015 and made a number of additional amendments. One amendment allows states the option of enrolling children of public agency employees into CHIP if the state's insurance would require cost-sharing that exceeds 5% of the family's income. Maine should examine the benefit of this for state employees and the state employee health plan. If a state has a wait list for its CHIP program, the state must develop a process for these children to receive coverage through the Exchange.

Maine's current analysis of the impact of the ACA on MaineCare financing is included as Appendix C.

*Simplified Eligibility Determinations*

In order to simplify eligibility determinations, the ACA requires that state Medicaid and CHIP programs coordinate their eligibility with the state's Exchange, allowing individuals to access health coverage through a "no wrong door" approach and to allow a single application be used for the determination of health coverage in Medicaid, CHIP or through the Exchange. To foster this approach, states must develop a secure interface between all public programs to allow for the free exchange of data and determinations of program eligibility. The state must also provide for online eligibility and redeterminations beginning in 2014. The state must also provide outreach assistance focused on enrolling vulnerable and underserved populations in MaineCare and CubCare. As Maine begins to design its Exchange, a key design feature will be to determine how the state anticipates providing joint outreach and eligibility determinations across programs. This will include how to best leverage the current joint application process that DHHS utilizes today for MaineCare and CubCare, as well as the existing application process for Dirigo.

[52]This does not provide federal coverage for infertility treatment.

The ACA also requires states to adopt a Modified Adjusted Gross Income (MAGI) standard to be used in determining an individual or family's income. Under MAGI, all applications for the non-aged, blind and disabled population will be provided with an automatic 5% income disregard. There are no other disregards allowed and there is no asset test. This simplified eligibility does not apply to all Medicaid populations, but only for individuals under the age of 65 who do not have disabilities. For individuals that are currently eligible but who would not continue to be eligible based on new MAGI rules, states are required to continue coverage through March 31, 2014, or their next redetermination period.

*Benefit Provisions*
The ACA requires that state Medicaid programs add a number of mandatory benefits, including smoking cessation benefits, hospice coverage for children even if still being treated for a terminal illness, and family planning services.[53] Additionally, the ACA incentivizes states to eliminate cost sharing for preventive services by offering a 1% increase in FMAP for those services.

Beginning in 2011, states may utilize a new state plan option to provide health home health services to individuals with certain chronic conditions. In November 2010, CMS released guidance on this new option which will allow states to pay designated health homes to provide comprehensive care management, care coordination and health promotion services, comprehensive transitional care, patient and family support, and utilization of HIT to link services. As a state participating in Medicare's multi-payer medical home demonstration, Maine may also be interested in pursuing this health homes options. CMS will provide planning grants to implement at a state's regular match rate for these services. Upon implementation the services will receive 90% FMAP for the first two years.

### b. Opportunities to Coordinate Coverage through MaineCare and the Exchange

*The Basic Health Plan*
Section 1331 of the ACA provides that a state may operate a Basic Health Plan for individuals with incomes greater than 133 and up to 200% of the FPL who otherwise could be served in either MaineCare or the Exchange. It also allows for legally resident aliens with incomes to 133% of the FPL to receive coverage through the Basic Health Plan.

The Basic Health Plan is conceived as a separate health plan offered through the Exchange. If a state elects to implement a Basic Health Plan, the federal government will provide 95% of the funds that would have been available through premium tax credits and cost-sharing subsidies for participating individuals toward the cost of coverage. The Basic Health Plan would be offered through one or more health insurers that are chosen through a competitive procurement. Maine has the opportunity to contract with the same health plans to provide coverage through MaineCare, the Basic Health Plan and the Exchange.

[53]While providing a family planning option for individuals that are not otherwise eligible for Medicaid is a state option under the ACA, it is a requirement to provide family planning services to those that are eligible for Medicaid benefits.

Coverage in the Basic Health Plan must include at least the essential health benefits and meet the 85% medical loss ratio requirement that applies to large groups. Further, while premiums may be no higher than those tied to the second lowest price Silver plan provided through the Exchange, benefits must meet the Platinum level for individuals with incomes to 150% of the FPL, and must meet the Gold level for those with incomes between 151 and 200% of the FPL. This could present a challenge to offering such a plan as it may be difficult to provide a higher level of benefits for a lower cost. In addition to the benefit standards, the ACA directs states to consider innovative features such as care coordination, incentives for preventive care use and appropriate service utilization. While the design of the Basic Health Plan is not yet known, potential benefits of a state Basic Health Plan include protecting families from higher levels of cost sharing in the Exchange.

As part of its Exchange planning grant, Maine should consider whether it should implement the Basic Health Plan as a bridge between MaineCare and the Exchange. To answer this question, the state must analyze whether it would be able to offer the higher level of benefits at a lower premium price with the funding it will receive in lieu of the premium tax credits for those enrolled; the administrative issues associated with having a package for only a certain set of individuals within the Exchange, and the impact on the overall Exchange risk pool of separating these individuals.

*Medicaid Managed Care Initiative*

Following a feasibility study focused on implementing managed care for MaineCare, DHHS is planning to issue a procurement in the spring of 2011 to select a set of managed care vendors to provide services to the MaineCare population. The goal of the procurement is to enhance quality of care by measuring and rewarding outcomes while reducing the growth rate in per person spending in MaineCare. The program would align financial incentives of members, providers, insurers and the State. DHHS plans to enroll all MaineCare groups into managed care over a three year time period.

As DHHS develops its managed care program for MaineCare members, it is important to be mindful about the ability to collaborate across public programs, including with the Exchange, to leverage economies of scale and covered lives. This is particularly true where there is likely to be a large amount of movement between MaineCare and the Exchange as family incomes tend to fluctuate. In addition, there will be situations where individuals in the same family will be eligible for different coverage.

The amount of coordination across programs may be limited to sharing similar functions and best practices or may go as far as utilizing the same managed care plans to serve individuals in MaineCare and in the Exchange. Overlapping functions could either be staffed through a single vendor or state staff, such as enrollment broker functions. MaineCare and the Exchange could leverage learning and best practices across programs for similar contract requirements, including provider network and access requirements, cultural competency, quality measurements, and performance incentives. Moreover, DHHS and the Exchange could work together to forward payment reform models and innovations, including Accountable Care Organizations (ACOs) and Medical Homes. Finally, it will be important for the Exchange and DHHS to consider policy implications of coverage start dates to ensure appropriate continuity of care for individuals

whose coverage will move between MaineCare and subsidized coverage in the Exchange based on changes to family income and/or employment status.

### c. Payment Reform Opportunities Focused on Medicaid

As described in greater detail in Section VII, the ACA provides a number of opportunities for payment reform demonstrations. These opportunities extend to the Medicaid program and include demonstrations for:

- Pediatric ACOs;
- Bundled payments for integrated care around a hospitalization;
- Global capitated payment models for safety net hospitals; and,
- Emergency psychiatric demonstration allowing for payment to an Institute for Mental Disease (IMD) for stabilization of an emergency medical condition.

In addition, the ACA includes the availability of up to $100 million in grant funds to state Medicaid programs to develop preventive care programs, including those focused on:

- Tobacco cessation;
- Weight control;
- Lowering cholesterol;
- Lowering blood pressure; and,
- Improving management of diabetes.

In an effort to improve access to primary care in the Medicaid program, the ACA provides for increased Medicaid payments for primary care services provided by general medicine, family medicine and pediatric practices in 2013 and 2014. The enhanced payments will be equal to the Medicare rate in a given geographic area and the difference between the state's rate and the Medicare rate will be fully funded with federal dollars. Maine should anticipate pressure to continue these enhanced payment rates at its regular FMAP beginning in 2015.

Finally, the ACA reforms the Medicaid Disproportionate Share Hospital (DSH) program and reduces available DSH payment beginning in 2014. The Secretary of HHS is charged with developing a methodology, however, the statute contemplates that states with the lowest levels of uninsured and those that do not target their DSH allotments to hospital with high Medicaid or uncompensated care will see the largest reductions in their allotments. It appears that Maine, like other states that utilize its DSH payments to fund coverage for childless adults will be protected from at least some of the reduced DSH.

### d. Long-Term Care

While much of the attention to the ACA focuses on changes in insurance, coverage and capacity regarding the delivery of acute medical care, a significant portion of the law addresses the long-term care system. Long-term care – often referred to as long-term services and supports (LTSS) – accounts for a substantial part of spending in MaineCare. Given the amount of spending by MaineCare on long-term care and the aging of Maine's population, it is particularly important to consider the opportunities in the ACA to improve access to community-based services and reduce overall spending.

LTSS refer to the medical and non-medical services, equipment and other supports that help people meet their daily needs and improve the quality of their lives over an extended period. LTSS may be provided in people's homes, elsewhere in the community, or in residential facilities. At the facility level, Maine's LTSS system includes nursing homes as well as Private Non-Medical Institutions (PNMI). DHHS believes PNMIs should be characterized as institutional facilities for this purpose, though federal oversight agencies put them in the category of community care. This disagreement has implications for Maine's ability to take advantage of some ACA provisions, discussed below.

Mainers of all ages use LTSS, but the chance of needing services increases with age. This is important for Maine, which has an older than average population that is getting even older. Medicaid (MaineCare) is the predominant payer for LTSS. Nationally, Medicaid accounts for about half of spending on LTSS. The proportion is similar in Maine, where MaineCare is the most common financing source. Not surprisingly, LTSS account for a large portion of Maine's (and all states') Medicaid budgets; MaineCare spends hundreds of millions of dollars per year for both facility-based and community-based services.

*LTSS provisions in the Affordable Care Act*

There are a number of provisions dealing with LTSS in the ACA. Some present options for states in their Medicaid programs, others are changes in federal policy with which states must comply. There are also several grant and demonstration opportunities for states to consider. The LTSS provisions in the law fall into three categories:

***1. Provisions to rebalance the delivery of LTSS***

Medicaid's eligibility rules and benefits design have historically favored institutional care. The criteria for elders to qualify for nursing home care are less restrictive than the eligibility criteria for community-based services, and many home- and community-based services (HCBS) are offered in Medicaid only under program waivers and made available to a limited number of individuals with specific conditions or levels of need. A number of provisions in the ACA are an explicit effort to shift policy toward greater reliance on HCBS and less on facility-based care.

**Community First Choice option**. This gives states the option of covering personal attendant services, which enable many people with disabilities to live at home rather than in an institution, as part of the regular Medicaid program rather than under a special waiver. To help pay for the benefit, a state's Medicaid federal matching rate (about 64% in Maine[54]) would be increased by 6 percentage points for this service. As Maine already includes this coverage within its Medicaid state plan, the state should explore this option for additional financing.

**Removal of barriers to providing HCBS.** This provision updates Section 1915(i) of the Social Security Act, which governs HCBS in the Medicaid program. It allows a state to provide a broader range of HCBS under its regular Medicaid state plan, to a broader range of members. Previously, states could offer HCBS under 1915(i) that were more limited in scope than could be authorized by a waiver, and could not include members up to the income level that waivers allow. The ACA broadens the scope of services states can offer under 1915(i), and allows states

[54] The 64% FMAP reflects Maine's current level of cost-sharing of the Medicaid program, without the enhanced FMAP that is being provided to states and scheduled to expire in June 2011.

to serve members who meet the same financial and functional criteria as under their current HCBS waivers. Once again, though, amending a state plan in this way exposes a state to a level of financial risk it might not be able to support in the current economic climate. In the long run, these two provisions give states much more flexibility to align services with needs in appropriate settings. But budget constraints might inhibit states from taking advantage of this flexibility right now.

**Expansion of "Money Follows the Person" rebalancing demonstration**. This program, begun in 2006, provides federal grants to help states transition individuals from facilities to community-based care. Maine did not participate in the original demonstration, but it has received a planning grant to develop a proposal for the extension, which will run through 2016.

**State Balancing Incentive Program.** This provision gives states financial incentives, in the form of enhanced federal match, to shift more of its LTSS from facility- to community-based care. States that use less than 50% of their Medicaid LTSS spending on non-institutional services would qualify for the incentive payments. Whether Maine would qualify depends on definitions: if PNMI spending were categorized as institutional, then the state would qualify with less than half of its Medicaid LTSS spending going to community-based services. Currently, however, the federal government classifies PNMI spending as community-based.

**Spousal impoverishment protections for HCBS recipients.** When someone enters a nursing home and is covered by Medicaid, program rules require that the spouse of the nursing home resident be allowed to protect a prescribed level of income and assets from being used to pay for care. Though this has been a federal requirement for spouses of nursing home residents since 1989, it is only a state option to protect spouses of Medicaid members receiving LTSS in their home or community from having to contribute virtually all of their assets to the cost of the services. Maine does not exercise this option. Beginning in 2014, all states will be required to provide this protection from impoverishment to the spouses of HCBS recipients as they do now to the spouses of nursing home residents. The ACA specifies that this requirement will be in place for five years. This will mean some added cost to the MaineCare program, though this cost will likely be much smaller than the anticipated savings MaineCare will realize from the additional federal matching funds the program will receive.

**Medicare Part D.** The ACA also includes the elimination of cost sharing in the Medicare Part D prescription drug program for Medicare/Medicaid dual eligible members enrolled in a HCBS waiver program who would otherwise require facility-based care.

### *2. Provisions to improve access to and delivery of LTSS*

A number of pieces of the ACA are intended to improve people's access to LTSS, or to improve the quality of services that people receive. These include:

**Funding to expand Aging and Disability Resource Centers (ADRC).** ADRCs act as a single point of entry for information, referrals and services to elders and people with disabilities. The ACA authorizes grants of $10 million per year in fiscal years 2010 through 2014. To date, Maine has received nearly $700,000 in grants from the ACA for its ADRCs.

**Elder Justice Act.** The federal government will award grants and carry out activities that provide greater protection for and prevent abuse and neglect of individuals seeking care in LTSS facilities. The Act also provides incentives for individuals to train and seek employment at LTSS facilities.

**Nursing home transparency and improvement.** A number of ACA sections seek to improve the transparency of information about nursing homes, including requiring disclosure of ownership, publication of staffing and state survey data, and more detailed reporting of expenditures. The ACA also strengthens the enforcement of quality standards, oversight of large national chains, and protection of residents of facilities that are closing.

### *3. Provisions to broaden the financing of LTSS*

The ACA includes one major provision intended to shift financing of LTSS away from stressed state Medicaid programs and toward private sources. The **Community Living Assistance Services and Supports (CLASS) program** helps individuals plan and save for future potential LTSS needs. When the program begins, working individuals will be able to contribute, through payroll deduction, to a fund that will pay a cash benefit to individuals who have been enrolled for at least five years and who meet a specified level of need. The CLASS benefit can be used for community- or facility-based services, and the program will require no health screen and will not exclude people with pre-existing conditions. The program is voluntary, however, so its long-term financial sustainability depends on the participation of a broad range of people, young as well as old, and those less likely to need LTSS in the short-term.[55] If successful, CLASS could reduce future MaineCare expenditures by reducing the number of people who spend down their own resources and then must turn to MaineCare to finance their LTSS.

*Policy issues*

There are a number of issues concerning long-term care that policy makers in Maine should consider, including:

- Should the state take advantage of the rebalancing opportunities available in the Community First Choice option and the Section 1915(i) changes, or should it defer this until economic conditions improve in the state?

  The state could use these provisions to provide HCBS to more people who might otherwise have to enter a facility to receive needed services, which would be desirable. But the state would have less control over the budget and utilization of these services if they were made an entitlement under the Medicaid state plan.

- How should the state advocate with the federal government for favorable terms in the State Balancing Incentive Program, including consideration of PNMI spending as institutional?

[55] The National Commission on Fiscal Responsibility and Reform – the Commission charged by President Obama to make recommendations for reducing the federal budget deficit – cited in its final report the view of "many experts" that the financing of CLASS is financially unsound and recommended that it be reformed or repealed.

Maine would benefit financially if the federal government were to acknowledge PNMIs as institutions.

- How active a role should the state take in promoting participation in CLASS – by individuals, who must voluntarily enroll; by employers, which must elect to make payroll deduction available for the program; and by the state government, which can set an example as an employer itself?

  Maine could realize significant savings in its MaineCare budget with widespread enrollment in a financially sustainable CLASS program. The state would not want to promote something that was not a good deal for its residents and businesses, though. Regulations yet to be issued, describing the details of how the program will work, and updated financial projections will be important factors in how the state answers this question.

**Recommendations for Next Steps for MaineCare and CubCare**
As described above, the ACA makes a number of changes to Medicaid program requirements and financing and presents states with a number of opportunities.

*Financing*
DHHS conducted a preliminary estimate that shows net savings to Maine from the ACA, attached as Appendix C, and continues to refine its financial analysis of the ACA on MaineCare and CubCare. The initial analysis continues to be refined as the federal government issues new regulations clarifying the implementation of the ACA. While the ACA provides for significant enhanced funding for MaineCare and CubCare beginning in 2014, the State will need to balance the enhanced funding in the long term with its current budget pressures given the state's current budget deficit. In order to receive enhanced match, Maine must maintain current eligibility and benefit levels or apply for a federal waiver of maintenance of effort based on its budget deficit, which would allow the state to reduce eligibility for optional populations and optional services.

In budgeting for the MaineCare and CubCare programs beginning in 2014, Maine will need to factor into its budget estimates assumptions for length of stay in the programs based on the individual mandate requirement. This will not only bring new members to the MaineCare and CubCare programs but may also result in longer average stays on the program. In addition to increased membership, the program's budget may need to include additional administrative resources to implement new requirements under the ACA including changes to eligibility determinations and benefit changes, as well as new program integrity and reporting requirements that are placed on the program.

*Coordination with the Exchange*
There are a number of opportunities for DHHS to coordinate with the Exchange, including coordinating and streamlining eligibility determinations, implementing the Medicaid managed care initiative, determining whether to offer a Basic Health Plan option, and leveraging covered lives to promote payment reform initiatives across Maine.

Going forward, DHHS should work closely with the entity that is to serve as the Maine Exchange to conduct joint planning that allows for streamlined provision of coverage and benefits for Maine citizens while leveraging the strengths and opportunities in each of the separate programs.

*Long Term Care Opportunities*
Given the level of state spending on long-term care, the ACHSD recommends that DHHS prioritize its efforts to increase use of home- and community-based care and reduce spending on institutional long-term care. As a first step, DHHS should continue to refine its analysis of the financial impact of required long term care provisions, including changes to spousal impoverishment rules. In addition, DHHS should consider the options and incentives the ACA offers and, to the extent state financing permits, take advantage of opportunities to increase the use of home and community based care, improve the long-term care information and referral network, and upgrade the workforce.

## VII. Payment Reform Opportunities in the ACA

MRSA 2 Chapter 5, subsection 104(7)(H) charges the Advisory Committee on Health System Design (ACHSD) with developing payment reform options that:

- Reduce total health care spending without shifting costs to consumers or reducing access; and
- Reduce rates of increase in health care spending and costs to a level that is equivalent to the rate of increase in the cost of living.

To meet this charge, the ACHSD formed a Payment Reform Work Group.[56] In its work, the Payment Reform Work Group proposed and the ACHSD adopted the following six core principles[57] for payment reform in Maine:

- Support integrated, efficient and effective systems of care, delivery and payment;
- Promote a patient-centered approach to service delivery and payment;
- Encourage and reward the prevention and management of disease;
- Promote the value of care over volume to measurably lower costs
- Support payment and processes that are transparent, easy to understand, and simple to administer for patients, providers, purchasers and other stakeholders; and,
- Balance the interests of patients, payers, and providers while pursuing necessary change.

Over the course of 2010, the Payment Reform Work Group has been monitoring the activities of several delivery system and payment reform initiatives that are ongoing in Maine, including efforts to develop Accountable Care Organizations (ACOs), use bundled payment mechanisms, develop patient-centered medical homes (PCMH), and increase use of pay-for-performance models.[58] In January 2010, the ACHSD submitted an interim report to the Maine State Legislature on the preliminary findings of its Payment Reform Work Group.[59]

### a. Payment Reform Elements within the ACA

The Affordable Care Act (ACA) of 2010 includes a number of opportunities to advance payment reform initiatives, including the creation of Exchanges, insurance reforms, and delivery system and payment reform opportunities. Maine will continue to leverage the private and public sector work under way on payment reform, notably the leadership of employers and providers.

1. Exchanges

A key element of the ACA is the creation of Exchanges in each state, as described more fully in Section V. Individuals and small businesses purchasing through the Exchange will be able to access federal premium tax credits toward that coverage. Since this is the only way to access these subsidies, there are likely to be a significant number of lives covered through the

[56]Appendix D includes a list of Payment Reform Work Group members. All members of the Work Group are also members of the ACHSD.
[57]See Chapter VI, *Pay for What Matters*, 2010-2012 Maine State Health Plan.
[58]For detailed discussion of these payment reform models and specific Maine initiatives, see Appendix B, Payment Reform Opportunities in the ACA, presented to the Payment Reform Working Group on November 4, 2010, accessible at www.maine.gov/healthreform.
[59]Report to the Legislature to Advance Health Care Payment Reform in Maine, January 11, 2010.

Exchange. Given that there will likely be a large number of lives, the ACHSD and other Maine policymakers have shown interest in developing a robust Exchange that can help facilitate the efficiency and effectiveness of the health care market. A number of key features within the Exchange design in the ACA give it particular potential to impact long-term cost containment and premium growth. Specifically, the Exchange:

- Creates four standard coverage levels;
- Creates potential for increased competition, including the offering of multi-state plans within the Exchange; and
- Is responsible for certifying health plans and monitoring and rewarding quality.

2. Delivery System and Payment Reform

The ACA includes a large number of opportunities specifically focused on delivery system and payment reform, including restructuring the internal organization of CMS to promote flexibility and experimentation, the inclusion of initiatives to incentivize primary care and prevention, stimulating innovative provider payment reform and delivery system change, and promoting quality and public health. These sections of the law are grouped together as it is quite difficult to separate how care is delivered from how care is reimbursed. If the ACA is going to be at all successful in directing cost containment it is likely to be through these initiatives.

*a. Creation of the CMS Innovation Center*

The ACA requires CMS to create a Center for Medicare and Medicaid Innovation. This new center officially launched on November 16, 2010,[60] and is charged with testing innovative payment and service delivery models for both Medicaid and Medicare. The Center for Innovation will focus on reducing spending in health care while improving quality. $10 billion will be appropriated for programs between 2011 and 2019. The Center for Innovation is expected to be at the core of a number of demonstration and payment reform programs, including those that test all-payer health reforms, by conducting demonstrations to "identify, validate, and scale models that have been effective in achieving better outcomes and improving the quality of care."[61]

*b. Incentivizing Primary Care and Prevention*

The ACA includes a number of initiatives that focus on promoting primary care and prevention using incentives. Specifically, the ACA provides for increased payment rates for primary care from both Medicare and Medicaid. Medicare will give primary care doctors 10% bonus payments from 2011 through 2015. Medicaid will increase provider payment rates for primary care services to 100% of Medicare's rates in 2013 and 2014. The increased payments will be funded with federal dollars. It is expected that states will be pressured to maintain the rate increases using their regular Medicaid matching rates beginning in 2015. The ACA also provides opportunities for community health centers to improve access to care through federal grants for construction, operating expenses and new access points.

The ACA focuses on prevention and wellness through new support for employer wellness programs. The ACA includes small business grants to establish wellness programs between

[60]See CMS press release launching the Center for Medicare and Medicaid Innovation, November 16, 2010, accessible at www.innovations.cms.gov.
[61]Dr. Richard Gilfillan, Acting Director of the Innovation Center, Ibid.

2011 and 2015. The ACA also gives employers the authority to reward employees for participation in wellness programs. Finally, the ACA promotes prevention by eliminating cost-sharing for preventive services for insurance enrollees and Medicare beneficiaries, and incentivizing state Medicaid programs to eliminate such cost-sharing.

*c. Stimulating Innovative Provider Payment Reform*

By far the most promising aspects of the ACA in relation to cost containment are those initiatives that stimulate innovative provider payment reform coupled with delivery system reform, including medical homes, bundled payments, and increased use of pay-for-performance.

The ACA also takes significant steps to encourage the development of Accountable Care Organizations (ACO). A number of providers in Maine have begun working toward the development of an ACO, spurred on by the opportunities provided in the ACA, but it is important to understand that the ACO is currently just a concept with a number of significant operational details yet to be determined. An ACO may integrate a number of different providers, including physicians and hospitals, among other providers. Creating new constellations of providers with new organizational structures as ACOs raises new and interesting opportunities and challenges. The Federal Trade Commission is currently examining its rules and regulations regarding the development of ACOs. Here in Maine, the Hospital and Health Care Provider Cooperation Act currently permits parties to a proposed horizontal integration (e.g.: mergers between hospital and hospital or physician and physician) to submit their plans to the State in advance for review and approval. The Hospital and Health Care Provider Cooperation Act does not now include vertical integration (e.g., Hospital and physician groups) within in its purview. Given the change in landscape, further exploration about whether and how the Hospital and Health Care Provider Cooperation Act could be a useful tool in facilitating ACO development should be considered. DHHS would need adequate resources to assure sufficient supervision of any additional transactions that could be added to the law.

In addition to reviewing this Act, it also may be necessary for Maine to consider amending its insurance laws to allow for providers to take on an increased level of insurance risk without meeting all of the reserve requirements of managed care organizations. There are a limited number of states, including California, Minnesota, and Maine, that currently have rules in place that allow for providers to assume risk, but the Maine downstream risk law has not been evaluated for possible amendments since its enactment in 2000.

*d. Promoting Quality and Public Health*

Finally, the ACA lays the foundation for a national strategy to improve health care quality. This builds on the effort for a children's health care strategy begun under the Children's Health Insurance Program Reauthorization Act (CHIPRA). CMS is charged with proposing core quality measures in 2011 for public comment and finalizing measures in 2012. Plans and providers participating in the Medicare program or in state Exchanges will be required to participate in quality initiatives and their performance may be publicly reported.

In addition, the ACA makes Medicare data available for inclusion within state all-payer databases. While Maine gets this information today, there is hope that the speed in which Medicare releases the data will increase. Having this information will allow state policy makers to more quickly identify trends in health care costs and quality and take action based on a complete set of data.

### b. Next Steps for Maine in Payment Reform

Health care providers, employers, and consumers in Maine are energized and already actively working on payment and system delivery reform activities. In its deliberations on payment reform strategies, the Payment Reform Work Group of the ACHSD considered five major options across a continuum for potential state involvement in payment reform activities. These options are not mutually exclusive and by no means represent the only potential courses of action. They were designed to start discussion, and include:

- Monitoring ongoing multi-stakeholder initiatives and leveraging those efforts;
- Providing infrastructure support for developing and ongoing initiatives;
- Conducting joint planning and implementation of payment reform across public programs that purchase health care;
- Using the Exchange to maximize purchasing clout and thereby advancing payment reform through Exchange requirements, and
- Setting specific policy direction and model for payment reform through legislation and require health plans/providers to follow.

The Payment Reform Work Group focused on its previously expressed principles for improving quality while reducing costs and voiced interest in continuing to monitor ongoing efforts and to provide support in reducing barriers to payment reform strategies. In addition, the Payment Reform Work Group reiterated the ACHSD's interest in developing a robust Exchange that could be a focal point for payment and system delivery reform activities. The Payment Reform Work Group expressed interest in state purchasers collaborating on payment reform efforts before the Exchange goes live. The Payment Reform Work Group did not show interest in the state taking the lead in setting a specific policy direction or payment reform model for the state.

**Recommendations for Payment Reform**

The ACHSD concurs with the Payment Reform Work Group in supporting an efficient and effective health care market that has appropriate tools, governance structure, and operations to ensure new delivery and payment reform models aimed at reducing costs while improving the quality of care. Payment reform discussions should include providers, payers, consumers and other stakeholders. The ACHSD recommends the following actions to ensure ongoing reform activities continue in Maine:

- Conduct ongoing monitoring, through the ACHSD, of multi-stakeholder payment reform initiatives and of regulatory barriers to payment reform, including Rule 850.
    - Monitor market trends to ensure the application of different models does not create market chaos.
    - Measure progress of different initiatives on a quarterly basis, focusing attention on a set of milestones that address measures of quality and cost.
    - Monitor Medicare activities around payment reform and consider whether the state can leverage these activities.
- Provide infrastructure support for developing and ongoing payment reform initiatives.
    - Identify existing state regulatory barriers to payment reform and make timely recommendations regarding how they should be addressed.
        - Assess the pros and cons of reducing barriers to ACO development through amendments to the Hospital and Health Care Provider Cooperation Act or other avenues.
        - Consider the role of the Bureau of Insurance in regulating and monitoring the development of ACOs and identifying issues in a timely manner.
    - Identify the impact of payment reform initiatives on patients, providers and Maine businesses, including evaluation of tradeoffs between incentives for system integration and risks of increased market power, and recommend how they be addressed.
    - Facilitate the provision of timelier all-payer claims data to provider, payer and purchaser organizations.
- Continue efforts to develop a robust Exchange that will include payment and system delivery reform as part of its ongoing strategy.
    - Link efforts to implement Medicaid managed care with payment reform and coordinate Medicaid purchasing strategy with that of the Exchange for consistency and effectiveness in policy.

## VIII. Policy Options for the Dirigo Assessment (Health Access Payments)

In 2014, the ACA will begin offering new federal insurance tax credits to help individuals and families purchase health insurance. These tax credits will completely overlap the subsidies that Maine currently provides to individuals through the Dirigo Choice program. However, other roles of the Dirigo Health Agency, such as leading health care quality improvement activities and providing insurance subsidies to employees of small businesses, will not be directly affected by the ACA's new tax credits. The Dirigo Health Agency and the subsidies it provides to eligible individuals are largely funded through a 2.14% assessment on all paid medical claims (called Health Access Payments). Given that Dirigo Choice coverage will no longer be necessary for many individuals after 2014, policymakers need to decide what to do with the existing assessment. Policy options range from repealing the assessment entirely to maintaining it in-part or in-full to fill remaining coverage gaps, continue with non-subsidy Dirigo initiatives, or cover costs of new ACA activities.

### a. Dirigo Health Reform in Maine

Maine enacted Dirigo Health Reform legislation in 2003 as a multi-faceted approach to improving health care quality, addressing rising costs, and expanding access to medical services and coverage. The Dirigo law established the Dirigo Health Agency (DHA) as an independent state agency responsible for:

- ***Access:*** Arranging for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis, and
- ***Quality:*** Monitoring and improving the quality of health care in the State through the Maine Quality Forum.

DHA launched the Dirigo Choice program to provide insurance options to individuals, sole proprietors, and employees of small businesses. Eligible people earning less than 300% of the Federal Poverty Level (FPL) can receive subsidies to help them buy Dirigo Choice coverage. Subsidies are graduated based on income level with the most generous subsidies going to people earning the lowest incomes (see Table 3 and Chart 1). DHA also administers several other coverage programs where most or all of the funding comes from the federal government:

- Pre-Existing Condition Insurance Plan (PCIP)
- Health coverage tax credit (HCTC) for workers who lost jobs due to foreign trade
- Part-time worker coverage voucher program, and
- MaineCare parent expansion for parents with children under age 18 (150-200% FPL).

DHA's Maine Quality Forum and Dirigo Choice subsidies, as well as some funding for other coverage programs, are financed through Health Access payments (2.14% assessment on all paid medical claims). The level of this assessment was based on the average savings documented in the program since its inception. The total revenue from the assessment in Fiscal Year 2011 budget is projected to be $42.1 million. Most (93%) of this budget, $39.2 million, pays for health care coverage, with $36.9 million covering Dirigo Choice subsidies and $1.3 million for voucher program subsidies. $2.7 million goes towards the agency's operating budget and $1 million covers administration of the Maine Quality Forum (all SFY 2011 estimates). All Health

Access payments go directly to DHA to fund coverage subsidies, agency operations, and quality activities. There is no impact on the state's general fund.

**Table 3: Premium subsidies in the Dirigo Choice program by income level**

| Income | | |
|---|---|---|
| **% of Federal Poverty Level (FPL)** | **$ amount for individual** | **Subsidy*** |
| <150% | <$15,315 | 80% |
| 150-199% | Up to $20,420 | 60% |
| 200-249% | Up to $25,525 | 40% |
| 250-299% | Up to $30,630 | 20% |
| 300%+ | > $30,630 | No subsidy |

*Note: To be eligible for subsidies in Dirigo Choice or the part-time worker voucher program, assets may not exceed $60,000 for a household of 1 or $120,000 for a household of 2 or more.*
** Subsidies are adjusted depending on assets.*

### b. ACA health insurance premium tax credits and Dirigo Choice

Beginning in 2014, the ACA introduces insurance premium tax credits for individuals and families with low-to-moderate incomes. Premium tax credits will be available to people earning between 133% and 400% of the Federal Poverty Level (FPL -- see Table 4 dollar amounts). Cost-sharing tax credits will be available for people earning 133% FPL to 250% FPL. People who qualify for these federal tax credits will be able to use them to purchase health insurance through a state-based health insurance exchange. Federal insurance tax credits will be refundable—people will be able to receive them in advance even if they don't owe any annual income taxes.

Two-thirds of Mainers under age 65 earn less than 400% FPL,[62] which means that about 500,000[63] people will potentially be income-eligible for federal assistance in purchasing health insurance. Eligible populations will include individuals and families earning up to 400% FPL, current individual enrollees in Dirigo Choice, uninsured Mainers, and privately insured Mainers struggling with costs of private insurance.

[62] Estimate using the American Community Survey, 2009.
[63] Estimate using data from the Current Population Survey. This number includes only people who are ineligible for MaineCare, Maine's Medicaid program. It also includes many people who, though income eligible, would be covered through other sources (usually an employer) so this is an upper bound, not an estimate, of the number of Mainers who would actually receive subsidized coverage.

"Crowd out" provisions in the ACA restrict eligibility for tax credits to people who do not have access to affordable and adequate health insurance through an employer or government program. Some Mainers with employer-sponsored insurance (ESI) may nevertheless qualify for federal tax credits due to these provisions, if their coverage is determined to be unaffordable or inadequate.[64] Nearly all of those with incomes less than 400% FPL who currently buy insurance on the individual market should be eligible for federal assistance.

The Lewin Group and Families USA estimated the total amount of premium tax credits that will be available to Mainers in 2014 at $450 million.[65]

**Table 4: Dollar amounts corresponding to the Federal Poverty Level**

| FPL | Annual Income (Individual) | Annual income (Family of 4) |
|---|---|---|
| 100% | $10,830 | $22,050 |
| 133% | $14,404 | $29,327 |
| 150% | $16,245 | $33,075 |
| 200% | $21,660 | $44,100 |
| 250% | $27,075 | $55,125 |
| 300% | $32,490 | $66,150 |
| 400% | $43,320 | $88,200 |

### c. Policy issues: ACA premium tax credits and Dirigo Choice

New federal tax credits will completely overlap Dirigo Choice subsidies for individuals in 2014 and beyond, which prompts a policy question: What should Maine do about the Dirigo Assessment given that much of its revenue currently funds coverage subsidies for eligible individuals? The assessment also finances the Dirigo Health Agency's operations budget, quality improvement initiatives through the Maine Quality Forum, and coverage subsidies for other populations such as employees of small businesses.

Despite the significant increases in coverage that the ACA will likely bring to Maine, gaps in coverage will persist in some areas. Employees of small businesses that have an offer of employer-sponsored coverage can currently receive assistance through Dirigo Choice and the Voucher Program, but this population will not be eligible for ACA tax credits. Some people with low and moderate incomes may remain uninsured because they cannot afford the insurance premiums of subsidized plans or employer-sponsored coverage. Table 5 shows the average premiums and out-of-pocket costs that individuals who receive insurance tax credits will likely face beginning in 2014. Although federal tax credits will be more generous than current Dirigo

[64] The ACA defines affordable employer-sponsored insurance (ESI) as having premiums totaling less than 9.5% of an employee's income. The law defines adequate ESI as having an actuarial value greater than 60%.

[65] Families USA and the Lewin Group. "Lower taxes, lower premiums: The new health insurance tax credit in Maine." Families USA Foundation, October 2010. As explained previously, this estimate number represents a conservative estimate of how many Mainers will receive federal premium tax credits.

subsidies for individuals, a question remains about whether this assistance will be adequate given the requirement to buy coverage under the new federal insurance mandate.

**Table 5: Estimated premiums and cost-sharing that individual policy holders will face under new federal insurance tax credits**

| Federal Poverty Level | 2010 Individual annual income (midpoint in range) | Total estimated annual spending required, consisting of: | Average premiums after ACA premium tax credits* | Average OOP cost after ACA cost-sharing tax credits* |
|---|---|---|---|---|
| 133-150% | $15,300 | $626 | $525 | $102 |
| 151-200% | $19,000 | $1,199 | $979 | $220 |
| 201-250% | $24,400 | $2,210 | $1,753 | $457 |
| 251-300% | $29,800 | $3,127 | $2,620 | $508~ |
| 301-400% | $37,900 | $4,111 | $3,603 | $508~ |
| >400% | > $43,300 | No subsidy | No subsidy | No subsidy |

** Midpoint estimates.*
*~ No cost-sharing subsidies for people earning more than 250%FPL.*

The introduction of ACA premium tax credits will also prompt other questions about populations enrolled in coverage through DHA. For instance, the state share of coverage for the MaineCare parent expansion population is paid through the Dirigo Assessment. How this population will be covered after 2014 must still be decided: the state could transition them to the Exchange, to a Basic Health Plan if Maine chooses to create one, or continue their coverage in MaineCare. This issue is further explored in the Medicaid section of this report.

The question of whether federal tax credits will be adequate is also relevant for the broader population. For families earning 133-200% FPL, Maine could continue MaineCare, establish a Basic Health Plan, or require parents to purchase coverage on the Exchange. Premiums and cost-sharing will be considerably higher in plans offered through the exchange than in MaineCare (see Table 6).

**Table 6: Premium limits in MaineCare vs. plan offered on the Exchange**

| Percent of FPL | Premium Limit in MaineCare | Premium Limit in the Exchange |
|---|---|---|
| 133% FPL ($24,352 for family of 3) | $0/month | $61/month |
| 150% FPL ($27,465 for family of 3) | $16/month | $91/month |
| 200% FPL ($36,620 for family of 3) | $64/month | $192/month |

*Note: In the exchange, out-of-pocket limit for people earning 100-200%FPL is $1,983 for an individual and $3,967 for a family (1/3 of HSA limit).*

Maine must show the federal government sufficient progress in the establishment of a health insurance Exchange by 2013 for implementation in 2014 or the federal government will step in to create one on the state's behalf. DHA already performs many functions of an Exchange as outlined by the federal law. Among its roles and responsibilities, DHA manages an online insurance marketplace, provides consumer assistance through case workers to enrollees and applicants, offers an online subsidy calculator, and administers subsidized plans. If State policymakers choose to eliminate the Access Payments prior to 2014, these functions may have to be recreated for an Exchange, possibly at greater cost.

**d. Policy Environment in 2014**

Maine's health care policy environment will look very different in 2014. The ACA increases access to insurance by creating an array of new coverage options for individuals, families, and small businesses through new premium and cost-sharing tax credits for individuals earning 133 to 400% FPL, and an expansion of eligibility for the Medicaid program to anyone earning up to 133% FPL. New consumer protections in the insurance market should also make coverage more accessible to dependents up to age 26, people with pre-existing conditions, and many others. Considerable investments in health care infrastructure—including development of a health insurance exchange and increased funding for community health centers and the primary care workforce—should expand access to care and coverage at the state and community levels.

The law also introduces new taxes, fees, and assessments to finance the coverage expansions and infrastructure investments. Key players in the health care industry—health insurers, pharmaceutical companies, and medical device manufacturers—will face billions of dollars in new taxes. Nationally, new taxes on insurers will amount to about 1% of total health insurance premiums. Individuals and couples earning high-incomes (more than $200,000 for individual and $250,000 for joint tax filers) will face increased Medicare taxes. Doctors will also see a decrease in the growth of their payment rates in the Medicare program.

### e. Policy Options for the Dirigo Assessment

Given the new policy environment that the ACA will create, policymakers in Maine face important questions about what to do about the Dirigo Assessment. Table 7 provides a high-level view of eight options and includes the rationale and pros and cons for each. Further detailed analysis would be necessary to evaluate each option regarding cost, potential coverage take-up, feasibility, and other factors.

**Recommendation**

Use resources from Maine's Exchange Planning grant to perform further analysis of these policy options. More analysis will be needed to determine the cost estimates and potential effects on coverage for each option, including repeal.

**Table 7: Eight policy options for the Dirigo Assessment (Health Access payments)[66]**

| Description | Rationale | Pros | Cons |
|---|---|---|---|
| **1. Maintain a portion of assessment to subsidize small business employers' share of premiums for employee health coverage after federal small business tax credits phase-out.** | Federal small business tax credits will only be available for two years beginning in 2014, so businesses may drop coverage when assistance is no longer available. | This would help to maximize coverage in the state by promoting and sustaining employer-sponsored insurance (ESI) among small businesses, particularly those with 26-50 employees. | Revenue from the assessment may not be sufficient to provide assistance to all employees who need help with coverage. |
| **2. Maintain the assessment to subsidize coverage for employees of small businesses.** | Current Dirigo subsidies go directly to employees to help offset the costs of coverage, whereas ACA small business tax credits are for employers with 25 or fewer workers and are available for only two years after 2013. | This would help to maximize coverage in the state by making insurance more affordable for more Mainers. Also, it would protect some small business employees from facing more expensive insurance premiums and out-of-pocket costs under federal reform. | the Exchange anticipates broader enrollment by small businesses. |
| **3. Maintain a portion of the assessment to cover administrative costs of the health insurance Exchange and related federally-required quality initiatives.** | The ACA requires Exchanges to be financially self-sustaining in 2015 and beyond. The legislature would determine how much to allow for administrative costs. | Access payments are already in effect for all paid claims, including those from self-insured plans. | The state would be re-allocating funds from an assessment originally collected for another purpose |
| **4. Maintain assessment to establish a reinsurance program that protects populations that may experience higher insurance rates under the ACA.** | Some Mainers could face higher insurance costs under the ACA due to new community rating rules, or if the state decides to merge the individual and small group insurance markets. Reinsurance could target particular groups that face rate increases or be applied generally to make the market more | Maximize insurance coverage by helping to make it more affordable for Mainers. | Revenue from assessment may not be sufficient to meet the need because the exchange anticipates broader enrollment. |

[66] The Table is not meant to be inclusive of all pros and cons related to the potential options for the Dirigo Assessment.

| | | | |
|---|---|---|---|
| | predictable for carriers and more affordable for small employers. | | |
| **5. Maintain a portion of assessment to supplement ACA tax credits and reduce premium costs for people who have difficulty affording coverage.** | Maine residents with low and moderate incomes – both MaineCare enrollees who transition into more expensive federally subsidized plans and uninsured people who are exempt from the individual mandate -- may find insurance unaffordable despite federal tax credits. | Maximize insurance coverage in Maine by covering people who are exempt from the federal mandate and reduce cost-shifting to uncompensated care. | Federal tax credits may make insurance adequate and affordable for most Mainers. |
| **6.Retain a portion of assessment to pay for quality improvement initiatives, health information exchange, and other initiatives that seek to improve health outcomes and reduce costs.** | Beyond paying for coverage, the assessment supports Dirigo reforms, such as the Maine Quality Forum, which facilitate public-private partnerships to address long-term problems such as quality improvement, reducing disparities, and containing costs. | Investment in improving health outcomes and supporting information exchange could help to moderate health care cost increases in the long-term. | Addressing long-term issues may be a secondary concern to other immediate issues facing the state. |
| **7. Maintain a portion of assessment to wrap coverage of state mandated benefits for some or all ACA tax credit recipients.** | ACA tax credits might not cover some of Maine's mandated benefits, so the assessment would help residents afford coverage available through the exchange, if the legislature elects to continue the mandates. | This would make insurance more affordable for Mainers if federally-defined "essential health benefits" do not include all state mandated benefits and if the legislature does not amend state laws to eliminate them. | Claims payers will face assessment costs, though not all Mainers will utilize these supplemental benefits. |

| | | | |
|---|---|---|---|
| **8.Repeal assessment in 2014.** | The ACA makes insurance tax credits available to individuals and small businesses, which will partially replace current Dirigo subsidies. | Payers would no longer face an assessment on all paid claims. | Insurance subsidies would no longer be available to employees of small businesses. The Maine Quality Forum would lose funding and likely become unsustainable. Maine would lose the ability to invest in quality activities, pay for the administrative expenses of an exchange, cover remaining uninsured, or address other coverage gaps. |

## IX. Quality Improvement Opportunities in the ACA

Maine is well-positioned to benefit from the ACA's significant investments in health care quality improvement. Maine has established a robust state-level quality measurement and reporting infrastructure through committed partnerships between public and private sector stakeholders. The ACA invests in building mechanisms to measure quality and report outcomes, coordinating a national quality strategy across government agencies, and supporting collaboration between public and private entities. The law also devotes resources to experiment with quality improvement initiatives at the national, state and local levels. Maine has an opportunity to leverage the new federal activities to build upon its existing quality improvement efforts.

### a. Quality in Maine

Maine has benefited from public and private sector commitment to improving health care quality. Some of the many players, including the Maine Health Data Organization (MHDO), the Dirigo Health Agency's Maine Quality Forum, the Maine Health Management Coalition (MHMC), and Quality Counts (QC), have led collaborative and parallel efforts to address quality issues while engaging providers, payers, and the public.

MHDO houses an All-Payer Claims Database (APCD), which has been active since 2003. Maine was the first state in the country to require fully-insured payers and administrators of self-insured plans to report claims data. Following Maine's lead, many other states have since pursued creation of similar data warehouses. Beyond the APCD, MHDO collects additional data regarding inpatient care, outpatient care, ambulatory services, and quality.

MHMC is an employer-led partnership comprising health care providers, health plans, and other businesses. MHMC is committed to maximizing the value of health care received by its members' employees and dependents by encouraging good health care choices, facilitating the public availability of medical quality and cost information, and encouraging high quality and efficient care. The coalition maintains a website where consumers and providers can view comparative ratings for high-cost surgical procedures and doctors and hospitals across Maine. These data are based on national standards developed by federal agencies including AHRQ and CMS.

DHA's Maine Quality Forum (MQF) is responsible for improving the quality and safety of health care in the State of Maine. MQF helps consumers make informed health care choices by reporting on the cost and quality of doctors, hospitals and others who provide care. The MQF uses claims information from the MHDO and hospital discharge data to examine outcomes of care and describe geographic variations in service utilization. The information is publicly available on the MQF's website and is used to spur quality improvement across the state.

QC is a non-profit organization focused on consumer and provider engagement to improve health care quality and promote chronic illness prevention and care in Maine. QC leads collaborative efforts on several state-wide quality initiatives including Robert Wood Johnson's Aligning Forces for Quality (AF4Q) projects, and Maine's Patient-Centered Medical Home Pilot. Dirigo Health Agency/Maine Quality Forum and MHMC partner with QC on both of these initiatives.

AF4Q is a national program launched by the Robert Wood Johnson foundation in March 2007. Maine is one of fifteen sites across the United States. AF4Q seeks to improve health care quality in hospitals, facilitate the development and implementation of effective public reporting, data collection, and performance measurement, engage consumers in health care quality discussions, reduce health care disparities, and improve health outcomes for vulnerable populations.

Maine is also participating in a Patient-Centered Medical Home (PCMH) initiative, which is a three-year pilot that began in January 2010. The pilot includes Medicaid and most private payers in Maine. The state applied for inclusion of Medicare, which the federal government approved in November 2010. Twenty-six primary care practices across Maine are participating in the first round of the pilot. The ultimate goal is to achieve statewide adoption of the PCMH model, but the initial work centers on evaluation of clinical quality, patient experience and empowerment, cost and resource use, and practice change to promote greater integration and care coordination.

**b. Quality Improvement in the Affordable Care Act**

The ACA pursues health care quality improvement through building a centralized infrastructure to support this work at the federal level, developing a national strategic plan to drive the work forward, and investing at the state and local levels in quality measurement, data reporting, and experimentation with innovative payment and delivery models.

The ACA directs the federal Health and Human Services Secretary to develop a National Quality Strategy in consultation with states. A major goal is to develop standard quality measures and provider-level outcomes measures that states will implement. A multi-stakeholder advisory group and state Medicaid and CHIP programs will provide critical feedback that informs the development of standards and reporting tools.

Federal planning groups will support quality improvement efforts. A new Interagency Work Group for Health Care Quality will be chaired by the federal Secretary of Health and Human Services and include senior representatives from many executive branch agencies. The Work Group will facilitate collaboration between federal departments and agencies to develop quality improvement strategies and reporting mechanisms, avoid duplication of efforts, and align public and private sector activities. The law also gives the Agency for Healthcare Research and Quality's (AHRQ) Center for Quality Improvement and Patient Safety greater responsibilities to build the evidence-base for delivery system innovation through research, program evaluation, and dissemination of finding and best practices.

The ACA establishes two new funding sources that will invest heavily in quality improvement. Beginning in 2010, the Prevention and Public Health Trust Fund will fund community health and clinical prevention initiatives at the state and local level, as well as research and tracking of health outcomes measures. The Center for Medicare and Medicaid Innovation (CMMI) will invest in innovative health care delivery and payment activities at the national, state, and local levels. The goal is to cultivate programs that contain costs and improve patient safety and replicate successful efforts across the country.

The law advances quality improvement in the Medicare and Medicaid programs through measurement and reporting, creation of new programs to promote innovative care delivery, and funding for local and national activities that build the evidence base for delivery system change. In Medicare, a new Independent Payment Advisory Board will develop proposals to reduce Medicare spending while not sacrificing quality of care. A Medicare "shared savings" program allows providers to form as Accountable Care Organizations that will be accountable for the cost and quality of care received by their patients. Medicare pilots and demonstrations addressing quality include payment reform initiatives (value-based purchasing, payment bundling, gainsharing demonstration, etc.), as well as long term care projects that rebalance care away from institutions to community-based settings. The federal government will also support payment reform initiatives in the Medicaid program, such as restricted payment for health care-acquired conditions, global payment system demonstration, and Pediatric ACOs. Delivery system initiatives in Medicaid include patient-centered medical homes for chronically ill populations, integrated care around hospitalizations, emergency psychiatric demonstration, and maternal and childhood home visitation programs.

The ACA will also introduce medical malpractice demonstration grants beginning in Fiscal Year 2011. These will be five-year grants for states to develop tort litigation alternatives at local level that allow for dispute resolution and reduce medical errors. Federal grantors will give preference to state programs that improve access to liability insurance and enhance patient safety, as well as those that form multi-stakeholder partnerships.

**c. State roles and responsibilities in quality improvement**

Maine's robust quality infrastructure and long-standing public/private partnerships prepare the state to benefit from the quality investments in the ACA and influence the federal government's work in this area. The federal Department of Health and Human Services will formulate adult health quality measures at the national level and work with states to standardize reporting based on a core set of measures. Quality reporting by state Medicaid and CHIP programs will become mandatory after September 30, 2014. Maine will have an excellent opportunity to experiment with delivery system and payment reform at the state level by taking advantage of federal support for quality improvement, reducing disparities, increasing transparency, coordinating care, and containing costs.

**Recommendations**

Going forward, Maine should utilize the opportunities in the ACA to continue to provide health care quality leadership throughout Maine and nationally by leveraging the Dirigo Health Agency/Maine Quality Forum, MHDO, and the state employee health plan. Maine should also build on current public/private partnerships. Maine has a long tradition of collaboration on quality initiatives by public and private purchasers, providers, government, and non-profits.

To take advantage of the opportunities in the ACA, we recommend that as part of the 2012-2014 State Health Plan, Maine craft a strategic plan to leverage ACA investments to support and build on Maine's quality improvement efforts as well as efforts to forward public health initiatives. The strategic plan should include a process to assure integration of current efforts in Maine with ACA initiatives.

## X. **Indian Health Provisions in the Affordable Care Act**

A number of ACA provisions specifically address health and health care needs among members of Indian tribes and tribal organizations. The provisions address important public health issues as well as access to and financing of care, workforce development, facility construction and delivery system organization.
The most significant part of the law with regard to Indian Health is the reauthorization and extension of the Indian Health Improvement Act. This omnibus legislation enacts a broad range of improvements to health care for Indians, including:

*Increasing the Indian health professional workforce.* The Act allows for the establishment of a national Community Health Aide program for Indian tribes and tribal organizations. It also authorizes funding for demonstration programs to address chronic shortages of professionals in Indian health programs.

*Improving health services.* The Act focuses on a number of important public health areas and provides for services such as:

- Diabetes prevention and treatment
- Long-term care and hospice
- Training for professionals in education, law enforcement and social services on the identification, prevention and treatment of mental illness
- Establishment of epidemiology centers to assist tribes and tribal organizations in identifying public health priorities, targeting services and tracking progress
- Expansion of a program for prevention, control and elimination of tuberculosis to include other communicable and infectious diseases, including hepatitis and HIV
- Creation of an Office of Indian Men's Health, a counterpart to the existing Office of Indian Women's Health.

*Building health facilities.* The Act calls for the creation of a health care facility priority system to guide the construction of Indian health facilities.

*Improving access to health services.* The Act allows tribes and tribal organizations to use funds available for health benefits to purchase coverage in any form, including state-licensed insurers, managed care organizations, and high-deductible health plans or health savings account arrangements. It provides grants for tribes and tribal organizations to conduct outreach to enroll members into Medicare, Medicaid and CHIP. It also encourages expansion of the arrangements for sharing medical facilities between the Indian Health Service, the Veterans Administration and the Department of Defense.

*Expansion of behavioral health programs.* Title VII of the Act had been "Substance Abuse Programs"; the reauthorization expands this title to "Behavioral Health Programs." It authorizes and directs the development of a comprehensive behavioral health and treatment program that emphasizes collaboration among alcohol and substance abuse, social services and mental health programs, and seeks to ensure that Indians have the same access to these services as do all U.S. citizens. This title also includes authorization for a youth suicide prevention demonstration program in five sites.

**Other provisions**
Aside from the reauthorization of the Indian Health Care Improvement Act, the ACA addresses issues regarding Indians' financing of health care. Members of Indian tribes are exempt from the financial penalty for not complying with the mandate to have insurance coverage. If Indians do purchase coverage through a state exchange, however, and have an income below 300 percent of the federal poverty level, they must be covered without any cost sharing (the Federal government pays for the increased actuarial value that results).

The ACA includes specific grants focused on Indian tribes and tribal organizations including promoting access to trauma care through grants to the Indian Health Service, Indian Tribal and urban Indian Trauma Centers to defray uncompensated care costs incurred in providing trauma care. Indian tribes and tribal organization, along with other entities, also are eligible to apply for a number of additional grant and demonstration programs authorized by the ACA. These include:

- Community transformation grants for community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a strong evidence base of effective prevention programming.
- Grants to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.
- Demonstration projects to provide low-income individuals with opportunities for education, training, and career advancement to address health professions workforce needs. Other entities in Maine have already received funding for two such programs: $2.2 million for nursing home health aides, and $748,000 for a personal and home care aide state training program.
- Grants to "teaching health centers" to establish or expand accredited primary care residency programs. Health centers operated by Indian tribes and tribal organizations are eligible for this funding. The Health Resources and Services Administration released a notice for this grant on November 29, 2010 and proposals are due on December 30.
- "Personal responsibility education" grants for programs to educate adolescents on abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections. The Maine Center for Disease Control has received a 5-year award of $250,000 per year for this program, and is now working with numerous stakeholders in the state to develop a comprehensive plan for the program.

**Recommendation:**

The State should collaborate with Maine's Indian tribes to take advantage of all appropriate programmatic and funding opportunities in the ACA, and Maine's tribes should be encouraged to apply for appropriate grants.

## XI. Public Health and the ACA

Maine's investment in state-level public health infrastructure and prevention efforts will allow the state to maximize the potential benefits of the ACA's many activities and investments in these areas. The federal law advances public health and prevention by removing barriers to access, developing a national policy for prevention and wellness, addressing these issues in public programs, and devoting resources to build the evidence base for reform through experimentation at the national, state and local levels. Maine has already established a robust public health infrastructure at the state and regional levels. Now the state has an opportunity to take advantage of the new federal efforts and build upon its existing infrastructure and investments in public health and prevention.

### a. Public Health and Prevention in Maine

Maine has demonstrated a strategic commitment to addressing public health concerns at the statewide and local levels. The state has established multiple bodies to tackle public health issues across the state, including the Statewide Coordinating Council and Public Health Workgroup. Their mission is to plan for infrastructure development with the goal of maximizing efficiency and effectiveness of public health care delivery given current resources. Maine has also set up eight Health Districts under DHHS. Each district has a Regional Coordinating Council that is dedicated to public health planning and coordination across local public, non-profit, and business sectors. Maine has also launched a statewide health awareness effort called the "Keep ME well" campaign that allows individuals to take a health risk assessment and search for health services through a consumer-friendly website (www.keepmewell.org).

Maine's public health and prevention efforts have been informed by the Triple Aim, which was developed by the Institute for Healthcare Improvement (IHI), the group that Dr. Donald Berwick led before becoming the head of the Center for Medicare and Medicaid Services (CMS). The Triple Aim strives to meet three goals: improving population health, enhancing patient experience by improving access and quality, and controlling costs.

### b. Public Health and Prevention in the Affordable Care Act

The ACA provides an unprecedented amount of federal support for public health, wellness, and prevention activities at the national and community levels. The law strives to remove barriers to accessing care for individuals and families through multiple means: First, the law eliminates cost-sharing for primary care and for many preventive services in private insurance and Medicare. Second, new consumer protections in the private insurance market and insurance subsidies for families and individuals with low and moderate incomes will increase access to health insurance. Third, the law appropriates $11 billion to help Community Health Centers with construction projects, operating expenses, and development of new access points. Likewise, there is a huge commitment to expanding the primary care workforce through investments in training and hiring of community health workers, allied and para-health professionals, primary care doctors, nurses, and nurse-practitioners.

The ACA also promotes a national strategy for prevention and wellness by building federal infrastructure that focuses on these important issues. The law establishes a National Prevention, Health Promotion and Public Health Council, which is an interagency group chaired by the

Surgeon General. The Council will coordinate a national public health promotion strategy and write an annual status report for Congress. Two independent task forces that existed prior to passage of the ACA will gain new roles and responsibilities. The U.S. Preventive Services Task Force and Community Preventive Services Task Force will review scientific evidence on clinical preventive services and develop recommendations that will become the basis for requirements on coverage offered through state-based Exchanges. The federal government will also launch an education and outreach campaign regarding preventive benefits. The ACA will also introduce a new requirement that chain restaurants post nutritional information, which should look very similar to a state law that Maine will implement in 2011.

New policies emphasize public health and prevention in the Medicaid and Medicare programs and the health insurance market. Medicare beneficiaries will face no out-of-pocket costs for many preventive services beginning on January 1, 2011. Other health insurance protections took effect in September 2010. The ACA also provides for a fully paid annual health risk assessment with a focus on prevention and wellness for each Medicare recipient. Medicare will also offer primary care doctors a 10% bonus payment in 2011 through 2015. In Medicaid, primary care services will receive increased payments up to 100% of Medicare rate during 2013 and 2014. States will receive 100% federal financing for these increased rates. Beginning in 2013, the ACA also offers an incentive—a 1% increase in federal matching rate—for states that eliminate cost-sharing for preventive services in their Medicaid programs.

Billions of dollars have already begun to flow to states and local entities to promote prevention and public health. The ACA contains over 100 categories of grants, pilot programs, and demonstration projects aimed at building the evidence base for delivery system and payment reforms that reduce disparities and promote healthy outcomes, wellness, and quality care. A new Prevention and Public Health Trust Fund will invest $15 billion over next five years—and $2 billion per year after that—in community and clinical prevention efforts, public health infrastructure, and research and tracking of prevention programs and health outcomes. The goal is to provide a sustained source of funding for state, local, and community-based public health programs. While this funding is substantial, it only represents a tiny fraction of overall spending on health care in the United States. Additionally, lawmakers' competing budgetary priorities already jeopardized some of the Fund's mission. Only half of the $500 million appropriated to the fund was used for public health and prevention programs in 2010.

The ACA invests more than $9 billion over 10 years to meet workforce needs in health professional shortage areas through the National Health Services Corps. The Health Resources and Services Administration (HRSA) designates Health Professional Service Areas, which are areas that have shortages of primary care, dental, or mental health providers. According to HRSA's website, shortage areas can be "geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility)."[67] Any individual or agency can request the designation of a shortage area. There are 219 shortage areas in Maine, so some of this funding should benefit areas of the state and populations with the greatest need.

[67] http://hpsafind.hrsa.gov/, accessed on 11/29/10.

Maine has already received more than $44 million through ACA grants and programs. Grants focusing on public health and prevention include:

- Construction, renovation, & expansion of two Community Health Centers (CHCs) – $5,100,000
  - Penobscot CHC (Bangor), Katahdin Valley Health Center (Patten)
- Personal and Home Care Aide State Training Program - $747,632
- Early Childhood Home Visitation Programs - $667,546
- Tribal maternal, infant, and early childhood home visitation programs – $700,000
- Grants from Prevention and Public Health Fund:
  - Strengthening Public Health Infrastructure - $1,758,786
  - CDC HIV Surveillance Grant - $60,000
  - CDC Tobacco Quitlines Grant - $53,098
  - Epidemiology & Laboratory Capacity/Emerging Infections Program Grant - $337,410

Maine will have the opportunity to consider many more promising grant opportunities promoting public health, prevention, and workplace wellness that will be released in the coming months and years. Key opportunities that have not yet been released (as of 11/29/10) include:

- Prevention
  - Grants to fund outreach campaign regarding preventive benefits (Sec. 4004)
  - Incentives to prevent chronic diseases in Medicaid populations (Sec. 4108)
  - Grants to research dental caries prevention and management (Sec. 4102)
- Public Health infrastructure
  - Community Transformation Grants (Sec. 4201)
    - Community prevention activities
  - Promoting healthy aging and living well (Sec. 4202)
    - Community interventions and screenings
- Workplace wellness
  - Grants for small businesses to establish wellness program (2011-2015)
  - Employer-based wellness programs
    - Allow employers to offer employee rewards for participation in wellness initiatives
    - Wellness demonstration project: Establish 10 state programs by July 2014
    - Allow states to apply similar rewards for wellness program participation in the individual market

**c. State roles and responsibilities in public health**

Maine will not face any new requirements due to the public health provisions of the ACA. However, the law offers many opportunities for the state to leverage federal funding to develop innovative delivery system and payment reforms that bolster the state's public health system. Maine could take affirmative steps to benefit from the new grants and incentives to increase access to care, promote prevention and wellness, and build the state's primary care workforce and infrastructure.

**Recommendations**

As described in Section VIII above, and building off the legal requirement for a Maine State Health Plan, the 2012-2014 Plan should include a strategic plan, to improve health outcomes, address disparities, promote prevention, and maximize ACA resources to support this work.

Further, DHHS should continue to pursue ACA funding for public health initiatives that meet Maine's strategic goals and should build on existing state public health infrastructure using ACA funds to secure accreditation for these efforts.

Finally, DHHS should collaborate with the local business community to promote employee wellness.

## XII. Conclusion

As detailed above, the ACA provides significant opportunity to improve access, quality and health status, reduce health disparities and contain health care costs, and it places new requirements on individuals and states to meet those goals. This report provides Maine policymakers with a detailed understanding of the ACA, its implications for Maine and policy options to consider as Maine continues to work through implementation. Key findings include:

- the ACA increases access to coverage by providing assistance for individuals with incomes up to 400% of the FPL (about $88,000 for a family of four), on a sliding-scale basis so level of assistance decreases as income increases;
- the ACA makes a number of changes to federal insurance law; while many similar laws already existed in Maine, the state will need to consider whether to conform with federal law or continue with its current requirements in the areas of medical loss ratio and community-ratings;
- the ACA provides a new marketplace for insurance purchase with the creation of Health Insurance Exchanges; there are specific functions required of Exchanges but Maine has flexibility to design the organization and structure in a way that works best for the individuals and small businesses it will serve;
- the ACA emphasizes the importance of quality and public health, and provides resources to states and local organizations through grants to promote standardized quality measurement and prevention; and,
- the ACA provides a number of mechanisms to develop programs to contain costs through support of health system redesign and payment reform initiatives, and the inclusion of Medicare in those initiatives.

While the process to implement the ACA will not be an easy one, there are real potential benefits to Maine from the implementation of the ACA, including:

- Federal funds to replace state dollars being used to subsidize health insurance premiums and to cover all low-income Mainers under MaineCare;
- New marketplace for individuals and small businesses with up to 100 employees to purchase health insurance in a more competitive market that will include two nationwide private plans
- National standards for quality
- Grants and other resources to support public health efforts, including prevention
- Containment of health care cost growth across all payers

## Appendix A

## ACHSD MEMBERS
## Maine Advisory Council on Health Systems Development

Brian Rines, PhD, Chair
Mental Health Representative
Psychologist
Gardiner

Lani Graham, MD, MPH, Co-Chair
Public Health Representative
Portland

Maroulla S. Gleaton, MD D.
Health Care Delivery Representative
Atlee Gleaton Eye Care
Augusta

Anne P. Graham, MSN, RN, CPNP
Public Health Care Financing Representative
No. Yarmouth

Andrew F. Coburn, PhD
Private Health Care Financing Representative
Muskie School of Public Service
Portland

Nona O. Boyink
Long Term Care Representative
Maine General Medical & HealthReach Network
Waterville

Arthur J. Blank, President & CEO
Health Care Delivery (Hospitals) Representative
Mount Desert Hospital
Bar Harbor

Edward F. Miller
Consumer Representative
American Lung Association of Maine
Augusta

David H. Brenerman
Large Business Representative
UNUM
Portland

James Highland, PhD
Small Business Representative
Compass Health Analytics, Inc.
Portland

Robert K. Downs
Health Insurer Representative
AETNA
Pittsfield

Dora A. Mills, MD, MPH
DHHS/CDC Representative
Center for Disease Control
Augusta

Joshua Cutler, MD
Quality Representative
Portland

Senator Peter Mills
Legislator
Skowhegan

Representative Anne Perry
Legislator
Calais

Representative Charles Priest
Legislator
Brunswick

Representative Wesley Richardson
Legislator
Warren

John P. Carr
Consumer Representative
Maine Council of Senior Citizens
York

Gail Dana-Sacco, PhD, MPH
Health Disparities Representative
Wabanaki Center
Orono

Senator Lisa Marrache
Legislator
Waterville

## Appendix B:
## FPL Chart for an Individual with Health Insurance Maximum

| FPL | Annual Income | Maximum % Income for Health Insurance | Maximum Annual Cost of Health Insurance |
|---|---|---|---|
| 133% | $13,579 | 3.00% | $407 |
| 150% | $15,315 | 4.00% | $613 |
| 175% | $17,868 | 5.15% | $920 |
| 200% | $20,420 | 6.30% | $1,286 |
| 225% | $22,973 | 7.18% | $1,649 |
| 250% | $25,525 | 8.05% | $2,055 |
| 275% | $28,078 | 8.78% | $2,465 |
| 300% | $30,630 | 9.50% | $2,910 |
| 325% | $33,183 | 9.50% | $3,152 |
| 350% | $35,735 | 9.50% | $3,395 |
| 375% | $38,288 | 9.50% | $3,637 |
| 400% | $40,840 | 9.50% | $3,880 |

# Appendix C: DHHS Financial Analysis

This document contains the estimated impact of policy options available through the Patient Protection and Affordable Care Act on Maine's Medicaid Program. The information that follows:

* is based on policy decisions which have yet to be made
* is based on our understanding of PPACA today
* includes enrolment information consistent with the State Health Access Data Assistance Center
* represents only the General Fund Impact

**Waitlist & New Population**

| | | FMAP | Estimated Members | General Fund |
|---|---|---|---|---|
| * PMPM based on FY09 expenditures less PNMI, Mental Health, Transportation & Community Support | 2014 | 100.00% | 29,210 | 1,314,275 |
| * PMPM inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2% | 2015 | 100.00% | 29,651 | 1,356,321 |
| | 2016 | 100.00% | 30,079 | 1,399,721 |
| * Estimated Members based on Non-Cat waitlist, SHADAC uninsured, shifting Dirigo members, adjusted for young adults leaving foster care | 2017 | 95.00% | 30,493 | 10,814,169 |
| | 2018 | 94.00% | 30,895 | 13,248,426 |
| | 2019 | 93.00% | 31,284 | 15,874,395 |
| * Enhanced FMAP | 2020 | 90.00% | 31,661 | 22,979,867 |
| | | | | **66,987,174** |

**Current Non-Cat Population**

| | | FMAP | Estimated Members | General Fund |
|---|---|---|---|---|
| * PMPM based on FY09 expenditures less PNMI, Mental Health, Transporation & Community Support | 2014 | 81.90% | 14,233 | (14,624,800) |
| * PMPM inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2% | 2015 | 85.52% | 13,792 | (17,549,760) |
| | 2016 | 89.14% | 13,364 | (20,474,720) |
| * Estimated Members based on annual budget of $80.3M divided by PMPY | 2017 | 88.76% | 12,950 | (20,167,680) |
| | 2018 | 90.98% | 12,548 | (21,961,440) |
| * Enhanced FMAP used based on recognition as an Expansion State | 2019 | 93.00% | 12,159 | (23,593,600) |
| | 2020 | 90.00% | 11,782 | (21,169,600) |
| | | | | **(139,541,600)** |

**CHIP**

| | | FMAP | Estimated Members | General Fund |
|---|---|---|---|---|
| * General Fund based on FY09 filed CMS 64 & CMS 21-B | | | | |
| * Cost inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2% | 2014 | 98.49% | 15,528 | (12,931,894) |
| | 2015 | 98.49% | 15,528 | (13,345,715) |
| * Estimated Members based on April 2010 Enrollment | 2016 | 98.49% | 15,528 | (13,772,778) |
| * FMAP Increase of 23 percentage points for CHIP | 2017 | 98.49% | 15,528 | (14,213,507) |
| | 2018 | 98.49% | 15,528 | (14,668,339) |
| | 2019 | 98.49% | 15,528 | (15,137,726) |
| | 2020 | 98.49% | 15,528 | (15,622,133) |
| | | | | **(99,692,091)** |

**Convert Parents over 133% FPL into the Exchange**

| | | FMAP | Estimated Members | General Fund |
|---|---|---|---|---|
| * PMPM based on FY09 expenditures | | | | |
| * PMPM inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2% | 2014 | 62.65% | 14,629 | (10,651,388) |
| | 2015 | 62.65% | 14,629 | (10,992,233) |
| * FMAP based on FFIS estimated for FFY12 | 2016 | 62.65% | 14,629 | (11,343,984) |
| * Additional savings of $5,000,000 annually to Dirigo Health. | 2017 | 62.65% | 14,629 | (11,706,992) |
| | 2018 | 62.65% | 14,629 | (12,081,615) |
| * In 2011, States can choose to convert eligibles over 133% FPL into the exchange or basic health plan by FY14 | 2019 | 62.65% | 14,629 | (12,467,227) |
| | 2020 | 62.65% | 14,629 | (12,867,210) |
| | | | | **(82,111,650)** |

**Foster Care Kids Stay until 26**

| | | FMAP | Estimated Members | General Fund |
|---|---|---|---|---|
| * | 2014 | 62.65% | 751 | 1,582,516 |
| PMPM based on FY09 expenditures | 2015 | 62.65% | 751 | 1,633,141 |
| * PMPM inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2% | 2016 | 62.65% | 751 | 1,685,415 |
| | 2017 | 62.65% | 751 | 1,739,338 |
| * Estimated Members based on eligibles aged 18 to 25 (Foster care and Adoption), adjusted for pregnancy, death, & incarceration rates and income | 2018 | 62.65% | 751 | 1,795,011 |
| | 2019 | 62.65% | 751 | 1,852,435 |
| | 2020 | 62.65% | 751 | 1,911,709 |
| * FMAP based on FFIS estimated for FFY12 | | | | **12,199,564** |

**Rebates**

| | | General Fund |
|---|---|---|
| * The Act, increased the prescription drug rebates on brand drugs from 15.1% to 23.1% after 12/31/09. | 2010 | 1,751,662 |
| * For generic drugs this increase is 11-13%. | 2011 | 3,425,468 |
| * The increase in theses rebates go solely to the Federal Government. | 2012 | 5,285,023 |
| | 2013 | 5,671,918 |
| * GHS provided an estimated impact for 2010-2013. 2014-2020 is estimated based on 2013. | 2014-2020 | 39,703,425 |
| | | **55,837,495** |
| * The loss of rebates begins retroactively 1/1/2010. | | |
| * A budget request will be submitted for the FY11 Emergency Budget and FY12 & FY13 Biennial Budget. | | |

**Health Reform Estimated Impacts on the Medicaid Program 2010 - 2020 = ($186,321,109)**

**Net Impact by Year**

| Aggregates: | | General Fund |
|---|---|---|
| * Cost of Waitlist & New Population | 2010 | 1,751,662 |
| * Savings from Enhanced FMAP on Non-Cat Population | 2011 | 3,425,468 |
| * Savings from Enhanced FMAP on CHIP beginning 2011 | 2012 | 5,285,023 |
| * Savings from Converting Parents over 133% FPL | 2013 | 5,671,918 |
| * Cost of Foster Care Kids Stay until 25 | 2014 | (29,639,373) |
| * Cost of loss of Rebates (retroactive) is still being refined | 2015 | (33,226,328) |
| | 2016 | (36,834,429) |
| **Notes:** | 2017 | (27,862,755) |
| * States that demonstrate deficits may eliminate coverage for Parent Expansion populations over 133% FPL (2011-2013) | 2018 | (27,996,040) |
| | 2019 | (27,800,805) |
| | 2020 | (19,095,449) |
| * State employee health plan will generate savings from retiree health insurance | | **(186,321,109)** |

## Appendix D
## PAYMENT REFORM WORK GROUP MEMBERSHIP

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