

## VIII Implement Federal Health Reform

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### Background

In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability Reconciliation Act of 2010, legislation that makes major changes to the nation's health care system. National health care reform aspires to universal coverage, improved health care quality, strengthened public health and prevention, and cost containment by promoting shared responsibility among individuals, government, employers, health care providers, and insurers. Key elements include:

- An individual insurance mandate that requires individuals and families to purchase insurance if it is affordable for them;
- Expansion of the Medicaid program to all Mainers and qualifying immigrants earning up to 133% of the federal poverty level or FPL (\$10,380 per individual) and federal tax credits to provide insurance subsidies for low- and middle-income earners up to 400% ;
- Requirements that larger employers provide coverage or pay an assessment; incentives for small businesses to provide coverage to their employees;
- Cuts in the growth of Medicare payments to providers and new incentives to promote health care quality, care-coordination, and preventive care;
- Changes in insurance market rules that allow more people to buy and retain private coverage;
- Payment reform incentives and pilots favoring primary care, medical home and global payments;
- Opportunities to improve access to primary care by expanding the number of primary health care settings and the primary health care workforce;
- New taxes on certain health sector business, high-income families, and high-cost health plans; and
- Support for states to improve public health, prevention and health care quality.

While the federal government, through the PPACA, retains control of the implementation of many of the public health and quality initiatives included in the law, national reform relies on states to carry out and monitor many of the major changes, particularly regarding the Medicaid expansion; new insurance market rules; promotion of quality, service delivery and payment reforms; and creating state-level insurance markets called Exchanges. State insurance regulators and the National Association of Insurance Commissioners (NAIC) have been given a significant role in the development of the new federal standards, as well as their implementation and enforcement.

Maine has a long history of health reform and is well positioned to implement the PPACA. Specifically, Maine has been a leader in expanding access to the uninsured through insurance reforms, Medicaid expansions and the enactment of Dirigo Health reform in 2003. In 2009, Maine was one of 13 states to be awarded a State Health Access Program grant from the US Health Resources and Services Administration. This grant, renewable until 2014, provides funding to develop a voucher program, offered through the Dirigo Health Agency, to uninsured lower income part-time and direct care workers who have access to employer coverage but cannot afford it. Multiple insurance companies will participate in the voucher program providing eligible workers with vouchers supporting a variety of affordable health insurance products. Coupled with the Dirigo Health Agency's current capacity to negotiate on behalf of DirigoChoice enrollees, the experience in this grant of working with multiple insurers and a voucher program provides additional experience to inform Maine's transition to an Exchange, as required in 2014.

Because the SHAP program is a limited 5-year demonstration, a condition of the grant was to develop a plan to ensure sustainability of coverage when grant funds end. The enactment of federal health reform provides just such an opportunity to sustain our coverage initiatives. Using our HRSA grant funds, Maine is able to quickly develop this health care reform implementation plan to implement health reform in Maine and assure that people now covered by various Dirigo access initiatives will continue to have sustainable coverage when national reform is fully implemented.

State reforms instituted in 2003 have improved Maine's uninsured rate to the sixth best in the nation in 2009 (up from 19<sup>th</sup> in 2003) and the state population's health status to thirteenth best in the nation in 2009 (up from 25<sup>th</sup> in 2003). Through the state Medicaid and Children's Health Insurance Program (CHIP), Maine currently provides generous publicly funded health benefits. MaineCare already covers childless adults, a group not ordinarily eligible, and families at income levels above the federally required minimum. In addition to dramatically improving health care access since 2003, Maine has developed significant health system infrastructure to support reform. Specifically:

- Multiple state agencies and legislative committees are dedicated to overseeing the state's health care system and driving innovation;
- Prior state-level reforms place Maine ahead of the coverage curve and align the state's insurance market regulations with the new federal rules;
- Maine's commitment to quality measurement and data reporting give the state a head start on federal reforms and provide a good foundation on which to build future efforts;
- Newly established public health infrastructure and innovative initiatives such as Keep Me Well and the Wellness Council can be leveraged to further advance individual and employee health programs under federal reform;
- The state already administers health care tax credits, insurance subsidies, a large employer insurance voucher program, and a consumer-focused website through the Dirigo Health Agency; and

- A MaineCare managed care initiative, consistent with PPACA principles, is in the planning stages.

## Financing federal reform

The federal health reform law dedicates more than nine-hundred billion dollars over ten years to expand insurance coverage, implement new insurance rules and Exchanges, and support delivery system change. These costs are offset by savings in the Medicare and Medicaid programs and by new taxes on individuals and businesses. The Congressional Budget Office estimates that national health care reform will reduce the federal deficit by \$124 billion over ten years. New federal spending for Medicaid and CHIP, in the form of an increase in the rate at which the federal government matches state spending, and for insurance subsidies to help low- and moderate-income people afford coverage, will directly affect Maine's state spending on health coverage for its residents. Federal insurance subsidies for small businesses will also be available to urge small employers to offer coverage. About 37,000 small businesses in Maine could benefit.

### ***Revenue Provisions***

Funding for federal health care reform comes in part from several new taxes and assessments on businesses and individuals, and in part from spending reductions, in Medicare, largely by eliminating subsidies provided to insurance companies that run Medicare Advantage plans. Some policy experts predict that new quality, care-coordination, payment reform and service delivery changes will produce additional savings for the government and other payers, but the Congressional Budget Office did not account for most of these initiatives in its cost estimates because their implementation and impact are not yet clear.

Medicare savings come from reductions in the growth in Medicare provider rates and the introduction of a productivity adjustment, which will advantage some providers and disadvantage others. The law restructures the Medicare Advantage program and reduces Disproportionate Share Hospital (DSH) payments under the Medicare program. The law also increases the rebate drug manufacturers pay to state Medicaid programs, with the incremental proceeds (and, in Maine's case, some additional rebate funds as well) going to the federal government and reduced rebate revenues for states.

Revenue will also be generated through new taxes and fees on high-income earners and on certain health sector businesses such as pharmaceutical and medical device companies. The law levies taxes on health insurers, including an excise tax on high cost health plans that will phase in beginning in 2018. Individuals who earn more than \$200,000 per year and couples who earn more than \$250,000—between 1.5% and 1.9% of Maine taxpayers—will face a 0.9% increase in the Medicare payroll tax on income over that threshold and will owe a 3.8% tax on unearned income such as rents, investments, and dividends.

## Maine's role in implementing federal reform

The federal government will provide significant support for states to implement health care reform, but state action and new expenditures will be required in some key areas. Implementing the health reform law will require significant attention and activity by both the Executive and Legislative branches of government in Maine over the next several years. This state health plan chapter frames the most urgent policy issues and tasks identified to date. As the federal government begins to release draft regulations and shape the features included in the PPACA, new policy issues undoubtedly will arise. As described further below, Maine has put in place a structure within the Executive Branch through its Health Reform Steering Committee and its Advisory Council on Health System Development to implement health reform in a thoughtful and transparent manner. Further, the Legislature has also established the Joint Select Committee on Health Reform. These structures will allow for both the Governor and the Legislature to be well informed of the implications of the health reform law in Maine and to receive comprehensive policy options, analysis and recommendations.

Policymakers in Maine will face the following major policy questions in 2010 and beyond:

1. Will Maine establish a state health insurance Exchange that meets the federal requirements while serving the needs of the individuals, families, and businesses that use this marketplace or allow the federal government to do so? If Maine elects to run an exchange, how will it do so?
2. Whether Dirigo assessment on businesses will be needed and if so, how will it be utilized going forward?
3. Will Maine enforce the insurance market reforms, or allow federal regulators to assume these responsibilities? PPACA does leave the regulation of insurance to states but does so within a federal fallback provision through which federal HHS steps in to enforce the federal insurance requirements if the state fails to substantially enforce them
4. What strategic opportunities can the Maine Medicaid program (MaineCare) take advantage of under the PPACA? How will the eligibility expansions, payment rules and benefit requirements impact the current program?
5. How will Maine coordinate its system for public program eligibility determinations with the exchange given the new federal requirements?
6. What criteria and priorities will guide Maine's pursuit of grants, demonstration projects, and payment reform pilot programs offered through the PPACA?

The state faces numerous other choices about whether to take action on specific policy matters throughout the implementation process during the coming years. These opportunities range from promoting workforce development and wellness and public health and prevention programs to beginning the process of reforming the payment system and implementing innovative care delivery models. While Maine has a responsibility to take some actions due to new federal requirements, the state also has a wonderful opportunity to pursue its own path for reform given the flexibility provided under the PPACA.

This chapter highlights the major policy options delineated above and provides a detailed list of key activities that the state should consider as implementation moves forward in 2010 and beyond. This planning document will serve as a framework – a key document in the implementation of health reform, but identified state agencies will develop their own health reform work plans to direct specific activities identified here that fall within their responsibilities.

## Major Policy Options

Maine will need to consider a number of policy options throughout the implementation of the PPACA. This section presents five core areas where significant decision-making will need to occur in the short-term: 1) Exchange governance and infrastructure, 2) Dirigo assessments, 3) insurance reforms, 4) expansion of publicly funded coverage, and 5) payment and system reform and related funding opportunities. Other areas for consideration are presented in the Key Activities section below; as implementation activities begin it is possible that other planning questions will rise to the level of a major policy option.

### Exchange

Maine already conducts many of the functions envisioned in an exchange in the Dirigo program. There are several first-order decisions that state policymakers must consider regarding the governance and structure of an exchange. The first is whether Maine will accept responsibility for administering its own exchange. The PPACA provides states with an option to develop and manage their own exchange or to default to the federal government to operate the exchange.

#### ***Operating an Exchange***

States accepting responsibility for the exchange must establish an American Health Benefit Exchange to serve individuals who receive tax credits as well as others who are purchasing insurance on their own. The law also requires states to establish a Small Business Health Option Programs (SHOP) for employers with fewer than 100 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 an exchange or to default to the federal government, there are a number of issues to consider, including:

- Coordination with other health coverage programs
- Capacity
- Flexibility
- Efficiency
- Uniqueness of market characteristics

It would be advantageous for states to manage their own exchanges for several reasons. It would likely be less complex to coordinate benefits and eligibility across all state programs if the exchange operates in-state. Additionally, although federal standards for the state-level exchanges will be determined, it may be desirable to customize an exchange to best meet the needs of a state'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.

### ***Potential for Development of a Regional Exchange***

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 how similar the market characteristics (including demographics of those who will be purchasing through the exchange, number and type of carriers and plans, employer offer rates, etc.).

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 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.

### ***Who Administers the Exchange***

If Maine decides to implement its own exchange, subsequent choices arise such as whether the state should establish one or more exchanges and where to house the exchange(s). Maine will want to consider its population demographics, carrier market share, provider networks, capacity and resource requirements to determine whether one or more exchanges are warranted. In addition, estimates of the numbers of individuals and businesses expected to enroll in an exchange is important when considering whether to establish one or more exchanges. Whether to establish a new entity or build upon current state infrastructure is the next question that Maine faces. The exchange needs the capacity to accomplish an extensive list of tasks—including (but not limited to) processing applications, confirming eligibility for tax credits, billing premiums, monitoring employer contributions, reconciling payments, developing and maintaining a website, payment of commissions, ongoing marketing and outreach, assuring appropriate consumer protections are in place and developing and maintaining an electronic interface.

The exchange could be housed in a governmental agency. 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, but it also further removes the state from important and time-sensitive decision-making. Two separate exchanges would duplicate functions and could lead to added complexity and confusion for consumers. Moreover, Massachusetts experience of fewer than

expected small businesses purchasing through its exchange, may make it unlikely that an entirely new organization focused only on small businesses would be large enough to justify its start-up and on-going operational costs.

Creating a new state agency to house the exchange may be viewed as redundant since so much of the functionality already exists within another state entity. It would also create additional administrative burdens for carriers and others who will be required to report to and/or work with a growing number of state agencies. Another disadvantage is for recipients of benefits who may endure issues with continuity of coverage because of lack of coordination among the various agencies.

Regardless of where it sits, the exchange will require significant interface with other state agencies including, at a minimum, our Medicaid agency, the Bureau of Insurance and Maine Revenue Services.<sup>1</sup> In addition, Maine will want to evaluate the capabilities of organizations that play an intermediary role in our state to determine whether they have some of the needed capabilities to operate various functions of the exchange through a sub-contract.<sup>2</sup> These decisions will be critical in the short-term to meet federal deadlines for establishing the exchange.

### ***Funding to Support Development of the Exchange***

One of the many funding opportunities included within the PPACA is federal support to states for the development of the exchange. These federal funds become available within one year of the bill's enactment and continue through January 2015. The Governor's Office of Health Policy and Finance should submit an application for such funding, when it becomes available. This opportunity will allow the state to conduct detailed analysis on the advantages and disadvantages of operating its own exchange, joining a regional exchange or defaulting to the federally-run exchange by the required notification date to HHS of their intention to operate an exchange by January 1, 2013.

### ***Eligibility Determinations***

The PPACA requires streamlined eligibility across the Medicaid, CHIP and subsidy programs, providing a seamless point of entry common to Medicaid and subsidized insurance. This will require information system development likely subsidized by CMS.

Specifically, the law directs the U.S. Department of Health and Human Services to establish a system that offers a single application for Medicaid, CHIP, and federal subsidies.<sup>3</sup> Further, the law requires applicants to have the option to apply for benefits and subsidies through a website that provides a comparison of available benefits across plans participating in the Medicaid

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<sup>1</sup> Maine Revenue Services is likely to be involved in assisting the exchange in verifying individual and small business eligibility for subsidies based on individual income and employer size.

<sup>2</sup> For example, in Massachusetts the exchange subcontracts with an intermediary to provide sophisticated information technology needs without having to duplicate effort.

<sup>3</sup> The PPACA provides states with the option to develop a Basic Health Plan for individuals between 133-200% of the FPL. If Maine opts to develop such an option, eligibility for the Basic Health Plan must also be included in this streamlining effort.



program and the exchange. The federal law requires that Medicaid and CHIP programs accept eligibility determinations made by the exchange without any further determination. Likewise, the exchange must accept eligibility determinations for subsidies made through Medicaid and CHIP.

Today, the Dirigo Health Agency operates eligibility functions for subsidies and vouchers. The Maine Department of Health and Human Services (DHHS) operates an integrated eligibility system that performs eligibility functions for 26 public assistance programs, including MaineCare, Cub Care (CHIP) and Maine's prescription drug programs, and also including TANF and the Supplemental Nutrition Assistance Program. This integrated eligibility system provides streamlined "one-stop" access to services for Mainers that is not available in most states. DHHS is in the process of developing a web portal to its integrated eligibility system that will provide an electronic option for eligibility determinations, enrollments and re-certifications.

Specific policy questions to be answered include:

- Will the current web-portal activity being undertaken by DHHS accommodate the requirements under the PPACA that requires streamlined, on-line eligibility for subsidies and/or MaineCare be accessible to all?
- Will the web-portal serve as the only entry into the system or will there be other methods for eligibility applications to be accepted (e.g., provide for a "no wrong door approach")
- What modifications need to be made to the state's current eligibility system to provide for streamlined eligibility? What resources are needed? How long will such system modifications take to make?

In addition to deciding where eligibility determinations are made, Maine will also need to analyze its current determination of eligibility to meet the new federal requirement that eligibility be based on modified gross income and the elimination of an asset test for nonelderly applicants. The PPACA provides a specific definition of Modified Adjusted Gross Income, including an across the board 5% income disregard, and prohibits states from utilizing any other income disregards when determining eligibility, premiums and cost-sharing.

### ***Longer Term Decisions***

In the longer term, the state will have the opportunity to consider the impact of the exchange on health coverage generally and the insurance market specifically. First, in 2017, Maine will have the opportunity to consider seeking a five-year waiver from the federal government permitting the state to opt out of certain new health insurance requirements if the state is able to demonstrate that it provides universal coverage that is as comprehensive as the coverage required under an exchange plan and that such a waiver would not increase the federal budget deficit. Assuming the state determines it would like to maintain the federal health reform construct, the state also may want to consider how to implement the requirement that plans must be allowed to sell outside the Exchange. It is conceivable that a State could require any product sold outside the Exchange to be sold within it as well but states will need to await further federal guidance. Many of the first-order policy decisions outlined above should occur within a 6-month time frame. Maine will want to well prepare itself to respond to the federal government regarding

start-up exchange funds and seek to influence implementation decisions at the federal level. Once the high-level decisions are made, Maine can begin to contemplate the myriad of smaller policy decisions inherent in getting the exchange up and running.

It must be noted that all deadlines established in this chapter are subject to change, pending additional federal guidance

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**Goal VIII.1: To assure timely, effective and transparent implementation of PPACA in Maine**

**Task 1:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

**Decision Points – Exchange**

<u>Date</u>	<u>Action</u>
By 12/31/10	<u>Decision</u> to create exchange, and whether one exchange or two
	Decision on where exchange should be housed
	Form planning group to develop exchange; create work plan
By 6/30/11	Secure federal planning funds
By 1/30/12	Begin efforts to modify state eligibility systems, as needed to comply with federal law
By 1/1/13	Enact legislation creating exchange
1/1/14	Launch exchange

**Dirigo and the Federal Financing of Reform**

A central feature of the PPACA is the additional federal funding that will be available to support expansions in MaineCare coverage and to subsidize the purchase of private insurance for low- and moderate-income people not eligible for public coverage. The new federal dollars will supplant some and possibly all state subsidies available through DirigoChoice, and thus raise important policy questions about Dirigo’s existing funding mechanism.

***Dirigo Financing***

DirigoChoice provides subsidized health insurance premiums on a sliding scale for individuals and families with incomes up to 300 percent of the Federal Poverty Level (FPL).<sup>4</sup> The Dirigo subsidies are funded by a 2.14 percent assessment on claims paid by Maine health insurers and by third party administrators who run self-insured plans. The assessment is expected to generate \$42.1 million in State Fiscal Year 2010.

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<sup>4</sup> The 2010 federal poverty level for an individual is \$10,830 and \$18,312 for a family of three.

### ***New Federal Subsidies***

Beginning in 2014, federal premium credits will subsidize the purchase of health insurance through the Exchange for individuals and families with incomes between 133 percent and 400 percent FPL. The credits are structured so that people at the low end of this range would be responsible for paying 2 percent of their income toward a premium; at the upper end, 9.5 percent. There are also subsidies available to help people up to 250 percent FPL to pay their deductibles and copayments. Most people with incomes less than 133 percent FPL<sup>5</sup> will be eligible for Medicaid, with enhanced Federal funding.

Many current subsidized DirigoChoice enrollees will be eligible for the new federal tax credits. In fact, eligibility for the federal credit extends beyond the eligibility limit of 300 percent FPL for Dirigo subsidies, to 400 percent FPL. Small businesses will be eligible for time-limited tax credits for 50 percent of their costs of employee coverage if they pay half the employee premium. Small business tax credits will serve as a bridge until Exchanges are fully operational, when they are expected to negotiate more competitive rates for small businesses. As further described in the Coverage Expansion section below, it is also possible for Maine to shift some members with incomes between 133 percent and 200 percent FPL who are currently enrolled in MaineCare into a basic health plan in the Exchange to leverage more federal dollars or simply to transition them to coverage in the exchange.

Because the federal revenues for premium and cost sharing tax credits will replace state spending for most if not all DirigoChoice subsidies, the assessment dollars now collected from health plans may no longer be needed for subsidies. However, a portion of the assessment currently is utilized to fund statewide quality initiatives through Dirigo's Maine Health Quality Forum and the need for such funds remains. Maine may consider options for future assessments as follows:

- **Repeal the assessment beginning in 2014.** No longer collect an assessment on health insurance claims. In repealing the assessment, the state could require health insurers to apply the savings to reduce health insurance premiums. In repealing the assessment, Maine will need to consider what funds will be available to continue to fund statewide quality initiatives.
- **Retain assessment – either at the current level or a reduced rate.** The assessment on health claims provides significant funds to support Maine's current health care system. Despite the influx of new federal dollars into Maine, there will undoubtedly be gaps in funding that the state may want to consider. If federal tax subsidies are no longer available to small businesses or if they and the Exchange's buying power do not make small business costs more affordable, the state may want to continue some form of subsidy. In addition, Health InfoNet, Maine's electronic health information exchange needs sustainable funding, although would require only a small percentage of the current assessment. HIN has the potential to yield a positive return on investment through the improved efficiency of medical care, reduced medical errors, and lower cost. Some may

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<sup>5</sup> The federal law builds in a standard 5% of income disregard into the gross income test, making the actual income level for eligibility 138% of the FPL.

be used to continue to fund the work of the Maine Quality Forum. As noted below, the state may choose to continue mandates and will need a source of funds to pay for them. Both initiatives could be conducted with a reduced assessment level that would reduce, but continue a cost borne by premium payers.

- **Supplementing the federal subsidy to improve benefits.** The federal premium tax credit is tied to the value of a specific benefit plan which has not yet been defined.<sup>6</sup> While the federal plan must include preventive care and pediatric services, it is possible that the federally-specified benefits will not be as extensive as the benefits available in Maine today. To the extent that Maine currently has insurance mandates that are not included in the federal plan, or desires a richer (and so more costly) benefit package for individuals and families purchasing coverage through the Exchange, the State would be required to pay those costs. The state would need to review a variety of options, including using some of the assessment, to supplement the federal subsidy so that enrollees would not pay a larger share of their income than the federal law requires.
- **State subsidy to maximize coverage.** Some Mainers will be exempted from the requirement to have insurance because available options are too expensive given their family income levels. Assessment funds could be used for a state subsidy to help those who do not qualify for the federal tax credit to afford coverage

Prior to the start of the federal tax subsidies in 2014, Maine will undertake a detailed analysis of these and other options to determine the disposition of the Dirigo assessment.

### ***Public Option***

The PPACA permits states to develop a Basic Health Program for individuals with incomes between 133-200 percent of the FPL instead of providing such individuals with subsidies to purchase health insurance. However, these individuals and all those below 400 percent of poverty would be eligible for subsidies in the Exchange. Creating a Basic Health Plan would establish another program and may cause confusion. Conversely, the program could provide important benefits to lower income parents and, if coordinated with or an expansion of MaineCare, would provide an opportunity for parents and children to remain in the same plan while the Children's Health Insurance Program is in place. The state may consider whether it is interested in establishing a Basic Health Program and what would be entailed to meet federal requirements. A notable feature is that the PPACA restricts the funds available for a Basic Health Program to 95 percent of the premium and cost sharing subsidies that enrollees would have received if they were enrolled in a health plan through the Exchange. Under the PPACA, the Basic Health Program would become effective in January 2014 at the same time as the exchange.

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<sup>6</sup> The federal law requires HHS to define four benefit categories to be provided through an exchange. The basic plan, for which subsidies will be available, must provide minimum essential coverage at the actuarial value of 60% while the highest plan will require an actuarial value of 90%.

**Task 2:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

### **Decision Points – Dirigo and Federal Financing**

Date	Action
By 12/31/10	Develop list of options for disposition of Dirigo assessment
	Analyze cost and feasibility of assessment options
	Decision on whether to develop Basic Health Program
By 12/31/11	Decision on disposition of Dirigo assessment
By 6/30/13	Enact legislation to change Dirigo assessment Enact legislation to create Basic Health Plan, if appropriate
1/1/14	Changes to Dirigo assessment in effect Launch Basic Health Program, if applicable

## Insurance Reform

Although federal reforms include many of the types of insurance market reforms Maine has already implemented, it will be important to review Maine's laws to ensure that they meet the minimum federal standards. PPACA (similar to earlier federal HIPAA reforms) largely relies on state insurance regulators to monitor compliance. If a state is unable or unwilling, then federal regulators are allowed to come into a state and take over regulation to ensure compliance with national standards.

A key decision for Maine's policymakers will be whether to modify Maine's laws to ensure that the state's laws meet the minimum standards set out in federal law. Generally, state insurance regulators can only enforce state insurance laws, not federal laws. Absent modifications to state insurance law, federal enforcement would be necessary.

In addition, PPACA recognizes that insurance markets vary and that states have chosen a variety of ways to protect consumers. PPACA preserves the right of states to continue to do that. Because federal law sets a minimum standard, states have flexibility and can have and enact other laws and additional consumer protections.

Some key policy decisions that Maine will need to make immediately and before 2014 regarding the insurance market include:

- When to expand the definition of the small group market to include businesses with up to 100 employees
- Whether to merge the small group and individual markets

- How to participate in the development of national standards, directly and through the NAIC
- Whether to take an active role in enforcing the insurance market reforms, or allow federal regulators to assume these responsibilities
- What revisions to make to Maine's insurance laws to meet the minimum federal requirements, including medical loss ratio standards, rate review, and a variety of other consumer protection standards
- Whether to maintain or reduce the state's mandated insurance benefit requirements
- Whether to amend Maine's community rating bands to comply with lower federal requirements
- Whether to participate in interstate insurance compacts, beginning in 2016, that would allow for the sale of insurance products across state lines

### ***Individual and Small Group Markets***

One of the important considerations in this arena is whether to merge the non-group and small group markets. The Blue Ribbon Commission on Dirigo studied this issue and unanimously recommended that sole proprietors be allowed to purchase in the small group market and asked for a work group to study and report on three options, including merging the individual and small group markets.(January 2007) As a result, the Bureau of Insurance issued a report in May 2007 that examined the three options that determined that while there are several advantages to a merger, a merged market was likely to cause a decrease in individual premiums but an increase in premiums in the small group market under current market conditions The extension of the small group market to firms with 100 employees or fewer (up from 50 or fewer), coupled with the individual mandate, substantial financial subsidies to individuals and employer incentives, may now provide enough of a buffer against increased risk to merge the markets without causing an increase in small group premiums.

Maine will need to consider the advantages and disadvantages of merging these markets in a reformed environment. PPACA also increases the threshold for large employer status from 50 to 100, effective in 2014, but allows states to opt out during 2014 and 2015. Maine will have to decide whether to allow the expansion to take effect immediately or postpone implementation.

### ***Medical Loss Ratio***

As Maine does today, the PPACA requires health insurance plans to report medical loss ratios. Under the PPACA there is a minimum MLR of 85 percent in the large group market and 80 percent in the individual and small group market. Maine does not now regulate large group rates, and there are significant differences between Maine's current MLR requirements and the federal definitions. These inconsistencies will need to be examined and the state will likely need to amend its laws to comply with the minimum MLR allowable to be consistent with the federal law.

In addition to considering the minimum MLR, Maine will also need to consider how its current definition of MLR compares to the final regulation to be issued by the federal Department of Health and Human Services (HHS). The language used in the PPACA, which is the subject of a request for comments by HHS, is different from the definitions used in Maine and other states. This makes the comparison between current Maine requirements and the new federal requirements more complex. In addition, the regulations call for the issuance of partial premium rebates to consumers whose plans have MLRs that fail to meet federal standards. Maine currently requires premium rebates on a pro rata basis. The state may need to modify its process for monitoring a health insurer's premium rebates depending on the language of the upcoming federal regulations

### ***Rate Review***

The PPACA establishes a process for reviewing the reasonableness of health insurance premiums. While Maine already reviews and approves premium rates set by insurers in the non-group market, small group premium prices are not subject to prior approval as long as the insurer agrees to issue coverage on a guaranteed MLR basis. For guaranteed MLR products, rates are reviewed but not subject to prior approval. Large group market rates are filed for informational purposes.

Maine should consider whether there are further actions that could be taken by the Superintendent of Insurance to review rates and whether the state may qualify for grant funds to review health insurance increases. These funds become available in 2010.

### ***Consumer Protection and Rating Standards***

The PPACA establishes new federal minimum standards in a number of areas, including but not limited to protections for consumers with health conditions, expansion of dependent coverage, transparency in health insurance documents and communications, appeal processes, and limits on variations in premium rates. Although Maine law equals or exceeds federal requirements in many areas, other federal requirements are new, or are structured differently from their Maine counterparts.

Maine needs to evaluate its insurance laws and to make changes as appropriate. If states do not enforce the federal requirements, HHS is given the authority to step in.

### ***State Mandates***

The PPACA requires states to evaluate the cost of their state insurance mandates that are not included in the essential benefit plan that will be determined through federal regulation. Any person receiving federal tax credits for insurance through the exchange will not be credited for benefits above this basic benefit plan.

Once the regulations are promulgated for the essential benefit plan, Maine will need to determine whether or not it wants to fund any additional mandates through a state-only revenue source, such as the Dirigo assessment or general funds.

### ***Interstate Insurance Compacts***

The PPACA allows states, on a voluntary basis, to form “health care choice compacts” that allow insurers to sell policies in any state participating in the compact. As a starting point, Maine will need to determine whether it is interested in forming or joining a compact, and, if so, which states would likely be partners. Choice of state partners is a key decision as, under the federal law, an insurer is required to follow some but not all state insurance laws by each of the states participating in the compact. The insurer is only required to follow all the state insurance laws for the state in which the insurer is domiciled. For example, if Maine has stronger consumer protection laws than some of its state partners, Maine residents that purchase through the compact may not receive those same protections as Maine’s insurance regulators may not be able to fully enforce Maine’s laws. Federal regulations for interstate compacts will not be issued until 2013; with compacts beginning operations in 2016.

**Task 3:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

#### **Decision Points – Insurance Reform**

Date	Action
ongoing	Work with NAIC and HHS on development of federal insurance standards
By 9/30/10	Review Insurance Code provisions and Bureau of Insurance rules for consistency with federal requirements
By 12/31/10	Decision on whether to increase small group to firms with 100 employees; merge small and non-group markets
By 12/31/10	Apply for grant funding to review health insurance provisions, when available
By 12/31/11	Decision on whether to fund state insurance mandates in excess of federal mandates using state dollars
By 12/31/13	Decision on interest in forming an interstate insurance compact

### **Expansion of Publicly Funded Benefits**

Maine is ahead of most states in its use of MaineCare to cover low income people.<sup>7</sup> The PPACA provides for expansion of public programs through a combination of expanded Medicaid eligibility, enhanced federal match for Medicaid and CHIP, and the development of a subsidy program for the purchase of private insurance through an exchange for individuals with incomes

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<sup>7</sup> Today, MaineCare covers children to 200% of the FPL through a combination of Medicaid and CHIP; parents to 200% of the FPL; and pregnant women to 185% of the FPL. (200% if under 19)MaineCare also covers disabled individuals at varying income levels depending on whether income is earned and unearned.



up to 400 percent of the federal poverty level (FPL).<sup>8</sup> At the same time, the PPACA modifies the current prescription drug rebate policy in a way that reduces Maine's revenue by retaining a greater level of savings from prescription drug rebates for the federal government. Specifically, the PPACA expands eligibility for Medicaid to all individuals under the age of 65 to 133 percent of the FPL beginning in 2014. Enhanced Medicaid federal match rates will offset state funding for childless adults with incomes less than 100 percent FPL who now have coverage under MaineCare. Maine will also receive enhanced federal funding beginning in 2014 to cover childless adults earning between 100 percent FPL and 133 percent FPL, as well as those under 100 percent FPL who are on the program's waiting list. Because Maine previously provided coverage to some of the new mandatory categories, Maine is considered an expansion state under the federal law. As an expansion state, federal dollars will fully support the expansion of individuals between 100 and 133 percent of the FPL for the first three years. Like all states, Maine will be required to contribute a small percentage of this population's coverage costs beginning in 2017 (the state share increases each subsequent year and settles at 10 percent for 2020 and beyond). Maine will also receive enhanced match based on a statutory formula for those childless adults below 100 percent of the FPL who are already covered in Maine which will significantly reduce state funds required to cover these populations going forward, provided the state maintains current eligibility levels for the Medicaid and CHIP program, including for coverage of parents, pregnant women and persons with disabilities with incomes above 133 percent of FPL. Maine will also receive significant enhanced funding (23 percent points) for children covered in the state's CHIP program up to 200 percent FPL from 2014-2019.

The PPACA also creates a new mandatory categorical eligibility for former foster care children, regardless of income, until the age of 26. This section is effective on January 1, 2014.

While the expansions do not become mandatory until 2014, it is essential to immediately conduct analysis of the increases and decreases in federal revenue through the federal law and the long-term impact on required state-funding for these expanded benefits. Once the analysis is complete, Maine has a number of options to quickly consider including:

- Whether to allow childless adults into MaineCare prior to 2014 (at regular match), including potential movement of individuals currently in DirigoChoice and outright expansion
- Will the state be required to proactively identify former foster children for enrollment in Medicaid if they are under age 26 but have already aged out of the foster care system
- Assess whether Maine will have a budget deficit between January 1, 2011 and December 31, 2013, and if so, whether Maine will consider reducing eligibility for non-pregnant, non-disabled parents to 133 percent of the FPL and the impact on rates of uninsured in so doing

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<sup>8</sup> The 2010 federal poverty level for an individual is \$10,830 and \$18,312 for a family of three.

**Task 4:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

### Decision Points - Expansion

Date	Action
12/31/10	Conduct financial analysis of impact of expanding to childless adults prior to 2014
	Determine additional state dollars for such expansion
	Make decision on whether to expand prior to 2014
7/1/13	Determine how will identify former foster children to enroll in Medicaid program
7/1/10; 7/1/13	If budget deficit, determine whether will consider reducing eligibility as maintenance of effort requirement will be waived

## System and Payment Reform

Fundamental system reform that addresses public health, prevention and wellness, and how necessary health care is provided, paid for and monitored is a key focus of the PPACA. Maine is host to a large number of initiatives, both public and private, to improve the health of Mainers and the ways they receive and pay for health care. The Maine Wellness Council and the Healthy Maine Partnerships are examples of collaborations that improve the health and wellbeing of people who live and work in Maine. Dirigo's Maine Quality Forum leads efforts to improve the quality and safety of health care.

Payment reform efforts are described in detail in Chapter VI. Several payment reform initiatives are underway with state employees and the private sector, including the Maine Health Management Coalition's payment reform planning process for the state's largest employers and an initiative is underway with CIGNA, Bath Iron Works and providers. A 26 site patient centered medial home demonstration is also underway. The Legislature has tasked the Advisory Council on Health Systems Development to report back in January, 2011 with recommendations for action based on the models mentioned above.

The initiative that Maine's government, nonprofits, and businesses have taken to improve health care may put the state in a good position to take advantage of new opportunities in the health reform law. The PPACA takes a decentralized approach to promote payment and delivery system reform, through funding for demonstration projects, pilot programs, and grants targeted to states, municipalities, medical schools, hospitals, nursing homes, and other providers. Many of these projects focus on areas that have been a priority for Maine, including these examples (among many others):

- **Preventive Care:** Grants for medical schools to provide preventive care training for medical residents; support for non-profits, community-based organizations, and

governments to promote evidenced-based preventive health activities in local communities.

- **Wellness:** Funding for a wellness program demonstration and a preventive benefits outreach campaign; incentives to prevent chronic diseases in Medicaid
- **Quality:** Grants to institutions to adapt and implement models and practices that promote evidence-based quality and reductions in health disparities, and to states to develop quality measures and establish community health teams to support patient-centered medical homes
- **Expansion of Primary Care Health Care Settings and Workforce:** State health care workforce development grants, workforce diversity grants, and demonstrations to address health professions workforce needs and expand access to primary care through federally qualified health centers.
- **Payment reform:** Funding for demonstrations on global and bundled payments and pediatric accountable care organizations, planning grants for creating medical homes for people with chronic illness. Funding provides key opportunity for public purchasers, including Medicaid and Medicare, to lead or participate in multi-payor payment reform efforts.
- **Medical Malpractice Demonstration:** Funding available for development for an alternative medical malpractice system

Maine will need to review all of the relevant opportunities in the law, quickly prioritize them and develop relationships with researchers and others in order to best meet the state's goals for improved quality and system reform. As appropriate, the payment and system reform initiatives will be integrated into the Medicaid Managed Care initiative currently in the planning stages. Because each of these grants opportunities will be of interest to various stakeholder groups, there will be pressure on the state to apply for as many as possible. However, given the fact that most of these grants require some level of state matching funds or resource commitment and that the state has finite resources to implement, manage and monitor available opportunities, the Health Care Reform Implementation Steering Committee should develop a recommended set of criteria, with input from the Advisory Council on Health System Development, to follow in considering the application or support of such grants. Examples of appropriate criteria include:

- Priority in the State Health Plan
- Related initiatives underway in Maine
- Broad coalition of support
- Level of state funding required (lower is better)

In addition to developing a prioritization for grants that require the state to act as a lead, it is also important for Maine to develop an overall workforce development strategy to guide local organizations and health care providers on which grants are likely to be of the most benefit to Maine and support statewide priorities. These funds begin coming available in 2010.

**Task 5:** The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

#### **Decision Points –System & Payment Reform**

Date	Action
8/1/10	Review all grants provided for under PPACA and group into state led and other grants
	Develop a set of criteria to use in prioritization of grants; may require different criteria for different types of grants
	Prioritize state led grants and assign responsible state agency for each grant to lead development
9/1/10	Develop a strategy for state outreach to organizations and providers around available grants and how they fit within state priorities

## **Key Activities**

Implementation of health care reform will require considerable state staff resources over the next several years. As described above, the PPACA provides states with the opportunity and responsibility to administer much of the federal reforms. Through an Executive Order issued on April 22, 2010, Governor Baldacci established a Health Reform Implementation Steering Committee chaired by the Director of the Governor’s Office of Health Policy & Finance and including leaders of key agencies that will be charged with implementing the reform at the state level. All official work of the Health Reform Implementation Steering Committee will be done through public meetings. The Executive Order further identified the Advisory Council on Health Systems Development to serve as the advisory stakeholder group to advise the Steering Committee on health reform implementation.

**Task 6:** During its monthly meetings, the Advisory Council will review state agency analysis, options and recommendations regarding the major policy decisions described above and will provide its recommendations to the Governor and the Legislative Joint Select Committee on Health Reform. Over its next several meetings, the Advisory Council will take up the following major policy decisions:

- Exchange
- Payment and System Reform: Criteria for Applying for Grants
- Eligibility expansions
- Insurance Reforms
- Dirigo: Assessments going forward

Each Maine agency with responsibility to implement aspects of the health reform law shall develop a work plan including key milestones, key activities and a schedule for completion within the timeframes required under the federal law or as amended by the Legislature.

**Task 7:** Each agency will produce a work plan of all activities it must complete under the law by June 30, 2010.

**Task 8:** As Maine works to implement reform, the Health Reform Implementation Steering Committee will issue a progress report every 90 days to inform and update the Legislature, Advisory Council on Health Systems Development and other stakeholders on agency progress in implementing aspects of health reform, including, at a minimum, key decisions that have been made, key decisions remaining and policy considerations and recommendations, key tasks that have been accomplished and key tasks to be accomplished in the next 90 days. These progress reports should continue, at a minimum, through June 2014 when most of the reform activities will be implemented.

While each agency will create a detailed work plan for all of the tasks for which it is responsible, the matrix below provides an overview of key issues and activities required by the state under the health reform law, with a focus on those activities that need to be implemented in the short term.<sup>9</sup> Implementing the federal law will, at a minimum, require significant outreach and education, enactment of state legislation, development of state regulations, development of new programs and initiatives, implementation of health information technologies, and state business processes revisions. All of these activities will require input from the Legislature through its Joint Select Committee on Health Reform, the Advisory Council on Health Systems Development and other health care stakeholders.

The Table that follows describes the Key Activities and the high level to be completed. The Table also identifies the lead state agency for the high level activities and the deadlines for decisions and/or completion.

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<sup>9</sup> It is important to recognize that this matrix is not a comprehensive list of all activities that must be completed under health reform; each agency will further define additional activities to be implemented, particularly in the out years.

# Desired Outcomes

National health care reform has three primary goals: to reduce the number of individuals without health coverage; to improve the quality of health care provided; and to contain health care cost growth. The success of each of these goals is interdependent on the others.

1. Implementation of key activities on time and through efficient use of resources.
2. Increased federal support for Maine:
  - a. through enhanced federal reimbursement for health coverage for low and mid-income individuals and
  - b. through awards of grants for program development and implementation
3. Reduction in Maine's rate of uninsurance
  - a. from 9.6% in 2008 to 6% in 2012
  - b. to 3% in 2014.
4. Increased consumer-focused information on health insurance is easily accessible and available to consumers and consumer protections are in place
5. Increased health care information is available and accessible to businesses.
6. Increase percent of population with an identified primary care provider by 25% by 2014.
7. Reduction in avoidable hospital admissions, emergency room admissions, and unnecessary care.
8. Increase in provider payment arrangements based on quality outcomes
9. Slower growth in health care spending
  - a. Reduced rates of health insurance premium increases
  - b. Reduced per capita spending on health care
  - c. Reduced bad debt for hospitals and other health care providers
10. Increase use of Health Information Technology by Maine health care providers

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
<b>Administrative Activities</b>					
Grant Prioritization	Maine will need to develop criteria to help prioritize efforts to obtain and support federal funding available through grants available through PPACA (whether or not state must serve as the lead)	<ul style="list-style-type: none"> <li>- Review grants and bucket into groups that delineate opportunities for states to apply for grants and opportunities for other stakeholders to apply for grants; determine which grants require state or other matching funds</li> <li>- Develop a set of criteria to assist in prioritization of grant opportunities that state will lead or support</li> <li>- Based on criteria, prioritize grants for which state must be lead</li> <li>- Assign grant development to appropriate state agencies</li> <li>- Develop a set of criteria to prioritize state support for non state-led grants</li> </ul>	Steering Committee; ACHSD	Provide state matching funds	8/10
Evaluation	Plan for evaluation of major policy changes	<ul style="list-style-type: none"> <li>- Determine with Advisory Council on Health Systems Development and the Legislature's Joint Select Committee on Health Reform how to evaluate health reform and its impact on Maine;</li> <li>- Determine which agencies and/or organizations will perform evaluation of key policies and reforms;</li> <li>- Agencies to establish measures and begin collecting baseline data.</li> </ul>	Steering Committee	Provide money for evaluation and/or authorize agencies to seek outside funding	9/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Monitor Federal Activities	Review federal activities related to health reform on ongoing basis for impact on Maine activities	<ul style="list-style-type: none"> <li>- Serve as liaison to federal government and clearinghouse for federal issues</li> <li>- Review federal regulations, bulletins and other information about interpretation of PPACA provisions</li> <li>- Inform state agencies of activities</li> <li>- Coordinate Maine response to federal requests for input</li> <li>-consult with and engage appropriate state agencies</li> <li>-Consult with and engage appropriate state agencies</li> </ul>	GOHPF	Inform	Ongoing
Status Reports	Provide ongoing status reports to ACHSD and Legislature on progress in implementing health reform activities	<ul style="list-style-type: none"> <li>- Develop a template for ongoing status report to be utilized by state agencies;</li> <li>- Draft report and submit to ACHSD and Legislature every 90 days</li> </ul>	Steering Committee	Inform	Every 90 days (ongoing)
<b>Access</b>					
High Risk Pool	Monitor implementation of high risk pool	<ul style="list-style-type: none"> <li>- Monitor implementation of high risk pool (to be implemented in 8/10)</li> <li>- Consult with BOI</li> </ul>	GOHPF; Dirigo Health Agency	Inform	8/10
Reinsurance fund for retirees ages 55-64	Obtain reinsurance funds for state funded retirees	<ul style="list-style-type: none"> <li>- Apply for reinsurance funds (ASAP as funds on first come, first serve basis)</li> <li>-Analyze impact of state funds on state budget and provide Legislature with information</li> <li>- Educate private employers regarding availability of money;</li> <li>- Consult with BOI on outreach</li> </ul>	GOHPF: Dept. of Admin & Financial Services; DECD	Inform; May allow for reduced state money	9/10



Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
<b>Medicaid</b>					
Medicaid drug rebate	Consider changes to the state Medicaid drug formulary	<ul style="list-style-type: none"> <li>- analyze fiscal impact of changes to federal Medicaid rebate law identify potential changes to Medicaid drug formulary;</li> <li>- analyze fiscal impact of proposed changes to state Medicaid drug formulary</li> <li>- amend state regulations or sub-regulatory materials</li> <li>- provide appropriate notice to beneficiaries and providers</li> </ul>	DHHS	Inform; if financial loss may require new state money	8/10
Medicaid expansion prior to 2014	Decide whether to expand eligibility for childless adults up to 133% FPL prior to availability of enhanced FMAP in 2014.	<ul style="list-style-type: none"> <li>- Conduct financial analysis of expansion prior to 2014, including determination of whether any state funds are available to fund early expansion</li> </ul>	DHHS	Statutory change required to change coverage level to 133% for childless adults; would require additional state funds	8/10
Medical provider-acquired infections	Ensure that state rules prohibiting payment for never events is inclusive of provider-acquired infections as contained in PPACA	<ul style="list-style-type: none"> <li>- Confirm that federal rules on prohibiting payment for provider-acquired infections are consistent with Maine's current rules prohibiting payment</li> <li>- Incorporate hospital acquired condition exclusion in DRG payments, consistent with Medicare DRG methodology.</li> </ul>	DHHS		1/11

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Home and community-based services	Consider adopting federal options to enhance home and community based service state plan options	<ul style="list-style-type: none"> <li>- Analyze impact of adding state plan option for these benefits, including determination of population to be included and potential fiscal implications (both with and without enhanced federal funding)</li> <li>- Consider extent to which Maine qualifies for enhanced funding based on current balance of long term care services</li> <li>- If decide to utilize option, a number of next steps (draft state plan amendment; ensure sufficient community services; define population and extend new services; provide proper notice and rights of appeal (etc)</li> </ul>	DHHS	Would require statutory change; may require new state funds	Various dates beginning 10/10
Payment and delivery system reform	Consider applying for grants to assist with delivery system and payment reform in Maine: pilot program on Medicare payment bundling, global payment demonstration, Pediatric ACO demonstration, grants for medical homes for chronically ill patients.	<ul style="list-style-type: none"> <li>- Prioritize payment and delivery system reform opportunities and develop criteria with Advisory Council on Health Systems Development to be used in deciding which grants to pursue;</li> <li>-Determine partnerships for grant opportunities</li> <li>- Consider where state can be a lead vs. play a supporting role</li> <li>- Draft or assist leads in drafting of grants and by providing letters of support</li> </ul>	GOHPF; DHHS with ACHSD	Provide letters of support as needed;	Various dates; programs begin in 9/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Provider payments: DSH and primary care payments in Medicaid	Project potential net effects of increased federal revenue in 2013-14 and loss of federal revenue from reduced DSH allotments; consider options for redirecting additional funds.	<ul style="list-style-type: none"> <li>- Consider impact of increased rates to Maine providers through Medicaid (both short term and when enhanced funds end)</li> <li>- Consider impact on psych IMD DSH</li> <li>- Confirm that Maine is protected from DSH reductions based on waiver</li> <li>- Develop transition plan if reductions go in place when waiver period ends</li> </ul>	DHHS; GOHPF	Inform; Provide additional funds as necessary	10/11
Provider rates	Increase Medicaid rates for primary care to 100% of Medicare; 100% federal funding of incremental cost in 2013-14.	<ul style="list-style-type: none"> <li>- Determine difference b/w current rates and Medicare rates;</li> <li>- Make appropriate changes in MMIS to pay primary care providers 100% of Medicare;</li> <li>- Develop report showing difference in state developed rates and 100% of Medicare; Consider implications of existing PCCM, PCMH payments.</li> <li>- Submit claim for difference to CMS based on rules to be developed</li> </ul>	DHHS	Legislative authority to provide higher payment rate and plan for sunset of federal dollars	1/13
Federal Medicaid expansion to 133% FPL	Expand Medicaid eligibility to 133% FPL; adjust DirigoChoice eligibility and enrollment accordingly.	<ul style="list-style-type: none"> <li>- Amend MaineCare statute and regulations to allow for increased enrollment;</li> <li>- Provide notice to individuals enrolled in Dirigo that have opportunity to move to MaineCare</li> <li>- Make eligibility systems changes (including to decision trees and notices)</li> </ul>	DHHS	Statutory change	1/14

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
<b>Insurance Reforms</b>					
Web-based insurance marketplace	Participate in designing federal and state websites and web-based capacity for exchange and insurance market to help consumers identify affordable coverage options.	<ul style="list-style-type: none"> <li>- Bureau of Insurance to continue to work with NAIC on input into federal website, with input from Dirigo</li> <li>- Exchange to design state specific website to provide detailed information on specific Maine coverage options in exchange</li> </ul>	Bureau of Insurance; DHA	Inform	12/10
Small business tax credits	Inform and educate small employers about the availability of tax credits to subsidize insurance coverage for employees.	<ul style="list-style-type: none"> <li>- Develop fact sheets on availability of tax credits</li> <li>- Hold forums with small businesses to help understand tax credit opportunity (ongoing through 2014)</li> </ul>	Bureau of Insurance; GOHPF; DECD	Inform	8/10 (ongoing)
Conform Maine insurance rules to new federal rules	Review and Amend Insurance Laws and Regulations to Conform with PPACA	<ul style="list-style-type: none"> <li>- Review differences in federal law and state law for all insurance changes in federal law</li> <li>- As necessary, draft legislation and regulations conforming to federal law</li> <li>- Educate insurers on new requirements, including reporting requirements</li> </ul>	Bureau of Insurance	Amend statute to conform to federal law	Various dates; begins 9/10
Medical Loss Ratios	Insurers that fail to maintain adequate medical loss ratios will be required to provide rebates; monitor insurers to ensure compliance	<ul style="list-style-type: none"> <li>- Develop a method to oversee and monitor insurers activities</li> </ul>	Bureau of Insurance	May require amending of MLR statute	1/11
Co-Op Plans	Oversee possible development of private, non-profit, member-run Consumer Operated and Oriented Plan (CO-OP).	<ul style="list-style-type: none"> <li>- Bring together stakeholders for discussion of development of CO-OP</li> <li>- Consider pros/cons of development of such a CO-OP;</li> <li>- Consider regulatory and legislative changes necessary to allow for operation of new CO-OP</li> </ul>	Bureau of Insurance	Review statutory authority for CO-OP to operate in Maine and ensure licensing	1/13

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Standardize systems for eligibility and enrollment, claims and payment	Disseminate and start to enforce standardized rules for the simplification of insurance records in the areas of eligibility/enrollment, claims/payment, encounter, and authorization.	<ul style="list-style-type: none"> <li>- Educate Maine providers and insurers on federally developed standardized rules to administratively simplify insurance records</li> <li>- Include MaineCare and worker's comp insurers to ensure consistency across all interactions with providers</li> </ul>	Bureau of Insurance; DHHS	Require insurers & Medicaid to be involved	Various dates
Individual and employer mandates; penalties for non-compliance	Raise awareness of start of individual and employer mandates and penalties beginning 2014.	<ul style="list-style-type: none"> <li>- Determine potential mandate exemptions for individuals and employers (e.g., unaffordable coverage or provision of free choice voucher)</li> <li>- Develop fact sheets and FAQs to educate individuals and businesses about responsibilities under law</li> <li>- Consider conducting media campaign to promote enrollment to meet the mandate</li> <li>- Coordinate outreach and education activities with other ongoing outreach and education efforts</li> </ul>	GOHPF, Bureau of Insurance		1/14

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
New federal insurance rules and protections	Implement new reforms at the state level: <ul style="list-style-type: none"> <li>• Limit out-of-pocket spending below 400% FPL</li> <li>• ESI waiting period no longer than 90 days</li> <li>• Add federal-contracted multi-state plans to Exchange; Maine may want to require additional benefits (at state cost)</li> <li>• Consider merging individual and small group markets</li> </ul>	<ul style="list-style-type: none"> <li>- Evaluate existing laws for consistency with federal requirements</li> <li>- Develop regulations for insurers to comply with federal rules</li> <li>- Develop method within Exchange and MaineCare to ensure out-of-pocket maximums are tracked and complied with</li> <li>- Consider whether Maine will include state mandated benefits (at state cost)</li> <li>- Consider merging individual &amp; small group market</li> </ul>	Bureau of Insurance; State Exchange; DHHS	Statutory changes; decision on state mandated benefits & merging of individual and small group markets	Various dates; mostly 1/14
<b>Exchange</b>					
Setting up a state Exchange	Pursue planning grant for developing Exchange and SHOP; identify state agency to house Exchange.	<ul style="list-style-type: none"> <li>- Apply for grant funds to help develop exchange</li> <li>- Work with Advisory Council on Health Systems Development and Legislature to identify state agency or other nonprofit to house Exchange</li> <li>- Consult with BOI and DHHS</li> </ul>	GOHPF; DHA	Review and approval; Enact enabling legislation	12/10
Insurance subsidies for individuals, families, and businesses	Consider state tax implications of federal insurance subsidies	<ul style="list-style-type: none"> <li>- Review federal changes to determine whether cause automatic changes to state taxes</li> <li>- Based on review, identify if need to make changes to law either to extend same subsidy to state taxes or to not extend it</li> </ul>	Maine Revenue Services, GOHPF	Potential legislative change	12/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Building a state Exchange	Begin planning structure and functions of Exchange	<ul style="list-style-type: none"> <li>- Identify key functions of Exchange</li> <li>- Determine changes to current personnel needs in transition to an Exchange</li> <li>- Work collaboratively with MaineCare on how eligibility and subsidy payment will work</li> </ul>	GOHPF, DHA	New statutory language authorizing a Exchange	10/10
State Exchange	Launch the state Exchange and begin offering minimum essential coverage to individuals and small businesses.	<ul style="list-style-type: none"> <li>- Begin operations effective Jan 1, 2014</li> <li>- Provide outreach and education of exchange offerings</li> <li>- Provide coverage for insurance with assistance of subsidies to both individuals and businesses</li> <li>- Consult with BOI and assure plans sold through the exchange comply with Maine insurance rules</li> </ul>	State Exchange	Monitor; receive status reports	1/14

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
<b>Outreach and Education</b>					
Educate all parties about health law	Inform the public and key stake-holders about policy changes and other reforms.	<ul style="list-style-type: none"> <li>- Develop fact sheets and FAQs for all stakeholders (e.g., consumers, providers, businesses, insurers, etc) to clearly explain law and its implications</li> <li>- Hold forums across the state to assist in understanding of new law</li> <li>- Continue to provide outreach and education, particularly regarding eligibility for subsidies &amp; tax credits; as well as potential for penalties</li> </ul>	Steering Committee; ACHSD		8/10
<b>Prevention and Wellness</b>					
Wellness program grants	Raise awareness among small employers of grants (through 2015) to establish comprehensive wellness programs	<ul style="list-style-type: none"> <li>- Develop materials describing availability of grants to small businesses</li> <li>- Participate with small business advocacy organizations in development of forums</li> <li>- Inform small employers or coalitions of small employers of ability to receive grant funding to develop a tool kit to assist businesses with establishing wellness programs or availability of tool kit developed through Dirigo</li> </ul>	GOHPF DHHS DECD		1/11



Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Wellness incentives	Raise awareness among employers of the option to provide employees with rewards in the form of reduced premiums based on participating in a wellness program.	<ul style="list-style-type: none"> <li>- Develop materials describing options for employers to reduce premiums based on participation in wellness</li> <li>- Participate with business advocacy organizations in development of forums for businesses to describe opportunity</li> <li>-Eliminate co pays in public programs for preventive services and apply increased match.</li> </ul>	GOHPF; Bureau of Insurance; DHHS; State Exchange		1/13

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Wellness through the Exchange	Consider applying to conduct a Wellness Demonstration project that applies rewards in the individual market; evaluate whether Maine's existing wellness initiatives are consistent with new wellness options.	<ul style="list-style-type: none"> <li>- Work with insurers to consider Wellness Demonstration in individual market;</li> <li>- Based on current practices and potential changes, determine whether to develop a demonstration project to reward with premium incentives</li> </ul>	GOHPF; State Exchange; Bureau of Insurance		1/14
<b>Quality</b>					
Health Care Disparities	Maintain focus on reducing health care disparities	<ul style="list-style-type: none"> <li>- Ensure disparities are considered in quality improvement activities; measurement, and evaluation</li> <li>- Enhance collection and reporting of data, including access and treatment data for people with disabilities</li> </ul>	DHA; MQF; MCDC		3/12

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Medical malpractice	Consider applying for demonstration grant to develop alternatives to medical malpractice rules to reduce provider practice of defensive medicine	<ul style="list-style-type: none"> <li>- Work with key stakeholders (physicians, hospitals, and trial attorneys to develop a coalition to apply for demonstration grant</li> <li>- Consider if state can be a lead vs. play a supporting role</li> <li>- Assist leads in drafting of grants and by providing letters of support</li> </ul>	GOHPF; DHHS; Bureau of Insurance DHA-MQF Trial Court	Provide legislative authorization for medical demos	

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
<b>Long Term Care</b>					
CLASS	Raise awareness among individuals and employers of the opportunity to save for the eventual need for long-term supports using payroll deductions in the Community Living Assistance Services and Supports (CLASS) program.	<ul style="list-style-type: none"> <li>- Develop/distribute objective information to individuals and businesses about CLASS;</li> <li>- Inform the public about CLASS at public forums and events</li> <li>-Conduct financial analysis on impact of CLASS on MaineCare long term care costs</li> <li>- Consult with BOI</li> </ul>	DHHS	Inform	1/11
<b>Indian Health</b>					
Indian Health Care Improvement Act	Consider amendments to Indian Health Care Improvement Act	<ul style="list-style-type: none"> <li>-Review Indian Health Care Improvement Act, which is reauthorized &amp; amended in the PPACA</li> <li>-Consider impact of amended requirements on American Indians residing in Maine</li> <li>-Consider whether any corresponding changes are needed in Maine state law</li> </ul>	Tribes; DHHS MCDC	Inform	8/10

