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Testimony of Sara Gagné-Holmes

**Regarding the Final Report of the
Advisory Committee on Maine's Health Insurance Exchange**

November 1, 2011

Senator Whittemore, Representative Richardson and members of the Insurance and Financial Services Committee my name is Sara Gagné-Holmes and I am the Executive Director of Maine Equal Justice Partners. As you may know, Maine Equal Justice Partners is a nonprofit legal aid provider representing the interests of low-income individuals in the courts, before administrative agencies and in the Legislature. As a member of the Health Care for Maine Steering Committee, I also support the comments made by the other Steering Committee member organizations.

Before I begin, I would like to take this opportunity to thank the members of the Governor's Advisory Committee on Maine's Health Insurance Exchange for their prompt and efficient consideration of numerous issues in an extremely condensed time frame.

We have had an opportunity to review the Advisory Committee's final report and offer the following comments with the goal of contributing to the establishment of an Exchange that meets the wide-ranging needs of all Maine people with particular emphasis on the needs of people with low and moderate income.

Integration and Coordination between Medicaid and the Exchange

Although the Advisory Committee's final report did not directly address the issue of integration and coordination between Medicaid and the Exchange, it is vitally important that enabling legislation be written with integration influencing all critical components. The ACA will extend health insurance coverage by both expanding Medicaid eligibility and offering premium subsidies for the purchase of private health insurance through state health insurance exchanges. Both approaches are critical. Therefore, integration and coordination between the two are key to the successful implementation of coverage envisioned by the ACA.

The Urban Institute estimates that approximately 81,000 uninsured non-elderly Maine people will gain access to coverage through implementation of the ACA.¹ A separate analysis by the Kaiser Commission on Medicaid and the Uninsured estimates that there will be approximately 43,468 new Medicaid enrollees in Maine.² This, of course, is in addition to the thousands of Maine people who currently receive Medicaid and will continue to receive it post-reform. Accordingly, the Exchange must be designed in a manner that recognizes the importance of Medicaid as a dominant health care purchaser and vital source of coverage for a sizeable percentage of Maine's population.

Moreover, while Medicaid enrollees and individuals eligible for subsidies under the Exchange are two distinct coverage groups it is widely anticipated that there will be considerable movement between these groups. Over time incomes fluctuate and family composition changes, both affecting eligibility. A recent study of non-elderly adults estimates that "within six months, more than 35% of all adults with family incomes below 200% of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year 50%...will [change]."³ This same study notes that "By the end of three years, 29% of adults would have experienced *four or more* changes in eligibility."⁴

Again, the Exchange must be designed with the understanding that these fluctuations will exist and adopt strategies to address the disruptions in continuity and quality of care, which will result without the deliberate planning needed to mitigate them. Research shows that such disruptions in coverage have adverse effects on both access and administrative cost.⁵

Coordination and integration between Medicaid and the Exchange is essential at both the operations and policy level. With that in mind we recommend the following:

- **Ensure a "no wrong door" approach.** The ACA requires a seamless approach to coverage, meaning that regardless of where and with what knowledge a person applies for health coverage he or she is evaluated for all available programs (Medicaid and the Exchange) and offered the opportunity to enroll in the one that is most beneficial to that individual or family.⁶ This means that whether a person applied for help at DHHS or the Exchange, he or she must receive the same information about the most beneficial coverage available to them whether it is Medicaid or a premium subsidy available through the Exchange. Therefore, for example, it makes great sense to consider taking advantage of the State's investment in My Maine Connection to take applications from the many

¹ <http://www.rwjf.org/files/research/71998.pdf>

² <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>

³ <http://content.healthaffairs.org/content/30/2/228.full.pdf+html>

⁴ *Id.* (emphasis added)

⁵ Long SK, Coughlin T, King J. How well does Medicaid work in improving access to care? *Health Serv Res.* 2005;40(1):39-58; Weissman JS, Stern R, Fielding SL, Epstein AM. Delayed access to health care: risk factors, reasons and consequences, *Ann Intern Med.* 1991; 114:325-31; and Ku L, Ross DC. Staying covered: the importance of retaining health insurance for low-income families. Washington DC: Center on Budget and Policy Priorities; 2002.

⁶ Patient Protection and Affordable Care Act, Publ. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), section 2201 (b)(1)(C).

individuals who will use that system to apply for MaineCare and many other programs creating a real system of one stop shopping for those individuals.

- **Align eligibility methods, standards and enrollment processes between Medicaid and the Exchange to the greatest extent practicable.** Such alignment is beneficial to states as well as families. Simplified and consistent rules make it easier to communicate program information. It also ensures smoother transition between types of coverage which, as noted above, will be common in this population.
- **Work jointly with Medicaid to establish a seamless transition between Medicaid and the Exchange and vice versa.** As noted above there will be numerous individuals who will migrate between Medicaid and qualified health plans offered through the Exchange as their incomes and family circumstances change. This transition should be both seamless and occur in real time in order to prevent harmful disruptions in coverage. For example, on the date when an individual loses eligibility for MaineCare coverage, it is essential that the system work in such a way that enrollment in a qualified plan with subsidies in place occurs on the day following the loss of Medicaid eligibility.

Exchange Governance

- **Composition of Exchange Commission** [Part A, 2(d), pp. 6-7]

Although we recognize and appreciate the Advisory Committee's interest in limiting the Exchange's Commission to a manageable number of individuals to ensure efficient functioning, this goal must be balanced with the need to ensure that the Commission has sufficiently diverse expertise to undertake the range of responsibilities that it is required to undertake.

In order to ensure that the Exchange serves the best interests of all health care consumers as intended by the Affordable Care Act, it is crucial that the Commission include a representative of consumer interests who is familiar with the complex health coverage issues of low-income individuals. Such an individual will provide the Commission with expertise necessary to ensure that the Exchange is best positioned to address the coordination required with Medicaid and other public coverage programs. An individual with these qualifications would also be able to help ensure that the Exchange is structured in a manner that enables prompt enrollment in the correct coverage program and effectively serves those individuals whose fluctuating incomes cause them to move between subsidized Exchange coverage and Medicaid.

- **Creation of Advisory Committees** [Part A, 2(e), p. 8]

We strongly support the Advisory Committee's recommendation that the Exchange create advisory committees in order to consult regularly with stakeholders pursuant to the ACA. We urge you to go one step further and model the advisory committees' role on the MaineCare Advisory Committee (MAC).⁷ The DHHS is required to give the MAC "adequate opportunity for meaningful

⁷ 10-144 C.M.R. ch.101, sec. 1.23

participation in the consideration” of such things as policies and standards, legislative initiatives, fee schedules, utilization of services by members, content and dissemination of program materials, members issues and eligibility standards and other issues related to eligibility.⁸ This process has enhanced transparency and collaboration between providers, advocates and the DHHS.

Duties of Exchange: Navigators [Part A, 3, p.9, 1st bullet]

A key responsibility of the Exchange will be to establish a “navigator” program that will help eligible families and individuals access coverage through the Exchange, including learning about all coverage options available and how they may enroll. The ACA makes clear that entities qualified to act as navigators may include qualified “community and consumer-focused nonprofit groups.”⁹ Additionally, the ACA explicitly requires that any entity that serves as a navigator must “provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.”¹⁰ Particular emphasis is placed on the need for navigators to reach “uninsured and underinsured consumers.”¹¹ Thus, while producers and other agents may receive navigator grants (provided they are not paid by an insurer for a particular enrollment in a qualified health plan) it is clear that there is an important role for other types of entities in meeting this need.

For example, some people who are uninsured will qualify for Medicaid beginning in 2014 and will be able to apply through the Exchange portal. Non-profit community-based organizations with which this population may already have a trusted relationship may be appropriate navigators for this group. Similarly, some with limited literacy skills or limited English language proficiency may also have established relationships with community agencies that may be best suited to meet the needs of this group in a culturally and linguistically appropriate manner and could provide valuable translation services and also facilitate access to web-based applications for this population. Many of these organizations have significant experience in providing “facilitated enrollment” for these populations under the existing Medicaid and CHIP programs.

Although we agree that anyone serving as a navigator must be competent and adequately trained to perform this critical task, we do not believe that they need be licensed as producers under Maine law. Navigators do not need to have the level of knowledge and education currently required to sell a health insurance policy. Yet they will have to have a comprehensive understanding of Medicaid, CHIP, including the method and importance of income reporting, something not currently required in laws and rules governing Maine producers. If unnecessarily burdensome requirements are placed on entities seeking to act as navigators, then we may lose the opportunity to engage many trusted community partners with long experience reaching and working with individuals with low-income, limited English proficiency, or special health needs who are perhaps best equipped to perform this function for these populations.

⁸ *Id.* at 1.23-2

⁹ Section 1311(i) (2)(B) of the Affordable Care Act

¹⁰ Section 1311(i)(3)(E) of the Affordable Care Act

¹¹ Section 1311(i)(2)(A) of the Affordable Care Act

Basic Health Program [Part B, 3, p.13]

We support the Committee's recommendation to defer to the Exchange any decision on whether or not the State will adopt the Basic Health Program Option (BHP). The Exchange Commission will be in a better position to make this decision once it is more fully informed by forthcoming federal rules.

As you know, the ACA provides states with the option to provide coverage for individuals with incomes between 133 and 200% of the Federal Poverty Level through a "Basic Health Program".¹² The ACA charges the Secretary with significant responsibility for defining such a plan through regulation, yet those regulations have not yet been proposed. Thus, many key factors needed to analyze if this program will serve a particular State well are still uncertain and States are wise to wait for more detail before making a decision about whether or not to offer a BHP.

However, though more information is needed, we believe that the BHP option may have potentially significant advantages for both the State and low-income health care consumers. States are interested in the BHP option for both financial and policy reasons. The BHP will give states 95% of what the federal government would have spent in the Exchange on tax credits and subsidies for out-of-pocket costs for eligible individuals. One recent study notes that "preliminarily... federal Basic Health Program payments are projected to exceed by 29% what it would cost Medicaid to cover BHP-eligible adults in the average state."¹³ A second study finds that estimates suggest that states would save up to \$1,000 per member annually over Medicaid costs for that member.¹⁴

Moreover, depending on the design and administration of the BHP, this choice has the potential to better stabilize coverage by minimizing disruptions for those individuals whose fluctuating income causes them to move between a qualified health plan offered through the Exchange and Medicaid with all the resulting administrative costs that such "churning" produces. In addition, the BHP could also give states advantages on price and innovation by creating a larger pool of eligible individuals among state-administered plans.

For consumers, the BHP option increases the likelihood that parents and children will be in the same plan; minimizes the likelihood of gaps in coverage as financial and family circumstances change; and may help mitigate some of the more unaffordable cost-sharing requirements of the ACA.

Should the State decide to implement a Basic Health Program, then the integration issues highlighted at the beginning of my testimony become even more significant for the Exchange as it would be dealing with transitions between Medicaid, the BHP and subsidized and nonsubsidized individuals in the Exchange.

Thank you and I'd be happy to answer any questions you may have.

¹² Section 1331 of the Affordable Care Act

¹³ <http://www.statecoverage.org/files/TheBasicHealthProgramOptionUnderHealthReform.pdf>

¹⁴ http://healthreform.mckinsey.com/en/Insights/Reform_Center_Health_Intelligence/The_Basic_Health_Plan.aspx



**Comments of Hilary Schneider,
Director of Government Relations and Advocacy, The American Cancer Society
November 1, 2011**

Re: Final Report of the Advisory Committee on Maine's Health Insurance Exchange

Good afternoon, Senator Whittemore, Representative Richardson, and members of the Insurance and Financial Services Committee. My name is Hilary Schneider and I am the Director of Government Relations and Advocacy for the American Cancer Society (the "Society"). As you may know, the American Cancer Society is a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service. It is the largest voluntary health organization in the United States. While we are a national organization, we provide many services at the state and local levels. These include a toll-free number for cancer information and resources (1.800.227.2345), rides to treatment, discounted lodging, and many other support services for cancer patients and their families.

I would like to thank you for this opportunity to provide the following comments on the Advisory Committee's Exchange Report on behalf of the American Cancer Society and as a member of the Steering Committee of Health Care for Maine.

The American Cancer Society is dedicated to ensuring that quality care is available to all Maine people. While we have witnessed significant progress in cancer survivability, inadequate access to timely, quality health care is one of the greatest barriers to winning the war on cancer.

Historically, cancer patients and survivors have faced many challenges in an effort to find adequate, affordable health care. The reforms in the Affordable Care Act represent a profound structural change in how private insurance will operate and how consumers and patients will utilize the health insurance system - the creation of a new state-based health insurance exchange being one of the most important of these reforms. In order for cancer patients and their families to experience real changes in their ability to access, choose, and purchase adequate, affordable health care, policymakers at the national and state levels must tackle critical challenges related to the design, implementation, and governance of these new exchanges. We commend the Advisory Committee and the members of this committee for taking on this important challenge and for seeking public input throughout the process.

As you have heard in prior testimony, the American Cancer Society's national board and the organization's leadership made the decision in 2006 to enter the nation's health care debate about reform because change in the nation's health delivery system is so vital in the fight against cancer. Through a systematic review of the evidence and the views of organizational and external experts, the Society developed four principles for meaningful insurance - what we call the "4As" - Meaningful health insurance is adequate, affordable, available, and administratively

simple. The Society uses these principles to evaluate health reform proposals, including proposals related to the establishment of Maine's health insurance exchange.

Exchange Structure

Type of Entity

We believe the Exchange should be established as a quasi-governmental non-state agency.

As Commissioner Head noted in her September 13 memo to the Advisory Committee, establishing the Exchange within a state agency would result in the Exchange decision-making being subject to political pressure and make the Exchange subject to state procurement and personnel rules. In addition, the Commissioner notes that the Exchange would be assessed a proportional share of the department's overhead costs.

While the Commissioner cites many advantages to such an arrangement, we believe many, if not all, of these advantages could be realized through a quasi-governmental entity. Moreover, establishing the state Exchange as a quasi-governmental entity would likely result in greater trust and buy-in from the public and greater long-term stability if the decisions that govern the Exchange's operations are not viewed as being primarily politically-driven. Moreover, a quasi-governmental entity may be able to avoid the cumbersome processes of outside contracting and hiring that state agencies often encounter, leading to more streamlined operations and lower overhead costs. Also, it is unclear how an Advisory Commission will operate as part of a state agency. What authority will the Commission have over the decisions of the Executive Director? Will the decisions of the Commissioner of DFPR trump the decisions of the Advisory Commission?

Single or Dual Exchanges and Risk Pools

We support the Advisory Committee's recommendation that the state establish one unified Exchange, which includes a SHOP program. Such an arrangement will produce better policy coordination, increased operational efficiencies, and improved operational coordination. It will also avoid duplication of key Exchange functions including certification of qualified health plans, eliminate the need for duplicative information collection and reporting, and ensure more seamless coverage for individuals (who may be going back and forth between SHOP coverage through their jobs and individually purchased coverage that may be subsidized by premium tax-credits and cost-sharing reductions). **The Society recommends continuing to review the possibility of merging the individual and small group markets.** The analysis presented to the Commission by Gorman Actuarial did not reflect changes due to Public Law, Chapter 90. We recognize that merging the risk pools is a balancing act between the individual and small group markets with the goal of covering the most people. However, the small relative size of Maine's population, especially the population covered by the private market, lends itself to careful review and consideration of such a proposal and which outcome is likely to expand access to coverage for the most people.

Board Structure and Operations

Exchange Governance - Board

The Society believes it is important for the Exchange governance to include strong and diverse patient and consumer representation. Moreover, **the Society believes that any Board or Commission members with clear conflicts of interest should be prohibited from serving on**

any type of Board or Advisory Commission. It is detrimental to the goal of the exchange – to provide affordable health coverage to thousands of Mainers – and to taxpayers supporting premium tax credits if exchange boards are comprised of parties that have a financial interest in increasing the cost of health insurance. Individuals with a clear conflict of interest should be explicitly defined as individuals affiliated with health insurance issuers, insurance agents or brokers, health care providers or health care facilities. Additionally, this prohibition should explicitly extend to individuals affiliated with an entity whose primary line of business serves or whose clientele is largely comprised of individuals or organizations identified above as conflicted parties, such as major vendors, subcontractors, or other financial partners.

We suggest looking to Connecticut's Exchange law for strong conflict of interest language:

(2) (A) No appointee shall be employed by, a consultant to, a member of the board of directors of, affiliated with or otherwise a representative of (i) an insurer, (ii) an insurance producer or broker, (iii) a health care provider, or (iv) a health care facility or health or medical clinic while serving on the board or on the staff of the exchange. For purposes of this subdivision, "health care provider" means any person that is licensed in this state, or operates or owns a facility or institution in this state, to provide health care or health care professional services in this state, or an officer, employee or agent thereof acting in the course and scope of such officer's, employee's or agent's employment.

(B) No board member shall be a member, a member of the board or an employee of a trade association of (i) insurers, (ii) insurance producers or brokers, (iii) health care providers, or (iv) health care facilities or health or medical clinics while serving on the board or on the staff of the exchange.

(C) No board member shall be a health care provider unless such member receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

I have attached the relevant pages of the American Cancer Society Cancer Action Network's comments on the proposed federal rules for Exchange regulation for more details about our views on the Exchange Governance and conflicts of interest.

Moreover, in order to ensure transparency and public trust, the Board must be required to comply with public meeting laws.

We support the Advisory Commission's recommendations regarding ex officio, non-voting members representing DFPR and DHHS and support the recommended three-year terms, which are initially staggered.

Exchange Governance – Advisors

We support the Commission's recommendations regarding consultation with stakeholders. However, **we recommend adding an explicit recommendation for consultation with individuals with disabilities and advocates for persons with disabilities.** In addition, consultation with consumers should reflect the diversity of the disability community, including people living with physical, sensory, behavioral, mental and/or cognitive challenges or

combinations of them, as well as individuals with chronic diseases or conditions who have frequent contact with the health care system and ongoing health care needs. In particular, the Exchange would benefit from consultation with experts that can help the Exchange comply with and meet the intent of the Americans with Disabilities Act and other laws that help consumers with certain disabilities or impairments.

The Exchange would benefit from consultation with two other entities – Navigators and consumer entities with expertise in low-income tax policy. Navigators are an important source of information and will be able to report common barriers to enrollment or areas of consumer confusion. Entities with expertise in low-income tax policy may have useful advice for communicating important information about tax credits.

Exchange Operating Model

In order to best meet the needs of Mainers and provide them with the highest quality plans at the best price, it is essential to use the negotiating power of the Exchange. Since the insurers benefit from the Exchange's assistance in marketing and recruiting new customers, **it is important for the Exchange to have the ability to negotiate on such factors as price (e.g., premiums), benefits, and quality improvement programs.** Since the federal Exchange rules have not been finalized, it is hard to know if they will include adequate provisions for a Qualifying Health Plan. The Affordable Care Act statute requires that an Exchange must determine that making a health plan available is "in the interest of qualified individuals and qualified employers" in order to certify it as a Qualified Health Plan. One of the most important factors regarding whether a health insurance product serves consumers well is whether its rates are reasonable and fair. Therefore, the Society believes that state Exchanges should consider whether a plan has a history of unjustified rate increases when determining whether it is a QHP. Additionally, a plan with a history of unfairly denying claims or otherwise engaging in unethical conduct should also not qualify as a QHP. As such, we believe **the Exchange should independently assess whether the costs, conduct of the issuer, or any other features of the health plan would prevent its availability in the Exchange from being in the interests of qualified individuals or businesses.** If these provisions are included in the final federal rules, then the Advisory Commission's recommendations to comply with federal rules would be adequate. If not, then we suggest the statute reflect these additional requirements in order to ensure Mainers are being best served by the Exchange.

Entities Eligible to Contract with Exchange:

Similar to our comments above regarding Board composition, the Society believes that **contracting entities should be required to meet conflict of interest and confidentiality standards.** Any potential conflicts of interest should be required to be disclosed for any entity that the Exchange contracts with so that the public knows of a vendor's potential financial conflicts and to protect the personal data of consumers.

We support the inclusion of state agencies, including the Medicaid department, as eligible entities with which the Exchange may contract. We believe it is important that **contracting should be done carefully and should not interfere with the goals of increasing efficiency, reducing redundancy, and providing consumers with a seamless, one-stop shop.** It should be

clear that **the Exchange remains responsible for the performance of its contractors and their compliance with applicable requirements.**

Finally, **the Society believes that there are certain functions of the Exchange that should not be contracted out to any entity other than a state government agency in order to ensure strong public accountability for how these functions are performed.** These functions include eligibility determinations for such things as tax credits and cost-sharing reductions, as well as determining if plans are certified as QHPs. Whether these functions are performed well or poorly would not only affect small businesses, individuals and families, but also taxpayers who would be on the hook if costs are higher than they otherwise would be.

Navigators

The Society supports the recommendations that the Bureau of Insurance set up standards for Navigators. However, **we do not believe that Navigators should have to obtain a producer license as we believe this would violate the intent of the program,** which is to provide assistance to a wide variety of exchange-eligible consumers and businesses through diverse entities that meet the needs of various populations. We have made recommendations on the federal rules that HHS develop a model training and certification program for Navigators. If this recommendation is adopted, we recommend that the state use the federal training and certification program.

The American Cancer Society believes that the role of navigators is essential in assisting and supporting the best interests of consumers with a variety of diverse needs. More specifically, since individuals seek information from a variety of sources from whom they trust, it is important that there are a variety of choices for consumers with regard to navigators. It is important that there are navigators with a track record with communities and are culturally competent. In addition, there should be navigators that have experience with low-income populations, non-English speaking populations, populations with special health needs (e.g., chronic illnesses, disabilities) and small businesses. Finally, in order to ensure seamless integration between Medicaid and the state Exchange, it is important for there to be navigators that have experience with Medicaid eligibility.

Navigators should be compensated in a manner that supports their role in assisting individuals and small businesses with determining the best options for their specific needs instead of through a commission structure where individuals could be steered to products that provide the best financial outcome for the navigator or broker.

If participation by brokers and agents is allowed, we believe that the Exchange should develop rules and a monitoring system to minimize adverse selection threats and prohibit steering of enrollees for reasons unrelated to the consumer's best interests.

Regulation Beyond Exchange Plans

Adverse Selection

Keeping the rules the same for plans inside and out of the exchanges is critical to discouraging the use of differences in the rules to game the system and divide the sick from the healthy. Minimizing the potential for adverse selection is essential to the long term viability of the

exchange. In past state experiments, exchanges have tended to attract sicker and more costly enrollees. These sicker enrollees tend to drive premium prices higher, causing healthier individuals to seek coverage elsewhere, compounding the problem of increasing premium costs. While the Affordable Care Act includes some provisions to try to mitigate this risk, additional protections are likely needed. **Requiring that the rules are the same for plans inside and outside of the exchange will further help to mitigate the potential for adverse selection. At a minimum, the Society suggests that the Exchange legislation include the commissioning of a study to identify ways to mitigate against adverse selection.** Some other states have included this language in their law. Below is the language included in the Maryland law:

(d) The Exchange shall:

(1) in consultation with the advisory boards established under this act, and with other stakeholders, shall study and make recommendations regarding:

(B) the rules under which health benefit plans should be offered inside and outside the Exchange in order to mitigate adverse selection and encourage enrollment in the Exchange, including:

(i) whether any benefits should be required of qualified health plans beyond those mandated by the Federal Act, and whether any such additional benefits should be required of health benefit plans offered outside the Exchange;

(ii) whether carriers offering health benefit plans outside the Exchange should be required to offer either all the same health benefit plans inside the Exchange, or alternatively, at least one health benefit plan inside the Exchange; and

(iii) whether managed care organizations with Health Choice contracts should be required to offer products inside the Exchange, and whether carriers offering health benefit plans inside the Exchange should be required to also participate in the District Medical Assistance Program which provisions applicable to qualified health plans should be made applicable to qualified dental plans

More details on the positions outlined in this testimony can be found in the American Cancer Society Cancer Action Network's comments on the proposed federal rules governing the Exchanges, which can be found on the web at: <http://bit.ly/u42jwS>.

Thank you for your time and attention to this matter. I would be happy to answer any questions you may have about this testimony.

Excerpts from relevant sections of the American Cancer Society Cancer Action Network's comments on proposed federal regs:

develop interim enforcement mechanisms. One possibility would be a corrective action plan process, under which a transition to a federal Exchange would occur only if the corrective action plan is not successful. In addition, HHS should make back-up plans for those states that do not or are unable to provide a 12-month advance notice. This should clearly provide HHS the authority to act immediately if the state Exchange ceases to function, regardless of the reason. HHS' back-up plans should seek to minimize problems for consumers, especially gaps in coverage, which can occur when a state ceases operating an Exchange without following the established procedures. For example, HHS could arrange for consumers to remain with their existing qualified health plans, at least on an interim basis, despite the fact that the Exchange that certified those plans is not operating.

The proposed rule also does not specifically address the process for transitioning from a state-operated to a federally facilitated Exchange when the state Exchange is not complying with federal requirements and standards. This is another case where a backup plan for quickly providing at least interim coverage to consumers would be important, since states in this scenario may not cooperate on a transition plan and HHS may have fewer than 12 months to establish a federally facilitated exchange.

Recommendations: HHS should address how it will enforce the requirement for states ceasing operation of an Exchange to provide sufficient notice to HHS and to coordinate with HHS in order to make a smooth transition. HHS should develop a range of options for enforcement, including interim options like corrective action plans, that are less extreme than withholding subsidy or Medicaid funding. In addition, HHS should establish a process for transitioning to a federally facilitated Exchange in cases when a state-operated Exchange is determined to be non-compliant with the requirements for insurance exchanges or Exchange coverage. HHS should establish backup processes to ensure that adequate coverage (through qualified health plans or other programs) is available to consumers if a state ceases operation of its Exchange without giving 12 months notice to HHS or collaborating on a transition plan.

§155.110 Issues related to Contracting

§155.110 Entities eligible to carry out Exchange functions

Some states will delegate specific Exchange functions to outside contractors; however, the Exchange must remain accountable for meeting all federal and state requirements. There should be limits to the functions that can be contracted to outside parties and contracting entities should be required to meet conflict of interest and confidentiality standards. We support the inclusion of Medicaid as an eligible contracting entity.

§155.110(a)

HHS seeks comment on functions that web-based outside entities could perform. The functions they could perform should not include any of the functions listed above as "inherently governmental." In particular, HHS notes the requirement that "advance payments of the premium tax credit and cost-sharing reductions may only be accessed

through an Exchange.” Whatever functions a web-based entity might ultimately perform for a state, it is clear that delivery of subsidies is not one of them, and HHS should continue to make this clear.

For functions that are not inherently governmental, the potential promotional gains in linking the Exchange to established web-based entities should be weighed against likely consumer confusion about which website is the “right” venue for the purchase of insurance that will be eligible for a tax subsidy, the extra costs associated with such a vendor, and the potential for mismanagement of consumers’ personal information. For example, a web-based entity could use the personal information collected to steer healthy individuals to plans outside of the Exchange. As with any contractor, conflicts of interest should be disclosed. This is not just a theoretical concern. In California and likely other states, the website ehealthinsurance.com — a licensed health insurance broker — is noting its interest in helping to operate Exchanges.

We support the inclusion of Medicaid as an eligible contracting entity.

§155.110(b)

Section 1313(a)(5) of the Affordable Care Act directs that “the Secretary will provide for the efficient and nondiscriminatory administration of Exchange activities...” This provides a clear basis, and signals strong intent, for the Secretary to ensure that states use governmental staff to perform critical Exchange functions and prohibit states from privatizing inherently governmental functions.

Moreover, many functions of the Exchange are “inherently governmental,” as defined in OMB Circular No. A-76 (revised 2003).¹ One of the purposes is “to make agencies accountable to taxpayers for results achieved....” The Guidance states that:

“An inherently governmental activity is an activity that is so intimately related to the public interest as to mandate performance by government personnel. These activities require the exercise of substantial discretion in applying government authority and/or in making decisions for the government. Inherently governmental activities normally fall into two categories: the exercise of sovereign government authority or the establishment of procedures and processes related to the oversight of monetary transactions or entitlements.”

Applying these principles to the Exchanges, HHS should determine the following activities to be “inherently governmental” and not eligible for contracting to a non-governmental entity:

- Establishing standards for qualified health plans offered in the Exchange (and ensuring these standards are consistent with section 1557 of the Act);
- Negotiating with or selecting plans to participate in the Exchange;

¹ Revision to the Office of Management and Budget Circular NO. A-76, “Performance of commercial Activities.” Federal Register, Vol 68, No. 103, May 29, 2003, p. 32134.

- Certifying and decertifying plans to be offered in the Exchange, including the ability to exclude plans if it is in the interests of individuals and employers in the state or if a plan proposes unjustified premium increases;
- Regulating the practices of insurance plans in the Exchange including monitoring marketing practices, ensuring that benefits are not designed to cherry pick healthier enrollees, ensuring adequate choice of providers, monitoring the handling of consumer complaints;
- Administering risk adjustment mechanisms among participating insurers;
- Determining whether individuals qualify for the federal premium tax credit and the cost-sharing reductions and if they do not, screening and enrolling them for eligibility for public programs like Medicaid;
- Establishing and administering an appeals process for individuals denied eligibility for the tax credit;
- Determining hardship exemptions for individuals and employers from the requirement to purchase health insurance or face a penalty;
- Determining penalties for employers who drop or don't provide health care for their employees and who obtain premium tax credits through the Exchange;
- Establishing and administering an appeals process for employers challenging penalties;
- Establishing policies and procedures for verification of Social Security numbers, tax credit eligibility and immigration status with federal agencies;
- Resolving inconsistencies with information as reported by the Social Security Administration, Department of the Treasury or Department of Homeland Security;
- Handling and transmitting a variety of confidential information including federal income tax return data, income and other information included in Medicaid applications, and Social Security Administration data;
- Establishing eligibility criteria, selecting and overseeing the Navigator program; and
- Assessing fees to participating health insurers or to otherwise fund the ongoing operation of the Exchange.

Because of how the decisions that are made in these areas will determine, for example, whether low- and moderate-income individuals and families obtain the premium tax credits and cost-sharing reductions to which they are eligible and thus whether they can obtain health coverage, it is essential for strong public accountability for how these functions are performed. Whether they are performed well or poorly would not only affect small businesses, individuals and families, but also taxpayers who would be on the hook if costs are higher than they otherwise would be. We believe that the best way to ensure accountability is through the use of governmental staff who will carry out these functions without bias and conflicts of interest and in the best interest of the public. The States and HHS should use their enforcement authority to ensure transparency in contracting, such as by verifying that contracted work has not been inappropriately subcontracted.

While it may be appropriate to delegate some functions of the Exchange to a private contractor, such as designing IT programs, many functions of the Exchange must be performed by governmental staff that are accountable to the public. In particular,

mechanical functions such as data processing and other IT requirements, as well as billing, collection and payment reconciliation of premiums that should be considered for private sector contracting where competitive markets exist and for which performance can be readily monitored.

HHS indicates that Exchanges should include “copies of any agreements into which the Exchange has entered” to carry out Exchange functions. (p.41871) Sharing copies of agreements only after they have been signed may prove to be problematic. There are numerous examples of states ill-advisedly entering into expensive contracts with poor results and at a waste of taxpayer money due to the state’s inexperience, inattention, or overriding political decisions in contracting. For example, both Texas and Indiana ran into severe problems when they retained commercial vendors to transition to new IT systems for Medicaid and Food Stamps; California automated its Child Support Enforcement system at great expense only to find that it was not interoperable with the states’ other systems.

Recommendations:

Reference OMB Circular No. A-76 (revised 2003) as model guidance to states indicating what functions government should perform and what may be contracted out under the supervision of a government entity.

Retain the expectation in §155.110(b) that the Exchange remains responsible for ensuring that all contracted functions are met. Add conflict of interest and privacy provisions to ensure that the Exchange, HHS and the public know of a vendor’s potential financial conflicts and to protect the personal data of consumers.

HHS should require that Exchanges submit to HHS for approval contracts in excess of \$5 million (\$1 million in the case of noncompetitive acquisitions), similar to the requirement for approval of SNAP Automated Data Processing contracts. For smaller contracts, HHS should encourage states to share potential contract language in advance as part of its ongoing communication process.

§155.110 Entities eligible to carry out Exchange functions

Entities eligible to carry out Exchange Functions §155.110(a) and (b)

We support the requirement that, in the event an Exchange enters into an agreement with an eligible entity to carry out one or more functions of an Exchange, the Exchange remains the principle entity responsible for ensuring that all federal requirements are met. Furthermore, certain exchange functions are inherently governmental and thus must be performed by public entities.

While we recognize the possible benefit or need for an Exchange to seek such agreements with eligible entities – particularly the state Medicaid agency for the purposes of eligibility and enrollment – we are concerned that certain functions may not be appropriate or eligible for outsourcing to a third party, non-governmental entity. Specifically, the process of making determinations of an individual’s eligibility for Medicaid, CHIP, federally funded premium tax-

credits or cost-sharing reductions should not be contracted out to private entities nor should the appeals process for eligibility determination be contracted out. Additionally while some aspects of grievances and appeals of other issues could possibly be handled by a third party, the consumer should always have recourse via a process that is directly overseen by the Exchange.

Recommendation: The final rule should clarify that certain functions of an exchange may not be contracted out to a non-governmental entity, particularly the determination of individuals' eligibility for Medicaid, federally subsidized QHPs, or other coverage programs.

Entities eligible to carry out Exchange Functions §155.110(c)

It is critical that CMS establish minimum requirements for all exchange governing boards. In particular, we support the requirement that any such governing bodies must be administered under a publicly adopted charter or bylaws and must hold regular public meetings with advanced notice provided to the public. Additional requirements to ensure transparency, openness, and fair practices are welcome as well.

We strongly recommend that HHS require that all exchange governing boards prohibit membership of individuals that possess a clear conflict of interest. It is detrimental to the goal of the exchange – to provide affordable health coverage to millions – and to taxpayers supporting premium tax credits if exchange boards are comprised of parties that have a financial interest in increasing the cost of health insurance. Individuals with a clear conflict of interest should be explicitly defined in regulations as individuals affiliated with health insurance issuers, insurance agents or brokers, health care providers or health care facilities. Additionally, this prohibition should explicitly extend to individuals affiliated with an entity whose primary line of business serves or whose clientele is largely comprised of individuals or organizations identified above as conflicted parties, such as major vendors, subcontractors, or other financial partners.

We believe that HHS should clearly define representatives of consumer interests. Such a definition should include: individuals who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the individual exchange; small business employees who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the SHOP exchange; and non-profit organizations that represent or advocate on behalf of the individuals in the categories mentioned above. Additionally, for purposes of board membership, HHS should separately define representatives of small employers as small business owners who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the SHOP exchange. HHS should perhaps include language in the regulations that permit this definition to be adjusted once a state permits larger employers to enter the SHOP.

If HHS intends, as stated in the preamble and in §155.110(c)(3), to ensure that exchange governing boards predominantly represent consumer interests, then the final rule must be more explicit on this issue. Specifically, if HHS ultimately will permit conflicted parties to serve on exchange boards, there should be more representatives of consumer interests (as defined above) than conflicted voting members and consumer interests should constitute an overall majority and

a voting majority of the board. A precedent for such a requirement exists in 42 USCS § 254b(k)(3)(H) regarding requirements of governing boards for Federally Qualified Health Centers (FQHCs), where a majority of the board must be individuals being served by the health center.

Prohibiting – or at least limiting – representation from conflicted parties is crucial to the success of exchanges. Health insurers have a direct financial interest in the outcome of exchange policy decisions. While it has been proposed in certain states that board members must recuse themselves in instances of conflict, we believe that *all* exchange governing board decisions would pose a conflict for insurers. As such, health insurers would be unable to serve on a governing board in any meaningful capacity. While we recognize the specific expertise and knowledge representatives of insurers may provide, such expertise can and should be harnessed through other formal, non-governing channels, such as a robust stakeholder consultation process. Brokers and agents, too, could be conflicted, particularly in states where it is customary for insurers to pay brokers a percentage of the insurance premium. Health care facilities and practicing, individual health care providers, also have significant conflicts of interest. Any conflict of interest permitted in exchange governance has the potential to result in decisions that disproportionately benefit these financially conflicted parties, likely at an increased cost to states, the federal government, and the consumer.

In addition to direct financial conflicts, a role in governance may give insurers the opportunity to set policies to the detriment of consumers. For example, if a state's dominant insurer is on the exchange governing board, it may block initiatives meant to increase insurance competition by bringing in new market entrants. In this manner, including insurers and other conflicted parties onto the exchange board may reduce the potential for exchanges to achieve a truly competitive and successful marketplace.

If insurers and other conflicted parties are permitted on a governing board in certain states, HHS must ensure provisions to mitigate such financial conflict and potential adverse impact on consumers. One important step, as outlined above, is to limit insurer representation to equal to or less than the number of members representing consumer interests.

We also strongly recommend that HHS be more explicit in the standards exchanges must meet in terms of policies on ethical practices and conflict of interest. Specifically, HHS should set a minimum benchmark standard for exchanges requiring board members and staff to:

- Disclose any affiliations (financial or otherwise) that may cause the appearance or presence of a conflict of interest with their role in an exchange;
- recuse themselves from all discussion and votes associated with such conflict;
- refrain from accepting any gifts (or any gifts exceeding a reasonable limit) from any individual or entity that can be considered a conflicted party; and
- report any potential unethical action or transgression on behalf of themselves, staff, board members, or vendors.

Recommendations: The final rule should require all exchange governing boards to prohibit membership of individuals that possess a clear conflict of interest. Conflicted parties

should be defined as individuals affiliated with health insurance issuers, insurance agents or brokers, health care providers or health care facilities. Individuals should also be considered conflicted if they (or an entity they are affiliated with) has as a primary line of business the service of conflicted parties or a clientele largely comprised of conflicted parties. The final rule should clearly define representatives of consumer interests.

If the final rule permits conflicted parties to serve on exchange boards, consumer interests (as defined above) should constitute an overall majority and a voting majority of the board. HHS must also provide explicit standards for exchanges to meet regarding ethical practices and conflicts of interest, including by barring conflicted parties from participating in votes on or discussions about issues on which they are conflicted.

SHOP Independence Governance, §155.110 (e)

We strongly support the preamble statement that a single governance structure for both the individual market Exchange functions and SHOP will produce better policy coordination, increased operational efficiencies and improved operational coordination. It would also avoid duplication of key Exchange functions including certification of qualified health plans, eliminate the need for duplicative information collection and reporting, and ensure more seamless coverage for individuals (who may be going back and forth between SHOP coverage through their jobs and individually purchased coverage that may be subsidized by premium tax-credits and cost-sharing reductions).

We therefore strongly disagree with the proposed rules at §155.110 (e) that permit a State to elect to create an independent governance and administrative structure. There is nothing at all in section 1311(b) of the Affordable Care Act that explicitly permits states to have a separate structure. The preamble, however, states that because states can provide a single exchange for both individuals and small businesses that this means that States can operate their individual and SHOP exchanges entirely separately. This reading is inconsistent with the statute. Section 1311(b)(1) states that each State must establish *an* American Health Benefit Exchange that among other purposes and functions, provides for the establishment of a Small Business Health Options program (SHOP) under section 1311(b)(1)(B) of the Affordable Care Act. This seems to imply a State is required to establish a single administrative and operational structure with one of the structure's duties to to administer and operate a SHOP exchange for small businesses). Moreover, nothing in section 1311(b)(2) discusses governance or administrative structure but rather about the option for States to use a single Exchange for both individual and small businesses to provide "Exchange" *services* such as offering QHPs..

Recommendations: §155.110(e)(1) should be struck and §155.110 (e)(2) should be renumbered accordingly. It should also be amended to delete any reference to governance or administrative structure and instead codify the actual language of section 1311(b)(2) of the Affordable Care Act to read as follows: "If a State chooses to provide only Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers."

DELTA DENTAL PLAN OF MAINE PROPOSED REVISIONS

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA c. 89 is enacted to read:

CHAPTER 89

MAINE HEALTH BENEFIT EXCHANGE ACT

§ 7001. Short title

This chapter may be known and cited as “the Maine Health Benefit Exchange Act.”

§ 7002. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. **Commission.** “Commission” means the Maine Health Benefit Exchange Commission established in section 7005.
2. **Commissioner.** “Commissioner” means the Commissioner of the Department of Professional and Financial Regulation within the meaning of chapter 901 of Title 10.
3. **Educated health care consumer.** “Educated health care consumer” means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical and scientific matters.
4. **Exchange.** “Exchange” means the Maine Health Benefit Exchange established in section 7003.
5. **Executive Director.** “Executive Director” means the Executive Director of the Maine Health Benefit Exchange.
6. **Federal Affordable Care Act.** “Federal Affordable Care Act” has the meaning given to this term in section 14.
7. **Federally Recognized Indian Tribe.** “Federally Recognized Indian Tribe” means the Passamaquoddy Tribe, the Penobscot Nation, the Houlton Band of Maliseet Indians as defined in 25 U.S.C. sections 1722(a) and (h), the Aroostook Band of Micmacs as defined in Pub. L. 102-171, section 3(1).
8. **Health benefit plan.** “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

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A. "Health benefit plan" does not include:

- (1) Coverage only for accident or disability income insurance or any combination thereof;
- (2) Coverage issued as a supplement to liability insurance;
- (3) Liability insurance, including general liability insurance and automobile liability insurance;
- (4) Workers' compensation or similar insurance;
- (5) Automobile medical payment insurance;
- (6) Credit-only insurance;
- (7) Coverage for on-site medical clinics; or
- (8) Insurance coverage *similar to any coverage listed in subparagraphs (1) to (7) above*, as specified in federal regulations issued pursuant to the federal *Health Insurance Portability and Accountability Act of 1996*, Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

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B. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

- (1) Limited-scope dental or vision benefits;
- (2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or
- (3) Limited benefits *similar to those listed in subparagraphs (1) and (2) above* as specified in federal regulations issued pursuant to the *federal Health Insurance Portability and Accountability Act of 1996*, Public Law 104-191.

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C. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

- (1) Coverage only for a specified disease or illness; or

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(2) Hospital indemnity or other fixed indemnity insurance.

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D. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

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(1) Medicare supplemental health insurance as defined under the

United States Social Security Act, section 1882(g)(1);

(2) Coverage supplemental to the coverage provided under 10 *United*

States Code, chapter 55; or

(3) Supplemental coverage similar to coverage listed in sub

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9. **Health carrier.** "Health carrier" or "carrier" means:

A. *An insurance company licensed in accordance with this Title to provide health or dental insurance;*

B. *A health maintenance organization licensed pursuant to chapter 56;*

C. *A preferred provider arrangement administrator registered pursuant to chapter 32;*

D. *A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24;*

E. *An insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance as defined in section 707, subsection 1, paragraph C-1; or*

F. *Any other entity providing a plan of health or dental insurance, health or dental benefits, or health services that may lawfully provide such benefits under state and federal law.*

10. **Health insurance producer.** "Health insurance producer" means a person required to be licensed under the laws of this State to sell, solicit or negotiate a health or dental benefit plan.

11. ~~**Qualified dental plan.** "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7009, subsection 5.~~

12.

11. Qualified employer. “Qualified employer” means a small employer that elects to make its full-time employees, and, at the option of the employer, some or all of its part-time employees, eligible for one or more qualified health plans or qualified stand-alone dental benefit plans offered through the SHOP Exchange, provided that the employer:

- A. Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or
- B. Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

1312. Qualified health plan. “Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the ~~federal~~ Federal Affordable Care Act and section 7009.

1413. Qualified individual. “Qualified individual” means an individual, including a minor, who:

- A. Is seeking to enroll in a qualified health plan or qualified stand-alone dental benefit plan offered to individuals through the Exchange;
- B. Resides in this State *within the meaning of the federal* Federal Affordable Care Act;
- C. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and
- D. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

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14. Qualified stand-alone dental benefit plan means a stand-alone dental benefit plan that has been certified in accordance with section 7009 subsection 5.

15. Secretary. “Secretary” means the Secretary of the United States Department of Health and Human Services.

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16. SHOP exchange. “SHOP Exchange” means the Small Business Health

Options

Program established pursuant to section 7008, subsection 2, paragraph I.

17. Small employer. "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year, *provided that for plan years beginning before January 1, 2016, "small employer" means an employer that employed an average of not more than 50 employees during the preceding calendar year.* For purposes of this subsection:

- A. All persons treated as a single employer under Section 414(b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as a single employer;
- B. An employer and any predecessor employer shall be treated as a single employer;
- C. *Employees for purposes of determining the number of employees employed shall mean "eligible employees" as defined under section 2808-B, unless Federal law requires a different rule to be used to determine the number of employees and such Federal law preempts state law, in which case the number of employees shall be determined in accordance with Federal law;*
- D. If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer must be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and
- E. An employer that makes enrollment in qualified health plans and/or qualified stand-alone dental benefit plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, must continue to be treated as a small employer for purposes of this *chapter* as long as the employer continuously makes enrollment through the SHOP Exchange available to its employees.

18. Stand-alone dental benefit plan means a policy, contract, certificate or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986.

§ 7003. Maine Health Benefit Exchange established; declaration of necessity

1. **Exchange established.** The Maine Health Benefit Exchange is hereby established as a governmental agency within the Department of Professional and Financial Regulation.

2. **Exchange Functions.** The Exchange shall facilitate the purchase and sale of qualified health plans and qualified stand-alone dental benefit plans; provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans and qualified stand-alone dental benefit plans; and meet the requirements of this chapter and any regulations implemented under this chapter.

3. **Contracting authority.** The Exchange may contract with an eligible entity for any of its functions described in this chapter. For the purposes of this subsection, “eligible entity” includes, but is not limited to, the MaineCare program or any entity that has experience in individual and small group health insurance or benefit administration, or has other experience relevant to the responsibilities to be assumed by the entity, except that an eligible entity does not include a health carrier or an affiliate of a health carrier.

4. **Intergovernmental Agreements and Coordination.** The Exchange may enter into information-sharing agreements with federal and other state agencies and other state exchanges to carry out its responsibilities under this chapter; such agreements shall include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws, rules and regulations.

§ 7004. Executive Director

1. **Appointment.** The Commission shall recommend candidates for Executive Director to the Commissioner and the Governor. The Executive Director shall be appointed by the Governor subject to review by the joint standing committee of the Legislature having jurisdiction over insurance and financial services and to confirmation by the Legislature. The position of Executive Director is a major policy-influencing position as designated in Title 5, section 934. The Executive Director serves at the pleasure of the Governor.

2. **Duties.** The Executive Director shall supervise and manage the Exchange in consultation with the Commission and the Commissioner.

§ 7005. Maine Health Benefit Exchange Commission

1. **Duties.** There shall be established a Commission to advise the Executive Director and the Commissioner regarding technical issues related to the Exchange.

2. **Appointments.** The Commission consists of 9 voting members and 2 ex

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officio, nonvoting members as follows:

- A. *The 9 voting members of the Commission are appointed by the Governor subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters, and confirmation by the Senate.*
- B. *The Governor shall appoint the voting members as follows:*
 - (1) *At least one member representing insurers;*
 - (2) *At least one member representing health insurance producers;* (3) *At least one member representing health care providers;*
 - (4) *At least one member representing employers with an average of not more than 50 employees during the calendar year preceding the member's appointment;*
 - (5) *At least one member representing employers with an average of not less than 51 but not more than 100 employees during the calendar year preceding the member's appointment;*
 - (6) *At least one member representing consumers; and*
 - (7) *At least one member representing federally recognized Indian tribes in the State.*
- C. *The appointments of all voting members shall be made in accordance with state conflicts of interest laws. The appointments of voting members shall also be made in accordance with the ~~federal~~Federal Affordable Care Act so that a majority of the voting members of the Commission do not have conflicts of interest, as defined in regulations implementing the ~~federal~~Federal Affordable Care Act.*
- D. *The 2 ex officio, nonvoting members of the Commission are:*
 - (1) *The Commissioner or the commissioner's designee; and*
 - (2) *The Commissioner of the Department of Health and Human Services or the commissioner's designee.*

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3. **Qualifications of voting members.**— A majority of the voting members of the Commission must have relevant experience in the following areas:

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- A. Health benefits administration;
- B. Health care finance;
- C. Health plan purchasing;
- D. Health care delivery system administration;
- E. Public health;
- F. Health policy issues related to the small group and individual markets and the uninsured; or
- G. Any additional areas of relevant experience identified in the federal Affordable Care Act.

4. **Terms of office.** Voting members of the Commission serve 3-year terms. Any vacancy for an unexpired term must be filled in accordance with subsections 1 and 2. A member may serve until a replacement is appointed and qualified. Of the initial members, 3 members serve an initial term of one year, 3 members serve an initial term of 2 years, and 3 members serve an initial term of 3 years in order to achieve a staggered set of terms. Voting members may serve up to 2 consecutive terms, not including any initial term of less than 3 years.

5. **Chair.** The Governor shall appoint one of the voting members of the Commission as the chair of the Commission.

6. **Quorum.** Five voting members of the Commission constitute a quorum.

7. **Affirmative vote.** An affirmative vote of 5 members is required for any action taken by the Commission.

8. **Compensation.** A member of the Commission is entitled to compensation according to the provisions of Title 5, section 12004-G, subsection 14-H; a member must receive compensation whenever that member fulfills any Commission duties in accordance with Commission bylaws.

9. **Meetings.** The Commission shall hold regular public governing meetings that are announced in advance. All meetings of the Commission are public proceedings within

the meaning of Title 1, chapter 13, subchapter 1.

10. Governance. *The Commission shall adopt rules in accordance with section 7008, subsection 4 that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest, including disclosure of financial interests by members of the Commission, that meet the requirements of the ~~federal~~Federal Affordable Care Act and any applicable state law to the extent not inconsistent with the ~~federal~~Federal Affordable Care Act.*

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§ 7006. Records

Except as provided in this section, information obtained by the Exchange under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

1. Financial information. *Any personally identifiable financial information, supporting data or tax return of any person obtained by the Exchange under this chapter is confidential and not open to public inspection.*

2. Health information. *Health information obtained by the Exchange under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information covered by chapter 24 or Title 22, section 1711-C is confidential and not open to public inspection.*

§ 7007. General Requirements

1. Coverage. *The Exchange shall make qualified health plans and qualified stand-alone dental benefit plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.*

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2. Qualified health plan plans required. *The Exchange shall not make available any health benefit plan that is not a qualified health plan nor any stand-alone dental benefit plan that is not a qualified stand-alone dental benefit plan.*

3. Dental benefits. *The Exchange shall allow a health-carrier to offer a qualified stand-alone dental benefit plan that provides limited-scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the ~~federal~~Federal Affordable Care Act.*

4. No fee or penalty for termination of coverage. *Neither the Exchange nor a carrier offering health benefit plans or stand-alone dental benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored*

coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

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§ 7008. Powers and duties of the Maine Health Benefit Exchange

1. Powers. *Subject to any limitations contained in this chapter or in any other law, the Exchange shall have and may exercise all powers necessary or convenient to effect the purposes for which the Exchange is organized or to further the activities in which the Exchange may lawfully be engaged, including the establishment of the Exchange.*

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2. Duties. The Exchange shall:

- A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the ~~federal~~Federal Affordable Care Act and pursuant to section 7009, of health benefit plans as qualified health plans; and of stand-alone dental benefit plans as qualified stand-alone dental benefit plans;
- B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- C. Provide for enrollment periods, as provided under Section 1311(c)(6) of the ~~federal~~Federal Affordable Care Act;
- D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans and qualified stand-alone dental benefit plans may obtain standardized comparative information on such plans, and for a fee, permit carriers to maintain a landing page with hyperlinks to the carrier's website;
- E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the ~~federal~~Federal Affordable Care Act and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the ~~federal~~Federal Affordable Care Act;
- F. Use a standardized format for presenting health and dental benefit options in the Exchange, including the use of the uniform outline of coverage established under the ~~federal~~Federal Public Health Service Act, 42 *United States Code*, Section 300gg-15 (2010);
- G. In accordance with Section 1413 of the ~~federal~~Federal Affordable Care Act, inform individuals of eligibility requirements for the Medicaid program under the *United States Social Security Act*, Title XIX, or the

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State Children's Health Insurance Program under the United States Social Security Act, Title XXI, or of eligibility requirements for any applicable state or local public program and if, through screening of an application by the Exchange, the Exchange determines that an individual is eligible for any such program, enroll the individual in that program;

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the ~~federal~~*Federal Affordable Care Act*;

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I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, enabling any qualified employer to specify a level of coverage that any of its employees may enroll in any qualified health plan and qualified stand-alone dental benefit plan offered through the SHOP Exchange at the specified level of coverage; and determine whether to provide other ways for the

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SHOP Exchange to allow a qualified employer to offer one or more plans to its employees, provided that the SHOP Exchange shall not preclude a qualified employer from selecting a single qualified health plan and a single qualified stand-alone dental benefit plan to offer to its employees;

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J. Subject to Section 1411 of the ~~federal~~*Federal Affordable Care Act*, issue a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that Section because:

- (1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
- (2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty;

K. Transfer to the *United States* Secretary of the Treasury the following:

- (1) A list of the individuals who are issued a certification under paragraph J, including the name and taxpayer identification number of each individual;
- (2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because:

- (a) The employer did not provide the minimum essential coverage; or
 - (b) The employer provided the minimum essential coverage, but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value; and
- (3) The name and taxpayer identification number of:
- (a) Each individual who notifies the Exchange under Section 1411(b)(4) of the ~~federal~~*Federal Affordable Care Act* that *the individual* has changed employers; and
 - (b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee ~~of the employer~~ described in paragraph K, *subparagraph 2* who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

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M. Perform duties required of the Exchange by the Secretary or the United States Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost sharing or individual responsibility requirement exemptions;

N. Select entities, *through the award of grants or contracts*, to serve as navigators *who meet the requirements of* Section 1311(i) of the ~~federal~~*Federal Affordable Care Act*, standards developed by the Secretary, *and any registration or licensing requirements established by the Bureau of Insurance in consultation with the Exchange and the Department of Health and Human Services*; and award grants or contracts to enable navigators to:

- (1) Conduct public education activities to raise awareness of the availability of qualified health plans; and qualified stand-alone dental benefit plans;
- (2) Distribute fair and impartial information concerning enrollment in qualified health plans and qualified stand-alone dental benefit plans and the availability of premium tax credits under Section 36B(c)(2)(C) of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the

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~~federal~~Federal Affordable Care Act;

- (3) —Facilitate enrollment in qualified health plans and qualified stand-alone dental benefit plans;
- (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under ~~federal~~Federal Public Health Service Act, 42 United States Code, Section 300gg-93 (2010) or any other appropriate state agency or agencies, for an enrollee with a grievance, complaint or question regarding a health benefit plan or stand-alone dental benefit plan or coverage or a determination under that plan or coverage; and
- (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

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- O. Review the rate of premium growth within the Exchange and outside the Exchange and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;
- P. Consult with stakeholders *regarding* carrying out the activities required under this *chapter*, including, but not limited to:

(1) —

Educated health care consumers who are enrollees in qualified

- (1) health plans and qualified stand-alone dental benefit plans;
- (2) Individuals and entities with experience in facilitating enrollment in qualified health plans; and qualified stand-alone dental benefit plans;
- (3) Representatives of small businesses and self-employed individuals;
- (4) *Representatives of the MaineCare program*;
- (5) Advocates for enrolling hard-to-reach populations; and
- (6) *any other groups or representatives required by the federal Affordable Care Act*;

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The Commission shall consult with an advisory committee, the members of which are appointed by the chief and council for each tribe of the federally recognized Indian tribes in the State. The Commission may

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appoint other advisory committees that include stakeholders to advise and assist the Commission in discharging its responsibilities under this chapter. Members of any advisory committee serve without compensation but may be reimbursed by the Exchange for necessary expenses while on official business of the advisory committee.

Q. Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the *Commissioner* a report concerning such accountings;

R. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the ~~federal~~*Federal Affordable Care Act* and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

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(1) Investigate the affairs of the Exchange;

(2) Examine the properties and records of the Exchange; and

(3) Require periodic reports in relation to the activities undertaken by the Exchange;

S. In carrying out its activities under this *chapter*, avoid using any funds intended for the administrative and operational expenses of the Exchange for ~~— staff —retreats, —promotional —giveaways, —excessive— executive~~ compensation or promotion of federal or state legislative and regulatory modifications; and

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T. *Allow health insurance producers to enroll individuals and employers in any qualified health plans and qualified stand-alone dental benefits plans and to assist individuals in applying for*

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premium tax credits and cost-sharing reductions for plans sold through the Exchange.

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3. **Budget.** The Exchange shall submit a budget for its administration and operation to the Commissioner. The Exchange shall conduct an analysis of, and make recommendations to be included in the initial budget regarding, how the Exchange can be self-sustaining by 2015.

4. **Rulemaking.** The Exchange may adopt rules as necessary for the proper administration and enforcement of this chapter pursuant to the Maine Administrative Procedure Act. Unless otherwise specified or required by the Maine Administrative Procedure Act, rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Rules adopted pursuant to this subsection shall be consistent with the ~~federal~~Federal Affordable Care Act.

5. **Funding; Publication of costs**

- A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this chapter.
- B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on a *publicly accessible* website to educate consumers on such costs. This information must include information on money lost to waste, fraud and abuse.

6. **Adjudications.** Any adjudications by the Exchange shall be conducted in accordance with the Maine Administrative Procedure Act and the ~~federal~~Federal Affordable Care Act and shall be considered final agency actions for purposes of the Maine Administrative Procedure Act.

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§ 7009. Health benefit plan certification

1. **Certification.** The Exchange may certify a health benefit plan as a qualified health plan if:

- A. The *health benefit* plan provides the essential health benefits package described in Section 1302(a) of the ~~federal~~Federal Affordable Care Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified stand-alone dental benefit plans, as provided in subsection 5, if:
 - (1) The Exchange has determined that at least one qualified stand-alone dental benefit plan is available through the Exchange to supplement the plan's coverage; and
 - (2) The carrier makes prominent disclosure at the time it offers the

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plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric *dental* benefits and that qualified stand-alone dental benefit plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

- B. *The forms for the health benefit plan meet the requirements of chapter 27, and the rates for the health benefit plan meet the requirements of chapter 33 or chapter 35, as applicable;*
- C. The *health benefit* plan provides at least a bronze level of coverage, as determined pursuant to section 7008, subsection 2, paragraph E unless the plan is certified as a qualified catastrophic plan, meets the requirements of the ~~federal~~*Federal Affordable Care Act* for catastrophic plans, and will be offered only to individuals eligible for catastrophic coverage;
- D. The *health benefit* plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the ~~federal~~*Federal Affordable Care Act* and, if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the ~~federal~~*Federal Affordable Care Act*;
- E. The health carrier offering the *health benefit* plan:
 - (1) Is licensed and in good standing to offer health insurance coverage in this State;
 - (2) Offers at least one qualified health plan in the silver level and at least one plan in the gold level *as described in Section 1302(d)(1)(B) and Section 1302(d)(1)(C) of the federal*~~Federal~~*Affordable Care Act* through each component of the Exchange in which the carrier participates. *As used in this subparagraph, "component" means the SHOP Exchange and the Exchange;*
 - (3) Offers at least one qualified health plan that provides the essential health benefits package described in Section 1302(a) of the Act without benefits that duplicate the minimum dental benefits of stand-alone dental benefit plans, if the Exchange has determined that at least one qualified stand-alone dental benefit plan is available through the Exchange to supplement the health plan's coverage.
 - (4) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;
 - (5) Does not charge any cancellation fees or penalties in violation of section 7007, subsection 4; and

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(56) Complies with the regulations developed by the Secretary under Section 1311(c) of the ~~federal~~*Federal Affordable Care Act* and such other requirements as the Exchange may establish; and

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F. The *health benefit* plan meets the requirements of certification *established by regulation promulgated* by the Secretary under Section 1311(c) of the *federal Affordable Care Act and by the Exchange pursuant to section 7008, subsection 4* and, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance.

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2. **Authority to exclude health benefit plans.** The Exchange shall not exclude a health benefit plan:

- A. On the basis that the *health benefit* plan is a fee-for-service plan;
- B. Through the imposition of premium price controls by the Exchange; or
- C. On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances *in which* the Exchange determines the treatments are inappropriate or too costly.

Carrier requirements. The Exchange shall require each health carrier seeking certification of a *health benefit* plan as a qualified health plan to:

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A. ~~A.~~ Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the *superintendent* under the ~~federal~~*Federal* Public Health Service Act, *42 United States Code, Section 300gg-94 (2010)* into consideration when determining whether to allow the carrier to make plans available through the Exchange;

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B. ~~B.~~ Make disclosure separately of the price for the pediatric dental benefit if the plan provides a comprehensive essential benefits package described in Section 1302(a) of the Act, provided that the health carrier is not required to offer the pediatric dental benefit for sale on the Exchange on a stand-alone basis.

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C. Make available to the public and submit to the Exchange, the Secretary and the *superintendent* accurate, transparent and timely disclosure of the following:

- (1) Claims payment policies and practices;

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- (2) Periodic financial disclosures;
- (3) Data on enrollment;
- (4) Data on disenrollment;
- (5) Data on the number of claims that are denied;
- (6) Data on rating practices;
- (7) Information on cost sharing and payments with respect to any out-of-network coverage;
- (8) Information on enrollee and participant rights under Title I of the ~~federal~~Federal Affordable Care Act; and
- (9) Other information as determined appropriate by the Secretary;
The information required in this paragraph *must* be provided in plain language, as that term is defined in Section 1311(e)(3)(B) of the ~~federal~~Federal Affordable Care Act; and

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ED. Permit *an* individual to learn, in a transparent and timely manner upon the request of the individual, the amount of cost sharing, including deductibles, copayments and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through a publicly accessible website and through other means for *an* individual without access to the Internet.

4. **Application of licensing or solvency requirements.** The Exchange *may* not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that ensures fairness between or among health carriers participating in the Exchange. *The Exchange shall not be subject to state licensure or solvency requirements. No employee of the Exchange shall be permitted to engage in activities that require state licensure unless such employee is licensed to engage in such activities in accordance with state licensure requirements.*

5. **Application to qualified stand-alone dental benefit plans.** The provisions of this chapter that are applicable to qualified health plans also apply to the extent relevant to qualified stand-alone dental benefit plans except as modified in ~~this subsection~~ accordance with subparagraphs (A), (B), (C) and (D) below or by *rules* adopted by the Exchange.

A. ~~The Exchange shall be offering the stand-alone dental plan if the carrier~~ The Exchange may certify a dental plan as a qualified stand-alone dental benefit plan if the carrier

1. is licensed to offer dental coverage, but need not be licensed to offer

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other health benefits;

2. Offers at least one stand-alone dental benefit plan that includes only the essential pediatric dental benefit requirement of Section 1302(b)(1)(J) of the Federal Affordable Care Act, provided that this requirement shall not limit dental carriers from providing other stand-alone dental benefit plans that are certified by the Exchange;
 3. Charges the same premium rate for each stand-alone dental benefit plan without regard to whether the plan is offered through the Exchange and without regard to whether is offered directly from the carrier or through a producer;
 4. Submits the premium rates and contract language to the superintendent for approval;
 5. Does not charge any cancellation fees or penalties in violation of 24-A MRSA Section 7007 (4); and
 6. Complies with the regulations developed by the Secretary under Section 1311(d) of the Federal Affordable Care Act and such other requirements as the Exchange may establish.
- B. The *qualified stand-alone dental benefit plan* must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to Section 1302(b)(1)(J) of the *federal Federal Affordable Care Act*, and such other dental benefits as the Exchange or the Secretary may specify by rule or regulation.
- C. Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified stand-alone dental benefit plan and the other benefits are provided by a carrier through a qualified health plan, if the plans are priced separately and are also made available for purchase separately at the same price.
- D. The Exchange shall not exclude a stand-alone dental benefit plan:
- (1) On the basis that the plan is a fee-for-service plan; or
 - (2) Through the imposition of premium price controls by the Exchange.

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§ 7010. Relation to other laws

Nothing in this *chapter*, and no action taken by the Exchange pursuant to this *chapter*, shall be construed to preempt or supersede the authority of the *superintendent* to regulate the

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business of insurance within this State. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans or qualified stand-alone dental benefit plans in this State shall comply fully with all applicable insurance laws of this State and rules adopted and orders issued by the superintendent.

~~applicable health insurance laws of this State and rules adopted and orders issued by the superintendent.~~

Sec. 2. 5 MRSA § 934, sub-§ 1, paragraph F is enacted to read:

F. Executive Director, Maine Health Benefit Exchange;

Sec. 3. 5 MRSA § 12004-G, sub-§ 14-H is enacted to read:

14-H.

Health Care, Maine Health Benefit Exchange Commission, \$100 per diem and expenses, 24-A MRSA § 7005.

Sec. 4. 10 MRSA § 8001, sub-§39 is enacted to read:

39. The Maine Health Benefit Exchange

Sec. 5. Repeal of 24-A MRSA c. 89. *If the U.S. United States Supreme Court overturns all or part of the federal Federal Affordable Care Act or the federal Federal Affordable Care Act is repealed (in whole or in part) after the date of enactment of this chapter, within 60 days of such decision the Exchange shall recommend to the Legislature and the Governor whether to continue the Exchange.*

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Statement by Delta Dental Plan of Maine on the proposed Maine Health Benefit Exchange Act

Provided to the Insurance and Financial Services Committee November 1, 2011

Senator Whittemore, Representative Richardson, and members of the committee, my name is Christine Alibrandi. I'm here with Chris O'Neil and together we are representing the Delta Dental Plan of Maine. Delta Dental of Maine appreciates this opportunity to offer feedback on the draft legislation to create a health benefit exchange in Maine. Delta Dental has a strong presence in the state's dental insurance market and we hope to continue that role, on and off the state's exchange.

We've looked at the draft legislation, which represents the very comprehensive work performed by the Advisory Committee on Maine's Exchange. We'd like you to consider some refining revisions to achieve our shared goal of crafting the best possible product out of this process for consumers, state regulators and the small businesses that want to participate in the exchange market.

The changes we're suggesting are the result of extensive legal and legislative work performed by Delta Dental at the federal level, as well as with state legislators across the country, to ensure what we are offering is consistent with the federal act while at the same time reflecting our state's unique insurance laws and qualities.

Our proposed revisions fall under two general themes

1. Ensuring Maine's exchange law will reflect stand-alone dental plans as presented in the ACA.
2. Promoting transparency to better inform and aid consumers who will be purchasing health benefit plans and stand-alone dental benefit plans through the Exchange.

As you know, all health plans offered on a state's exchange must cover the ACA defined "essential health benefits." Of the ten essential health benefits, one is dental coverage for children, which is referred to as the "pediatric dental benefits" requirement. (This is one of the terms not yet defined by the federal government, but we presume it will include at least twice-annual cleanings and sealants, but not braces.) The ACA allows health insurance providers to offer plans without dental only if at least one stand-alone dental plan is offered on that state's exchange. Delta Dental intends to participate on the exchange, which will open the door to stand-alone medical insurers' participation on the exchange.

Northeast Delta Dental

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Psychologically Healthy
Workplace Awards



This provision of the ACA benefits the health insurers that don't currently offer dental but want to sell their products in the exchange marketplace. As importantly, it benefits consumers because it offers them more choices of health providers and plans. And, please note that many Maine residents currently receive their dental benefits separately from their medical plans.

A significant issue for consumers will be transparency in pricing. Some health insurers might offer bundled products where the medical and dental benefits are together in one plan. In order for consumers to be able to compare medical plan to medical plan and dental plan to dental plan, the medical and dental parts of a bundled product need to be separately priced. In other words, for a consumer to make an "apples to apples" comparison of dental plans, she will need to see what the health insurers are charging for the dental portion of their bundled product in order to compare it to the stand-alone dental plans. Consumers will need that separate pricing since cost is a critical factor consumers consider when making the best choice for their families.

One particular revision we are offering worth noting creates a revenue stream for the state to pay for the Exchange. We are recommending that carriers be permitted to maintain a landing page on the Exchange website where the carriers can differentiate products and allow consumers to contact a customer service representative to learn more about product offerings. (Surveys have found that 33 - 50% of consumers want to speak to a customer service representative before making a purchasing decision on an exchange, and that number increases to 63% for those eligible for subsidies on an Exchange.) The carriers would pay a fee to maintain the landing page, which will help defray some of the state's cost of maintaining the Exchange.

Thank you for your time. Chris O'Neil and I look forward to working with the committee as this important legislation moves forward. I am happy to answer any questions you may have.

Delta Dental Plan of Maine contacts:

Christine Alibrandi, Esq.
Health Care Reform Coordinator
603.223.1162

Christopher P. O'Neil
Lobbyist for DDPME
207.590.3842

Memorandum
Re: Delta Dental Plan of Maine
Proposed Changes to Health Benefit Exchange Legislation

Delta Dental Plan of Maine (“DDPME”) applauds the work of the Advisory Committee on Maine’s Health Insurance Exchange set forth in its September 20, 2011 “Recommendations Regarding the Maine Health Benefit Exchange.” DDPME looks forward to offering its stand-alone dental benefit plans to Maine residents through the Maine Health Benefit Exchange.

In developing the Federal Affordable Care Act, Congress recognized the key role oral health plays in overall health by including “pediatric oral services” as part of the Essential Health Benefits Package required under the law. Moreover, the Federal Affordable Care Act expressly allows the offering of stand-alone dental plans in Health Benefit Exchanges. The draft legislation recommended by the Maine Advisory Committee, which is based upon the model legislation prepared by the National Association of Insurance Commissioners (“NAIC”), recognizes the role of stand-alone dental benefit plans under the Maine Health Benefit Exchange.

This Memorandum discusses DDPME’s proposed modifications to the Maine Advisory Committee’s draft legislation. DDPME’s proposed changes fall into two broad categories:

- Modifications to increase consumer options, protect consumers’ current dentist relationships, and promote transparency to inform and aid consumers who are purchasing health benefit plans and stand-alone dental benefit plans through the Exchange; and
- Modifications to more clearly reflect the Federal Affordable Care Act’s inclusion of stand-alone dental plans in the Health Benefit Exchange.

Noteworthy changes, material or technical, are discussed below:

- a. DDPME recommends not using the term “qualified dental plan,” a term coined by the NAIC, and replacing that term with “qualified stand-alone dental benefits plan.” (See new subsections 14 and 18 of Section 7002 defining “qualified stand-alone dental benefits plan” and “stand alone dental benefits plan,” which comport with the relevant sections of the Internal Revenue Code that originally defined “stand-alone dental plan” which was also the definition adopted in the Federal Affordable Care Act). The reason for this change is to preempt any future confusion by using the same terminology in the Maine legislation as is used in the Federal Affordable Care Act.
- b. In Section 7008(2)(d), DDPME recommends carriers be permitted to maintain a landing page on the Exchange website where the carriers can differentiate products and allow consumers to contact a customer service representative to learn more about product offerings. (Surveys by Massachusetts Health Connector and by Price Waterhouse find that 33-50% of consumers want to speak to a customer service representative before making a purchasing decision, and that number increases to

63% for those eligible for subsidies on an Exchange.) The revised language includes a requirement that carriers pay a fee to maintain the landing page, which will help defray some of the cost of maintaining the Exchange.

- c. We estimate that at least 40% of dental insurance subscribers in Maine currently receive their dental benefits through a stand-alone dental plan. The Federal Affordable Care Act is not intended to replace or disrupt existing health care markets or cause consumers to terminate their existing relationships with health care providers, including dentists. It is therefore essential that the Exchange require carriers to offer at least one health plan that does not include dental benefits so that Maine residents are not forced to pay twice for the benefits already covered in their stand-alone plan whether it's an existing plan they want to retain or a new plan they want to purchase on the Exchange. It is also essential that Maine consumers have the ability to compare the price of their existing stand-alone dental plans with both the price of dental plans that are embedded ("bundled") in health insurance plans and with the price of stand-alone dental plans offered on the Exchange. DDPME suggests two revisions to accomplish these goals:

1. Each health carrier participating in the Exchange shall offer at least one plan that does not include the dental benefits provided by stand-alone dental benefit plans. This will enable consumers who want to maintain their existing stand-alone dental coverage to do so while also purchasing health insurance through the Exchange. See Section 7009(1)(E)(3).
2. Each health carrier offering a bundled plan (health and dental benefits) shall set forth separately the price for the dental benefit under the bundled plan so that consumers can make an "apples to apples" comparison of the price of the bundled dental benefit with that of the stand-alone dental benefit. See Section 7009(3)(B).

Both of these changes are consistent with existing Maine insurance law which provides that it is an unfair trade practice for an insurer to require a consumer to purchase additional insurance that the consumer does not want in order to obtain a desired coverage. See 24-A Section 2168-A.

- d. Likewise, Delta Dental is proposing Section 7009 (5)(A)(2) which would have all dental carriers provide at least one plan option that covers only the essential pediatric dental benefit requirement. This would allow consumers to buy the minimum insurance needed to satisfy the federal mandate and not require them to purchase benefits they do not want.
- e. The NAIC Model legislation that served as the basis for the Maine Advisory Committee's draft legislation does not clearly state the certification process for stand-alone dental plans seeking to participate in the Exchange. Amended Section 7009(5) addresses that omission and sets forth the certification requirements applicable to health plans under the Exchange that are also relevant to and should apply to stand-alone dental plans.



Reverend Robert Carlson, *President*
Kevin A. Lewis, *CEO*

Testimony before the Joint Standing Committee on Insurance and Financial
Services on Maine's Health Insurance Exchange

Kevin Lewis, CEO
Maine Primary Care Association
November 1, 2011

The Maine Primary Care Association (MPCA) is pleased to provide comment on the recent set of recommendations put forth by the Advisory Committee on Maine's Health Insurance Exchange on the formation of the Maine Health Benefit Exchange. To best explain and support our focus on certain Exchange implementation policies, we believe the following background review is appropriate.

Background on MPCA: MPCA is the statewide membership organization for federally qualified health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout Maine, and is a Section 501(c)(3) tax-exempt organization.

MPCA's mission is to increase access to primary care by advancing the strength and sustainability of health centers as the patient-centered safety net for the people of Maine. Incorporated in 1981, MPCA has steadily grown to fulfill its mission through the development and delivery of information, technical assistance and advocacy. MPCA programs focus on multiple areas: health information technology adoption and meaningful use; quality improvement, promotion of patient centered medical homes, health disparities collaboratives; behavioral health integration; risk management; outreach and enrollment; patient navigation; tobacco cessation; domestic violence prevention and a wide variety of technical assistance through community development, information technology, financial management and support of chronic disease care initiatives.

There are at present 19 FQHCs with more than 63 sites serving over 175,000 patients statewide. Maine is fifth in the nation for the percentage of our population receiving high quality, comprehensive primary care services at FQHCs. Approximately 30 percent of health center patients are MaineCare members, 19 percent are Medicare beneficiaries, 16 percent are uninsured, and 35 percent have private commercial coverage of one type or another, and more frequently underinsured for purposes of primary care. Three in four FQHC patients have family income below 200% of the Federal Poverty Level.

To qualify as an FQHC, a health center must be serving a designated medically underserved area or a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center and the health center must offer services to all persons in its area, regardless of one's ability to pay.

Composition of Exchange Governance

- Exchange governance should be established through a fully functioning governing Board.
- Exchange governance should have at least a majority of its members comprised of "consumer representatives" and that term should be defined to include a customer of an Exchange plan or a representative of a non-profit organization that serves or advocates for constituencies served by the Exchanges.
- Governance representation should specifically include at least one individual representing safety net providers—such as the Maine Primary Care Association—that have been providing services to low-income uninsured individuals and families who are likely to be

enrollees in QHPs that are certified by the Exchanges. Representation by safety net providers (as well as by consumer organizations representing low-income individuals) is important because of our familiarity with the issues of coordination of various coverage programs and systems including MaineCare. We are also quite familiar with issues relating to literacy, cultural competency, transportation and related barriers to access.

- Members of the Exchange Governance (or Commission in the case of the proposed recommendations by the Advisory Committee) should not have a conflict of interest—and thus should not include insurers or those affiliated with the insurance industry or a related trade association or an entity that would contract directly with the Exchanges such as QHPs or MCOs or a related group. To the extent that Maine legislation allows members of the Exchange governance that have a conflict of interest, those members should be required to recuse themselves from any discussion or vote on a topic in which they have such a conflict.

Navigators

- Navigators should not be subject to licensure. Instead, the Exchange should establish a Navigator training curriculum and certification requirements, and set quality standards and develop mechanisms to assess Navigator performance and accountability in meeting these standards.
- Navigators should be required to facilitate enrollment into Medicaid and CHIP, and the Basic Health Plan, in addition to the QHPs of the Exchange. This will aid and streamline the enrollment process by eliminating barriers to coverage, facilitate seamlessness across coverage sources, and prevent losses of coverage which have been shown to result in worse health outcomes and eventually the need for more expensive care.
- Navigators' duties should include assisting consumers in applying for premium tax credits and cost-sharing reductions. Navigators should be subject to specific requirements regarding translating materials and providing oral assistance through competent interpreters or bilingual staff to LEP individuals.
- The Navigator program should be established to adequately assist those living in medically underserved areas (MUAs) and work with low-income populations especially given that this is where most of the growth in coverage will occur (see chart below).
- No fewer than two types of qualified entities should be selected by the Exchange to serve as Navigators and at least one of those entities should be a community or consumer-oriented non-profit organization.

Maine State Totals

Base Case Coverage	Total	Transitions in Coverage under PPACA							
		Exchange Employer	Exchange subsidy	Exchange no subsidy	Private Employer	Private Non-Group	Private Retiree	Medicaid/ CHIP	Uninsured
Employer	644,136	23,158	24,315	10,158	570,962	271	-	12,142	3,130
Non-Group	72,062	1,458	17,699	843	10,663	36,780	-	4,558	61
Retiree	17,782	-	-	-	-	-	16,382	1,400	-
Medicaid/ CHIP	211,578	2,048	13,950	1,199	5,382	-	-	188,998	-
Uninsured	168,383	8,433	34,825	7,968	27,456	-	-	38,184	51,517
Total*	1,416,147	35,097	90,789	20,168	614,463	37,051	16,382	245,282	54,708

*The totals of this chart include enrollment levels in Champus, Medicare and Dual Eligibles which aren't shown above. The full table is included as an attachment.

Source: Ingenix Consulting

Duties of Exchange

Choice is paramount, and so too is the connection between providers and employers, worksite wellness, and the engagement in value based purchasing of health care. Employer based coverage may be an accident of history, but the fact that we spend most of our waking hours in an employment setting means that this is the environment that we must engage in order to reach individual employees effectively. In the context of supplying employers and employees the greatest possible choice of coverage options, the marketplace could readily foster employee health activation strategies that span not only product lines, but issuers themselves. So rather than a focus on single QHPs, MPCA supports an Exchange that leads to greater choice, comparison and availability of consumer engagement tools.

Exchange Funding

Any assessments or fees imposed on health carriers for the purposes of supporting the functions of the Exchange should be levied across all health carriers, not just those with QHPs within the Exchange. To only assess QHPs within the Exchange would impose an additional cost of business for those operating within the Exchange. Greater expenses translate to higher premiums which could contribute to adverse selection within the Exchange overall, eventually leading to a death spiral as individuals and small groups peel out of the Exchange for benefit plans outside the construct of the Exchange. For the Exchange to work as the promoter of transparency and facilitator of competition, the same fees and assessments must be found both within and outside of the Exchange.

Basic Health Plan

MPCA supports the creation of a Basic Health Plan as vital to achieving optimal coverage levels in Maine, engaging low-income consumers in health insurance, and providing the State of Maine with greater federal financial resources. The Basic Health Plan is essential for the engagement of individuals and families with incomes between 138% and 200% FPL. Moreover, this is a winner for the State of Maine financially as well. As pointed out by the Advisory Committee: "The federal funding for the basic health program may be more advantageous to the State than covering higher-income individuals in Medicaid or having them cycle in and out of Medicaid."

Thank you for the opportunity to comment on the recommendations of the Advisory Committee on Maine's Health Insurance Exchange on the formation of the Maine Health Benefit Exchange.

Attachment: Expected Shifts in Coverage Sources under PPACA as forecasted prior to the passage of PL 90
 Source: Ingenix Consulting

Maine State Totals		Transitions in Coverage under PPACA								
Base Case Coverage	Total	Exchange Employer	Exchange subsidy	Exchange no subsidy	Private Employer	Private Non-Group	Private Retiree	Champus	Medicare	Dual Elig
Employer	644,136	23,158	24,315	10,158	570,962	271	-	-	-	-
Non-Group	72,062	1,458	17,699	843	10,663	36,780	-	-	-	-
Retiree	17,782	-	-	-	-	-	16,382	-	-	-
CHAMPUS	25,963	-	-	-	-	-	-	25,963	-	-
Medicare	195,721	-	-	-	-	-	-	-	195,721	-
Dual Elig	80,522	-	-	-	-	-	-	-	-	80,522
Medicaid/ CHIP	211,578	2,048	13,950	1,199	5,382	-	-	-	-	-
Uninsured	168,383	8,433	34,825	7,968	27,456	-	-	-	-	-
Total	1,416,147	35,097	90,789	20,168	614,463	37,051	16,382	25,963	195,721	80,522



**Consumers for
AFFORDABLE
Health Care**

*Advocating the right to quality, affordable
health care for every man, woman and child*

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**Statement of Mitchell Stein, Policy Director,
Consumers for Affordable Health Care and Health Care
To the Joint Standing Committee on
Insurance and Financial Services
Public Comment on Exchange Advisory Committee's Report**

Tuesday, November 1, 2011

Senator Whittamore, Representative Richardson, and Members of the Joint Standing Committee on Insurance & Financial Services, my name is Mitchell Stein, and I serve as the Policy Director for Consumers for Affordable Health Care. Our mission is to advocate for the right to quality, affordable health care for every man, woman and child.

I'm here this afternoon to comment on the Exchange Advisory Committee's report. My comments will focus on four areas where we disagree with the report's recommendations. They pertain to the structure, governance, duties and funding of the Exchange. That said there is much in the report that we agree with and would like to compliment the Committee on their hard work and thorough deliberations.

The common thread that will run through these comments is the recognition that at its heart, the Exchange is being created to benefit those who obtain health coverage through it. The Maine people who use the Exchange will have wide-ranging needs. These users will include patients with chronic and life-threatening illnesses, low- and moderate-income individuals, people with mental and physical disabilities and people of all ages and from various racial and ethnic groups.

To see the successful operation of an Exchange for all of these disparate groups it will be necessary for Maine to create a transparent, aggressive Exchange accountable to the people of this state and dedicated to providing them the best health coverage available at a cost they can afford.

With respect to the structure of the Exchange, while the Exchange Advisory Committee recommended the Exchange be housed within the Department of Professional and Financial Regulation, we think the Exchange should be created as an independent public agency. Doing so would ensure that the operations of the Exchange were transparent and removed from the administrative needs of an already large Department.

Furthermore, having the Exchange as an independent agency would allow for the governance of the Exchange to be through an independent Board. Having a Board run the Exchange would remove day-to-day political considerations from factoring in to the Exchange's decisions and ensure that the Exchange was directly accountable to the people of Maine through the Board.

The Exchange should have a governing board that includes consumers, small businesses and insurance experts who don't work for the health care industry. This will ensure that the board will make smart decisions reflecting the interests of those who will be utilizing the exchange and improves both quality and efficiency of the Exchange while avoiding conflicts of interest.

Those who would profit from enrollment should not govern the Exchange. Exchange governance should exclude those with conflicts of interest due to a direct financial stake in the health system. This includes organizations and individuals representing hospitals, physicians, insurers, and brokers. While the input of these constituencies will be important and may be obtained through advisory groups they should not have decision making power as members of the board.

With respect to the duties of the Exchange, while the Advisory Committee recommended that the Exchange accept and make available all qualified health plans we believe the Exchange should be more active in selecting health plans. One of the great benefits of creating an Insurance Exchange is that if properly structured it can give small businesses and individuals the power to bargain in the market similar to the way large employers currently operate. By banding together to purchase health insurance through an Exchange it will be possible to leverage their combined buying power in the market.

Allowing the Exchange to negotiate on price, benefits, and quality, and thus to selectively contract with the most appropriate health plans, will further the goal of providing Exchange participants with high quality affordable health plan options.

The Exchange should not be required to accept all eligible insurers without any negotiation or competitive process. Furthermore, the Exchange should have the ability to determine which health plans should be accepted into the Exchange and which fail to meet the standards necessary, so that there is a variety of benefit options and pricing available.

Maine's Exchange board should also work to provide consumers with the best options available by rewarding plans with payment incentives for providing strong benefits (such as coordinated, high quality care), reductions of hospital readmissions and reductions in health care disparities.

With respect to how the Exchange is funded it should be spread among all purchasers of health coverage in the state. If a fee is added on plans sold through the Exchange only, then the same plan sold outside the Exchange would cost less. This would inevitably lead to adverse selection, limiting who utilizes the Exchange to only those who had no other option. A robust healthy Exchange is in all of our interest – in order to accomplish this it will be necessary to avoid adverse selection.

In conclusion we would like to make one more suggestion that might be more acceptable to all the members of this committee than some of our more controversial comments. As mentioned in our comments regarding funding, it will be important to avoid adverse selection with respect to those utilizing the Exchange and those purchasing coverage outside the Exchange. We would respectfully suggest that any legislation furthering the creation of an Exchange include a provision for studying this issue and how it could best be avoided. At least three Exchange bills (MD, CT and DC) include such a provision.

A strong Maine based Exchange is good for Maine businesses, good for Maine consumers and therefore good for Maine overall. We hope the committee will bear these comments in mind as you continue to work on creating Maine's Exchange. Thank you for the opportunity to speak to you today. I'm happy to try and answer any questions the committee might have.

