TASK FORCE ON HEALTH CARE COVERAGE FOR ALL OF MAINE

Meeting Agenda
January 22, 2018
9:30 am to 4:00 pm
Room 220, Cross State Office Building

- ❖ Welcome and Introduction of Chairs and Members
- ❖ Summary of Dec. 20 meeting
- ❖ What is Coverage?
  - ❑ Current levels of coverage
    - ➢ Private Health Insurance Coverage—written information provided by the Bureau of Insurance
    - ➢ Coverage through MaineCare—written information provided by the Department of Health and Human Services
    - ➢ Coverage through Multiple Employer Welfare Associations *Tom Brown, Maine Automobile Dealers Association; Jamie Py, Maine Energy Marketers Association*
    - ➢ Coverage for Uninsured/Underinsured *Rebecca Sperrey and Carol King, Eastern Maine Health System*
  - ❑ Economic impact of coverage/costs
    - ➢ *Garrett Martin and James Myall, Maine Center for Economic Policy*
    - ➢ *Jacob Posik, Maine Heritage Policy Center*
    - ➢ *Steve Butterfield, Consumers for Affordable Health Care*
  - ❑ Task Force Discussion—What should "coverage" be?

Lunch break

- ❖ Public Comment *(limited to 3 minutes per person)*

Task Force on Health Care Coverage for All of Maine

Overview of Materials Received from the Bureau of Insurance

- Chart of Health Coverage in Maine through 2016 *(blue)*
- Summary of 2018 Essential Health Benefits Required to Be Covered by Health Plans and List of Benefits Typically Excluded *(yellow)*
- Information Relating to Deductibles and Out-of-Pocket Costs for Current Health Plans *(gold)*
- Examples of Current Premiums for Individual Health Plans, including Advanced Premium Tax Credit *(green)*
- Information Relating to 2017 Market Share for Individual, Small Group and Large Group Health Insurers *(white)*

January 22, 2018

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Ricker Hamilton, Commissioner

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TO: Members, Task Force on Health Care Coverage for All of Maine

FROM: Ricker Hamilton, Commissioner

DATE: January 22, 2018

SUBJECT: Response to Request for Information

On January 18, the Task Force on Health Care Coverage for All of Maine requested information regarding the following:

1. *Demographics for the number of Maine residents currently covered under the MaineCare program, in total and with a breakdown by category of eligibility;*
2. *A summary of current benefits and coverage provided under MaineCare for each category of eligibility; and*
3. *A summary of out-of-pocket costs (premiums, copayments and other cost sharing requirements) required for MaineCare members.*

Please see the information you requested below.

1. **Enrollment**

Our latest caseload report (for Nov 2017) shows 264,664 enrolled members, with the following breakdown:

1. Parents of a Child Under Age 21 with Income <=100% FPL	36167
2. Individuals with a disabling condition (includes Katie Beckett)	54035
3. Individuals 65 or Older	24140
4. Transitional Medicaid	4839
5. Foster Care & Adoption Assistance	4888
6. Pregnant Women	3038
7. Temporary Medicaid	11
8. Aged, State Supplemental Only	297

9. HIV Waiver	445
10. Prisons (Emergency and Inpatient Only)	178
11. Aliens (Emergency Only)	1234
12. Spenddown	208
13. Breast and cervical	170
14. Limited Family Planning	2317
15. Age 21-26 Parents Insurance	119
16. Waivers*	62
17. CHIP – Medicaid Expansion	6736
18. CHIP – Cub Care	4541
19. MSP and DEL	33540
20. Age 18 and Under	82399
21 Age 19 and 20	5300

*The majority of HCBS waiver members are eligible under the disabling condition category.

2. **Benefits**

A. The following categories are eligible for full MaineCare benefits:

1. Parents of a Child Under Age 21 with Income <=100% FPL
2. Individuals with a disabling condition (includes Katie Beckett)
3. Individuals 65 or Older
4. Transitional Medicaid
5. Foster Care & Adoption Assistance
6. Pregnant Women
7. Temporary Medicaid
8. Breast and cervical
9. Age 21-26 Parents Insurance

10. CHIP- Medicaid Expansion

11. CHIP- Cub Care

12. Age 18 and Under

13. Age 19 and 20

14. Waivers

15. Spenddown (after spenddown is met)

16. Breast and Cervical

Full benefits include: Physician Services, Clinic Services, Hospital, Psychiatric Hospital, Pharmacy, Behavioral Health Services, Substance Abuse Treatment, Dental (age 21 and under only, with the exception of emergency services), Community Support Services, Children's Rehabilitative Services (Age 21 and Under) , Private Non-Medical Institution Services, Nursing Facility Services, Nurse Practitioner Services, Vision Services, Podiatry Services, Chiropractic Services, Imaging, Durable Medical Equipment, Developmental Clinic Services (age 21 and Under), Rehabilitation Services, ICF/IID Services, Physical Therapy, Occupational Therapy, Speech and Language Therapy, Targeted Case Management, Health Homes services, Consumer Directed Personal Care, Private Duty Nursing, Personal Support Services, Home Health, Day health Services, Adult Family Care Homes, Non Emergency Transportation, Ambulance Services, School Based Services (age 21 and under only), Hospice, Ambulatory Care Clinics, Dialysis Services, Laboratory Services, Family Planning Services, Telehealth Services, and Home and Community Based Waiver Services.

Most benefits have additional restrictions (for example based on age or diagnosis) and all services must be medically necessary.

B. The HIV Benefit is a Limited benefit and includes the following services: Physician Services, Targeted Case Management, Hospital, Psychiatric Hospital, Pharmacy, Community Support Services, Health Homes Services, Laboratory Services, Imagining, Non emergency Transportation, Ambulance Services, Ambulatory Care Clinics, Behavioral Health Services, Family Planning Services, Clinic Services, Nurse Practitioner Services, Children's Rehabilitative Services (Age 21 and Under), Developmental Clinic Services (age 21 and Under), Physical Therapy, Occupational Therapy, and Substance Abuse Treatment.

C. Prisoners are eligible only for Emergency and Hospital (Inpatient) services.

D. Aliens are eligible only for Emergency services.

E. Members enrolled in the Limited Family Planning Benefit are eligible only for Family Planning and related services.

F. Maine Low Cost Drugs for the Elderly or Disabled (DEL) covers a percentage of the cost of certain prescription drugs.

G. Aged State supplemental only members receive assistance paying Medicare premiums, but are not eligible for MaineCare benefits.

3. Cost Sharing

A. Co-payments: Copayments are based on the cost of a service to MaineCare, and are assessed as follows.

MaineCare Payment	Member Payment
$10 or less	$0.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50 or more	$3.00

Members eligible under the HIV Waiver are submit to the following co-payments:

Drugs: $10 for 30 day supply

Physician Visits: $10

Ambulance Services, Outpatient Hospital Services, Inpatient Hospital Services, FQHC Services, RHC Services: $3

Physical Therapy, Occupational Therapy, Psychologist Services, Mental Health Clinic Services, Substance Abuse Services: $2

The following services/members are exempt from copayments

a. Family Planning services and supplies.
b. Services furnished to members under twenty-one (21) years of age.
c. Services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, nursing facility, ICF/IID, or other medical institution, or a resident of a private non-medical institution, if that individual is determined by the Department to be responsible, as a condition of receiving services in that institution, to have an "assessment" or a "cost of care."
d. Services and drugs furnished to pregnant women, including services and drugs provided during the three months following the end of a pregnancy.
e. Services received under the Limited Family Planning Benefit.
f. Members in State custody.

g. Services provided in Indian Health Service Centers and services for Native American members who are eligible to receive services funded by Contract Health Services.

h. Members under State guardianship.

i. Members receiving Hospice Services.

j. Emergency Services.

k. Tobacco cessation services and products.

B. Premiums. Certain members, including members eligible under the Katie Beckett benefit (which allows children whose medical conditions meet institutional level of care but who otherwise would be financially ineligible for MaineCare), members eligible under CHIP, and members eligible under the HIV waiver with incomes over 150% FPL must pay premiums for services. These premiums are determined by the individual program limits and by the member's financial status.

Maine Bureau of Insurance

2018 BENCHMARK ESSENTIAL HEALTH BENEFITS CHART

Please note: All benefits must be listed in the policy/certificate and schedule of benefits.

Confirm compliance and IDENTIFY the specific LOCATION (page number, section, paragraph, etc.) of the BENEFIT in the last column.

(Revised 1/19/2018)

REQUIRED BENEFIT	DESCRIPTION OF BENEFIT	CONFIRM COMPLIANCE AND IDENTIFY SPECIFIC LOCATION OF BENEFIT IN FILING
Allergy Testing and Injections	Provide benefits for allergy testing and injections.	
Ambulance Services	Provide benefits for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. The carrier may specify circumstances for which this service is covered.	
Ambulatory Surgery Centers	Provide benefits for certain covered services provided by ambulatory surgery centers.	
Anesthesia Services	Provide benefits for anesthesia only if administered while a Covered Service is being provided, except as outlined in the 'Dental Procedures' provision.	
Autism Spectrum Disorders	Provide coverage for members for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders is covered when it is determined by a licensed physician or licensed psychologist that the treatment is Medically Necessary Health Care, as defined in the Certificate of Coverage. The carrier may specify that a licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually. **The policy or contract may limit coverage for applied behavior analysis to the actuarial equivalent of at least $36,000 worth of visits/services per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.** **Coverage for prescription drugs for the treatment of autism**	

	spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition.	
Blood Transfusions	Provide benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.	
Chemotherapy Services	Provide benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by the carrier for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by the carrier for medically accepted indications or as required by law.	
Chiropractic Care/ Manipulative Therapy	Provide benefits for chiropractic care and manipulative therapy for treating acute musculo-skeletal disorders. No benefits are provided for ancillary treatment such as massage therapy, heat, and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for Maintenance Therapy for chronic conditions. **Must provide at least 40 visits per year.**	
Clinical Trials	Benefits include coverage for services given to the member as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.	
Contraceptives/Family Planning	Provide benefits for family planning and prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis.	
Dental Procedures	Provide benefits for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the Member is classified as vulnerable.	
Dental Services	Provide benefits only for the following: Setting a jaw fracture, removing a tumor (but not a root cyst), removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting, treatment within six	

	months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later, repairing or replacing dental prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later.	
Diabetic Services	Provide benefits for diabetes medication, equipment, and supplies which are medically appropriate and necessary. Benefits are limited to: insulin, insulin pumps, oral hypoglycemic agents, glucose monitors, test strips, syringes, lancets, and Outpatient self-management and educational services used to treat diabetes if services are provided through a program that is authorized by the Maine Diabetes Prevention and Control Program within the Center for Disease Control and Prevention.	
Diagnostic Services	Provide benefits for Diagnostic Services, including diagnostic laboratory tests and x-rays, when they are ordered by a provider to diagnose specific signs or symptoms of an illness or injury or when the services are part of well-baby or well-adult care stated as covered under this contract.	
Durable Medical Equipment and Prostheses	Provide benefits for the rental or purchase of the least expensive Durable Medical Equipment necessary to meet your medical needs. If the member rents the equipment, the carrier will make monthly payments only until it's share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first. Benefits for replacement or repair of purchased Durable Medical Equipment are subject to the carrier's approval. The carrier does not provide benefits for the repair or replacement of rented equipment. Supplies are covered if they are necessary for the proper functioning of the Durable Medical Equipment. If more than one treatment, prosthetic device, or piece of Durable Medical Equipment may be provided for the disease or injury, benefits will be based on the least expensive method of treatment, device, or equipment that can meet the members need.	
Prostheses	Provide benefits for Prostheses, including artificial limbs and prosthetic appliances.	
Early Intervention Services	Provide benefits for early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay. The carrier may specify that a referral from the child's primary care provider is required. **The policy or contract may limit coverage to the actuarial equivalent**	

	of at least $3,200 worth of visits/services per year for each child not to exceed the actuarial equivalent of $9,600 worth of visits/services by the child's 3rd birthday.	
Emergency Room Care	Provide benefits for emergency room treatment received for medical emergencies.	
Foot Care	Provide benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered.	
Freestanding Imaging Centers	Provide benefits for Diagnostic Services performed by Freestanding Imaging Centers. Carrier may specify that all services must be ordered by a Provider.	
Hearing Care	Provide benefits for wearable hearing aids for covered Members up to age 18. Coverage is limited to one hearing aid for each hearing-impaired ear every 36 months. The carrier may specify that related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing. **The policy or contract may limit coverage to the actuarial equivalent of at least $1,400 per hearing aid for each hearing-impaired ear every 36 months.**	
Home Health Care Services	Provide benefits for home health care services when services are performed and billed by a home health care agency. The carrier may specify that a home health care agency must submit a written plan of care, and then provide the services as approved by the carrier. **Must provide unlimited visits pursuant to benchmark plan.**	
Hospice Care Services	Provide benefits for Hospice Care services furnished by a Home Health Agency to a Member who is terminally ill and the Member's family. A Member who is terminally ill means a person who has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course. Provide benefits for Hospice Care services by a Home Health Agency up to 24 hours during each day of care. The carrier may specify that Hospice Care services are provided according to a written care delivery plan developed by a Hospice Care Provider and the recipient of Hospice Care	

	services. Prior approval may be required. Coverage for Hospice Care services is provided in either a home or Inpatient setting. Hospice Care services include, but are not limited to: Physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and Durable Medical Equipment, occupational, physical or speech therapies, home health care services, bereavement services, and volunteer services.	
Hospice Respite Care	Provide benefits for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member or other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide Hospice Care. The carrier may specify that before the patient receives respite care at home, a Home Health Agency must submit a plan of care for approval.	
Inpatient Hospice Services	Provide benefits for Inpatient Hospice Care at an acute care Hospital or Skilled Nursing Facility. The same services are covered for Inpatient Hospice Care as are covered under the 'Inpatient Hospital Services' provision.	
Inborn Errors of Metabolism	Provide benefits for metabolic formula and special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by Inborn Error(s) of Metabolism. This benefit is limited to those Members with diseases caused by Inborn Error(s) of Metabolism. **Must provide coverage for metabolic formula and up to the actuarial equivalent of at least $3,000 worth of prescribed modified low-protein products per year.**	
Independent Laboratories	Provide benefits for Diagnostic Services performed by independent laboratories. The carrier may specify that all services must be ordered by a Provider.	
Infant Formula	Provide benefits for amino acid-based elemental infant formula for children 2 years of age and under. The carrier may specify that benefits are provided when a provider has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial	

	infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. The carrier may specify that a provider may be required to confirm and document ongoing medical necessity at least annually. Benefits for amino acid-based elemental infant formula will be provided without regard to the method of delivery of the formula. Benefits are provided when a covered Provider has diagnosed and through medical evaluation has documented one of the following conditions: symptomatic allergic colitis or proctitis; laboratory – or biopsy-proven allergic or eosinophilic gastroenteritis; a history of anaphylaxis; gastroesophageal reflux disease that is nonresponsive to standard medical therapies; severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; cystic fibrosis; or malabsorption of cow milk-based or soy milk-based infant formula.	
Infusion Therapy	Provide benefits for infusion therapy when services are provided by a licensed Provider, facility, ambulatory infusion center, or home infusion therapy provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered.	
Inhalation Therapy	Provide benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.	
Inpatient Hospital Services	Provide benefits for the following Inpatient Hospital services: room and board, including general nursing care, special duty nursing, and special diets, in a semiprivate room or a private room when medically necessary or when the facility offers only private rooms; use of intensive care or coronary care unit; diagnostic services; medical, surgical, and central supplies; treatment services; hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy, and radiotherapy services; Phase I Cardiac Rehabilitation; medication used when the member is an inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational	

	New Drugs are not covered unless approved by the carrier for medically accepted indications or as required by law; blood and blood derivatives; prostheses or orthotic devices; newborn care, including routine well-baby care.	
Massage Therapy	Provide benefits for massage therapy when services are part of an active course of treatment and the services are performed by a covered provider. A massage therapist is not a covered provider.	
Medical Care	Provide benefits for medical care and services including office visits and consultations, Hospital and Skilled Nursing Facility visits, and pediatric services.	
Medical Supplies	Provide benefits for medical supplies furnished by a Provider in the course of delivering medically necessary services. The carrier may specify that this benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are medically necessary for injecting insulin or a drug prescribed by a Physician.	
Mental Health and Substance Abuse Services	Provide benefits for only the following Mental Health and Substance Abuse services when they are for the active treatment of Mental Health and Substance Abuse disorders. The carrier may specify that these services must be part of an established plan of treatment and must be performed and independently billed by a Provider acting within the scope of his or her license. Benefits for Inpatient, Outpatient, and day treatment services for Mental Health and Substance Abuse are provided when the member receive them from a Provider. Covered Services include the following: **Inpatient Services** in a Hospital or any Facility that the carrier must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification. **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs. **Residential Treatment,** specialized 24-hour treatment in a licensed Residential Treatment Center, offering individualized and intensive treatment including: observation and assessment by a psychiatrist weekly or more often, rehabilitation, therapy, and education.	
Morbid Obesity	Provide limited benefits for treatment of Morbid Obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years.	

	The carrier may specify that benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty.	
Nutritional Counseling	Provide benefits for nutritional counseling when required for a diagnosed medical condition.	
Obstetrical Services and Newborn Care	Provide benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy.	
Office Visits	Provide benefits for office visits. Office visits include visits to a retail health clinic. Services at a retail health clinic are limited to basic health care services to Members on a 'walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by physician's assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.	
Online Visits	When available in the member's area, coverage will include online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. Non Covered Services include, but are not limited to, communications used for: reporting normal lab or other test results, office appointment requests, billing, insurance coverage or payment questions, requests for referrals to doctors outside the online care panel, benefit precertification, physician to physician consultation Please refer to the "Telemedicine" provisions for additional or different services available.	
Organ and Tissue Transplants	Provide benefits for organ and tissue transplant procedures listed below. The carrier may specify that the member must receive prior approval before he/she is admitted for any transplant procedure. Transplants include: heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.	
Human leukocyte antigen testing/Cost of testing for bone marrow donation suitability	Provide coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements: A. The Member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;	

	B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a; C. At the time of the testing, the Member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found. This benefit is limited to one test per lifetime.	
Orthotic Devices	Provide benefits for certain Orthotic Devices, such as orthopedic braces, back or surgical corsets, and splints. The carrier may specify that they do not provide benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.	
Outpatient Services	Provide benefits for the following Hospital Outpatient and Rural Health Center services: Emergency room services/emergency care; removal of sutures; application or removal of a cast; diagnostic services; surgical services; removal of impacted or unerupted teeth; endoscopic procedures; blood administration; radiation therapy; outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. The carrier may specify that benefits for these services have special requirements. **Must provide at least 20 visits per year for physical and occupational therapy combined and 20 for speech therapy.** **Must provide at least 36 visits per cardiac episode.**	
Parenteral and Enteral Therapy	Provide benefits for parenteral and enteral therapy, including supplies and equipment needed to appropriately administer parenteral and enteral therapy. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with	

	enteral therapy.	
Physical and Occupational Therapy	Provide benefits for short-term physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement. Carrier may specify that services are covered only when provided by a licensed Provider acting within the scope of his/her license. Carrier may specify that no benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment. **Must provide at least 20 visits per year for physical and occupational therapy combined.**	
Prescription Drugs	Provide benefits under the member's prescription drug card program for FDA approved prescription drugs and medicines bought for use outside a Hospital.	
Preventive and Well-Care Services	Provide benefits for preventive care services that meet the requirements of Federal and State law, including certain screenings, immunizations and physician visits.	
Radiation Therapy	Provide benefits for Radiation Therapy.	
Reconstructive Surgeries, Procedures and Services	Provide benefits for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. The carrier may specify that reconstructive surgeries, procedures and services must be: 1. necessary due to accidental injury; or 2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or 3. Medically Necessary Health Care to restore or improve a bodily function, or 4. necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. (Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate) or 5. reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance.	
Skilled Nursing Facility Services	Provide benefits for Inpatient Skilled Nursing Facility services. **Must provide at least 150 days per year.**	
Smoking Cessation	Provide benefits for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking	

	cessation. NRT products can include but are not limited to: nicotine patches, gum, or nasal spray. The carrier may specify that these products and medications must be prescribed by the member's Physician. Provide benefits for follow-up smoking cessation education and counseling. Provide benefits for completing an approved smoking cessation program.	
Speech Therapy	Provide benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement. Carrier may specify that services are covered only when provided by a licensed Provider acting within the scope of his/her license. **Must provide at least 20 visits per year for speech therapy.**	
Surgical Services	Provide benefits for surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care.	
Telemedicine	Provide benefits for telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a covered health care Provider. Coverage for health care services provided through telemedicine will be determined in a manner consistent with coverage for health care services provided through in-person consultation.	

Maine Bureau of Insurance January 19, 2018

Possible Excluded Benefits:

Some coverage is limited or covered at a higher cost share. Some laboratory tests may not be considered preventive and will require meeting a deductible or coinsurance.

Some benefits are excluded can be purchased with additional coverage such as Dental and Vision.

Typically Excluded

1. Infertility Treatments
2. Cosmetic Surgery
3. Acupuncture
4. Adult Hearing Aids
5. TMJ
6. Holistic or alternative treatments

(13)

2018 Available Health Plans in Maine: Deductibles and Out-Of-Pocket Maximums*

Type of Health Plan	Annual Deductible	Annual Out-Of-Pocket Maximums
Individual	$1000 to $7350	$6000 to $7350
Small Group	$0 to $6300	$1500 to $7350

This reflects the cost for a single person; the annual out-of-pocket maximum for family coverage is $14,700.

*Information provided by the Bureau of Insurance {email from Marti Hooper, January 19, 2018}

MAINERS WITH HEALTH COVERAGE (Source U.S. Census Bureau) (Total Population including over 65 years old)									
	2008	2009	2010	2011	2012	2013	2014	2015	2016
All People (Numbers in Thousands)	1,299	1,301	1,313	1,314	1,316	1,314	1,316	1,315	1,317
Not Covered	10.4%	10.5%	10.1%	10.7%	10.2%	11.2%	10.1%	8.4%	8%
Covered by Private or Gov. Health Insurance	89.6%	89.5%	89.9%	89.3%	89.8%	88.8%	89.9%	91.6%	92%
Employment-based	57.6%	55.8%	55.0%	54.3%	53.6%	53.1%	53.0%	53.4%	54.7%
Direct Purchase	15.3%	13.5%	12.7%	12.4%	13.3%	11.9%	13.5%	15.5%	16.3%
TRICARE	3.1%	3.1%	3.2%	3.2%	3.0%	3.4%	3.3%	3.2%	3.4%
Medicaid	21.2%	21.7%	22.9%	23.0%	23.6%	22.5%	20.9%	20.1%	19.2%
Medicare	17.8%	18.1%	18.5%	18.9%	19.9%	20.5%	21.1%	21.9%	22.1%
VA Care	3.2%	3.2%	3.3%	3.5%	3.3%	3.4%	3.6%	3.4%	3.1%

There is overlap when individuals are enrolled in more than one type of coverage.
Source: "Table HIC-4_ACS. Health Insurance Coverage Status and Type of Coverage by State All People: 2008 to 2015"
Located: http://www.census.gov/library/publications/2016/demo/p60-257.html,
https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html.
Accessed on: 10/23/17.

Commercially insured reported covered lives by carriers as of 12/31/2016 346,167 (Large group 204,069 + small group 63,626 + individual 81,472). Large group may be under reported because carriers with less than $5 million in premium do not report the number of members covered.
http://www.maine.gov/pfr/insurance/publications_reports/yearly_reports/rule945/pdf/Rule945_Report_Charts_Graphs.pdf.

Data comes from the market snapshots posted to the Bureau website. 2013-2014 are year-end and then we changed to 1st quarter reporting to capture the open enrollment for ACA. 2017 individual enrollment did go down through the year.

Market	2013	2014	% change	2015	% change	2016	% change	2017	% change
Individual	32,049	61,541	92%	84,175	37%	87,767	4%	85,300	-3%
Sm Group	87,396	75,708	-13%	73,943	-2%	70,555	-5%	65,455	-7%

2018 Individual Health Plan Premiums after APTC Subsidies

Based on Income Level by Age and Geographic Area | Maine Bureau of Insurance | 8/29/2017

	Premium cap	2.01%		4.03%		6.34%		8.10%		9.56%		100%	
	Actuarial Value	94%		87%		73%							
	Income	$ 12,060		$ 18,090		$ 24,120		$ 30,150		$ 36,180		$ 48,240	
	FPL	100%		150%		200%		250%		300%		400%	
	Full Premium	APTC	Premium After APTC	APTC	Premium After APTC	APTC	Premium After APTC	APTC	Premium After APTC	APTC	Premium After APTC	APTC	Premium After APTC
Area 1													
35 yr old	$ 370.24	$ 350.04		$ 309.49		$ 242.81		$ 166.73		$ 82.01		$ -	$ 370.24
45 yr old	$ 437.50	$ 417.30	$ 20.20	$ 376.75	$ 60.75	$ 310.07	$ 127.43	$ 233.99	$ 203.51	$ 149.27	$ 288.23	$ -	$ 437.50
55 yr old	$ 675.65	$ 655.44		$ 614.89		$ 548.21		$ 472.13		$ 387.41		$ -	$ 675.65
Area 2													
35 yr old	$ 392.67	$ 372.46		$ 331.91		$ 265.23		$ 189.15		$ 104.43		$ -	$ 392.67
45 yr old	$ 464.00	$ 443.80	$ 20.20	$ 403.25	$ 60.75	$ 336.57	$ 127.43	$ 260.49	$ 203.51	$ 175.77	$ 288.23	$ -	$ 464.00
55 yr old	$ 716.57	$ 696.37		$ 655.81		$ 589.13		$ 513.05		$ 428.33		$ -	$ 716.57
Area 3													
35 yr old	$ 433.96	$ 413.76		$ 373.20		$ 306.52		$ 230.44		$ 145.72		$ -	$ 433.96
45 yr old	$ 512.79	$ 492.59	$ 20.20	$ 452.04	$ 60.75	$ 385.36	$ 127.43	$ 309.28	$ 203.51	$ 224.56	$ 288.23	$ -	$ 512.79
55 yr old	$ 791.92	$ 771.72		$ 731.17		$ 664.48		$ 588.41		$ 503.68		$ -	$ 791.92
Area 4													
35 yr old	$ 556.78	$ 536.58		$ 496.03		$ 429.35		$ 353.27		$ 268.55		$ -	$ 556.78
45 yr old	$ 657.93	$ 637.73	$ 20.20	$ 597.18	$ 60.75	$ 530.50	$ 127.43	$ 454.42	$ 203.51	$ 369.70	$ 288.23	$ -	$ 657.93
55 yr old	$ 1,016.05	$ 995.85		$ 955.30		$ 888.62		$ 812.54		$ 727.82		$ -	$ 1,016.05

2017 Financial Results for Health Insurance Companies in Maine

This publication contains summaries of the information that insurers must provide annually to the Bureau of Insurance. Information is displayed for each market segment of the fully insured market (i.e., for policies under the State's jurisdiction):

- Large group (employers with more than 50 employees)
- Small group (employers with 50 or fewer employees)
- Individual (those who buy their own health insurance)

The summaries below show information for each of Maine's largest health insurers (those companies that had $5 million or more in direct written health insurance premium in Maine for major medical and stop loss combined). The "All Other Companies" category includes aggregate data (except for enrollment and per member per month data) for companies with less than $5 million of premium. The following information is shown:

- The number of people enrolled
- Premiums (how much money was collected)
- Claims (how much money was paid to healthcare providers)
- Administrative Expenses (how much money was spent on administration)
- Underwriting Gain or Loss (how much money was left)

People Enrolled

The number of people enrolled is equivalent to the number of covered lives, including dependents, at the end of the prior calendar year.

Table 1: Enrollees as of December 31, 2016

Insurers	Totals 2016	Totals Change %	Large Group 2016	Large Group Change %	Small Group 2016	Small Group Change %	Individual 2016	Individual Change %
Aetna Health Inc. + Aetna Life Ins Co.	31,538	4%	16,298	-3%	14,640	9%	600	126%
Anthem Health Plans of ME Inc.	170,018	0%	132,426	3%	17,249	-16%	20,343	-3%
CIGNA Health & Life Ins Co.	14,639	23%	14,639	23%	0	0%	0	0%
Harvard Pilgrim Health Care Inc. + HPHC	71,291	8%	36,669	-1%	21,350	-22%	13,272	951%
Maine Community Health Options	58,525	-11%	959	97%	10,309	19%	47,257	-17%
United Healthcare Ins Co.	3,156	36%	3,078	61%	78	-81%	0	0%
Total	**349,167**		**204,069**		**63,626**		**81,472**	

Notes:

1. Only 945 report Long form filers provide covered lives data.

Figure 1. 2016 Percentage of Large Group Enrollees by Company

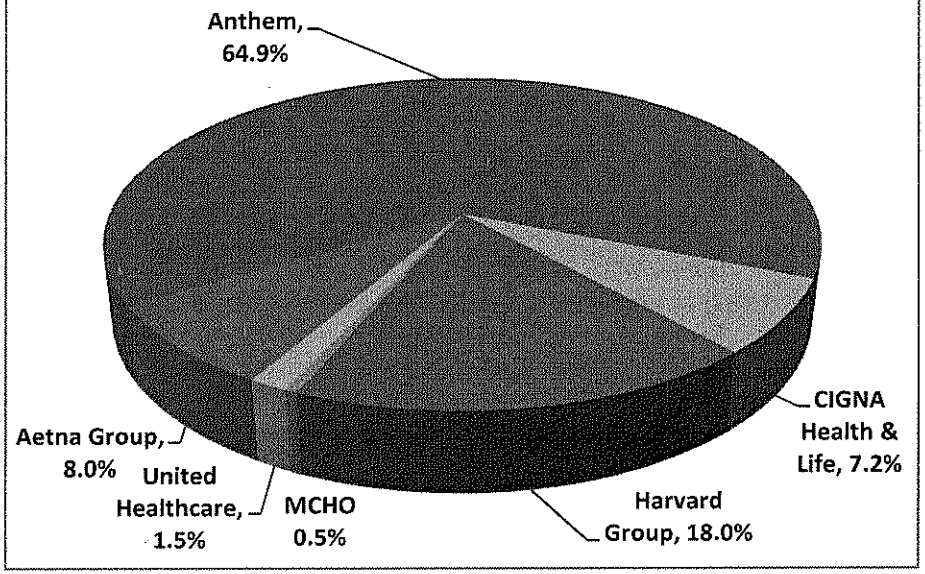


Figure 2. 2016 Percentage of Small Group Enrollees by Company

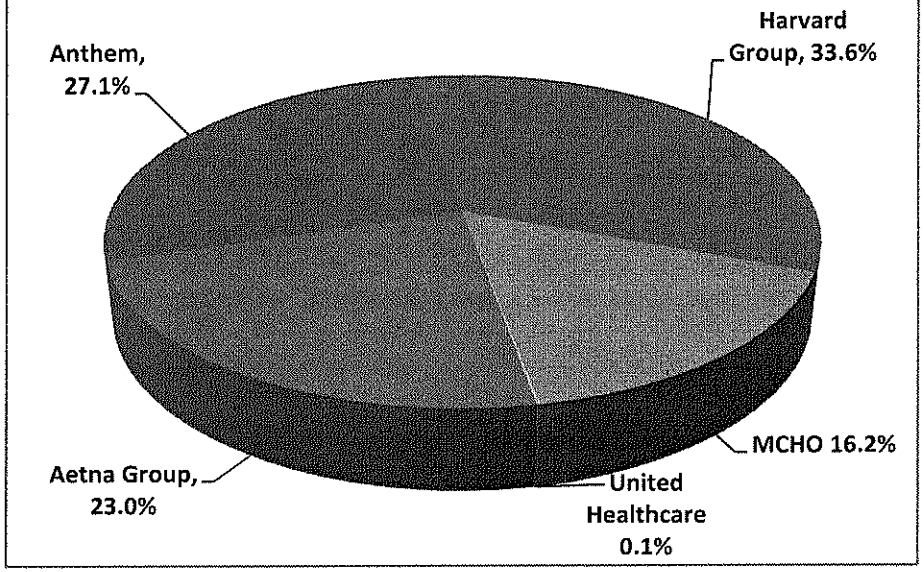


Figure 3. 2016 Percentage of Individual Enrollees by Company

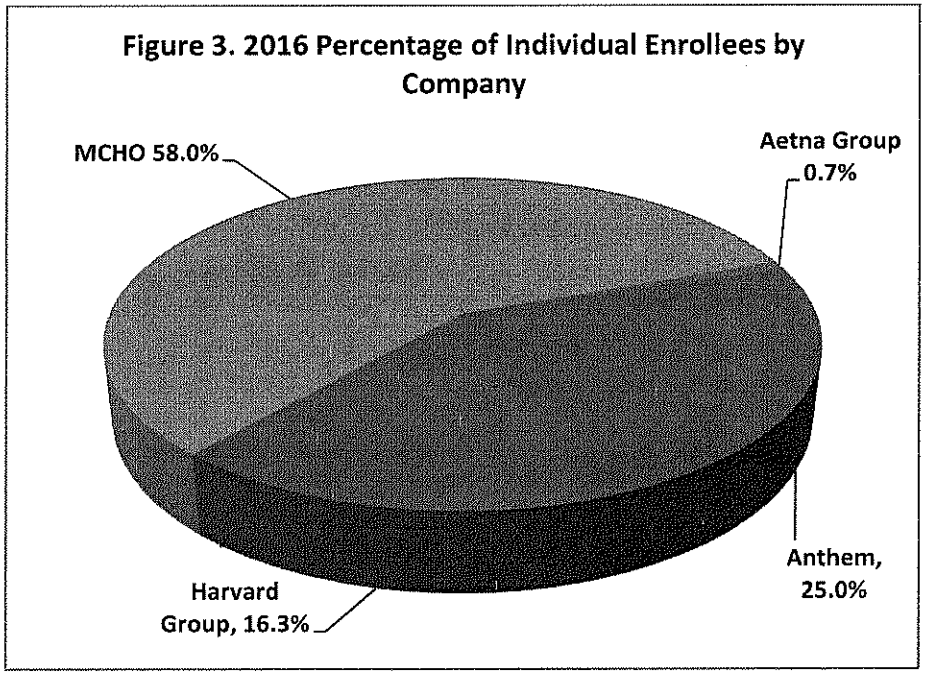
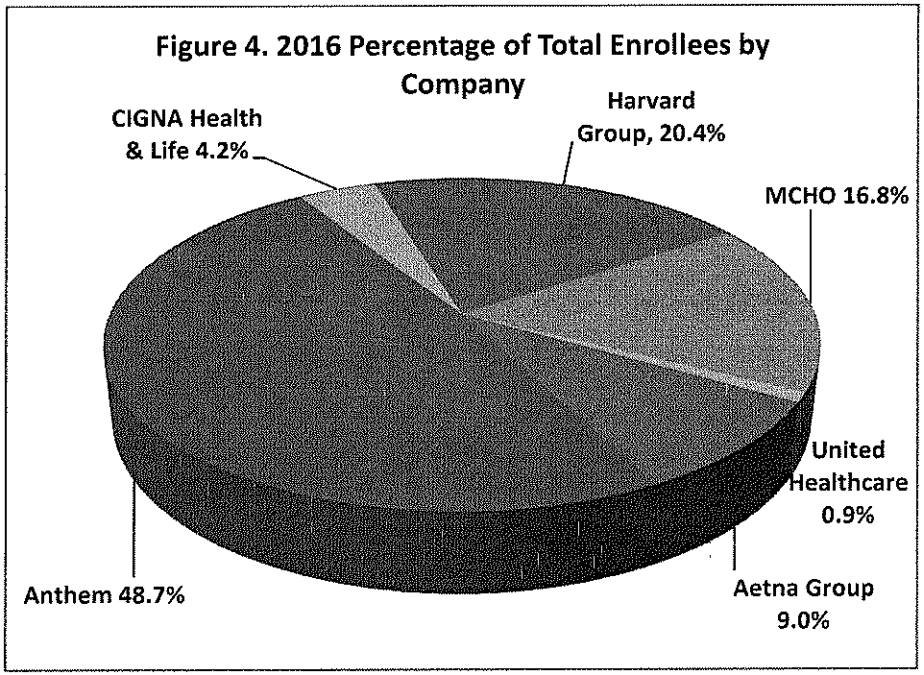


Figure 4. 2016 Percentage of Total Enrollees by Company

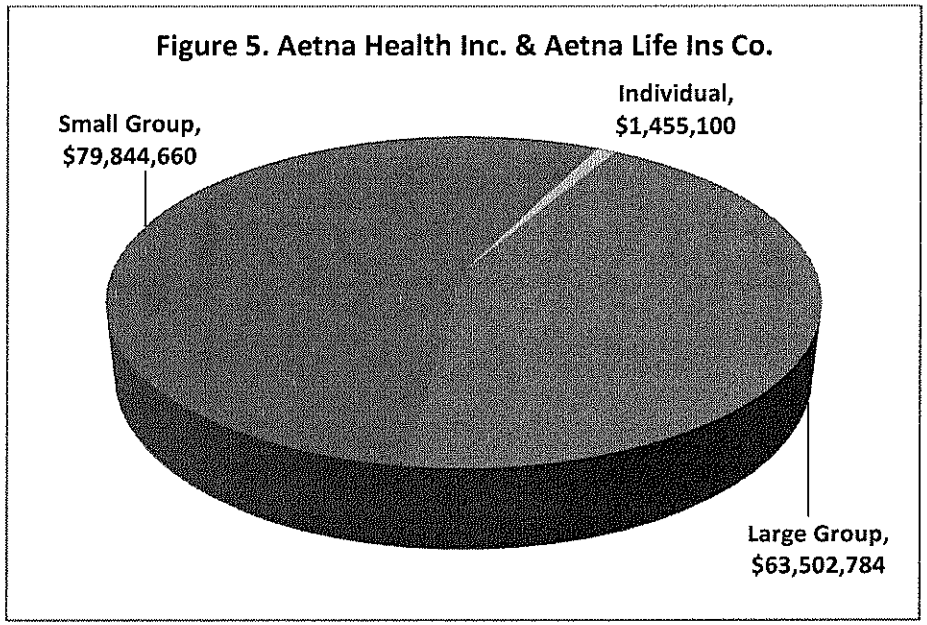


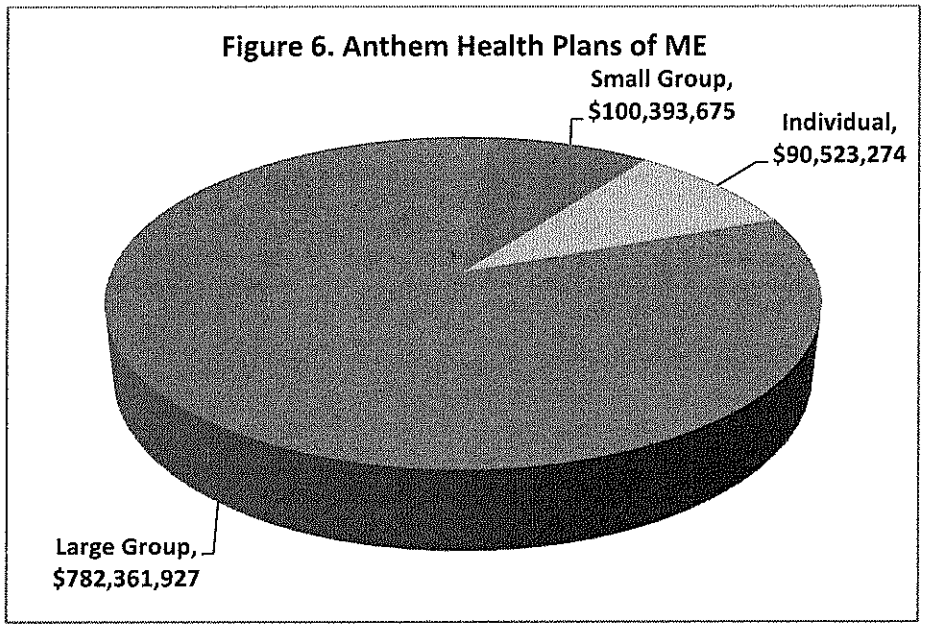
Premiums Earned

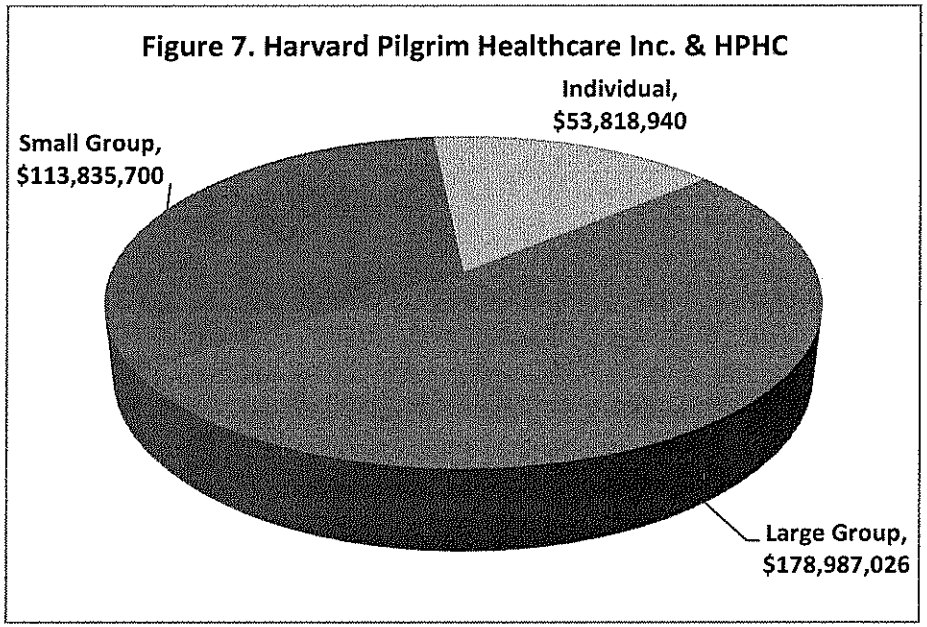
Table 2: 2016 Premiums Earned

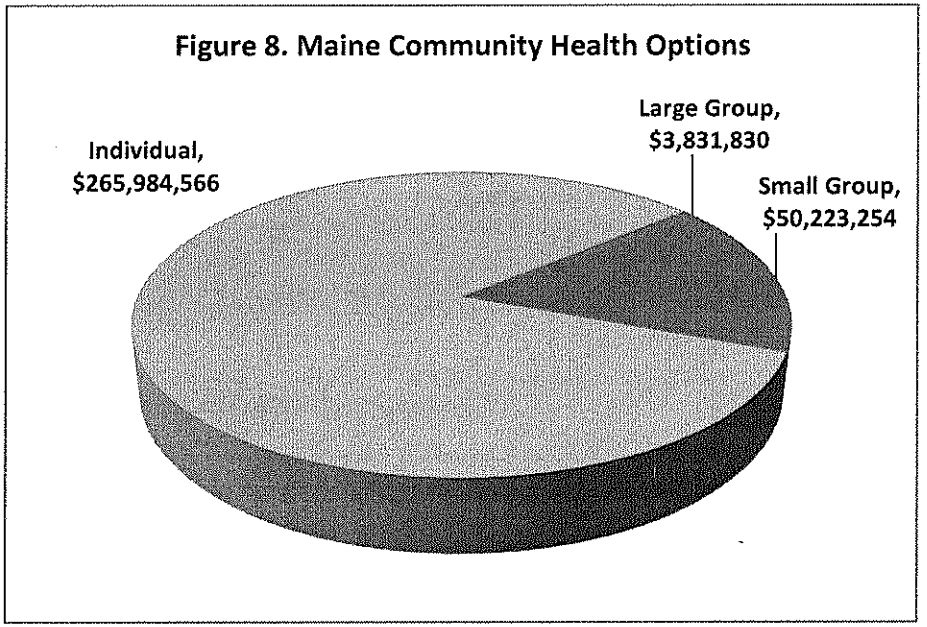
Insurers	Totals 2016	Change %	Large Group 2016	Change %	Small Group 2016	Change %	Individual 2016	Change %
Aetna Health Inc. + Aetna Life Ins Co.	$144,802,544	1%	$63,502,784	-6%	$79,844,660	7%	$1,455,100	90%
Anthem Health Plans of ME Inc.	973,278,876	1%	$782,361,927	5%	$100,393,675	-17%	$90,523,274	-3%
CIGNA Health & Life Ins Co.	63,561,942	2%	$63,561,942	2%	$0		$0	
Harvard Pilgrim Health Care Inc. + HPHC	346,641,666	15%	$178,987,026	6%	$113,835,700	-9%	$53,818,940	597%
Maine Community Health Options	320,039,650	23%	$3,831,830	106%	$50,223,254	349%	$265,984,566	8%
United Healthcare Ins Co.	20,391,317	41%	$19,856,883	69%	$534,434	-80%	$0	0%
All Other Companies	9,481,471		$7,342,801		$6,481		$2,132,189	
Total	**1,878,197,466**		**1,119,445,193**		**344,838,204**		**413,914,069**	

Premiums by Market Segment for Selected Companies









Premium per Member Month

Insurance policies vary widely in terms of deductibles, co-payments, policy limits, and restricted provider networks. Therefore comparing the average premium for different companies may be like comparing apples and oranges. Also, when looking at the percentage change in average premium from year to year, keep in mind that some employers and individuals make changes to their policies to lower their premiums and this may lower the percentage increase from year to year.

Table 3: 2016 Premium per Member Month

Insurers	Large Group 2016	Change %	Small Group 2016	Change %	Individual 2016	Change %
Aetna (Aetna Health Inc. + Aetna Life Ins Co.)	$313	-12%	$501	22%	$197	-32%
Anthem Health Plans of ME Inc.	$504	3%	$436	-5%	$356	-1%
CIGNA Health & Life	$382	-16%				
Harvard Pilgrim Health Care Inc.	$410	12%	$395	6%	$389	-29%
Maine Community Health Options	$374	42%	$391	71%	$409	14%
United Healthcare Ins Co.	$539	5%	$540	5%		
Total	**$472**	**-3%**	**$427**	**7%**	**$394**	**8%**

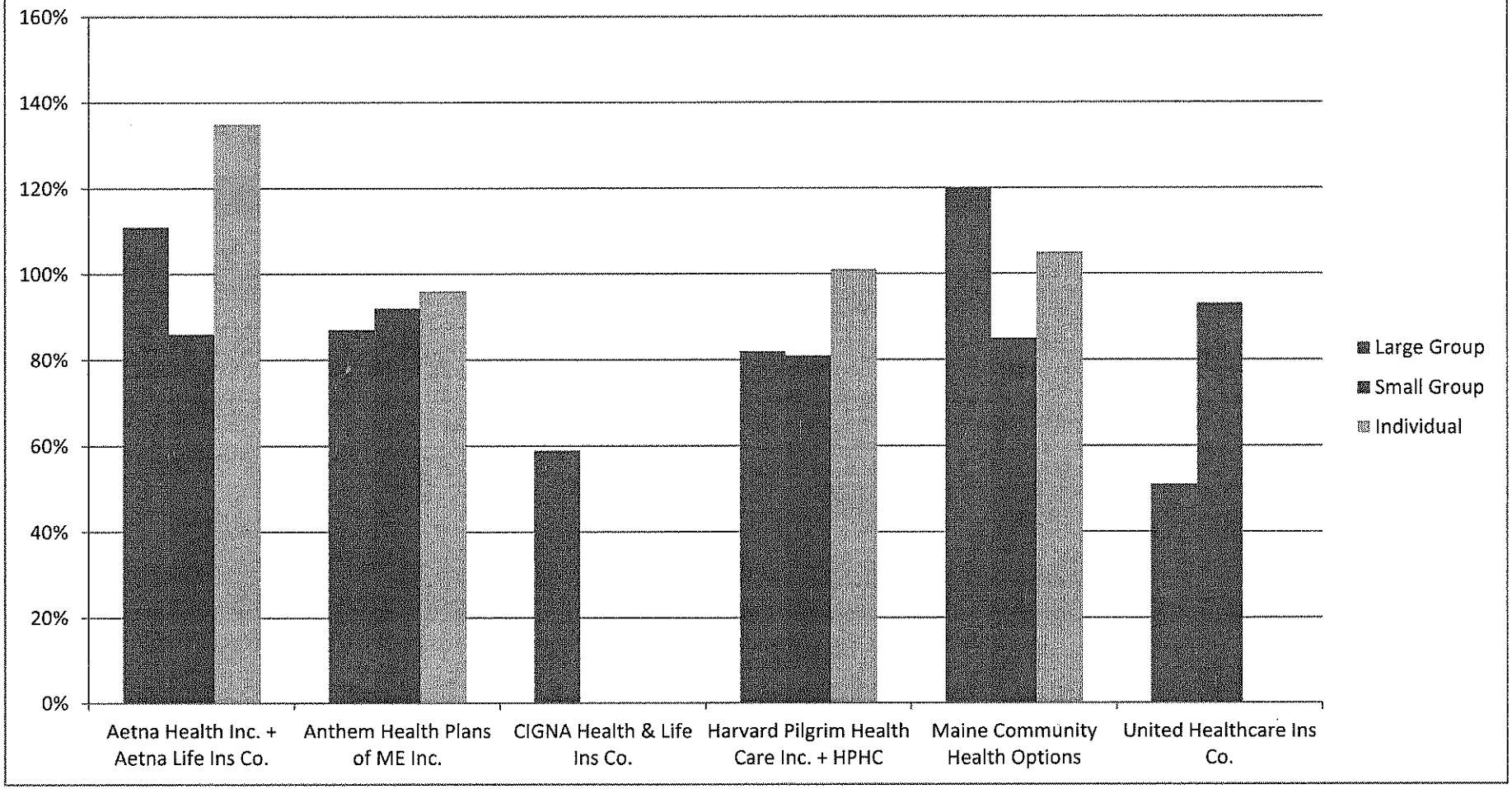
Claims Paid

The total claims paid are the amount of money paid by insurance companies to health care providers and hospitals for medical services received by their members. The table below shows the amount of claims paid by insurance company and how those claims payments compare to the amount of premiums paid to the insurance company. A percentage above 100% means that the company paid more to healthcare providers than they collected in premiums from employers and individuals. On the other hand, a percentage below 100% means that the company paid less to healthcare providers than they collected in premiums. The graph following this table shows the percentage of premiums paid for claims by market segment.

Table 4: 2016 Dollar Amount Spent of Claims and Percentage of Premium

Insurers	Total 2016 Claims	Large Group 2016 Claims	% of Premium	Small Group 2016 Claims	% of Premiums	Individual 2016 Claims	% of Premiums
Aetna Health Inc. + Aetna Life Ins Co.	$141,339,200	$70,423,750	111%	$68,953,145	86%	$1,962,305	135%
Anthem Health Plans of ME Inc.	$857,261,690	$678,255,160	87%	$92,426,978	92%	$86,579,552	96%
CIGNA Health & Life Ins Co.	$37,420,182	$37,420,182	59%	$0	0%	$0	0%
Harvard Pilgrim Health Care Inc. + HPHC	$294,448,447	$147,124,509	82%	$92,711,645	81%	$54,612,293	101%
Maine Community Health Options	$325,482,591	$4,596,125	120%	$42,642,768	85%	$278,243,698	105%
United Healthcare Ins Co.	$10,593,533	$10,096,131	51%	$497,402	93%	$0	0%
All Other Insurers	$6,533,840	$5,717,748	78%	-$26,757	-413%	$842,849	40%
Total	**$1,673,079,483**	**$953,633,605**	**85%**	**$297,205,181**	**86%**	**$422,240,697**	**102%**

Figure 9. 2016 Percent of Premium Paid for Claims by Company and Market Segment



Claims per Member Month

When looking at the percentage change in average claims from year to year, keep in mind that some employers and individuals make changes to their policies to lower their premiums and this may lower the percentage increase. If employers and individuals choose plans with higher deductibles or fewer benefits to minimize increases in premiums, then their claim costs will only show part of the picture of the change in their healthcare costs.

Table 5: 2016 Claims per Member Month

Company	Large Group 2016	%Change	Small Group 2016	%Change	Individual 2016	%Change
Aetna Health Inc. + Aetna Life Ins Co.	$348	29%	$433	59%	$266	27%
Anthem Health Plans of ME Inc.	$437	1%	$402	10%	$340	17%
CIGNA Health & Life Ins Co.	$225	-8%				
Harvard Pilgrim Health Care Inc. + HPHC	$337	3%	$322	8%	$395	-3%
Maine Community Health Options	$449	178%	$332	32%	$428	28%
United Healthcare Ins Co.	$274	-26%	$502	48%		
Total	**$396**	**-1%**	**$368**	**19%**	**$402**	**23%**

Administrative Expenses

Administrative expenses include all expenses other than claims paid to healthcare providers. These expenses include things like office space, salaries, office supplies, marketing, taxes (other than federal income tax), lobbying expenses, and cost containment expenses (which reduce the amount of healthcare services provided, including utilization review, fraud detection, disease management programs, and case management). Overall, administrative expenses were lower for large groups (employers with more than 50 employees). The graph below the table shows the percentage of premiums paid for administrative expenses by market segment.

Table 6: 2016 Amount of Administrative Expenses and Percentage of Premiums Paid for Administrative Expenses

Company	Totals 2016	Large Group 2016	% of Premium	Small Group 2016	% of Premium	Individual 2016	% of Premium
Aetna Health Inc. + Aetna Life Ins Co.	$31,355,104	$13,128,456	21%	$18,056,765	23%	$169,883	12%
Anthem Health Plans of ME Inc.	$96,829,753	$63,735,698	8%	$18,160,499	18%	$14,933,556	16%
CIGNA Health & Life Ins Co.	$23,250,832	$23,250,832	37%	$0		$0	
Harvard Pilgrim Health Care Inc. + HPHC	$58,722,622	$27,813,607	16%	$21,510,858	19%	$9,398,157	17%
Maine Community Health Options	$49,970,200	$545,566	14%	$8,131,055	16%	$41,293,579	16%
United Healthcare Ins Co.	$915,538	$872,550	4%	$42,988	8%	$0	
All other Companies	$1,485,266	$793,189	11%	$32,544	502%	$659,533	31%
Total	**$262,529,315**	**$130,139,898**	**12%**	**$65,934,709**	**19%**	**$66,454,708**	**16%**

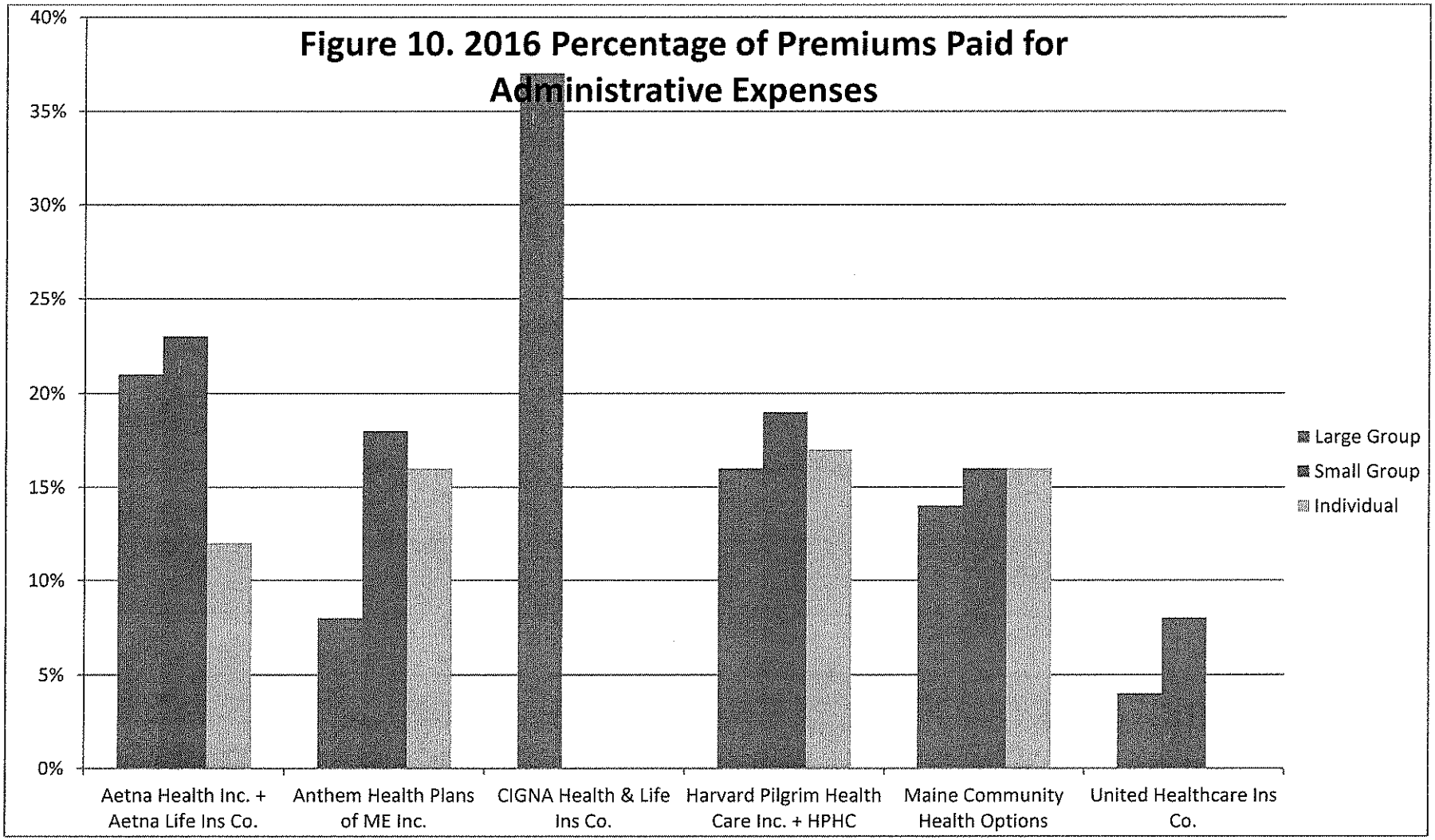


Figure 10. 2016 Percentage of Premiums Paid for Administrative Expenses
40%
35%
30%
25%
20%
15%
10%
5%
0%
Large Group
Small Group
Individual
Aetna Health Inc. + Aetna Life Ins Co.
Anthem Health Plans of ME Inc.
CIGNA Health & Life Ins Co.
Harvard Pilgrim Health Care Inc. + HPHC
Maine Community Health Options
United Healthcare Ins Co.

Underwriting Gain or Loss

The underwriting gain or loss is the amount of premium dollars left, or the shortfall, after claims and administrative expenses are paid. A negative number (displayed in red) means that the company lost money in that particular market segment. Underwriting gain is the major component of company profits. Profits also include investment income and are reduced by federal income tax.

Table 7: 2016 Underwriting Gain or Loss

Company	Totals 2016	% of Premium	Large Group 2016	% of Premium	Small Group 2016	% of Premium	Individual 2016	% of Premium
Aetna Health Inc. + Aetna Life Ins Co.	-$27,230,799	-19%	-$20,049,422	-32%	-$6,504,289	-8%	-$677,088	-47%
Anthem Health Plans of ME Inc.	$19,187,433	2%	$40,371,069	5%	-$10,193,802	-10%	-$10,989,834	-12%
CIGNA Health and Life Ins Co.	$2,890,928	5%	$2,890,928	5%				
Harvard Pilgrim Health Care Inc. + HPHC	-$6,529,403	-2%	$4,048,910	2%	-$386,803	0%	-$10,191,510	-19%
Maine Community Health Options	-$39,383,711	-12%	-$1,606,151	-42%	-$2,213,510	-4%	-$35,564,050	-13%
United Healthcare Ins Co.	$8,882,246	44%	$8,888,202	45%	-$5,956	-1%		
All other Companies	$1,282,348	14%	$655,191	9%	-$935	-14%	$628,092	29%
Total	**-$40,900,958**	**-2%**	**$35,198,727**	**3%**	**-$19,305,295**	**-6%**	**-$56,794,390**	**-14%**