

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

**Meeting Agenda**

**March 2, 2018**

**9:30 am to 4:00 pm**

**Room 220, Cross State Office Building**

- ❖ Welcome and Introduction of Chairs and Members
- ❖ Discussion of Survey
- ❖ Workers' Compensation Reform: Are there Lessons/Parallels?  
*Michael Bourque, Chief Executive Office, Maine Employers Mutual Insurance Company*
- ❖ Reinsurance: Past, Present and Future for Maine Guaranteed Access Reinsurance Association  
*Christopher Howard, Maine Guaranteed Access Reinsurance Association*
- ❖ Options for Cost containment
  - State Options for Prescription Drug Pricing  
*Ellen Schneiter, National Academy for State Health Policy*
  - State Options for Price Controls
- ❖ Lunch break
- ❖ Options for a Public Model  
*Tom Sterne, M.D and Dean Felton*
- ❖ Discussion of Next Steps—Scheduling of 4<sup>th</sup> meeting and possible formation of study groups
- ❖ Public Comment (*limited to 3 minutes per person*)

## **Task Force on Health Care Coverage for All of Maine**

January 22, 2018

### **Draft Meeting Summary**

#### *Task Force Members Present:*

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

*Task Force Members Absent:* Sen. Eric Brakey

Staff: Colleen McCarthy Reid

### **Welcome and Introductions**

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

### **Summary of December 20<sup>th</sup> Meeting**

The task force briefly reviewed and accepted the summary of the December 20<sup>th</sup> meeting.

### **Presentations: What is Coverage?**

The meeting focused on health care coverage---the current levels of health care coverage and the economic impact and costs of coverage. The following presentations and materials were provided to the task force. The materials provided to the task force are posted on the task force's website at: <http://legislature.maine.gov/uploads/originals/healthcarecoveragematerialsjan22.pdf> and <http://legislature.maine.gov/uploads/originals/healthcarecoverageadtlmtgmtrlsjan22.pdf>

Private health insurance coverage. Staff reviewed the written materials submitted by the Bureau of Insurance:

- ❖ Chart of Health Coverage in Maine through 2016;
- ❖ Summary of 2018 Essential Health Benefits Required to Be Covered by Health Plans and List of Benefits Typically Excluded;
- ❖ Information Relating to Deductibles and Out-of-Pocket Costs for Current Health Plans; \
- ❖ Examples of Current Premiums for Individual Health Plans, including Advanced Premium Tax Credit; and
- ❖ Information Relating to 2017 Market Share for Individual, Small Group and Large Group Health Insurers.

MaineCare coverage. Staff reviewed the written materials submitted by the Department of Health and Human Services outlining:

- ❖ Demographics for the number of Maine residents currently covered under the MaineCare program, in total and with a breakdown by category of eligibility;
- ❖ A summary of current benefits and coverage provided under MaineCare for each category of eligibility; and

- ❖ A summary of out-of-pocket costs (premiums, copayments and other cost sharing requirements) required for MaineCare members.

Coverage provided through MEWAs (multiple employer welfare arrangements). Bruce Gerrity provided an overview of the regulatory oversight of and coverage provided by the two multiple employer welfare arrangements currently operating in Maine—the Maine Auto Dealers Association MEWA and the Maine Energy Marketers Association MEWA. Mr. Gerrity explained that MEWAs are specifically allowed under federal ERISA law to be regulated by the states unlike a single-employer self-insured health plan. MEWAs are closely scrutinized and regulated by the Maine Bureau of Insurance pursuant to Title 24-A, chapter 81 of the Insurance Code. MEWAs are required to be organized as a nonprofit and to be governed by a board of trustees.; the plan of operation must be filed with the Bureau of Insurance.

MEWAs are required under State law to comply with requirements for guaranteed issue and guaranteed renewal and to include all mandated benefits. The plans may not underwrite on the basis of claims history, but can discriminate on the basis of a member’s financial solvency as all members are jointly and severally liable for all claims. MEWAs are required to offer at least one ACA-compliant plan, but other benefit designs are permitted. Rates are reviewed by the Bureau of Insurance, but no rate hearing is required. Mr. Gerrity also pointed out that MEWAs can establish minimum participation rules based on a certain time frame that helps maintain stability of the plan.

Coverage for the uninsured and underinsured. Rebecca Sperrey and Carol King of Eastern Maine Healthcare System (EMHS) provided information to the task force on EMHS’ experience related to providing health care services to the uninsured and underinsured. Ms. Sperry indicated EMHS provided \$60.9 million in 2017 and had approximately \$83 million in bad debt.

Ms. Sperrey outlined the financial assistance program offered to patients, which includes free care based on income, special prescription drug and community grant programs, financial counselors providing enrollment assistance in ACA plans and MaineCare, payment plans and balance forgiveness. Ms. Sperrey also described EMHS’ compliance with recent legislative efforts toward price transparency, cost estimates prior to service and the “right to shop” for certain health care services. EMHS employs 30 financial counselors to assist “self-pay” patients with billing and payment. Ms. Sperrey estimated that EMHS employs approximately 200 people assisting with billing and payment by commercial and government payers.

Economic Impact of Coverage and Costs. The task force invited comments on the economic impact and costs of health care coverage from representatives from the Maine Center for Economic Policy (MCEP), Consumers for Affordable Health Care (CAHC) and the Maine Heritage Policy Center (MHPC).

James Myall of MCEP provided data showing insured Mainers continue to struggle with paying for health insurance, particularly those close to the federal poverty level. Mr. Myall also cited data showing that health care costs continue to rise and consume an increasing share of Mainer’s income. Finally, Mr. Myall noted that the unaffordability of care or lack of health care coverage impacts a person’s health, access to preventive care and rate of drug addiction.

Steven Butterfield of CAHC focused his comments on the ways in which the cost of health care are a barrier to receiving needed care. Mr. Butterfield cited research and data demonstrating that: 1) cost is a barrier that impacts consumer behavior; 2) costs are rising faster than consumers can keep up with; 3) consumers cannot “shop” their way to saving the overall trend in the health care system, nor should they be expected to; and 4) consumers are not over-utilizers and Americans do not “use” more health care than consumers in other comparable countries.

Jacob Posik of MHPC was not able to provide his comments in person, but submitted written comments to the task force. MHPC's comments cautioned the task force that the solution for providing affordable health care services cannot be done through increased government spending and taxes. MHPC encouraged the task force to consider a free market solution like the direct primary care model and described the direct primary care model.

### **Public Comment**

The task force accepted public comment on the charge to the task force and the health care topics under discussion. Seventeen people provided comments. Copies of the written testimony submitted to the task force are posted on the task force website at:

<http://legislature.maine.gov/uploads/originals/healthcarecoveragepublictestimonyjan22.pdf>

### **Task Force Discussion: Next Steps**

After listening to the presentations and public comment, the task force discussed their options for next steps and the following members commented.

- Rep. Sanborn: Continue to focus on diagnosing what is broken in the current system and identifying possible policy solutions or levers for state-level reform; Identify questions and see if agreement is possible
- Rep. Perry: Consider Oregon study and criteria used to develop health care options
- Sen. Gratwick: Focus on developing RFP for further study of health care models and see if members can coalesce around certain principles; Must decide between taking incremental steps or proposing revolutionary changes
- Trish Riley: Scope of study is too much given the limited time; focus first on incremental steps to increase access (Medicaid expansion and stabilize individual market) and to simplify payment and billing systems and then look at design options for universal health care; Think about how to define "universal access"
- Rep. Chace: More structure needed; Lay out choices for task force members and then narrow down to figure out commonality; Think about ways to manage and control costs
- Kevin Lewis: Take incremental steps—align value and address waste; Look at pharmaceutical spending; Consider changes to reinsurance mechanism (Maine Guaranteed Reinsurance Association)
- Sen. Carson: Believe it is consistent with task force charge to make recommendation as a group to move forward and implement Medicaid expansion

### **Third Meeting**

The third meeting will be held on March 2, 2018. It is anticipated that the fourth meeting will be scheduled shortly after adjournment of the Second Regular Session.

The meeting adjourned at 3:58 pm.

**Task Force on Health Care Coverage for All of Maine**

Survey Questions—7 respondents

Note from the chairs: We have developed this survey as a tool to help us better understand the areas of agreement and identify possible areas of disagreement among the task force members. We hope to use the results of the survey and the expertise of our task force members to frame our remaining work.

1. Do you agree that all Maine residents should be required to have health care coverage?

YES	NO
5	2

Comments: Yes or self- insured with no charity care

2. Do you agree that there should be a limit to what an individual pays for health care coverage based on a certain amount or percentage of income?\*

YES	NO
5	1

*\*Does not include 7 responses as one respondent did not answer yes or no*

Comment from Respondent who did not answer yes or no: I'm not opposed to helping those of limited means but a percentage of income is not the right measure in isolation.

3. Do you agree that all health plans should be required to provide a certain level of minimum benefits? Please explain.

YES	NO
6	1

Comments:

- Yes, so that the insured can be assured of basic health care from caregivers in our medical care delivery system
- Yes and those should be adequate to assure comprehensive coverage - it may be something less than the current EHB but should not be "bare bones"
- Yes, especially preventative care. There should be a baseline of coverage with the ability to add coverages that individuals may opt for.
- No- there needs to be more flexibility for plans to innovate and individuals to purchase the coverage they want/need.

4. Do you agree that the affordability of health care coverage needs to be addressed? If so, what steps would you recommend?

YES	NO
7	0

Comments:

- Offer a single payer, publicly sponsored and funded system (funded by payroll taxes, and income taxes on others w/ ability to pay)
- Cost containment, public option.
- Costs are largely driven by the underlying cost of care and the inefficiency of the system. Initiatives like global budgets and rate-setting like MD, MA and VT show promise
- We need to control cost of care, more competitive and control costs of drugs
- Reduce RX, Hospital, Provider, Insurer, Brokers overheads, costs, and profits by aligning with Medicare reimbursements, providing pricing transparency, and quality metrics.
- Yes- that requires addressing the underlying cost of care. That requires an honest analysis of the structure and cost of the current delivery system, ongoing cost transparency, opportunity for service providers to enter and innovate in the market, and freedom for consumers to choose care providers and options.

5. Do you agree that access to health care coverage needs to be addressed? If so, what steps would you recommend?

YES	NO
6	1

Comments:

- A Medicare for all or single payer system (paid for by taxes) should be an option--with a second (higher) tier of care available for those willing to pay--as exists for "private pay" consumers in other countries.
- Affordability
- Medicaid expansion must be completed; state could develop a robust reinsurance to make individual coverage more affordable
- Access to care is important but in a rural state very difficult. I think more telemedicine needs to be made more accessible but the smaller hospitals will not be able to provide all services to all patients some more critical care will need to be centralized
- I do not see an issue with access. The issue is cost

6. Do you agree that administrative costs in the current health care system need to be addressed? If so, what steps would you recommend?

YES	NO
6	1

Comments:

- The administrative overhead costs of private, for profit health insurance should only be kept for "private pay" higher level health care--immediate access to surgery when desired but not medically necessary, private hospital rooms, etc.
- But it is- like fraud and abuse- is an easy target and not the largest cost driver. We already limit insurer costs via MLR and need to look at the complexity of the system as an admin cost driver, e.g. separate billing processes could be standardized
- Administrative costs for both providers and carriers. Right now carriers are limited to 15% administrative costs I would suggest that we look at similar limitation on the provider side as well as the facility costs. A billion dollar expansion will make health in Maine less affordable and less accessible to most Mainers
- There are simpler models like DPC in terms of administrative costs, but we need to be careful thinking about reducing admin costs with regulations as they often contribute to admin costs in the first place.

7. Do you agree that the cost and pricing of health care services need to be addressed? If so, what steps would you recommend?

YES	NO
6	1

Comments:

- But not sure. One step: cost-free medical education for those willing to enter a public health service--whether generalist or specialist.
- Price comparison shopping with incentives
- Meaningful and complete transparency is needed in addition to connecting the buyers and sellers more directly.

8. Do you agree that the cost and pricing of prescription drugs need to be addressed? If so, what steps would you recommend?

YES	NO
7	0

Comments:

- Allow negotiation by all consumers at all levels. Also, study and employ strategies used in England, Canada and other countries where prices are much lower.
- Collective bargaining and purchasing
- A fast growing but still small part of spend. Rate-setting of high cost drugs; transparency of PBMS and alternatives to same- too many hands in the supply chain adds to cost
- Price transparency as well as quicker introduction of generic drugs to the market place
- Increased FDA, SEC, and DOJ oversight and penalties.
- Again transparency is the first step. We also need more distribution options such as dispensing through the doctor's office and clinic/office settings for infusions. We need patients to have incentives to seek lower cost options and delivery settings.

9. Do you have any ideas for other state-level policy changes to improve the current health care system? Incremental or short-term improvements?

Comments:

- Link health maintenance and preventative measures with providing lower cost insurance. Real prevention--smoking cessation, weight loss and control (managing the obesity epidemic), nutrition and exercise programs for both healthy and at-risk people. Run a pilot for a study, and see what savings can be achieved.
- Public option
- Medicaid expansion;
- require all insurance sold in individual market to be in one risk pool;
- require all health care purchased with public dollars to jointly purchase and negotiate prices;
- develop a public option or buy in to the aforementioned public payers plan
- I don't believe state level policy will be enough. It needs to be federal universal coverage
- Repeal of certificate of need laws or remove barriers to entry for new providers. Continued steps to improve transparency of pricing.

10. The task force is required to develop at least 3 proposals for providing coverage for all. Which model or models should the task force pursue? Please rank in order of highest to lowest priority.

3.4	a. A design for a government-administered and publicly financed universal payer health benefits system that is decoupled from employment, that prohibits insurance coverage for the health services provided by the system and that allows for private insurance coverage of only supplemental health services
3.17	b. A design for a universal health benefits system with integrated delivery of health care and integrated payment systems for all individuals that is centrally administered by State Government or an entity under contract with State Government;
4.00	c. A design for a public health benefits option administered by State Government or an entity under contract with State Government that allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans; or
3.83	d. A design for a private system consistent with state and federal law
2.0	e. Other (please describe)



**Presentation by Michael Bourque, President/CEO, The MEMIC Group  
to the Task Force on Health Coverage for All of Maine**

**March 2, 2018**

Good morning and thank you so much for inviting me to share some thoughts concerning healthcare policy and perhaps some of the parallels with workers' comp.

The challenge, as you well know, is daunting. Health care costs continue to rise and with it, the cost of insurance. This is hampering businesses and economic growth; few private insurers want to compete in the market; and little seems to be changing amid growing partisan and philosophical rancor. Sounds depressing?

Well, actually I'm optimistic because that description is the Maine workers' comp environment of a little more than 25 years ago.

Just as healthcare makes headlines today, in 1992 we had a broken workers' compensation system with too many injuries, expensive litigation, and well-intentioned but ineffective government interventions in the marketplace. It was crippling the economy, spurring businesses and insurers to flee the state. Costs had spiraled out of control.

But these days you don't see too many front page headlines about workers' compensation (unless MEMIC is paying a dividend or there is a new rate decrease). That's because people came together (sometimes kicking and screaming), they made comprehensive reforms, and they fixed a system that was broken.

It wasn't easy -- there was a 17 day state government shutdown in 1992 --but people from the public and private sectors came together, they looked at the best systems across the country, and in a matter of a few months, constructed a lasting solution. It included creating, from

scratch, a private, employer-led mutual company to be a competitive force and the guaranteed market for workers' compensation insurance.

It was bold and a dramatic change, but it worked. Within 5 short years of MEMIC opening its doors in January of 1993, lost time injuries were reduced by 30%, and insurance costs were cut in half. A Portland Press Herald editorial called MEMIC "A Maine Miracle."

In the last 25 years, work-related injuries have dropped by 40 percent, billions of dollars have been saved due to workplace safety initiatives, minimal litigation, expert injury management and a return of competition. I'm proud to say that MEMIC has been the foremost leader in workplace safety and, as we like to say, safety pays dividends.

In fact, MEMIC has returned more than \$240 million to Maine employers through dividends and the return of capital contributions.

So how does Maine's quarter century of success translate to tackling health care? First, we need to come together to do it again. And, in coming together, we need to agree on the fundamental cost-drivers before we can debate the best solutions.

I believe there are four policy issues that need to be resolved:

- Prevention and a certain amount of personal responsibility for our own health
- The cost of healthcare services;
- The cost of pharmaceuticals; and
- Affordable access to insurance through a broad pool.

**Let's begin with prevention and personal responsibility** for our health. Just as preventing workplace injuries is at the heart of reducing workers' compensation costs, diet, exercise and healthy behaviors are the foundation of reducing health care costs. I don't believe I have to

remind this group of the fact that chronic diseases and mental health issues absorb nearly 86% of health care costs.

Chronic conditions and their impacts including as heart disease, stroke, cancer, Type 2 diabetes, and obesity are among the most common, costly, and **preventable** of all health problems. Let me repeat that last part, **preventable**. One key to MEMIC's success has been prevention. We believe \*truly\* that every injury is preventable. When we can make workplaces safer and prevent injuries from happening in the first place, we save everyone money, we prevent suffering and we save people's lives. As health care providers and public policymakers, any reform needs to focus on education and incentives to lose weight, eat well, regularly exercise and treat ourselves for the health challenges that we may be genetically disposed to.

Interestingly, these challenges in the overall health of our workforce have emerged as the biggest remaining challenge in workers' compensation as well. Maine's forestry industry is a good example. It was once very dangerous due to physical risks, but these days, we are doing less manual logging training using chainsaws, and more with ergonomic challenges similar to office workers in cubicles. Many of today's loggers find themselves spending their days seated, operating machinery in a confined cab; call it "the cabicle." That work has very different risks than wielding a chainsaw on the forest floor, but there are risks. They may be less obvious at first glance, but the side effects of an increasingly sedentary workforce are startling enough to provoke many experts to call sitting is "the new smoking."

The co-morbidities brought forth by obesity, high blood pressure, diabetes and substance abuse are making our remaining injuries longer in duration and more difficult to overcome. This is both a healthcare AND a workers' comp problem – and that's not even to mention a quality of life problem. Wellness, our motivation and responsibility for achieving it is primary. So – solve this conundrum and not only will we cut healthcare costs, but workers' compensation costs will go down even further!

**The second challenge** is the cost of services from all kinds of facilities. Technology and research do not come for free nor do highly skilled practitioners. That said, the fact is that the cost of health care services outpaces the consumer price index 2:1. That's not sustainable. Some of this is directly attributable to the cost-shifting that comes when the low rates paid by Medicare do not cover the costs of the services. But innovation and public policy need to change what we financially reward as well as reduce the cost of doing business -- that includes tort reform, which should reduce redundancy and defensive medicine. And, let me also be up front about the fact that workers' compensation includes a regulated fee schedule. While based on Medicare rates, it is a base rate that has a multiplier, making it higher than Medicare (though likely not as high as providers might wish!) That said, most providers participate in the workers' comp market.

**The third issue is the cost of pharmaceuticals.** To be sure, American pharmaceutical companies plow millions into research for drugs that are all but miracles, however, the free market has been abused when EpiPens jump from \$94 to \$609 simply because a company can legally do so, or that a single injection to save deteriorating eyesight can be priced at \$850,000. In Maine, currently, there is no fee schedule for prescription drugs in workers' compensation. But at MEMIC, close management of prescriptions, use of generics, and attention to the details makes our overall prescription costs about half of that in other states in the country. As our now-retired claims Senior VP used to say: "It's not magic; it's management." But to manage such issues, you need a regulatory structure – like workers' comp – that allows this to occur.

**Finally, there is, of course, the question of affordable access.** The foundation of insurance is the spread of risk – very large numbers of policyholders pooling their money to protect themselves against the possibility of loss. Workers' comp, with relatively few exceptions, requires all employers to cover every employee. That broadens the pool and spreads the risk (and the cost) across the population. We all understand the problems with cost-shifting when uncovered people nevertheless get care – which most of us certainly believe they should. Incidentally, when people are not otherwise covered, injuries or health problems that are not

work-related make their way into our system, thus increasing the cost. Workers' comp is, after all, first-dollar, no-out-of-pocket cost healthcare.

Most of Maine's private employers have fewer than 50 employees and in 2016 only 27% of them offered health insurance though 100% have workers' comp insurance. In total, 106,000 Mainers were without health insurance in 2016, and with current events at the national level, we could regress back to 2013 when 147,000 Mainers went without. That's a lot of people not in the pool but likely still getting healthcare, albeit later, and perhaps when it's most expensive.

Universal access to affordable health care is not a right under our constitution – but most of us believe it is a social and human imperative. I would say that our public policy ought to reflect that economic and moral truth – and that we're all in this together.

Since MEMIC's stated mission (written by our original board of directors some 25 years ago) includes a responsibility to strengthen the Maine economy, let me also mention that there is an economic imperative born of our demographics that should be considered. With Maine's aging workforce and shortage of skilled workers, we can't afford to leave anyone outside of the workforce because of poor health. Demographics tells us that in the next 15 years, we will lose 15 percent of our workforce, and even if we keep every single one of our children in Maine during that time, we will still be more than 50,000 workers short. Our economy cannot afford to leave anyone out of the workforce, and certainly not for health reasons. Further, a healthy employee is a safer, happier and far more productive contributor at their place of work.

So, using workers' compensation as a measure of the possible, imagine reducing chronic illness by 40 percent and insurance costs being cut by 60 percent! It sounds impossible, almost ridiculous. But it has been done before -- through tough choices, careful management, a managed but free market, and a willingness to compromise. If we are bold, if we come together and we work *really* hard, Maine truly IS a place where miracles can happen.



**Report to**

**Task Force on Health Care Coverage for All of Maine**

**MGARA Past, Present and Future**

**March 2, 2018**

## History of MGARA

**Introduction.** The Maine Guaranteed Reinsurance Association (“MGARA” or the “Association”) is a private non-profit reinsurance company providing reinsurance for the high risk segment of the individual health insurance market in Maine. The Association is governed by a Board of Directors consisting of 12 members, with 7 members appointed by the Maine Superintendent of Insurance and 5 members appointed by the member insurers<sup>1</sup>.

In May 2011, the Maine State Legislature passed Public Law Chapter 90 “An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services” (“PL90”). Included in the many components of PL90 was the establishment of the Association as a reinsurance program for the higher risk segment of Maine’s individual health insurance market. The portion of PL90 establishing the Association was codified at 24-A MRS c. 54-A.

The Association was formally organized as a Maine non-profit corporation on January 23, 2012 and, following an initial start-up phase, commenced reinsurance operations on July 1, 2012. MGARA operated for an 18 month period beginning July 1, 2012 and ending December 31, 2013. Effective as of January 1, 2014, the Association’s operations were suspended. The suspension is currently scheduled to expire on December 31, 2023, unless an earlier re-start is authorized.

Prior to the implementation of the Patient Protection and Affordable Care Act (“ACA”), Maine was a leader in state-level innovation designed to reduce Mainers’ healthcare costs and increase their access to affordable health coverage. MGARA represented the State’s flagship innovation -- a legislatively established private nonprofit organization operating a reinsurance program for the higher-risk segment of the State’s individual health insurance market. MGARA generated an approximate 20% annual rate reduction in the individual market during its 18 months of operation. That highly successful program was placed in suspension with the advent of the ACA, to avoid the imposition of redundant costs on the Maine market through parallel federal and state reinsurance programs.

**Program Description.** As a foundational matter, the Board developed a basic mission statement for the Association to be used as a guide and filter for all major decisions to be made in implementing its reinsurance program. The mission statement has two parts:

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<sup>1</sup> Seven members appointed by the superintendent: 2 members chosen from the general public and who are not associated with the medical profession, a hospital, an insurer or a producer; 2 members who represent medical providers; one member who represents individual health insurance consumers who is not associated or formerly associated with the medical profession, a hospital, an insurer or a producer; one member who represents a statewide organization that represents small businesses; and one member who represents producers. 24-A MRS 3953(2).

- To operate the reinsurance program described in the Enabling Act in such manner as to maximize the impact of the Association in lowering the cost of health insurance in Maine's individual market; and
- To do so without jeopardizing the solvency of the Association.

The reinsurance program operated by the Association reinsures health insurance policies ceded to the Association by primary carriers operating in Maine's individual health insurance market either voluntarily or on a mandatory basis based on the presence of certain specified high-risk conditions. The Association's reinsurance program was intended to reduce insurance costs in Maine's individual health insurance market by providing reinsurance for a significant portion of the coverage provided through individual health insurance policies. The Association's reinsurance program provided reinsurance coverage for 90% of reinsured claims between \$7,500 and \$32,500 and 100% of reinsured claims over \$32,500 (without a cap).

MGARA's reinsurance program costs are spread across the individual, group and self-insurance markets by means of a two-part funding mechanism:

- (1) Assessments payable by all health insurers and third-party administrators operating in the State of Maine and
- (2) Reinsurance ceding premiums charged to the carriers ceding policies to the Association.

Throughout its period of operation, the Association set the assessment at \$4 per person per month ("PMPM") and premiums at a rate of 90% of the premium charged under the underlying policy.

***Historical Results.*** Over MGARA's period of active operation (2012 6 mo. and 2013), MGARA paid approximately \$66 million in claims and generated a positive fund balance of approximately \$5 million. Based on rate filings submitted by insurance carriers operating in Maine's individual market, the MGARA program generated an approximate 20% reduction in requested rates. By way of example, Anthem Health Plans of Maine, Inc.'s ("Anthem") 2013 rate filing sought a rate increase of 1.7%. Anthem projected that without the MGARA reinsurance program, its 2013 rate increase would have been 21.6%.

Despite this success, the MGARA reinsurance program was rendered largely redundant during the pendency of the federal transitional reinsurance program established under the ACA and Department of Health and Human Services ("Federal Transitional Reinsurance Program"), because both programs offered reinsurance for the individual health insurance market in Maine. Although the reinsurance offered under each program was very different, each program served essentially the same function.<sup>2</sup> The ACA established a three-year federal transitional reinsurance

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<sup>2</sup> The ACA established a temporary uniform national reinsurance program to be operated across all 50 states in the



program, which, like MGARA, was funded through assessments on each state's insurance market, including Maine's. In order to avoid imposing redundant costs on the Maine market through parallel federal and state individual market reinsurance programs, consistent with recommendations from MGARA and the Superintendent, the Legislature amended MGARA's enabling legislation to suspend MGARA's reinsurance program during the pendency of the Federal Reinsurance Program. That legislation called for reactivation of MGARA as of January 1, 2017. The Federal Transitional Reinsurance Program ended as scheduled on December 31, 2016; however, subsequent legislation has extended MGARA's suspension through December 31, 2023.

The extension of MGARA's suspension resulted from the realization that the current structure of the ACA's subsidies for Exchange participants in the form of advance premium tax credits ("APTC") creates an economic disincentive for Maine to implement any MGARA-like reinsurance program. To the extent a reactivated program has the effect of reducing premiums for many persons obtaining individual health insurance coverage on the federally-facilitated exchange in Maine (the "Exchange"), these lower premiums would in turn decrease the APTC amount to which Maine's Exchange participants are entitled, and which the federal government must pay, under the ACA. This result would represent a measurable cost-savings to the federal government, effectively funded by assessments on Maine's insurance market.

A potential solution to the APTC conflict described above has been identified under the ACA as it exists today. Current Section 1332 of the ACA permits a state to apply for approval to waive specific provisions of the ACA to permit the state to operate a health insurance program that deviates from those provisions, provided that the state can demonstrate that its program will "provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver, would provide coverage that is at least as comprehensive and affordable as would be provided absent the waiver, and would not increase the Federal deficit."<sup>3</sup> Maine should be able to demonstrate that MGARA's program meets all of these criteria.

The ACA currently provides that a state that applies for and receives a waiver pursuant to Section 1332 (a "1332 Waiver") is eligible to receive "the aggregate amount of such [premium tax] credits or [cost-sharing] reductions that would have been paid on behalf of participants in the Exchanges ... had the State not received such waiver, ... for the purposes of implementing the State plan under the waiver."<sup>4</sup> Accordingly, if Maine were to apply for and obtain a 1332 Waiver, Maine would be eligible to receive pass-through funding<sup>5</sup> equal to the federal government's cost-

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years 2014, 2015, and 2016. The Federal Transitional Reinsurance Program provided coverage for 80% of claims between \$60,000 and \$250,000 across the entire individual insurance market, and will be funded through assessments payable by all health insurers and TPAs (including those operating in Maine) at a rate of approximately \$5.25 per person per month. As a result, Maine's individual market would be subject to double assessments for overlapping reinsurance coverage if both the Association and the Federal Transitional Reinsurance Program operate continuously. Accordingly, it is the Board's conclusion that Maine should only be serviced by one of these programs.

<sup>3</sup> 31 CFR Part 33, Guidance issued 12/16/2015.

<sup>4</sup> 42 U.S.C. 18052(a)(3).

<sup>5</sup> The applicable regulations use the term "pass-through funding" to refer to this return of savings to the state

savings resulting from MGARA's positive effect on premium rates and corresponding reduction in the amount of APTC claimed by Maine's Exchange participants.

Cognizant of the success of its pre-ACA health reform efforts and the unfavorable rate effects associated with the absence of any individual market reinsurance program in the State, MGARA has been actively seeking a means of re-starting its program as rapidly as possible.

## Current Status

As previously indicated, MGARA remains under suspension. Unless an earlier resumption of operations is ordered by the superintendent, in accordance with 24-A MRS 3953(1)(A), operations of the association are suspended until December 31, 2023. Under its statutory mandate, if the Board proposes a revised plan of operation that calls for the resumption of operations earlier than December 31, 2023, and the superintendent determines that the revised plan is likely to provide significant benefit to the State's health insurance market, the superintendent may order the association to resume operations in accordance with the revised plan. In order for this to occur, one of the following conditions must exist:

(1) A 1332 Waiver is approved by CMS alleviating the windfall effect described earlier;  
or

(2) The ACA is repealed or amended in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.

Maine's individual market has grown significantly in the ACA environment, from approximately 28,500 individuals in 2013 to over 91,000 in 2017 (with over 79,000 On-Exchange and 11,741 Off-Exchange). Approximately 86% of the individual market is insured through the Exchange. A very high percentage of the individual market qualifies for APTC subsidy, with 57% of the individual market and 66% of the On-Exchange market at less than 250% of the Federal Poverty Level ("FPL") and 29% of the individual market between 250% FPL and 400% FPL. Recent increases in premium rates reflect, among other things, the continued absence of an individual market reinsurance program in Maine following the cessation of the Federal Program. There is clearly a need for a program like MGARA to aid in rate reduction and market stabilization.

However, MGARA's analysis indicates that in the event MGARA were to restart its program in today's market, due to the structure of the federal APTC, the MGARA benefits would largely flow to the federal government, not the State of Maine. When federal subsidies represent a large percent of individual market premium, as they do in Maine, any reinsurance subsidy will principally benefit the federal government. This occurs because in the subsidized segment of the market, member premium is determined largely by household income, not rates or experience. So, in the subsidized segment of the market, if reinsurance lowers premium, the federal APTC is reduced and the cost to members changes very little. The lion's share of the economic benefit would flow to the United States Treasury in the form of reduced APTC subsidy

flowing into Maine.

In a state like Maine, the combination of older population and lower household incomes (compared to national averages) align in a “perfect storm” resulting in a windfall to the federal government delivered by any MGARA-like reinsurance benefits due to reductions in APTC subsidy as a result of reduced premiums. The reduced APTC amount represents a measurable cost-savings to the federal government over the amount that would otherwise be claimed by Exchange participants in Maine in a given calendar year absent the MGARA reinsurance program.

In 2017 the MGARA Board identified the possibility of using a State Innovation Waiver under Section 1332 of the ACA (a “1332 Waiver”) to avoid the windfall to the U.S. Treasury. In short, a 1332 Waiver can be used to receive federal pass-through funding in the amount of savings that would be generated from the reduction in APTC subsidies resulting from the MGARA program. The proposed 1332 Waiver would resolve this conundrum by returning to Maine the economic benefit of the reduction in APTC payments generated through the operation of the MGARA reinsurance program in the form of federal pass-through payments (“Pass-Through Payments”).

The restart of the MGARA reinsurance program with a 1332 Waiver would assist in bringing increased certainty and stability to Maine’s individual health insurance market through a positive effect on premium levels. By reinsuring high-cost claims, the MGARA reinsurance program will spread risk across the broader Maine health insurance market, thereby lowering premiums.

## **MGARA’s Future**

The MGARA Board has been actively working on the development of an operational model and an economic and actuarial analysis to support a 1332 Waiver Application by the State, and is in the final review process before providing that analysis to the Superintendent of Insurance in support of the State’s 1332 Waiver Application. As will be discussed in greater detail below, the MGARA Board has not yet committed to re-starting operations because some serious concerns exist regarding reliability of federal funding of the Pass-Through Payments under the 1332 Waiver program. However, if adequate assurances of timely and continuous payment of Pass-Through Payments is received, MGARA has developed an operational plan that it believes could be successfully implemented.

Under a 1332 Waiver, the State would apply the federal funding that would have been paid to Maine Exchange participants absent the MGARA reinsurance program, as Pass-Through Payments under Section 1332(a)(3) of the ACA. This funding would be combined with MGARA’s existing funding mechanism (a \$4 PMPM assessment and ceding premiums) to support and enhance the MGARA reinsurance program. MGARA is projecting Pass-Through Payments of approximately \$46 million to \$52 million per year over the period 2019 to 2028.

In order to reestablish the MGARA reinsurance program, it is critical that these federal Pass-Through Payments be received, because the MGARA financial model is reliant on these funds for its solvency. MGARA is projecting that Pass-Through Payments will constitute 40-45% of its annual revenue over the period 2019-2028. Given the essentially breakeven financial model under which MGARA operates, any failure to receive these Pass-Through Payments would be devastating. MGARA's other revenue sources (a \$4 PMPM assessment and ceding premiums) are largely within its control. There is, however, significant concern within MGARA's Board regarding the reliability of federal Pass-Through Payments given the federal government's failure to honor other health insurance related payment obligations, notably, CSRs.

With the 1332 Waiver in place and MGARA reinsurance program in operation, MGARA projects a positive impact on premiums ranging from approximately 9% to 14% over the period 2019-2028. It goes without saying that the health care environment is extremely dynamic and that these are only estimates based on MGARA's actuarial and financial model. Actual results will, no doubt, vary from current modeling, and those variances could be substantial.<sup>6</sup> Nevertheless, the projected impact of the program is significant if the environment for restart of the program can produce confidence that Pass-Through Payments will be made on a timely and continuous basis. The MGARA Board is not yet comfortable that those conditions exist, and is exploring alternatives that could provide additional confidence; but no assurance can be given that those alternatives will actually materialize.

It is important to understand that, in the current ACA environment, the primary beneficiaries of the MGARA program will be individuals with household income exceeding 300% of the federal poverty level ("FPL") because premiums for that group are not afforded the same buffering under the ACA's APTC structure due to their income level. The majority of Exchange participants (i.e., those between 100% and 300% FPL) will, by and large, not be affected by increase or decrease in premium due to the compensation provided through APTCs, which have the effect of capping Exchange participants' financial exposure based on their household income.

MGARA's assessment authority is capped at \$4 PMPM. This assessment level was established in 2012, and will have increasingly less market impact in 2019 and each year thereafter than it did originally. Medical costs continue to increase and the static \$4 PMPM assessment is falling behind because it is not indexed to medical inflation, or even general inflation. Additionally, the increase in the size of the individual market (which has more than tripled since MGARA's inception) results in dilution of the ameliorative effect of the \$4 PMPM assessment – due to putting the same dollars into a much larger market. In order to maintain a consistent level of market impact, the assessment level would need to be adjusted to reflect increases in medical costs and market demographics. The amount of the Pass-Through Payments is directly related to the amount of the assessments made against the Maine

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<sup>6</sup> MGARA's actuarial and economic modeling includes assumptions for numerous factors that are not empirically verifiable, including such items as continued failure of federal government to pay CSRs, the effect of Medicaid expansion or lack thereof, the effect of repeal of the individual mandate, continued changes in the regulatory and political environment.

insurance marketplace. The larger the assessment amount, the larger the Pass-Through Payments could be.

MGARA's ability to adjust for these factors is somewhat limited; however, its enabling legislation does allow for increases in the attachment points for its reinsurance, which aids in mitigating the effect of these market forces. The go-forward operating model would make significant adjustments in the attachment points from the original 2012 levels to the levels projected to maintain MGARA's solvency. These changes adjust the original attachment points of 90% at \$7,500 in loss and 100% at \$32,500 in loss to 90% at \$35,000 in loss and 100% at \$65,000 in loss for 2019, and scaling up thereafter as needed.

Absent a 1332 Waiver, the MGARA reinsurance program will almost certainly remain in suspension. This is because, if operated without a 1332 Waiver, the MGARA reinsurance program would impose costs on the Maine insurance market without the materialization of a corresponding market benefit, as outlined above.

It is important to stress that although MGARA has identified the path described above, the lack of confidence in federal Pass-Through Payments is a clear and real impediment, therefore the MGARA continues to explore potential solutions, including concepts such as splitting the risk pool in a fashion that might be ACA-compliant and acceptable to CMS, possible federal legislation or regulatory relief and any other relevant alternatives. In conclusion, I turn again to the Mission Statement adopted by the Board in 2012, which is to:

- To operate the reinsurance program described in the Enabling Act in such manner as to maximize the impact of the Association in lowering the cost of health insurance in Maine's individual market; and
- To do so without jeopardizing the solvency of the Association.

As I think you can see, the Board's vision for MGARA's future remains true to this founding mission.

The foregoing analysis is based upon various assumptions stated therein. The health insurance and ACA environment is highly dynamic and the validity and accuracy of our assumptions will depend in large part on future events over which we have little or no control. Consequently, we cannot assure that MGARA's operating results will correspond to this analysis. To the extent the assumptions upon which the projections are based are incorrect or inaccurate, the anticipated benefits derived from any MGARA program might be adversely affected and the variations could be material.

Hopefully, you will find the foregoing helpful in your deliberations. Whether any of the analysis provided above will be relevant in those deliberations is unclear; however, the Board wants to be sure you have its most current thinking in this rapidly changing environment.

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# STATE WHOLESALE IMPORTATION EXPLAINED

NATIONAL ACADEMY FOR STATE HEALTH POLICY



Center for State **Rx** Drug Pricing

# STATE POLICY OPTIONS

1. Leverage **price transparency** laws to create accountability for drug pricing;
2. Create a **rate setting model** for oversight of in-state drug prices;
3. **Bulk purchase** and distribute high-priced, broadly-indicated, drugs that protect the public's health;
4. Utilize state unfair trade and **consumer protection laws** to address high drug prices;
5. Pursue **Medicaid waivers and legislative changes** to promote greater purchasing flexibility;
6. Organize drug benefit managers across state agencies to create a **State Pharmacy Benefit Manager**;

# STATE POLICY OPTIONS

7. Pursue return on investment pricing and forward financing;
8. Ensure state participation in Medicare Part D as Employer Group Waiver Plans.
9. Protect consumers against misleading marketing; and
10. State pension funds assume active shareholder role to influence pharmaceutical company actions.
11. Seek the ability to import drugs from Canada on a state-by-state basis;



# RATIONALE

- US consumers pay the highest prices in the world for life-saving and life-enhancing drug treatments.
- A 2013 Canadian Price Board study found that we pay about twice as much for brand name drugs

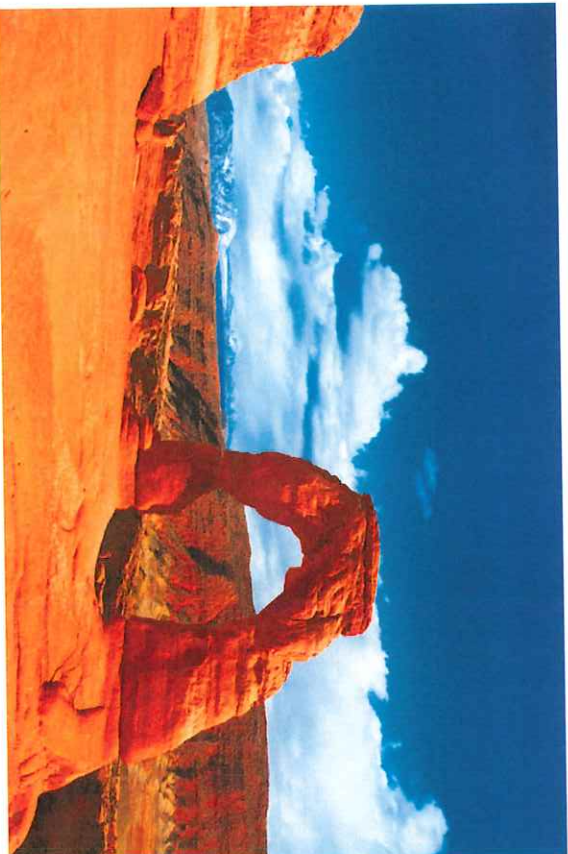
# UNIT PRICE COMPARISON OF HIGH-COST PATENTED NON-BIOLOGIC DRUGS

Product	United States		Canada (in USD)
Advair-Diskus (100 mg capsule) GSK	\$9.52		\$3.96
Eliquis (5 mg tablet) Bristol-Myers Squibb	\$6.21		\$1.60
Harvoni (90/400 mg tablet) Gilead Sciences	\$1,090.35		\$797.62
Lyrica (25 mg capsule) Pfizer	\$6.04		\$63
Strattera (100 mg tablet) Eli Lilly	\$14.81		\$3.96
Tecfidera (120 mg capsule) Biogen	\$119.24		\$11.92
Tracleer (125 mg tablet) Actelion Pharmaceuticals Ltd	\$173.09		\$47.18
Triumeq (300 mg tablet) ViiV Healthcare	\$83.36		\$31.51
Xarelto (15 mg tablet) Janssen, Inc	\$12.44		\$2.11

<sup>[1]</sup> Centers for Medicare and Medicaid Services. Medicaid.gov. *National Average Drug Acquisition Cost*. Accessed online May 22, 2017 at <https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html>

<sup>[2]</sup> Drugs.com. Accessed online at <https://www.drugs.com/>  
<sup>[3]</sup> Government of Saskatchewan. *Saskatchewan Online Formulary Database*. Accessed online May 22, 2017 at <http://formulary.drugplan.ehealthsask.ca/>

# THE IDEA



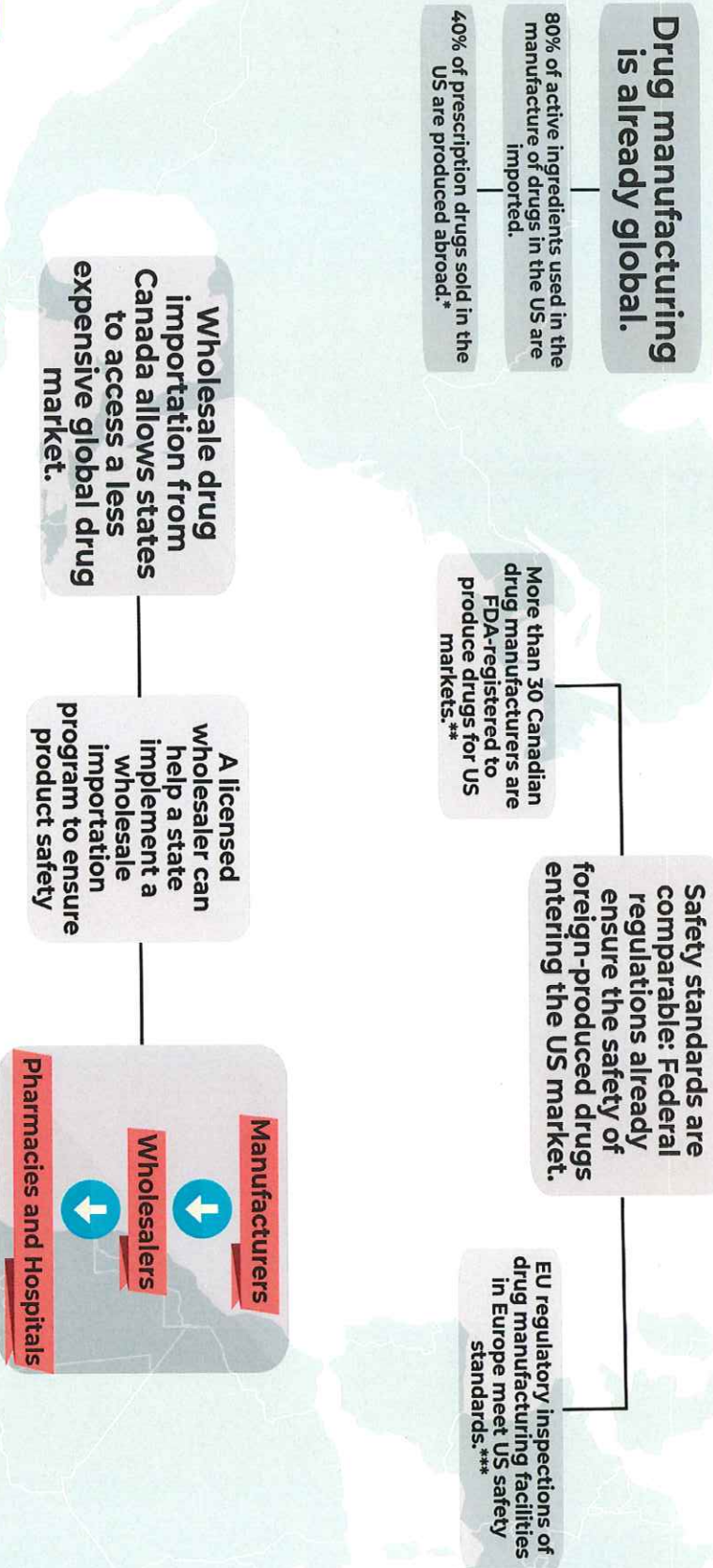
A state could implement a wholesale drug importation program to purchase drugs from Canada that are approved for sale on the Canadian market.

# WHOLESALE IMPORTATION

- A state-administered wholesale drug importation program could be large or small:
  - Available to all state residents or just people covered under state payer programs (such as state employees and prisons);
  - Include all state-licensed payers, distributors, and dispensers, or just a subgroup; and
  - Include many drugs or just a small number of products.
- Wholesale importation is NOT personal importation
  - Must assure the safety, potency, or purity of products shipped from Canada



# Is It Safe for States to Import Drugs from Canada? Yes, Here's Why



## Center for State Rx Drug Pricing

\*FDA Commissioner Margaret Hamburg, "The Safety of Prescription Drugs Made Outside the U.S.", The Diane Rehm Show (Feb. 20, 2014). Transcript accessed Sept. 7, 2017. <https://dianerehm.org/shows/2014-02-20/safety-prescription-drugs-made-outside-us>.

\*\*US Food and Drug Administration Database, "Drug Establishments Current Registration Site", Accessed Sept. 7, 2017. <https://www.accessdata.fda.gov/scripts/cder/dls/default.cfm>

\*\*\*FDA press release, "Mutual Recognition Promises new Framework for pharmaceutical inspections for United States and European Union", (Mar. 2, 2017). Accessed Sept. 7, 2017. <https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm544357.htm>

## WILL STATES SAVE BY IMPORTING DRUGS FROM CANADA? YES, HERE'S HOW

### **States can control profit margins and make sure savings are passed on to payers and consumers**

- A state can limit imported drug mark-ups and profit margins of suppliers, wholesalers, and distributors
- The state can limit what wholesalers and distributors charge for their administrative services
- Pharmacies and other dispensers must charge payers the Canadian price without any mark-up
- Pharmacies must charge uninsured people or those in their deductible period the Canadian price without any mark-up
- Health plans and other payers pay only the Canadian price without mark-up
- The state audits the program regularly to ensure consumers and payers continue to benefit financially

# How Does a State Implement a Drug Importation Program?

## The state sets up and administers a wholesale drug importation program.

The state contracts with only fully-licensed and regulated suppliers in Canada.

The supplier must comply with Canadian laws and import only drugs that Canada regulates.

## The state licenses a wholesaler to handle drug importation and distribution.

The wholesaler must operate in compliance with the state guidelines.

The wholesaler imports the drugs and distributes them only to state-licensed retail pharmacies.

## The state or its contractor ensures drug safety and quality.

Drugs from Canada would be routinely tested for purity and potency.

The state does not provide free samples, pharmacies and other dispensing entities order and pay for drugs as they currently do.

Drugs imported from Canada are never shipped or dispensed out-of-state.

## What federal approvals are needed for a state to initiate an importation program?

The state must prove that:

- The drugs will be tested regularly for safety and purity;
- The program does not put consumers at greater health risk than they are under in the current drug supply system; and
- The program will yield significant savings to the state's consumers.

## What state legislation is needed?

State lawmakers must approve importation legislation that meets all federal requirements.

To review state model legislation to establish a drug importation program, click [here](#).

For a copy of a legislator's guide and additional background materials about state drug importation legislation, contact Jane Horvath at [jhorvath@nashp.org](mailto:jhorvath@nashp.org).



Center for State  Drug Pricing



# QUESTIONS?

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<b>Task Force on Health Care Coverage for All of Maine</b>
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Overview of the Maryland's Rate Setting ProgramHistory

Currently, Maryland operates the nation's only all-payer hospital rate regulation system. The Maryland Legislature first authorized the Health Services Cost Review Commission (HSCRC), to set hospital rates for all payers in 1974. In order to ensure that the system applied to government payers like Medicare and Medicaid, Maryland negotiated and was granted a waiver of federal law that required Medicare and Medicaid to begin paying hospitals on the basis of HSCRC-approved rates in 1977. Under the waiver, all third party purchasers—insurance carriers, Medicare, Medicaid, uninsured individuals and others-- pay the same rate.

The Health Services Cost Review Commission is an independent agency with 7 commissioners appointed by Maryland's Governor. Four members may not have any connection with the management or policy of any hospital. The Commission's rate setting authority applies to 47 acute general, three specialty, and three private psychiatric hospitals in Maryland. The HSCRC's rate regulatory authority applies to inpatient services (as defined by Medicare) and outpatient and emergency services at a hospital (on the campus). The Commission does not regulate physician fees.

New All-Payer Model—Current Maryland Initiative

In 2014, Maryland received approval from the Centers for Medicare & Medicaid Services (CMS) for a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services with the goal of reducing costs and improving patient health.

Under the revamped waiver, all of Maryland's hospitals operate under fixed global budgets (they are provided a set amount of revenue per year and must care for all of their patients within that limit). The global budgets are determined by the HSCRC. Annual revenue is determined from an historical base period that is adjusted to account for inflation updates, infrastructure requirements, population driven volume increases, performance in quality-based or efficiency-based programs, changes in payer mix and changes in levels of UCC. Annual revenue may also be modified for changes in services levels, market share shifts, or shifts of services to unregulated settings.

The Maryland All-Payer Model requires the following:

- Maryland will limit its annual all-payer per capita total hospital cost growth to 3.58%, the 10-year compound annual growth rate in per capita gross state product.
- Maryland must generate \$330 million in Medicare savings over a five year performance period, measured by comparing Maryland's Medicare per capita total hospital cost growth to the national Medicare per capita total hospital cost growth.
- Maryland must achieve a number of quality targets designed to promote better care, better health and lower costs, including reductions in hospital readmissions, reductions in hospital acquired conditions and population health performance measures.

- If Maryland fails during the five-year performance period of the model, Maryland hospitals will transition over two years to the national Medicare payment systems.
- Maryland will also develop a proposal for a new model based on a Medicare total per capita cost of care test to begin no later than after the end of the five year performance period (expected to be approved in 2018 and implemented in 2019) This model will test whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health and reduced costs.

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Sources:

Maryland HealthCare Services Cost Review Commission,  
<http://www.hscrc.state.md.us/Pages/default.aspx>

Centers for Medicare and Medicaid Services,  
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10.html>

Cohen, Harold, Maryland's All-Payor Hospital Payment System,  
<http://www.hscrc.state.md.us/Documents/pdr/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf>

3/2/18

Good afternoon, Senator and Representative, and members of the Insurance and Financial Services Committee

My name is Tom Sterne. I am a retired physician and a member of Maine AllCare. I am joined by my colleague Dean Felton, a retired Lloyd's insurance executive and risk management consultant. We are here today to address a problem. Can the healthcare system in Maine now and in the future meet reasonable quality of care needs of its residents, be affordable and be equitably distributed?

Coverage for healthcare services in Maine is inadequate, both because of expense and because of poor distribution of services geographically and by specific needs, be they to combat opioid abuse, provide easily accessible OB-GYN services or to adequately care for the near elderly, elderly or disabled. Costs are high and prohibitive for many, even when insured, due to high deductibles and co-pays coupled with limited benefits and coverage. With these present realities, our residents face barriers in receiving basic and preventive healthcare services that will save both on-going medical expense and lives. Medical costs and prices are rising steadily above the rate of general inflation. Healthcare expenses will rise above \$18 billion by 2019. Administrative overhead currently present in our fee for service /multipayer system saps wasted dollars, generally between 18% and 25%, depending on the insurer, that could go to sustain desperately needed services. There is less assistance at the federal level likely in the near future- curtailments in federal revenues loom large and will further stress our residents and the State.

I challenge all of you here today to consider what I speak of and what we together surely can foresee. Current attempts at solutions in states such as ours are not working. Except for the limited coverage opportunity offered Federally by the ACA, normal marketplace mechanisms on which we primarily depend have not been successful toward expanding access of healthcare coverage for all our residents, nor in controlling medical prices and cost inflation.

What is it that we really want? I assert that we aspire to universal usable coverage for all Maine residents- voluntary, affordable at a fair price, and available for all, coupled with access to health promotion and disease prevention and that assures that no Mainer will be at risk of insolvency to achieve quality care.

We offer for your consideration a set of ideas- a model to stimulate your own thoughts as we step forward toward remedies, and to encourage you, so that you know that solutions to these problems are possible.

This model envisions the use of a unique and hybrid public-private collaboration to take the best advantage of the strengths of our current healthcare system, and

to develop over the next 5 years a revamped service provider reimbursement system managed centrally by a State sponsored Trust.

The model:

- will be State budget neutral over 5 years
- will use an innovative tax and operating structure to support a transition from fee for service to a "net cost" of service model. Net cost means netting of capital expenses unrelated to essential medical benefits for an expense reimbursement
- reduces stakeholder's administrative overhead
- reduces unnecessary medical care expenses
- better controls medical inflation
- uses centralized purchasing and claims processing for further cost containment
- provides fair reimbursements to all providers based on net costs
- provides an "essential benefits" package to all residents that meets or exceeds ACA standards
- with our private partners, will address and resolve the poor distribution of services as determined by geography and need
- offers education, training and benefits incentives to attract and retain staff in underserved areas
- is designed to be State sponsored, ERISA exempt, qualified under ACA and Medicaid waivers, and structured to receive and administrate all Maine healthcare revenues to be handled by the model

The cost reimbursement system envisioned:

- is not insurance
- is for all Maine residents
- is formed by the State, managed by a contracted private partner Trust Administrator, and has governance that includes all major stakeholders
- must be financially and operationally transparent to all stakeholders, regulators and particularly to the public, integrating the interests of stakeholder via an Oversight Board consisting of a majority of private and stakeholder representation
- reimburses providers fairly and expeditiously
- supports an annual wellness program for each participating resident to enhance preventative and quality care principles

- will be a dedicated "big data" HIPAA compliant system  
The functions of the Trust will be multiple and varied and will include:

1. single source centralized provider reimbursement claims process
2. acting as a central purchasing agent for providers for all supplies and pharmaceuticals
3. assuming responsibility for quality assurance standards, compliance and for dispute resolutions on all matters among the Trust, providers, insurers and the residents of Maine
4. negotiating net reimbursement costs with all provider services, aggregate caps for participating hospitals and setting the Trust budgets and claim attachment points for insurer in the reimbursement structures
5. overseeing the phased-in expansion of services into area service gaps throughout the state in conjunction with our private partners as determined by need in terms of location and services
6. maintaining data and data security to HIPAA standards
7. supporting academic research, especially health promotion and healthcare wellness delivery on issues such as addiction, smoking, nutrition, weight loss, chronic disease, etc.
8. recognizing the personal financial stress of deductibles and co-pays on residents, the model seeks to minimize this burden via financing programs for deductibles, deductible buy-backs from federal subsidies, and the use of annual caps on out-of-pocket payments.

## Tax Revenues

In addition to Federal revenues flow to the State through Medicare and Medicaid, we are contemplating the State's balanced use of other tax structures in lieu of insurance premiums paid by employers and residents, such as payroll tax, gross receipts tax to fund the Trust model and its transition. Further, we propose the adoption of a new and novel Transaction Tax (TT), a flat tax exacted on wholesale, retail, financial and Internet transactions done in Maine. Two-thirds of the revenues brought in by this tax would come from non-resident visitors. Our research estimates an annual TT revenue stream of \$500 million, which would be fully dedicated to the Trust. With the savings generated by the model's efficiencies, the blended use of state and federal tax revenues, the model establishes a framework for a stabilized healthcare provider system that will be affordable and accessible for Maine residents.

## Next Steps:

In order for the revamping of our fee for service system to take place, we are focused in the near term on education all of our residents, stakeholders and political representatives about the problems to be solved and the possibilities that

this hybrid private-public partnership brings to Maine. We endeavor to convince you, our providers our residents our business enterprises, insurers and all those in our population hoping perhaps for more than an incremental change, that his model is of great value now to our State. To that end, we offer you and all who have an interest in protecting the future the benefit of our research and data that we relied on to create the healthcare net cost reimbursement model we present today.

We are mindful that our models must be scrutinized and tested by regulatory, legal and actuarial expertise to win the confidence of the people and this Task Force. To that end, we propose establishing a business plan to move through the 1332 ACA waiver process and the complementary 1115 waiver process with these innovations in mind. We welcome your questions and comments. Thank you.

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FOR TASK FORCE REVIEW 3/2/18  
Follow up to 1/22 Briefing

Rebecca Sperrey  
Chief Revenue Officer, EMHS  
February 8, 2018

Follow up items from presentation to Task Force on Health Care Coverage January 22, 2018

**1. Net Revenue to Gross Revenue % compared to other Maine providers – relationship to cost**

Based on the MHA financial reports, the four health systems in Maine (Central Maine Healthcare Corp, Eastern Maine Healthcare System, Maine General Health and Maine Health) have had net revenue to gross revenue percentages ranging from 45.5% to 53.7%.

Operating costs to gross revenue percentages for the same period range from 45.7% to 53.2% producing very small or negative operating margins.

**2. The areas we see as broken and possible solutions:**

**a. Issues causing payers to deny claims – requiring re-work or write off**

- i. Insurance verification challenges
  1. Payers unable to provide electronic timely verifications
  2. Patients reported as covered when payment has lapsed – no pending status
  3. Government payers with inaccurate primary payer information (i.e. work comp) and the difficulty for the patient to update
- ii. Medical necessity verification is often a manual process with payer policies not providing clear direction
- iii. Prior authorization required for services challenges
  1. Variation of services requiring authorization by payers
  2. Variation in process and timeline for obtaining authorization
  3. Difficulty in obtaining timely authorization from payers
  4. Frequency of policy changes providing requirements
- iv. Claims adjudication practices – variation in utilization of denials reason and adjustment codes
  1. different definition for same codes across payers
  2. non-standard use of electronic payment files (835s)
- v. Denial of claims for issues at the payer with burden on the patient to correct
- vi. Payer requirements for Physician/Provider credentialing/enrollment are inconsistent

**b. Payer policy/contract inconsistency, vagueness, and inaccessibility**

- i. Commercial and Advantage plans variability in utilizing compliance with CMS – including inconsistent application of rules and alignment with payment methodology (examples: provider based, DRG, APC, bundling, readmissions and observation criteria)
- ii. Inconsistent requirements regarding appropriate bill form to be used (examples: professional services, hospital services, ancillary services, provider based billing – Forms 1500 and UB-04)

- iii. Unavailable or unclear payer reimbursement policies
- iv. Unavailable or incomplete payer fee and rate schedules
- v. Frequency of payer policy updates and expectations of acceptance by providers when financial harm is not evaluated prior to release
- vi. Inconsistent audit/lookback periods and unclear audit policies/protocols
- vii. Quality measurement criteria inconsistent and requiring document releases
- viii. Records release delays in payment or causing denials
- ix. Inconsistent timely filing requirements

c. Other process issues

- i. Not all payers utilize electronic claims and payments
- ii. Inconsistent payer compliance with coding principles
- iii. Inconsistent identification of patient responsibility
- iv. Inconsistent Explanation of Benefit forms
- v. Education regarding payer networks falls on providers
- vi. Challenges with Maine Care customer service and claims processing
- vii. Changing legislation with the burden on the provider to educate patients and incur the costs of compliance – often requiring manual efforts
- viii. Patient placement challenges leaving patients in a “no-pay” status

d. Recommendations for improvement

- i. Standardization of payer policy and consistent levels of compliance/adherence to CMS and State laws
- ii. Standardization of payer forms, codes, and requirements
- iii. Standard quality and utilization data requirements amongst payers and governmental agencies
- iv. Standard bill form utilization and filing time requirements
- v. Limits on frequency of policy changes and a requirement for payment impact reviews

3. ***The cost to collect data – detail by area (Patient Access, HIM/Coding, Patient Financial Services)***

EMHS cost to collect ratio (cost to net revenue) for FY17 was 4.4%

Area % of net revenue and total operating costs

Patient Access (pre-service)	0.9% or \$1.4M
HIM (coding/documentation)	1.4% or \$2.4M
Patient Financial Services (billing)	1.7% or \$2.8M
Revenue Cycle	0.4% or \$0.6M

This does not include the cost of technology – generally included are the operating costs of the revenue cycle areas.

4. ***The number of people we assisted with enrolling in the exchange or provided ACA counseling***

122 people were assisted with enrollment for 2018 open enrollment. Not all our service areas tracked appointments, but of those that did, there were 27 counseled with no enrollment.



**5. Bad Debt by payer (financial class) – Bad Debt recovery data (% collected)**

This is data from eight out of nine member hospitals, and six out of nine provider practice groups (Our Siemens data only). This chart shows the financial class of the patient’s account when transferred to Bad Debt (collections). The percentages are based on dollars transferred, not number of accounts.

Prior Financial Class	% of Dollars Transferred to Bad Debt
P: Payment Plan Accounts	7.4%
R: Self Pay after Medicare	6.2%
S: Self Pay - Uninsured	45.7%
T: Self Pay after Non-Medicare	44.0%
Other Financial Classes	0.8%
Reactivated	-4.1%
<b>Total</b>	<b>100%</b>

In FY 17 collection agency recoveries were approximately \$3.8M. The recoveries are on all accounts at the collection agency, not directly related to that year’s placements. Dollars recovered versus dollars sent to collection are just under 5%.

**6. How many people received charity care and how much – segregated by below 150% of FPL and between 150%-250% of FPL**

Estimated overall based on data from eight out of nine member hospitals, and six out of nine provider practice groups (Our Siemens data only)

Below 150% FPL                      approximately \$57M in Free Care  
150% – 250% FPL                      approximately \$4M in Financial Assistance

In December 2017, 771 individuals received financial assistance (501 were below 150% of the FPL)

**7. How many individuals are represented in Self Pay encounters**

Approximately 4,200 individuals create a monthly average of 9,000 – 11,000 self pay encounters based on a three month sample.