TASK FORCE ON
HEALTH CARE COVERAGE FOR ALL OF MAINE

Draft Meeting Agenda
October 2, 2018
9:00 am to 12:30 pm
Room 220, Cross State Office Building

- Welcome and Introduction of Chairs and Members
- Consider Preliminary Recommendations from Study Groups and Review Draft Outline of Report
  - Controlling Costs Study Group
  - Public Options Study Group
  - Structure of the Health Insurance Market Study Group
  - Additional recommendation proposed by Rep. Sanborn
- Discussion of Plans for Next Meeting
- Maine Medical Association's Statement on Reform of the U.S. Health Care System

Public Comment *(at discretion of the chairs, time permitting)*

TASK FORCE ON HEALTH CARE COVERAGE FOR ALL OF MAINE
PRELIMINARY FINDINGS AND RECOMMENDATIONS

{NOT YET VOTED ON OR AGREED TO BY FULL TASK FORCE— BASED ON STUDY GROUP DISCUSSIONS;
STUDY GROUP COMMENTS ON EACH PRELIMINARY RECOMMENDATION INCLUDED TO HELP INFORM TASK FORCE DISCUSSION}

Preliminary Recommendations of the Controlling Costs Study Group

The comments below represent the consensus of the Study Group members who were present at the September 20th meeting *(Rep. Chace was not present)*. The Study Group provides these preliminary comments and potential recommendations for consideration by the task force:

- ❑ ***Enact legislation to regulate pharmacy benefits managers***

At the suggestion of Rep. Sanborn, the Study Group discussed model legislation developed by the National Academy of State Health Policy that would set standards for pharmacy benefit manager (PBM) business practices and fiduciary duties and require licensure for PBMs. Under current Maine law, PBMs are required to register with the Bureau of Insurance. Rep. Sanborn believes that there is a role for government on this issue and that it would benefit all payers, including self-insured employers. Trish Riley explained that the model is designed to provide transparency and accountability for PBM business practices as it is very difficult to understand the "black box" of PBM contracts. Currently, 26 states have enacted legislation addressing PBMs. The model legislation includes common provisions from State law and will soon be updated to address "spread pricing." "Spread pricing" is a pricing model where payers purchase drugs at a retail rate higher than the discounted price negotiated by the PBM and the PBM retains the "spread"—the difference between the purchase price and the negotiated rate.

The Study Group noted that the model legislation can be changed and that some changes, if legislation were put forward in Maine, are warranted. For example, the model includes a ban on gag clauses which has already been enacted in Maine. Gag clauses refer to contractual provisions that prohibit a pharmacist from communicating with a consumer about the price differential between the cost of a drug if it were paid for out-of-pocket and the cost of a drug based on the copayment or other cost-sharing required for a drug under the consumer's health plan. Members also noted that another important factor to consider is the appropriate oversight entity for PBMs, whether it is the Bureau of Insurance or the Department of Health and Human Services. Staff explained that Maine did enact legislation in 2003 regulating PBMs, including a provision similar to the model's provision stating that PBMs have a fiduciary duty to payers. The law was repealed in 2011. Staff will review the legislative history to identify the policy reasons for the Legislature's actions in 2011.

Given the current state of prescription drug prices and the expanding role of PBMs, the members agreed that this is an appropriate time to take legislative action to address accountability and transparency of PBMs. The Study Group agreed to recommend that the Task Force put forward legislation to regulate pharmacy benefits managers, using the model legislation as the basis for the proposal.

More information on this issue and model legislation can be found at https://nashp.org/pharmacy-benefit-manager/ Current Maine law related to registration of PBMs can be found here: http://legislature.maine.gov/legis/statutes/24-A/title24-Asec1913.pdf

- ❑ ***Monitor activity in Vermont as it works to implement a state-sponsored wholesale importation program for certain high cost prescription drugs from Canada and explore opportunities for regional collaboration with Vermont and other New England states on wholesale importation program***

The Study Group considered a proposal to establish a state-administered system to import and distribute certain prescription drugs from Canada; drugs purchasers, including pharmacies, drug distributors and health plans, would agree to purchase and reimburse drugs based on the imported price. If enacted, this proposal would require a federal waiver/authorization. The National Academy for State Health Policy has developed model legislation. Vermont recently became the first state to enact legislation to authorize that State to establish an importation program and request the necessary federal waivers.

The members expressed some concerns about moving forward on this proposal. Ms. Riley noted that Vermont has a 'heavy lift" to obtain the necessary federal waivers to authorize the program and that federal law will limit the types of drugs that can be imported. For example, she explained that biologic drugs, which are among the most expensive, cannot be imported at this time. In addition, there are a number of administrative and business challenges to be considered if wholesale importation is to be implemented. Ms. Riley suggested that Maine may be better off waiting and trying to learn from Vermont's experience. Mark Hovey expressed concern about unintended consequences and whether costs would be shifted to other drugs. Although members noted that this approach may be more easily understood by consumers than other approaches, it was suggested that the group continue to monitor activities in Vermont and other states. Jeff Austin noted that the Legislature could require staff to report regularly on Vermont's activities. Rep. Sanborn agreed and noted that the Task Force will likely be considering how best to continue its work in the next Legislature through the re-establishment of a task force or through legislative committees. Rep. Sanborn also suggested that there may be opportunities for Maine and other states to collaborate with Vermont on an importation program.

The Study Group agreed to recommend that the Task Force require that staff continue to monitor and analyze Vermont's implementation of a wholesale importation program and to provide regular updates to the Legislature on those activities. The Study Group also agreed to recommend that the Legislature explore opportunities for regional collaboration with Vermont and other New England states related to a wholesale importation program.

More information on this issue and model legislation can be found at https://nashp.org/drug-importation/

- ❑ ***Continue further study and analysis of model legislation to establish state commission authorized to set maximum rates paid for certain high cost prescription drugs***

The Study Group discussed model legislation developed by the National Academy for State Health Policy that would establish a state commission to review the cost of certain prescription drugs based on parameters set forth in the law and establish a maximum amount that payers, both public and private, would pay for those individual drugs. Similar legislation has been put forward in Maryland, but has not been enacted. The creation of such a commission does not require federal approval to implement. It would set thresholds for price increases to trigger commission review and cap the payments for all payers. The commission does not set prices but would cap what payers pay for drugs.

The study group discussed whether to recommend that legislation be developed by the Task Force and introduced in the next session. Ms. Riley noted that one advantage to this proposal over the wholesale importation proposal is that all categories of drugs can be included, notably very expensive biologic drugs and new drugs to market. Mark Hovey reiterated his concerns about unintended consequences and

wondered whether the proposal needs more analysis of its costs and benefits. Rep. Sanborn noted the risks associated with the proposal that some manufacturers may respond by not making certain drugs available in Maine, despite the potential for public backlash. Sens. Carson and Gratwick expressed their support for the proposal, based on the belief that there need to be some steps taken to control rising drug costs. Rep. Sanborn reminded the group that the written comments provided by Rep. Chace suggest that he would not be in favor of this proposal. Rep. Chace provided comments on this proposal when it was previously circulated and his comments were distributed at Sept. 12th Task Force meeting.

Rep. Sanborn also expressed concern that the limits set in the model (whatever they were) could provide a way for manufacturers to price drugs in a manner that would avoid review if they were under the limit. Another concern for Rep. Sanborn is the need for funding the commission and where the funding would come from. Sen. Carson expressed the same concerns and suggested that the source or sources of funding require further study. Mark Hovey stated that if fee-based funding was expected it would raise significant concerns for employers as those fees are typically passed through directly, reminding members that the MGARA assessment is a significant concern for many employers.

Given the concerns, Jeff Austin asked whether the proposal was to recommend that a bill be introduced next session or that the task force or other stakeholder group develop legislation for introduction to a future session. Some members expressed their willingness to introduce a bill next session and to let the legislative process resolve any concerns. Mr. Austin said he would not be comfortable with a recommendation to introduce legislation in the next session, but thought it would be worthwhile to continue study and analysis of this proposal.

The Study Group agreed to recommend that the Task continue to study and analyze the model legislation and activities in other states to consider similar legislation.

More information and model legislation can be found at https://nashp.org/rate-setting/

- ❑ ***Defer consideration of ways to reduce administrative costs and reporting burden by standardizing billing for medical services to allow stakeholder additional time to develop recommendations***

At previous meetings, the Study Group members discussed the possibilities for reducing administrative costs through standardization of the billing and claims process. This issue was the focus for a 1998 legislative study by The Task Force to Study the Feasibility of a Single Claims Processing System for 3rd-Party Payors of Health Care Benefits. At that time, the task force declined to make recommendations for legislation and decided to defer to national efforts and private sector efforts to encourage electronical claims processing and simplify administrative claims processes. Many of the same issues raised years ago continue to exist today. Despite the use of the same form, government and commercial payers have different requirements for submitting claims. While Maine has enacted some laws designed to standardize the billing and claims process, the group determined that it may be useful to gather more information and suggestions from providers and payers for additional measures to streamline the claims process.

Jeff Austin has reached out to the State Uniform Billing Committee (SUBC) and providers to gather more information and seek suggestions for potential ways to streamline the process. One of the issues that members of the SUBC have expressed concerns about is the prior authorization process. One example described by Mr. Austin related to a recent proposed rule by DHHS for the MaineCare program; the proposed rule would require providers to call DHHS to determine if prior authorization is needed for lab services and then for providers to submit the necessary paperwork. Mr. Austin noted that hospitals alone provide approximately 250,000 lab services annually, frequently in evening and on weekends when DHHS will not be available for phone calls, and that the proposal raises many logistical concerns.

Because the next meeting of the SUBC isn't until after the Study Group and Task Force is expected to complete its work. Mr. Austin suggested that the Study Group defer any specific recommendation at this time. Mr. Austin and the Maine Hospital Association will work with the Maine Medical Association and members of the SUBC to develop recommendations and look for efficiencies in the process with all payers, public and commercial.

The Study Group agreed to defer consideration of ways to reduce administrative costs and reporting burden by standardizing billing for medical services to allow stakeholder additional time to develop recommendations.

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Preliminary Recommendations of the Public Options Group

Based on the Study Group's discussions to date, the following preliminary recommendations from the Study Group are suggested for consideration by the task force:

- ❑ ***Continue the work begun by the Task Force (and Public Options Study Group) to develop, study and analyze options for health care reform through the 129th Legislature***

The Study Group would like to spend more time developing a concept for a new model for providing health care coverage to residents of Maine. The Study Group acknowledged that the development of a public/private universal coverage model is a long-term endeavor; work should continue through the 129th Legislature.

- ❑ ***Seek funding for actuarial analysis and study of design options***

The Study Group acknowledged that any model or models would need careful actuarial analysis and study. Funding is needed for that analysis and the Task Force, Legislature and other stakeholders should pursue all avenues for additional funding.

- ❑ ***Incorporate the following elements into the design of any public option or other model for health care reform:***

  - ***System must be simpler and predictable***
  - ***Funded though contributions from all residents, including those receiving public benefits***
  - ***Coverage for all residents—everybody in***
  - ***Oversight through a centralized government trust or authority***
  - ***Coverage provided through existing carriers---focus competition among carriers on service and consumer engagement in health and wellness***
  - ***Provide agreed-upon "basic health plan" or uniform benefits package with supplemental coverage and benefits available***
  - ***Changes in reimbursement/payment model for health care provides to eliminate/reduce cost-shifting***
  - ***Reinsurance and risk adjustment for carriers***
  - ***Cost containment measures needed to bring down costs, including administrative costs and prescription drug costs***
  - ***Implement system for electronic sharing of individual health care data among carriers and providers---facilitate access to medical records/coverage information through single ID card***

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Preliminary Recommendations of the Structure of the Health Insurance Market Study Group

Unless noted, the comments below represent the consensus of the Study Group members. The Study Group provides these preliminary comments and potential recommendations for consideration by the task force:

- ***Continue to study and analyze possible statutory changes, including changes related to Maine's reinsurance mechanism (MGARA), the segregation of the individual risk pool, the definition of small group, and the determination/counting of full-time equivalent employees for insurance purposes***

While the members initially discussed a recommendation to seek a waiver to restart operations of Maine's reinsurance mechanism (MGARA) back in April, that recommendation is no longer relevant since a waiver request was submitted to and granted by the Federal government. MGARA's operations are expected to resume in January 2019. The members did discuss the potential for changes that would have an impact on MGARA's operations, including the segregation of the risk pool within MGARA to limit reinsurance to unsubsidized policies or policies sold off the federal marketplace, changing the definition of "small group", merging the individual and small group markets, expanding eligibility for reinsurance to small group policies as well as individual policies and changing the way in which an FTE is determined for insurance purposes. The members decided to recommend that there be continued study, analysis and research done by MGARA and the Bureau of Insurance on these potential policy changes.

- ***Monitor the practice of "silver loading" of ACA marketplace policies to mitigate impact of changes to cost sharing reductions under the ACA***

The study group discussed the impact of the elimination of cost-sharing reductions for enrollees in the federal marketplace that had incomes at or below 250% of the federal poverty level. For many enrollees, the impact of the reduction was mitigated by a practice called "silver loading". Rather than simply raising the cost of all ACA health plans ("bronze," "silver," "gold," and "platinum" plans), insurers added the CSR-related premium rate increases into just silver-level plan premiums. Because the ACA uses the premium for "silver" plans to determine the premium subsidies available to individuals with annual incomes below 400% of FPL, when premiums for silver plans increased, federal subsidies increased along with them. The study group recognizes that silver loading" has had a mitigating effect on premium increases for consumers receiving federal subsidies and recommends continued monitoring of activities at the federal and state level that affect the availability of cost-sharing reductions for enrollees in the federal marketplace or the practice of "silver loading".

- ***Monitor federal activity related to the Sec. 1332 waiver process and consider engaging Congressional delegation to seek changes to streamline the waiver process***

The study group acknowledged that several of the policy options discussed by the study group related to MGARA and the individual and small group market may require a 1332 waiver of certain requirements of the ACA. The requirements of the current waiver process are time consuming. Members noted that the task force should pay attention to activity at the federal level related to the waiver process and consider whether the task force should engage Maine's Congressional delegation to seek changes to streamline the waiver process for states.

❑ ***Monitor activity in states that have enacted a state-level individual mandate***

The study group discussed the issue of incentivizing the purchase of health insurance coverage and whether to recommend a state-level individual mandate to replace the federal mandate following its repeal. One member noted that it would be unfair to recommend such a mandate without providing access to coverage through Medicaid expansion and sufficient financial assistance to purchase health insurance in the face of premium increases. Other members wondered whether a mandate would really help without adequate enforcement and affordable options for coverage and whether it could be successful at the state level. Members agreed it would be useful to monitor New Jersey and other states that have recently enacted a state mandate. Members also discussed other policy options that could improve the stability of the individual market in the absence of a mandate. Members felt that financial incentives and financial assistance to purchase coverage could be more important than a mandate.

❑ ***Support implementation of Medicaid expansion*{does not represent consensus of Study Group members}***

A majority of the members support Medicaid expansion and believe the task force should consider a recommendation supporting expansion and efforts to implement expansion.

❑ ***Monitor how changes in federal rules for short-term health insurance policies impact Maine's individual market***

The members discussed the recent changes to federal rules related to short-term health insurance policies and reviewed Maine's current law governing short-term policies. Federal regulations governing short-term health insurance policies were changed in early August and become effective for short-term policies sold on or after October 2, 2018. The federal regulations extend the maximum coverage period for short-term policies from 3 months to less than 12 months (or 364 days). The regulation also permits carriers who offer short-term policies to renew those policies for a total of 36 months. The prior federal rule prohibited renewals. Current Maine law mirrors the federal rule by defining a short-term policy as one with a term of less than 12 months. However, Maine law prohibits renewal of short-term policies and limits the maximum coverage under successive short-term policies to 24 months. The federal rule allows states to regulate short-term policies in a more restrictive manner, including prohibiting the sale of short-term policies altogether. It was also suggested that that the task force could consider statutory changes to mirror the federal rules. The members agreed that it is important to monitor how the changes in federal rules may impact the sale of short-term policies in Maine health insurance market, the availability and affordability of health insurance coverage and the stability of the market for ACA-compliant individual health plans.

❑ ***Monitor implementation of "right to shop" programs by health insurance carriers subject to requirements***

The members discussed whether the "right to shop" program should be expanded to include additional categories of health care services. Because the effective date for health insurers subject to the law to offer health plans with "right to shop" incentives is not until January 2019, the members believe it is premature to recommend changes, but that the program should be monitored to determine if additional changes should be considered.

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- ***Monitor impact of reduction in federal funding for navigators and consider the possibility of providing State funding for navigators***

The members discussed the significant reduction in federal grant funding for navigators for the 2019 enrollment period. In terms of federal funding for navigator assistance in Maine, the total amount of funding allocated to Maine for the 2018-2019 program year is $100,000; this is a significant reduction in total funding as $551,750 was awarded in 2017. Maine's 2 grantees in 2017 were: 1) The Fishing Partnership Health Plan, which was awarded $100,000; and 2) Western Community Action Program, which was awarded $451,750. On September 12th, CMS announced the 2018 grant awards. Maine has one grantee: Western Maine Community Action Program was awarded $100,000. The members agreed to suggest that the task force monitor the impact of the reduction in federal funding for navigators and consider the possibility of providing state funding be provided for navigators.

- ***Consider changes to Maine Health Data Organization statute to strengthen reporting requirements related to health care costs***

During its discussion of the Maine Health Data Organization's capacity to provide health care cost information with Karynlee Harrington, the members talked about the possibility of amending MHDO's enabling law to improve the cost and quality information available to the public. The members agreed to recommend that statutory changes to Section 8712 of MHDO's governing statutes be considered to strengthen and integrate MHDO's collection and reporting of cost and quality measures.

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Additional recommendation Proposed by Representative Sanborn

This proposed recommendation has been made by Rep. Sanborn for the Task Force's consideration:

- [ ] ***Recommend by letter to the Presiding Officers that the Insurance and Financial Services Committee be renamed the Health Care and Financial Services Committee and that its jurisdiction be expanded to encompass:***
    - ***Prescription Drugs, including legislation to regulate pharmacies, pharmacist, pharmacy benefits managers and prescription drug costs***
    - ***Hospital and Other Health Care Facility Licensing and Regulation, including oversight of the Certificate of Need Program***
    - ***Health Information and Data, including oversight of the Maine Health Data Organization***
    - ***Health Care Professional and Occupational Licensing, including oversight of legislation relating to the licensing and regulation of health care professionals and their professional licensing boards***

This proposed recommendation flows from the fact that our efforts to get a handle on health care affordability and access issues will require a sustained effort over many years. A two-year task force or select committee that will dissolve at the end of the 129th Legislature does not represent the best path forward for these sustained efforts.

Instead, the Health Care and Financial Services Committee should be tasked with continuing to develop a more comprehensive model for driving down health care costs and increasing affordability and accessibility for all Mainers. This proposal unifies the jurisdiction over prescription drugs, hospitals and other providers, and health information and data within a single committee that has the time and capacity to focus on our health care system in its entirety. The HCFS Committee should also be responsible for continuing to study and monitor the innovations being introduced in other states and for working on a model for larger scale reform proposals in Maine. Rep. Sanborn proposes that the Task Force recommend that the HCFS coordinate its efforts closely with the Health and Human Services Committee so that public spending through the MaineCare program is part of the broader conversation about health reform as well.

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STATE OF MAINE
128th LEGISLATURE

Task Force on Health Care Coverage for All of Maine

November 2018

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Members:
Sen. Rodney L. Whittemore, Chair
Rep. Heather B. Sanborn, Chair
Sen. Geoffrey M. Gratwick
Sen. Eric L. Brakey
Rep. Robert A. Foley
Rep. Anne C. Perry
Rep. Paul Chace
Kristine Ossenfort
Joel Allumbaugh
Mark Hovey
Jeffery A. Austin
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Executive Summary

[TO BE ADDED]

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I. INTRODUCTION

The Task Force on Health Care Coverage for All of Maine was established by Joint Order, SP 592 as amended by House Amendment "A". The purpose expressed in the Joint Order was to ensure that all residents of the State have access to and coverage for affordable, quality health care and to study the design and implementation of options for a health care plan that provides coverage for all residents of the State. A copy of the Joint Order, S.P. 592 as amended, is included as Appendix A.

Although the Joint Order asked the Task Force to study the design and implementation of options for different health care plans providing coverage for all residents of the State, the Joint Order also provided authority and discretion for the Task Force to consider a broad range of issues affecting the accessibility and affordability of health care coverage. The Task Force agreed to approach its work to first understand what is broken in the current health care system and then to work together to identify potential policy solutions.

The Task Force has 16 members: 8 legislative members; and 8 non-legislative members representing interests specifically identified in the Joint Order. Senator Rodney L. Whittemore was named Senate chair and Representative Heather B. Sanborn was named House chair. Pursuant to the Joint Order, the legislative members are bipartisan and 7 of the 8 members also serve on the Joint Standing Committee on Health and Human Services or the Joint Standing Committee on Insurance and Financial Services. The Task Force members are:

Sen. Rodney L. Whittemore, Senate Chair	*Senate Chair and member of Insurance and Financial Services Committee, appointed by the President of the Senate*
Rep. Heather B. Sanborn, House Chair	*House Chair and member of Insurance and Financial Services Committee, appointed by the Speaker of the House*
Sen. Geoffrey M. Gratwick	*Senate member, appointed by the President of the Senate*
Sen. Eric M. Brakey	*Senate member of Health and Human Services Committee, appointed by the President of the Senate*
Sen. Everett Brownie Carson	*Senate member of Insurance and Financial Services Committee, appointed by the President of the Senate*
Rep. Robert A. Foley	*House member of Insurance and Financial Services Committee, appointed by the Speaker of the House*
Rep. Anne C. Perry	*House member of Health and Human Services Committee, appointed by the Speaker of the House*
Rep. Paul Chace	*House member of Health and Human Services Committee, appointed by the Speaker of the House*

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Kristine Ossenfort	*Representing the interests of health insurance carriers, appointed by the President of the Senate*
Joel Allumbaugh	*Representing the interests of consumers, appointed by the President of the Senate*
Mark Hovey	*Representing the interests of employers with greater than 50 employees, appointed by the President of the Senate*
Jeffrey A. Austin	*Representing the interests of hospitals, appointed by the President of the Senate*
Daniel Kleban	*Representing the interests of employers with fewer than 50 employees, appointed by the Speaker of the House*
Kevin Lewis	*Representing the interest of health insurance carriers, appointed by the Speaker of the House*
Francis McGinty	*Representing the interests of health care providers, appointed by the Speaker of the House*
Patricia Riley	*Representing the interests of consumers, appointed by the Speaker of the House*

The complete membership of the Task Force, including contact information, is included as Appendix B. As directed by the Joint Order, the President of the Senate and the Speaker of the House of Representatives invited the participation of the Commissioner of Health and Human Services and the Superintendent of Insurance or their designees, as members of the task force, but that invitation was declined. The Office of Policy and Legal Analysis provided staff support to the Task Force.

With authorization from the Legislative Council, the Task Force met 8 times: once in 2017 on December 20; and 7 times in 2018: January 22, March 2, April 2, May 23, September 12, October 2, and October 15. All of the meetings were held in the State House Complex in Augusta and open to the public. Live audio of each meeting was made available through the Legislature's webpage.

The Task Force also established a website which can be found at http://legislature.maine.gov/task-force-on-health-care-coverage. The website includes agendas, meeting materials and links to related resources.

This report fulfills the Task Force's requirement to submit a final report for presentation to the First Regular Session of the 129th Legislature.

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II. *[TO BE ADDED]*

III. TASK FORCE PROCESS

❖ Survey

As a tool to help better understand the areas of agreement and identify possible areas of disagreement among the Task Force members, the chairs developed a survey. The chairs anticipated that the results of the survey and the expertise of Task Force members would be used to frame the task force's remaining work. Thirteen of the 16 members responded to the survey. A summary of the survey responses can be found in Appendix__.

After reviewing the survey, the Task Force recognized that there was some common ground among the members, particularly with regard to reducing the cost of health care services and prescription drugs. The survey responses were used by the study groups as a framework for discussion.

❖ Study Groups

The Task Force formed 3 study groups organized around the following topics: Controlling Costs; the Structure of the Health Insurance Market; and Public Options. The chairs considered preferences expressed by members and named the following members to each study group:

Controlling Costs Study Group: Sen. Brownie Carson, Rep. Paul Chace, Jeff Austin, Trish Riley, Mark Hovey

Public Options Study Group: Sen. Geoff Gratwick, Rep. Bob Foley, Dan Kleban, Kevin Lewis

Structure of the Health Insurance Market Study Group: Rep. Anne Perry, Sen. Eric Brakey, Joel Allumbaugh, Kristine Ossenfort, Frank McGinty

The Study Groups were directed to develop potential policy recommendations related to each subject area for consideration by all members of the Task Force. The Study Groups used the time between the Task Force's May and September meetings for discussion. The following summarizes the discussions of each Study Group.

Controlling Costs Study Group. The Controlling Costs Study Group met 3 times in person or by conference call: March 28, May 21 and September 20. The Study Group also circulated proposals for consideration and comment in writing. Rep. Sanborn, House Chair of the Task Force, and Sen. Gratwick participated in some discussions.

The Study Group's goal was to develop both long-term and short-term approaches to controlling costs. The Study Group initially identified four areas of interest for further discussion:

1. Reduction of administrative costs in the billing/claim processes
2. Reimbursement/rate reform-- reasonable reimbursement to providers for services

3. Reduction of prescription drug costs/growth rate
4. Incentives to change behavior to avoid medical care cost--prevention

Between the May and September meetings of the Study Group, the members narrowed its focus to potential policy options to help control prescription drug costs. At the September 20th meeting, the Study Group developed its preliminary recommendations for consideration by the Task Force. Rep. Chace was not present at that meeting, but circulated written comments expressing concerns about the potential legislative recommendations prior to the meeting.

Public Options Study Group. The Public Options Study Group met 7 times: March 23, March 30, May 8, July 25, August 15, August 22 and September 5. Rep. Sanborn, House Chair of the Task Force, participated in some discussions.

The Study Group noted that significant time is needed to develop a concept for a new model or models for providing health care coverage to residents of Maine. The Study Group identified several important elements of any new health care model that must be included moving forward:

- System must be simpler and predictable
- Funded though contributions from all residents, including those receiving public benefits
- Coverage for all residents—everybody in
- Oversight through a centralized government trust or authority
- Coverage provided through existing carriers---focus competition among carriers on service and consumer engagement in health and wellness
- Provide agreed-upon "basic health plan" or uniform benefits package with supplemental coverage and benefits available
- Changes in reimbursement/payment model for health care provides to eliminate/reduce cost-shifting
- Reinsurance and risk adjustment for carriers
- Cost containment measures needed to bring down costs, including administrative costs and prescription drug costs
- Implement system for electronic sharing of individual health care data among carriers and providers---facilitate access to medical records/coverage information through single ID card

The study group acknowledged that any model would need careful actuarial analysis and study. The group also recognizes the difficult politics surrounding the enactment and implementation of such a model. Despite those challenges, the study group believes the system needs large scale and long-term reform.

Following the May task force meeting, the Public Options Study Group met four times by conference call. To facilitate public access, staff moderated the calls from the IFS Committee Room so members of the public could attend the meeting or listen through the audio links on the Legislature's website. The primary purpose of the calls was to discuss current and past health

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care reform efforts in several states and to discern what lessons could be learned as the study group considers potential recommendations for health care policy changes.

The following conference calls were held by the Study Group.

Wednesday, July 25th from 12:00 pm to 2:00 pm with Trish Riley, current task force member who was Director of the Governor's Office of Health Policy and Finance when Dirigo Health was enacted. Ms. Riley provided her perspective on the Dirigo Health Program here in Maine.

Wednesday, August 15th from 9:00 am to 11:00 am with Dr. Deb Richter. Dr. Richter is a physician and board member of Vermont Health Care for All. She discussed universal health care efforts in Vermont.

Wednesday, August 22nd from 12:00 pm to 2:00 pm with Lyn Gullette, Co-Operate Colorado, and Ivan Miller, Colorado Foundation for Universal Health Care. They discussed universal health care efforts in Colorado.

Wednesday, September 5th from 9:30 am to 11:30 am with John Colmers, Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Medicine. Mr. Colmers discussed health policy efforts in Maryland, including global budgeting and rate setting.

Structure of the Health Insurance Market Study Group. The Structure of the Health Insurance Market Study Group met five times: March 26, April 23, May 21, July 24 and August 28. Sen. Gratwick also participated in some discussions.

The Study Group focused on the consideration of policy recommendations related to the individual and small group health insurance market. The members hoped to develop recommendations that would target certain populations experiencing problems related to health insurance coverage in the existing market, including:

- Individuals who have incomes below 100% of the federal poverty level who do not qualify for the APTC (advanced premium tax credit);
- Individuals who are "lightly subsidized" and particularly sensitive to health insurance premium increases;
- Individuals who have incomes above 400% of the federal poverty level who do not qualify for the APTC; and
- Those enrolled in the small group health insurance market.

Study Group members noted that current federal law and uncertainty related to the action/inaction of the federal government are important factors in whether possible policy solutions can succeed at the state level to improve the affordability and stability of the health insurance market in Maine. Another significant factor not directly addressed by the study group is the underlying cost of health care, which drives the cost of health insurance; as a result, the efforts of the Controlling Costs Study Group and policy recommendations to control health care costs are very important.

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The Study Group considered a number of possible policy options and identified the advantages and disadvantages of each policy option and the potential barriers to implementation. The Study Group also discussed the importance of having data to inform its policy recommendations and talked with the Maine Health Data Organization about whether its claims database could be more rigorously utilized to determine cost drivers, cost variations, trends and quality. The Maine Health Data Organization provided certain information related to health care claims costs requested by the Study Group.

IV. RECOMMENDATIONS

[TO BE ADDED AFTER TASK FORCE MEETINGS ON 10/2 AND 1/15]

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APPENDIX A

Authorizing Joint Order

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APPENDIX B

Membership list, Task Force on Health Care Coverage for All of Maine

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Task Force on Health Care Coverage for All of Maine
September 12, 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. Robert Foley; Rep. Anne Perry; Joel Allumbaugh; Dan Kleban; Kevin Lewis; Frank McGinty; Kris Ossenfort; and Trish Riley.

Task Force Members Absent:
Sen. Eric Brakey; Rep. Paul Chace; Jeff Austin; and Mark Hovey.

Staff: Colleen McCarthy Reid

Welcome and Introductions

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

Update on Status of Sec. 1332 Waiver and Medicaid Expansion

Staff provided a brief update on the status of 2 items of interest to the Task Force.

Maine Guaranteed Access Reinsurance Association (MGARA) : The State of Maine, through the Bureau of Insurance, applied for a Section 1332 State Innovation waiver to the United States Department of Treasury and the Centers for Medicare and Medicaid Services (CMS) within the federal Department of Health and Human Services on May 9, 2018. The request permitted under Section 1332 of the federal Affordable Care Act seeks a waiver of certain provisions of the ACA to permit reinstatement of the Maine Guaranteed Access Reinsurance Association (MGARA) beginning in the 2019 plan year.

The waiver was approved on July 30, 2018.

Final rates for the 2019 plan year in the individual and small group markets have been approved by the Bureau of Insurance.

MGARA's Board of Directors must submit a revised plan of operations to the Bureau of Insurance for approval, consistent with the terms of the waiver. Based on discussions with the Bureau of Insurance, that revised plan of operation is being prepared and is expected to be submitted soon. The first quarterly assessment is expected to be due from carriers on April 30, 2019; federal funding pursuant to the waiver is also expected in April 2019.

Medicaid Expansion: Although Medicaid expansion approved by Maine voters and enacted into law effective July 2, 2018, the LePage Administration has not moved forward to implement the expansion because of disputes with the Legislature over whether additional appropriation of funding by the Legislature is needed. A lawsuit challenging the Administration's action has been filed and a final decision on the underlying legal issues is still pending.

As required by a preliminary court order, the State of Maine submitted a request for a State Plan Amendment related to Medicaid expansion on September 4, 2018. Concurrently with the submission of the SPA request, Governor LePage sent a letter on August 31, 2018 to Secretary of the U.S. Department of Health and Human Services Alex Azar and Administrator of the Centers for Medicare and Medicaid

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Services Seema Verma urging CMS to reject the SPA submitted by the State. It has also been widely reported by the media that DHHS has rejected Medicaid applications submitted to DHHS by those individuals otherwise eligible for Medicaid (based on expansion).

The background materials that were distributed to the Task Force are posted on the task force's website with the September 12th Meeting Materials at: http://legislature.maine.gov/doc/2411

Structure of the Health Insurance Market Study Group Update

The Structure of the Health Insurance Market Study Group met twice since the last Task Force meeting: July 24 and August 28. The following members of the Study Group have regularly attended meetings: Rep. Anne Perry, Kristine Ossenfort, Joel Allumbaugh and Frank McGinty. Sen. Gratwick also attended July 24 and August 28 meetings.

Rep. Perry briefly outlined the preliminary recommendations developed by the Study Group. Unless noted, the potential recommendations represented the consensus of the Study Group members. The recommendations include:

- *Continue to study and analyze possible statutory changes, including changes related to Maine's reinsurance mechanism (MGARA), the segregation of the individual risk pool, the definition of small group, and the determination/counting of full-time equivalent employees for insurance purposes*
- *Support the continuation of the practice of "silver loading" of ACA marketplace policies to mitigate impact of changes to cost sharing reductions under the ACA*
- *Monitor federal activity related to the Sec. 1332 waiver process and consider engaging Congressional delegation to seek changes to streamline the waiver process*
- *Monitor activity in states that have enacted a state-level individual mandate*
- *Support implementation of Medicaid expansion*(majority recommendation; not supported by all Study Group members)*
- *Monitor how changes in federal rules for short-term health insurance policies impact Maine's individual market*
- *Monitor implementation of "right to shop" programs by health insurance carriers subject to requirements*
- *Support State funding for navigators*
- *Make changes to Maine Health Data Organization statute to strengthen reporting requirements related to health care costs*
- *Monitor health insurance carrier practices related to prior authorizations and review of clinical appeals*

Several Study Group members suggested changes to the wording of the potential recommendations to clarify the intent. Joel Allumbaugh suggested that the language related to "silver loading" be changed to reflect that the Task Force cannot take action related to "silver loading" since it is a practice permitted at the discretion of federal and state regulators. The language should say that the Task Force should monitor the practice going forward. Mr. Allumbaugh also suggested that the language related to navigators be changed to recommend that the impact of the reduction in federal grant funding be monitored and that the possibility of State funding be considered. Ms. Ossenfort also suggested that the members consider whether the recommendation related to health insurance carrier practices for prior authorization addressed the focus developed by the Study Group to target certain populations in the individual and small group

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health insurance market. Sen. Gratwick, who had originally raised the issue, agreed with Ms. Ossenfort. The members agreed to remove that draft recommendation.

The Update from the Structure of the Health Insurance Market Study Group is posted on the website with the September 12th Meeting Materials at: http://legislature.maine.gov/doc/2411

Controlling Costs Study Group Update

After the May meeting, the Controlling Costs Study Group circulated proposals for consideration and comment by email. The focus has been on potential policy options to help control health care costs, particularly prescription drug costs.

Sen. Carson explained that the Study Group has discussed a proposal to establish a state-administered system to import and distribute certain prescription drugs from Canada; drugs purchasers, including pharmacies, drug distributors and health plans, would agree to purchase and reimburse drugs based on the imported price. If enacted, this proposal would require a federal waiver/authorization. The National Academy for State Health Policy has developed model legislation. Vermont recently became the first state to enact legislation to authorize that State to establish an importation program and request the necessary federal waivers. More information on this issue and model legislation can be found at https://nashp.org/drug-importation/

Another proposal that interests some of the Study Group members is a proposal developed by the National Academy for State Health Policy that would establish a state commission to review the cost of certain prescription drugs based on parameters set forth in the law and establish a maximum amount that payers, both public and private, would pay for those individual drugs. Similar legislation has been put forward in Maryland, but has not been enacted. More information and model legislation can be found at https://nashp.org/rate-setting/ The creation of such a commission does not require federal approval to implement. It would set thresholds for price increases to trigger commission review and cap the payments for all payers. The commission does not set prices but would cap what payers pay for drugs. Prior to the meeting, Rep. Chace submitted written comments expressing his concerns about the proposal. A copy of Rep. Chace's written comments are included with the Controlling Costs Study Group Update posted with the meeting materials at http://legislature.maine.gov/doc/2412

Rep. Sanborn proposed that the Study Group also consider model legislation to address pharmacy benefit manager (PBM) business practices. Model legislation developed by the National Academy of State Health Policy was distributed for review. More information on this issue and the model legislation can be found at https://nashp.org/pharmacy-benefit-manager/

The Study Group agreed to consider the model legislation suggested by Rep. Sanborn along with further consideration of other proposals related to controlling costs of prescription drugs. The Study Group will meet before the next Task Force meeting to see if consensus on any recommendations is possible.

Public Options Study Group Update

Following the May task force meeting, the Public Options Study Group met four times by conference call. The Study Group members are Sen. Gratwick, Rep. Foley, Dan Kleban and Kevin Lewis. Rep. Sanborn has also listened in on some calls. To facilitate public access, staff moderated the calls from the IFS Committee Room so members of the public could attend the meeting or listen through the audio links on the Legislature's website.

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The primary purpose of the calls was to discuss current and past health care reform efforts in several states and to discern what lessons could be learned as the study group considers potential recommendations for health care policy changes.

The following conference calls were held by the Study Group.

- **Wednesday, July 25th from 12:00 pm to 2:00 pm** with Trish Riley, former Director of the Governor's Office of Health Policy and Finance and current task force member. Ms. Riley provided her perspective on the former Dirigo Health Program here in Maine.

- **Wednesday, August 15th from 9:00 am to 11:00 am** with Dr. Deb Richter. Dr. Richter is a physician and board member of Vermont Health Care for All. She discussed universal health care efforts in Vermont.

- **Wednesday, August 22nd from 12:00 pm to 2:00 pm** with Lyn Gullette, Co-Operate Colorado, and Ivan Miller, Colorado Foundation for Universal Health Care. They discussed universal health care efforts in Colorado.

- **Wednesday, September 5th from 9:30 am to 11:30 am** with John Colmers, Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Medicine. Mr. Colmers discussed health policy efforts in Maryland, including global budgeting and rate setting.

Summaries of the conference calls are posted with the Controlling Costs Study Group materials on the Task Force's website at: http://legislature.maine.gov/doc/2411

Sen. Gratwick noted that the Study Group learned a lot through these conference calls and wants to continue discussions about how best to develop a proposal or proposals to provide health care to all Maine residents. Sen. Gratwick suggested that the Task Force should discuss further how best to move forward given the constraints of the Joint Order creating the Task Force and the desire to keep working to develop long-term solutions.

Rep. Foley also reported to the Task Force about his recent trip to Iceland and meeting with Iceland's Minister of Health. Rep. Foley described Iceland's health care system, which is both funded and administered by Iceland's government.

Next Meetings

The next meetings were tentatively scheduled for October 2 and October 15. Staff will poll members to determine whether morning or afternoon meeting time works best. Subsequently, the meetings were scheduled for October 2 and October 15 from 9:00 am to 12:30 pm.

Public Comment

Phil Caper, who is one of the founding directors of MaineAllCare, provied brief comments to the Task Force. Mr. Caper pointed out the criteria developed by MaineAllCare to help evaluate the group's position on policy proposals: Is it transparent? Is it simple? Does it contain costs? Does it cover everyone? and Is it politically sustainable? Mr. Caper acknowledged that there are constraints on policymakers, but asked the Task Force members to expand their definition of what's possible.

The meeting adjourned at 12:25 pm.

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Maine Medical Association

Charles F. Pattavina, MD, President | Robert J. Schlager, MD, President-Elect | Amy Madden, MD, Chair, Board of Directors
Gordon H. Smith, Esq., Executive Vice President | Andrew B. MacLean, Esq., Deputy Executive Vice President & General Counsel

Maine Medical Association Statement on Reform of the U.S. Health Care System

The Maine Medical Association (MMA) is a professional organization founded in 1853 and headquartered in Manchester, Maine representing more than 3900 physicians, residents, and medical students whose mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens.

The MMA believes that the current U.S. health care system continues to produce some of the world's most eminent clinicians and health care facilities who together provide some of the most advanced medical care in the world. But, it does not provide basic health care as well as many other developed countries and, therefore, is not serving our country or its people as well as it should. We face the problems with our current health care system in our daily encounters with patients. We believe that the United States can and must do better in providing health care to its people.

Our objective should be to achieve basic health care for every resident of Maine.

We support the "Quadruple Aim," a framework developed by the Institute for Healthcare Improvement describing an approach to optimizing the performance of our health care system. These core values are:

1. Improving the patient experience of care, including quality and satisfaction;
2. Improving the health of populations;
3. Reducing the per capita cost of health care; and
4. Improving the health and work life of health care clinicians and staff members.

Our health care system should strive to incorporate the following principles:

<u>The Physician-Patient Relationship</u>

1. Provide health care that is patient-centric and physician-directed.
2. Put the patient first and protect the sanctity of the physician-patient relationship, particularly respecting the physician's autonomy as advocate for the patient.
3. Promote the maximum possible choice in patients' selection of physicians.

<u>Structure of the Health Care System</u>

4. Support a strong and vital public health infrastructure that can collaborate fully with physicians and the health care system to advance population health.

Adopted by the Maine Medical Association Board of Directors on Wednesday, January 18, 2017

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5. Emphasize prevention and provide systemic support for healthier lifestyles, through incentives for identified health risk avoidance.
6. Stress pooling of clinical risk rather than medical underwriting.
7. Be efficient and have the ability to restrain rising health care costs at a system-wide level in the least intrusive way possible.
8. Have the ability to integrate and coordinate services in order to reduce fragmentation and the division of medical care into "silos."
9. Improve quality and minimize errors by relying upon evidence-based medicine, benchmarking, and outcome measures driven by clinicians and administrators working together.
10. Promote transparency of health care cost, quality, and outcome data.
11. Reduce the burden of administration to the greatest extent possible and include a billing system that is streamlined and consistent, as well as a payment system that is prompt and outcomes oriented.
12. Make health information technology (HIT), including electronic medical records (EMRs), more user friendly and more focused on clinical matters, rather than financial matters, and completely interoperable in order to facilitate rather than impede communication and work flow among clinicians, patients, and health care facilities.
13. Include a rational means of resolving medical liability disputes in order to restrain defensive medicine.

Public Support for the Health Care System

14. Be politically sustainable by including everyone as a participant and, therefore, a stakeholder in supporting it.
15. Be simple and fair, such that every participant can understand it and perceive that its financing burden and benefits are distributed fairly.

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