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Final Report of the JOINT SELECT COMMITTEE ON HEALTH CARE REFORM OPPORTUNITIES AND IMPLEMENTATION

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EXECUTIVE SUMMARY

The Joint Select Committee on Health Care Reform Opportunities and Implementation was established by joint order, H.P. 1262, to study the federal Patient Protection and Affordable Care Act (Public Law No. 111-148), referred to in this report as the ACA, and determine the State's opportunities for health care reform and the State's role in implementing the federal law. The Joint Select Committee has 17 legislative members; five members of the Senate and 12 members of the House of Representatives. Senator Joseph C. Brannigan was named Senate chair and Representative Sharon Anglin Treat was named House chair. Pursuant to Joint Order, the members are bipartisan and also serve on the Joint Standing Committee on Appropriations and Financial Affairs, the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Insurance and Financial Services. The Office of Policy and Legal Analysis and the Office of Fiscal and Program Review provided staffing support to the Joint Select Committee. With authorization from the Legislative Council, the Joint Select Committee met six times: May 20, June 22, September 21, October 1, October 19 and November 29. All of the meetings were held in the State House Complex in Augusta and open to the public.

In its study of the Affordable Care Act and the State's role in implementing the law, the Joint Select Committee was directed to consider the following issues:

- The impact of federal legislation on existing state law and programs that provide access to health care to residents of this State;
- The role of the State in the implementation and oversight of a health insurance exchange;
- The opportunity for the State to conduct pilot projects, including, but not limited to, pilot projects related to cost containment, payment reform, use of health care technology or health care coverage, with federal funding;
- The impact of federal legislation on the State's MaineCare program;
- How federal legislation affects the ability of the State to adopt a system of universal health care through a single-payer plan or other mechanism, including the use of Medicare, MaineCare and other state money to provide funding for universal health care in the State; and
- Any other issue related to implementation of the federal legislation.

Initially, the Joint Select Committee focused its efforts on educating members on the ACA and the key provisions that impact the State. To that end, the Joint Select Committee received presentations from several national experts and state officials on a number of key provisions in the federal law. The Joint Select Committee also received comment on the policy issues related to health insurance exchanges from stakeholders. In addition, the Joint Select Committee worked with staff to develop an implementation timeline for key provisions in the federal law to help identify policy issues for the 125th Legislature.

During its deliberations, the Joint Select Committee consulted with the Health Reform Implementation Steering Committee established by Governor Baldacci through executive order. The Steering Committee, chaired by Trish Riley, Director of the Governor's Office of Health Policy and Finance, was charged with providing leadership and coordinating implementation of the federal law by State Government. The Steering Committee is expected to submit a "white

paper" by the end of December 2010 with its analysis and recommendations for Maine's implementation of federal health reform.

The Joint Select Committee is pleased to offer its input and guidance to the 125th Legislature on the State's role, particularly the Legislature's role, in implementing the federal health reform law. While the Joint Select Committee recognizes the potential uncertainty regarding implementation of the federal health reform law, the Joint Select Committee worked diligently to study the ACA and the impact of its provisions on the State and State programs. The Joint Select Committee agreed that the Legislature has a significant role in the implementation and oversight of a health insurance exchange and that the health insurance exchange would be the major focus of its deliberations.

- **The Joint Select Committee makes the following consensus recommendations for the goals and elements of a health insurance exchange.**

Goals of Exchange. The Joint Select Committee supports the following goals for an exchange.

- Transparency
- Accountability to the public
- Portability
- One-stop shopping for access to health coverage so that the exchange is capable of determining eligibility for individuals in the exchange, Medicaid or other public health coverage programs
- Affordability
- Seamless transition for individuals and small businesses through coordination of eligibility and providers, i.e, same network of providers for families and between Medicaid and exchange
- Larger pool in the exchange equals lower costs
- Don't move backwards—maintain the level of health care coverage for those already with coverage
- Don't forget to interface with provider community
- Contain costs within Maine's health system and ensure sustainability of an exchange and the larger delivery system
- Make accessible for and focus on needs of individuals, small businesses and self-employed (sole proprietors)
- Build exchange to incent primary, preventive care
- Maintain choice of provider

Elements of Exchange. The Joint Select Committee supports the following elements as important to the design of an exchange.

- Maine should operate its own exchange initially, but should explore opportunities for a regional exchange or coordination of back office functions for an exchange with other New England states
- Maine should operate one exchange that serves the needs of individuals, families and small employers but recognizes different needs of individuals, sole proprietors and small businesses
- The exchange should have strong legislative oversight (whether administered by an independent state agency or quasi-state entity)

- Maine's exchange should take an active role in selecting health plans to contain costs and ensure quality
- Health plans operating in and out of the exchange should be subject to the same insurance rules
- The exchange has a role in standardizing plans to make it easier for consumers to select coverage
- Health plans in the exchange must be affordable
- The exchange must be more than just a website --- individuals and small businesses seeking assistance must have opportunity for face-to-face interaction
- Local access and consumer outreach are important functions for the exchange
- The exchange must provide one interface for consumers and small businesses to access exchange and other related services
- The exchange should take advantage of the existing functional capacity within state government to the extent possible
- The exchange should be accessible for providers and minimize their costs and administrative burden
- Navigators must be accountable and qualified with consideration of the need for licensing
- The Navigator program should consider a role for insurance producers, especially for small businesses, but will need to develop to avoid conflict of interest and determine compensation of producers

The Joint Select Committee also includes in this report the following consensus recommendations.

- **The State should pursue grant funding opportunities available under the ACA for pilot projects related to cost containment, payment reform and quality initiatives that are consistent with the criteria developed by the Governor's Steering Committee and presented at the Committee's June 22nd meeting.**

- **The policy committees having jurisdiction over insurance and Medicaid issues are best positioned to collectively review proposed health care legislation related to the ACA. The individual policy committees will have the common purpose and time throughout the legislative session to examine the complex issues expected to be brought forward in proposed legislation.**

- **The 125th Legislature should seek a legislative exchange/dialogue with other New England states on implementation of federal reform.**

- **Maine should build an integrated approach to health care so cost containment measures and quality initiatives continue to be incorporated in any reforms.**

The Joint Select Committee considered additional provisions in the ACA that could have a direct impact on the State and on State programs, including MaineCare, health insurance statutory and regulatory provisions and the Dirigo Health program. While this report does not make specific policy recommendations in these areas, the Joint Select Committee summarizes the potential policy issues and policy options that the 125th Legislature is likely to consider in the next biennium.

❑ Impact of ACA on the State's MaineCare Program

The 125th Legislature will be faced with a number of policy issues related to the impact of the ACA on the State's MaineCare program. While major Medicaid provisions would not be effective until 2014, there are a number of decisions that need to be made in the interim prior to 2014 implementation. The Joint Select Committee identified the following MaineCare-related policy issues facing the 125th Legislature in response to the changes contained in the ACA.

2010-2013 Interim Provisions

- ***Option to Expand Medicaid Eligibility***
- ***State Maintenance of Effort (MOE)Waiver***
- ***Other Interim Medicaid Provisions***
    - ***Changes to Medicaid prescription drug rebates – the original cost impact to the State has been reduced by subsequent Federal implementation decisions (2010)***
    - ***Coverage of tobacco cessation services for pregnant woman (2010)***
    - ***Prohibition on payments for health care acquired conditions (2011)***
    - ***Options for: community –based long-term care services; medical homes for individuals with chronic conditions; and wellness and prevention of chronic disease (2011)***
    - ***Demonstration projects for bundled Medicaid payments (2012)***
    - ***Pediatric accountable care organizations (2012)***
    - ***Emergency care treatment of adults with mental illnesses (2012)***
    - ***FMAP increase (1%) for coverage of preventative services and immunizations without cost-sharing (2013)***
    - ***Increased payments for primary care services for 2013 and 2014 with 100% federal funds (2013)***

2014 Provisions

- ***Expand Medicaid eligibility to all non-Medicare adults under age 65 with incomes up to 133% of FPL with enhanced FMAP for newly eligible individuals***
- ***Expand MaineCare coverage to former foster care children that have aged-out of foster care***
- ***MaineCare coverage for Adults from 133% to 200% of the FPL***
    - ***Move this population into the Exchange***
    - ***Exercise the Basic Health Plan Option***

Beyond 2014 Provisions

- ***Annual Medicaid Enrollment Reporting***
- ***Reduction in Enhanced Federal Medicaid Match***
- ***ACA Waiver Provisions***

❑ Impact of ACA on Maine's Health Insurance Laws

The 125th Legislature will be faced with many policy issues related to health insurance as significant provisions regulating private health insurance are included in the federal law. While some of the new insurance provisions took effect in 2010, others will be implemented between now and 2014. The Joint Select Committee identified the following policy questions facing the 125th Legislature in response to the changes contained in the ACA.

- ***In instances where state law already addresses in whole or in part the federal law, whether State law should be amended to conform to language of federal law to preserve the enforcement authority of the Maine Bureau of Insurance? Where Maine law provides more protection for insurance policyholders than the federal law, should Maine law be maintained?***

- ***Whether Maine should enact legislation to authorize health care cooperatives as permitted by the ACA?***

- ***Whether Maine's community rating laws should be changed to conform to federal law before the federal standard is implemented in 2014?***

- ***Whether the definition of small group under Maine law should be changed to conform to federal law? Whether Maine should delay implementation of the new federal definition of 1-100 in 2014 and 2015?***

- ***Whether Maine's individual health insurance market should be merged with the small group market for rating purposes?***

- ***After reviewing the "essential benefits" required under federal law, whether current mandated health benefits not required by federal law should be continued, amended or repealed? What impact will a decision to maintain current mandated benefits have on the State budget?***

- ***What type of mechanism for individual market reinsurance should be enacted? What form of risk adjustment should be adopted for the individual and small group market?***

- ***Whether Maine should allow interstate sales of health insurance? With what states? With what standards and regulation?***

❑ Impact of ACA on Dirigo Health Assessment

Under current law, the Dirigo assessment, or health access payment paid by health insurers and third-party administrators on paid health claims, is a major source of funding for the Dirigo Health Agency and its health coverage programs. The Dirigo assessment, established in statute as 2.14 % on all paid claims, resulted in approximately $42.1 million total revenue in 2009. Preliminary analysis presented to the Governor's Steering Committee indicated that the federal premium tax credits available under the ACA for individuals receiving coverage through a health insurance exchange can replace the Dirigo assessment as the source of premium subsidies for individuals. Based on information provided by the Governor's Steering Committee, the Joint Select Committee identified the following policy options relating to the Dirigo assessment:

- ***Repeal the assessment upon implementation of exchange in 2014***

- ***Use all or part of the assessment to provide subsidies for small business employers' share of premiums for employee health coverage after tax credits no longer available-***

- ***Use all or part of the assessment for subsidies for employees of small businesses***

- ***Use all or part of the assessment for administrative costs of the exchange***

- ***Use all or part of the assessment for a reinsurance program to reduce premium costs for certain individuals***

- ***Use all or part of the assessment to supplement federal tax credits to reduce premium costs for individuals purchasing coverage***

- ***Use all or part of the assessment for quality improvement initiatives and health information exchange***

- ***Use all or part of the assessment for costs of additional mandated benefits not included in essential benefits package***

❑ **State Option for Waiver – Alternatives to ACA**

Beginning in 2017, the ACA provides individual states the option to seek a waiver from the federal government from the requirements to provide health care coverage through a health insurance exchange. One of the Joint Select Committee's duties was to determine how the ACA law affects the ability of the State to adopt a system of universal health care through an alternative mechanism like a single-payer plan or other plan for universal coverage. The Joint Select Committee identified the waiver provision within the ACA as a potential opportunity for Maine to develop an alternative system to an exchange for providing universal health care to all residents.

Although this report contains several appendices, additional resources and background materials from the Joint Select Committee's deliberations are available at the following website: http://www.maine.gov/legis/opla/healthcarereform.htm.

I. INTRODUCTION

The Joint Select Committee on Health Care Reform Opportunities and Implementation was established by joint order, H.P. 1262, to study the federal Patient Protection and Affordable Care Act (Public Law No. 111-148), referred to in this report as the ACA, and determine the State's opportunities for health care reform and the State's role in implementing the federal law. A copy of the Joint Order, H.P. 1262, is included as Appendix A.

The Joint Select Committee has 17 legislative members; 5 members of the Senate and 12 members of the House of Representatives. Senator Joseph C. Brannigan was named Senate chair and Representative Sharon Anglin Treat was named House chair. Pursuant to Joint Order, the members are bipartisan and also serve on the Joint Standing Committee on Appropriations and Financial Affairs, the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Insurance and Financial Services. The complete membership of the Joint Select Committee is included as Appendix B. The Office of Policy and Legal Analysis and the Office of Fiscal and Program Review provided staffing support to the Joint Select Committee.

With authorization from the Legislative Council, the Joint Select Committee met six times: May 20, June 22, September 21, October 1, October 19 and November 29. 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 Joint Select Committee also established a website which can be found at http://www.maine.gov/legis/opla/healthcarereform.htm. The website includes agendas, meeting materials, links to related resources and audio recordings of all committee meetings.

II. JOINT SELECT COMMITTEE DUTIES

In its study of the ACA and the State's role in implementing the law, the Joint Select Committee was directed to consider the following issues:

- The impact of federal legislation on existing state law and programs that provide access to health care to residents of this State;
- The role of the State in the implementation and oversight of a health insurance exchange;
- The opportunity for the State to conduct pilot projects, including, but not limited to, pilot projects related to cost containment, payment reform, use of health care technology or health care coverage, with federal funding;
- The impact of federal legislation on the State's MaineCare program;
- How federal legislation affects the ability of the State to adopt a system of universal health care through a single-payer plan or other mechanism, including the use of Medicare, MaineCare and other state money to provide funding for universal health care in the State; and
- Any other issue related to implementation of the federal legislation.

In carrying out these duties, the Joint Select Committee was required to consult with stakeholders, including the Governor's Office of Health Policy and Finance, the Department of Health and

Human Services (DHHS), the Bureau of Insurance, health insurance companies, hospitals, health care providers, business and labor representatives and advocates for health care reform.

This report fulfills the Joint Select Committee's requirement to submit a report for presentation to the First Regular Session of the 125th Legislature.

III. JOINT SELECT COMMITTEE PROCESS

The Joint Select Committee focused its efforts on educating members on the ACA and the key provisions that impact the State. To that end, the Joint Select Committee received presentations from national experts on a variety of key issues, including:

- An overview of the ACA and the role of State Legislatures in its implementation from Joy Johnson Wilson of the National Conference of State Legislatures;
- An overview of the ACA provision's relating to health insurance exchanges from Amy Lischko, Tufts University School of Medicine;
- Implementing health insurance exchanges for small businesses from Terry Gardiner, Small Business Majority;
- Implementing health insurance exchanges for individual consumers from Michael Miller, Community Catalyst;
- An overview of the basic health plan option for States from Judy Solomon, Center for Budget and Policy Priorities; and
- An overview of the Taiwanese health care system and efforts in Vermont to pursue a waiver under the ACA from Dr. William Hsaio, Harvard School of Public Health.

The Joint Select Committee also received briefings from state officials on a number of topics, including:

- Regular updates on Executive Branch implementation activities from Trish Riley, Director of the Office of Health Policy and Finance;
- An overview of the ACA provisions affecting DHHS programs and an overview of the Medicaid managed care initiative from Brenda Harvey, Anthony Marple and Jenny Boydon, Department of Health and Human Services;
- An overview of insurance reforms in the ACA from Mila Kofman, Robert Wake and Katie Dunton, Bureau of Insurance;
- The early retiree reinsurance program in the ACA and the impact on the State Employee Health Plan from Frank Johnson, Executive Director of Employee Health and Benefits;
- Outreach efforts related to the small business tax credit from George Gervais, Department of Economic and Community Development and Anthony Gould, Maine Revenue Services; and
- The impact of ACA on Maine employers from John Dorrer, Department of Labor.

The Joint Select Committee also received comment on the policy issues related to health insurance exchanges from stakeholders, including:

- Maine Association of Health Plans;
- Anthem Blue Cross and Blue Shield of Maine;
- Maine Medical Association;
- Maine Primary Care Association;
- Maine State Chamber of Commerce;

- Maine Association of Independent Insurance Agents;
- National Federation for Independent Business-Maine chapter;
- AARP-Maine;
- Consumers for Affordable Health Care;
- Maine Peoples Alliance; and
- Maine Equal Justice Project.

In addition, the Joint Select Committee worked with staff to develop an implementation timeline for key provisions in the federal law to help identify policy issues for the 125th Legislature. See implementation timeline included as Appendix C.

IV. IMPLEMENTATION PLANNING BY STATE GOVERNMENT

During its deliberations, the Joint Select Committee consulted with the Health Reform Implementation Steering Committee established by Governor Baldacci through executive order. The Steering Committee is chaired by Trish Riley, Director of the Governor's Office of Health Policy and Finance. Other Steering Committee members are Brenda Harvey, Commissioner of Health and Human Services; Ellen Schneiter, Commissioner of Administrative and Financial Services; Anne Head, Commissioner of Professional and Financial Regulation; Karynlee Harrington, Executive Director of Dirigo Health; and Mila Kofman, Superintendent of Insurance. The Steering Committee was charged with providing leadership and coordinating implementation of the federal law by State Government. In the executive order, the Advisory Council on Health Systems Development was designated as the advisory stakeholder group to the Steering Committee. Beginning in May, the Steering Committee and Advisory Council on Health Systems Development each held public meetings once a month.

The Steering Committee is expected to submit a "white paper" by the end of December 2010 with its analysis and recommendations for Maine's implementation of federal health reform. A preliminary analysis of the State's role in implementation and policy options was prepared by the Governor's Office of Health Policy and Finance and is contained in Chapter VIII of the State Health Plan. Additional information related to the Steering Committee's activities and the impact of health reform on State Government can be found on the website, www.maine.gov/healthreform

V. JOINT SELECT COMMITTEE RECOMMENDATIONS

Pursuant to its charge, the Joint Select Committee discussed the role of the State in the implementation and oversight of a health insurance exchange as well as the opportunity for the State to conduct pilot projects with federal funding. The Joint Select Committee agreed that the Legislature has a significant role in the implementation and oversight of a health insurance exchange and that the health insurance exchange would be the major focus of its deliberations. The Joint Select Committee makes the following consensus recommendations with regard to the implementation of a health insurance exchange, pilot programs and grant funding, consideration of legislation related to the federal law, and the State's overall approach to health care reform.

❑ Implementation of a Health Insurance Exchange Pursuant to the ACA

By January 1, 2014, the federal ACA requires each state to have an exchange to facilitate the purchase of health insurance by individuals and small employers. Federal guidance issued by the federal Department of Health and Human Services describes an exchange:

"An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers."

Under the law, a state may choose to operate its own exchange in compliance with federal law or let the federal government operate and oversee the exchange in their state. If a state chooses to operate its own exchange, the state must notify the federal Department of Health and Human Services before January 1, 2013. The Joint Select Committee developed the following set of policy questions related to the structure, governance and operation of a health insurance exchange and used these questions as the basis for comments invited from stakeholders.

- ***Should Maine operate its own exchange or opt to let federal government administer? What are the benefits of operating the exchange? Are there any disadvantages?***

- ***How should an exchange be organized and governed? Should there be a separate exchange for individuals and one for small businesses? Should Maine consider forming an exchange with another state or states? Should the exchange be housed in a government agency, a nonprofit organization or another entity?***

- ***What rating rules should be in place for carriers offering individual and small group plans in an exchange? Should the same rules apply to plans offered within an exchange and outside an exchange? Should the same rating rules apply to individual and small group plans within an exchange?***

- ***What are the risks of adverse selection within an exchange? How can risk to carriers participating in an exchange be adjusted to reduce the impact on premiums? Are there different considerations relating to adverse selection for individual or small group plans?***

- ***The federal law requires a minimum of 5 plans to be offered through an exchange: plans offering 4 benefit levels or tiers---bronze, silver, gold and platinum---and a catastrophic plan for those under age 30 or who lack access to affordable plans. How many health plans or types of health plans should be available in an exchange and what policy considerations should guide this decision? Should an exchange have a role in standardizing plans and defining benefits and cost sharing?***

- ***Should the exchange have a role in selecting carriers to participate in an exchange? What criteria for participation should be included? How many carriers should participate? Or should all carriers be required to participate in an exchange?***

- ***How should an exchange be designed to be user-friendly to both individuals and small businesses? Should a website be the primary entry point to an exchange? How can an exchange be designed to provide access for individuals to other publicly-funded health plans? What other types of outreach and education are needed? What is the role of the Navigator program? What is the role of insurance agents?***

While the Joint Select Committee deliberated in the midst of governmental transition at the national and state level that may affect implementation of the federal law moving forward, the

Joint Select Committee agreed to focus on the issue of health insurance exchanges. Based on input from stakeholders and its discussions of the policy questions, the Joint Select Committee reached consensus on the following observations relating to the goals and elements of a health insurance exchange for Maine.

Goals of Exchange. The Joint Select Committee supports the following goals for an exchange.

- Transparency
- Accountability to the public
- Portability
- One-stop shopping for access to health coverage so that the exchange is capable of determining eligibility for coverage in the exchange, Medicaid or other public health coverage programs for individuals
- Affordability
- Seamless transition for individuals and small businesses through coordination of eligibility and providers, i.e., same network of providers for families, between Medicaid and exchange
- Larger pool in the exchange equals lower costs
- Don't move backwards—maintain the level of health care coverage for those already with coverage
- Don't forget to interface with provider community
- Contain costs within Maine's health system and ensure sustainability of an exchange and the larger delivery system
- Make accessible for and focus on needs of individuals, small businesses and self-employed (sole proprietors)
- Build exchange to incent primary, preventive care
- Maintain choice of provider

Elements of Exchange. The Joint Select Committee supports the following elements as important to the design of an exchange.

- Maine should operate its own exchange initially, but should explore opportunities for a regional exchange or coordination of back office functions for exchange with other New England states
- Maine should operate one exchange that serves the needs of individuals, families and small employers but recognize different needs of individuals, sole proprietors and small businesses
- The exchange should have strong legislative oversight (whether administered by an independent state agency or quasi-state entity)
- Maine's exchange should take an active role in selecting health plans to contain costs and ensure quality
- Health plans operating in and out of the exchange should be subject to the same insurance rules
- The exchange has a role in standardizing plans to make it easier for consumers to select coverage
- Health plans in the exchange must be affordable
- The exchange must be more than just a website---individuals and small businesses seeking assistance must have opportunity for face-to-face interaction
- Local access and consumer outreach are important functions for the exchange

- The exchange must provide one interface for consumers and small businesses to access exchange and other related services
- The exchange should take advantage of the existing functional capacity within state government to the extent possible (a chart identifying the potential functional capacity within current state programs is included as Appendix D)
- The exchange should be accessible for providers and minimize their costs and administrative burden
- Navigators must be accountable and qualified with consideration of the need for licensing
- The Navigator program should consider a role for insurance producers, especially for small businesses, but will need to develop measures to avoid conflict of interest and determine compensation of producers

The 125th Legislature will make the policy decision whether to operate the exchange and how the exchange should be structured. The Joint Select Committee believes the goals and elements of an exchange that the committee supports should be carefully considered before any legislation relating to health insurance exchanges is adopted.

❑ Pilot Programs and Grant Funding Opportunities

The Joint Select Committee recommends that the State pursue grant funding opportunities available under the Affordable Care Act for pilot projects related to cost containment, payment reform and quality initiatives that are consistent with the criteria developed by the Governor's Steering Committee and presented at the Committee's June 22nd meeting. The Joint Select Committee agrees that the following criteria are appropriate to evaluate grant funding opportunities for State Government:

- Strong relationship to the State Health Plan.
- Strong relationship to priorities of new administration and new legislature.
- Expands or improves related initiatives already underway in Maine.
- There is a level of support, resources and capacity available across stakeholders.
- Minimal state funding required (dollars and in-kind funding); recognize that new funding will require new state money to be appropriated.
- Enhances State's ability to meet legal and financial obligations.
- Promotes collaboration among providers and consumers and harmonization of delivery systems in communities.
- Clear focus on broad populations and overall impact of the specific grant.
- Flexibility of application and implementation process: can the State delegate?
- Sustainability after grant funding ends.
- Promote interstate cooperation as appropriate.

The Joint Select Committee received updates from the Governor's Steering Committee at each meeting on the status of grant opportunities and grant proposals submitted to the federal government. At the time of the Joint Select Committee's final meeting on November 29, 2010, more than $26 million dollars in grant funds had been awarded to the State. A chart outlining the grant awards, which was prepared by the Governor's Office of Health Policy and Finance, is included as Appendix E.

❑ Consideration of Legislative Proposals Related to the ACA by the 125th Legislature

The Joint Select Committee recommends that the policy committees having jurisdiction over insurance and Medicaid issues are best positioned to collectively review proposed health care legislation related to the ACA. The individual policy committees will have the common purpose and time throughout the legislative session to examine the complex issues expected to be brought forward in proposed legislation.

The Joint Select Committee also recommends that the 125th Legislature should seek a legislative exchange/dialogue with other New England states on implementation of federal reform.

❑ Maine's Approach to Health Care Reform

The Joint Select Committee recommends that Maine build an integrated approach to health care so cost containment measures and quality initiatives continue to be incorporated in any reforms.

VI. JOINT SELECT COMMITTEE DELIBERATIONS

As part of its duties, the Joint Select Committee considered a number of additional provisions in the ACA that could have a direct impact on the State and on State programs, including MaineCare, health insurance statutory and regulatory provisions and the Dirigo Health program. While this report does not make specific policy recommendations in these areas, the Joint Select Committee is including a summary of the policy issues for possible consideration by the 125th Legislature.

❑ Impact of ACA on the State's MaineCare Program

The 125th Legislature will be faced with a number of policy issues related to the impact of the ACA on the State's MaineCare program. While major Medicaid provisions would not be effective until 2014, there are a number of decisions that need to be made in the interim prior to 2014 implementation. The Joint Select Committee identified the following MaineCare-related policy issues facing the 125th Legislature in response to the changes contained in the ACA. At its June 22nd meeting, the Committee received a briefing from the Department of Health and Human Services and the Governor's Office of Health Policy and Finance regarding the preliminary estimated fiscal impact of the ACA on the State's MaineCare and related programs. These estimates are available at the Committee's website (http://www.maine.gov/legis/opla/HCRJune22ndsteeringcomm.pdf.)

2010- 2013 Interim Provisions

- ***Option to Expand Medicaid Eligibility***

  The ACA would allow the states to expand MaineCare coverage to non-categorical adults up to 133% of the FPL using the state's existing Federal Medical Assistance Percentage (FMAP) – no enhanced federal match would be available to finance this expanded coverage. The State currently covers these adults up to 100% of the FPL under a federal Medicaid waiver with participation limited under the terms of the Federal waiver. Exercising this ACA option would result in significant additional costs to the State in the interim. At its June 22nd meeting, the Committee was presented with preliminary estimates prepared by the DHHS that approximately 29,000 additional individuals would

be added to the Maine Care program under this option with a total estimated annual cost of $152.4 million and a State cost of approximately $55 million per year.

- ***State Maintenance of Effort (MOE)Waiver***

  In general, Section 2001(b) of the ACA requires states to maintain existing Medicaid eligibility levels in place as of March 23, 2010 through the implementation of an exchange (i.e., January 1, 2014) - and for children, through October 1, 2019. Meeting this MOE requirement is a condition for continued participation in the Medicaid program.

  The ACA includes a provision effectively waiving the eligibility MOE provisions between January 1, 2011 and December 31, 2013 for non-pregnant and non-disabled adults whose income exceeds 133% of the FPL. A state must certify on or after December 31, 2010 that it has or is projected to have a budget deficit during this period. The Maine Care population eligible for such a waiver of the MOE is referred to as the "Medicaid Expansion Parents" population with incomes up to 200% of the FPL.

- ***Other Medicaid Provisions***

  - Changes to Medicaid prescription drug rebates – the original cost impact to the State has been reduced by subsequent federal implementation decisions (2010)
  - Coverage of tobacco cessation services for pregnant woman (2010)
  - Prohibition on payments for health care acquired conditions (2011)
  - Options for: community –based long-term care services; medical homes for individuals with chronic conditions; and wellness and prevention of chronic disease (2011)
  - Demonstration projects for bundled Medicaid payments (2012)
  - Pediatric accountable care organizations (2012)
  - Emergency care treatment of adults with mental illnesses (2012)
  - FMAP increase (1%) for coverage of preventative services and immunizations without cost-sharing (2013)
  - Increased payments for primary care services for 2013 and 2014 with 100% federal funds (2013)

2014 Provisions

- ***Expand Medicaid eligibility to all non-Medicare adults under age 65 with incomes up to 133% of FPL with enhanced FMAP for newly eligible individuals***

  For Maine, the enhanced Federal match would apply largely to individuals with incomes below 100% of the FPL who are eligible for the current Maine Care non-categorical adult's waiver program but not participating because of Federal waiver limits; and to non-categorical adults from 100 to 133% of the FPL.

  While still included the Maine Care program, the State will continue to have options/decisions to make for this population. The State's current initiative to implement managed care, to be phased in over the next three years, would directly affect this population.

  The State will also need to update/simplify Medicaid eligibility systems for both current and newly eligible populations up to 133% of poverty and integrate Medicaid eligibility

determinations with eligibility for federal and cost sharing premium subsidies offered through an exchange.

- ***Expand Maine Care coverage to former foster care children that have aged-out of foster care. The ACA requires coverage up to 26 years of age beginning January 1, 2014***

- ***Maine Care coverage for Adults from 133% to 200% of the FPL***

    - ***Move this population into an exchange***

      Federal premium and cost sharing subsidies for this population would replace Maine Care funding. The benefit package available in an exchange based on the essential benefits package would likely be less than current MaineCare benefits. Integration of Medicaid eligibility determinations with eligibility for federal subsidies offered through the exchange will be critical.

      Coordinating family coverage with adults in an exchange and children continuing in MaineCare would be a challenge. Current initiatives to move MaineCare eligible populations to managed care plans that might also be offered in an exchange would help to address.

    - ***Exercise the Basic Health Plan Option***

      The ACA permits states the option to create a Basic Health Plan for uninsured individuals between 133% and 200% of poverty. States opting to provide this option would contract with one or more plans to provide coverage of at least the essential benefits package. States would be eligible to receive 95% of the funds that would have been paid for federal premium and cost-sharing subsidies for these individuals.

      The Joint Select Committee heard a presentation from Judy Solomon of the Center for Budget and Policy Priorities on the Basic Health Plan option and the potential impact if Maine were to pursue this option. The presentation identified a number of potential advantages and disadvantages to the State from exercising the Basic Health Plan option:

      Advantages

      - Strengthen the State's ability to negotiate with managed care plans and other insurers;
      - Increase the ability to innovate and better coordinate care
      - Simplify the transition to Medicaid expansion and premium credits in 2014
      - Provide more affordable and comprehensive coverage for beneficiaries
      - Lower administrative costs of MaineCare and an exchange: and
      - Decrease the potential gaps in coverage and disruptions of care for beneficiaries.

Disadvantages

- Decrease participation in health plans offered in an exchange making it harder to attract insurers and to pool risk; and
- Increase gaps and disruptions in coverage if not carefully planned.

Beyond 2014 Provisions

- ***Annual Medicaid Enrollment Reporting.*** The ACA requires states to provide annual reports to the Secretary of the Department of Human Services on Medicaid enrollment by eligibility category as well as a description of the outreach and enrollment processes used by the State. (2015)

- ***Reduction in Enhanced Federal Medicaid Match.*** Enhanced Federal Medicaid matching rates for newly and currently eligible populations will decrease to 90% by 2020.

- ***ACA Waiver Provisions.*** The ACA allows states to apply to the Secretary of the Department of Health and Human Services for the waiver of a number of the ACA requirements with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017.

❑ Impact of ACA on Maine's Health Insurance Laws

The 125th Legislature will be faced with many policy issues related to health insurance as significant provisions regulating private health insurance are included in the federal law. While some of the new insurance provisions took effect in 2010, others will be implemented between now and 2014. The Maine Bureau of Insurance gave several presentations on the ACA provisions affecting Maine's health insurance laws. The Joint Select Committee identified the following policy questions facing the 125th Legislature in response to the changes contained in the ACA.

- ***In instances where state law already addresses in whole or in part the federal law, whether State law should be amended to conform to language of federal law to preserve the enforcement authority of the Maine Bureau of Insurance? Where Maine law provides more protection for insurance policyholders than the federal law, should Maine law be maintained?***

Although federal law does supersede state law, the Joint Select Committee learned that states will retain enforcement authority if the state already has a law or adopts a law that meets the minimum standards in federal law. The Joint Select Committee identified several insurance provisions included in the ACA that are already addressed in whole or in part by current Maine law. The 125th Legislature will have to review the following provisions in comparison with current Maine law and determine whether technical drafting changes are needed to conform Maine law to the federal statutory standard. The Legislature also retains the authority to maintain any Maine law that is more stringent than the federal minimum standard for the benefit of policyholders.

ACA provisions effective in 2010. The following provisions in the ACA became effective for health insurance plans in 2010:

- Health insurance plans prohibited from including provisions imposing lifetime limits on essential benefits;
- Health insurance plans required to provide coverage for preventive services without imposing any deductibles or coinsurance for those services;
- Health insurance plans prohibited from imposing preexisting condition exclusions on children (those individuals age 19 and under);
- Health insurance plans required to provide coverage for dependents until age 26;
- Health insurance plans required to provide members the choice of primary care providers, including pediatricians and physicians practicing obstetrics and gynecology; health plans also prohibited from requiring prior approval for OB/GYN services; and
- Health insurances plans required to follow federal rules for internal and external review claims appeals

The Joint Select Committee extends special recognition and thanks to Maine's health insurance plans for their voluntary efforts to provide coverage for dependents before the effective date of that provision.

ACA provisions effective in 2011. In 2011, health insurance plans will be subject to new medical loss ratio standards of 80% in the individual and small group market and 85% in the large group market. The federal law requires health insurance plans to report their medical loss ratio in 2011 according to regulations and a formula developed with guidance from the National Association of Insurance Commissioners. Beginning in 2012, health insurance plans that do not meet the minimum medical loss ratio standards will be required to provide premium rebates to policyholders covered under those plans. As part of the medical loss ratio provision, the ACA does provide states the ability to request a waiver from the new medical loss ratio standard in the individual market if the application of the 80% standard may destabilize the individual market in that State. The Maine Bureau of Insurance notified the Joint Select Committee that a waiver request has been submitted to the Secretary of the federal Department of Health and Human Services to maintain the current minimum medical loss ratio of 65% in the individual market. A final decision on the waiver has not been made.

ACA provisions effective in 2014. The following provisions in the ACA will take effect for health insurance plans in 2014:

- Health insurance plans prohibited from imposing preexisting condition exclusions on adults (individuals age 20 and older);
- Health insurance plans prohibited from including provisions imposing annual limits on essential benefits;
- Guaranteed issuance requirements for all health insurance plans;
- Guaranteed renewal requirements for all health insurance plans; and
- Health insurance plans required to provide coverage for participation in clinical trials

- ***Whether Maine should enact legislation to authorize health care cooperatives as permitted by the ACA?***

The ACA includes a provision creating the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health care cooperatives to offer qualified health plans in the individual and small group health insurance markets in states in which they are licensed to offer such plans. The federal law appropriated $6 billion to finance the program and award loans and grant to establish cooperatives. To be eligible to receive funds, a

health care cooperative must: (1) not be an existing health insurer or sponsored by a state or local government; (2) be licensed in each state in which it offers qualified health plans; (3) be governed by majority vote of its members; (4) operate with a strong consumer focus; and (5) use any profits to lower premiums, improve benefits or improve the quality of health care delivered to its members. Because the federal law provides that loans and grants to assist the establishment of cooperatives must be made no later than July 1, 2013, any enabling legislation to permit the establishment of health care cooperatives in Maine must be adopted before that date. It is likely that the 125th Legislature will make the policy decision whether or not to authorize the establishment of cooperatives in Maine and enact enabling legislation for this type of entity in the Insurance Code.

- ***Whether Maine's community rating laws should be changed to conform to federal law before the federal standard is implemented in 2014?***

For health insurance plan years beginning on or after January 1, 2014, the ACA adopts several changes to the rating standards for individual and small group health insurance:

- Health insurance rates may not be based on health status or gender;
- Health insurance rates may vary based on age within a maximum rating band ratio of 3 to 1 and on the basis of tobacco use within a maximum rating band ratio of 1.5 to 1; and
- Health insurance rates may vary on the basis of geography and family size

Current Maine law has different standards for community rating of individual and small group health insurance. While Maine law does not allow rating based on health status or gender, the rating band in the individual market permits rates to vary based on age and geographic area within a rating band ratio of 1.5 to 1. In the small group market, rates may vary on the basis of age, geographic area, group size and occupation or industry within a rating band ratio of 1.5 to 1. The 125th Legislature will have these policy options related to community rating: (1) to amend Maine law to match the federal rating bands before federal implementation in 2014; (2) to amend Maine law to match the federal rating bands upon federal implementation in 2014; (3) to maintain the current rating bands in Maine law as a state may have a more restrictive rating standard than the federal law's maximum rating band of 3 to 1 for age or 1.5 to 1 for tobacco use; or (4) to amend the rating bands in Maine law in any way that does not exceed the federal maximum rating bands or is otherwise inconsistent with federal law.

- ***Whether the definition of small group under Maine law should be changed to conform to federal law? Whether Maine should delay implementation of the new federal definition of 1-100 in 2014 and 2015?***

The ACA defines small group in connection with a health insurance plan as an employer who employed at least 1 but not more than 100 employees. It also provides that individual states may choose to define small group as an employer with 50 or fewer employees until January 1, 2016. Under current Maine law, small group is defined as an employer with 50 or fewer employees. The policy question for the 125th Legislature will be to determine the impact of changing the definition of small group and whether the definition should be changed to conform to the federal law now or whether the new definition should be delayed until 2016.

- ***Whether Maine's individual health insurance market should be merged with the small group market for rating purposes?***

The ACA allows states to require the individual and small group health insurance markets to be merged into a single risk pool. At present, the individual and small group markets are separate risk pools in Maine. The Joint Select Committee notes that a prior legislative proposal to merge the individual and small group health insurance markets was not enacted after an actuarial study commissioned by the Maine Bureau of Insurance did not predict overall premium savings in the individual or small group markets. The Maine Bureau of Insurance intends to update the previous actuarial study to determine the impact of merging the individual and small group markets in the current environment. The Joint Select Committee believes the study will be a useful tool to help the 125th Legislature make the appropriate policy decision on merging the markets.

- ***After reviewing the "essential benefits" required under federal law, whether current mandated health benefits not required by federal law should be continued, amended or repealed? What impact will a decision to maintain current mandated benefits have on the State budget?***

Beginning in 2014, the ACA will require that health insurance plans provide an essential benefits package as part of all policies. The federal law states that the essential benefits package must include the following categories of health care services:

- Ambulatory services
- Emergency services
- Inpatient hospital services
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including vision and dental care

The specific details of the essential benefits package will be defined by the federal Department of Health and Human Services after public notice and opportunity for public comment. The federal law does not prohibit health plans from including benefits in excess of the minimum essential benefits. In fact, the law extends states the option of requiring health plans offered within the exchange to include benefits beyond the essential benefits package as long as the state provides the necessary funding for those benefits to those exchange members eligible for premium tax credits.

The Joint Select Committee anticipates that the federal regulations defining the minimum essential benefits package will be adopted during the 125th Legislature. The Legislature will need to review the essential benefits required under the ACA in comparison to the mandated health insurance benefits required under current Maine law and decide whether to continue, amend or repeal a mandated benefit that is not included in the essential benefits package. Further, the Legislature will have to consider the financial impact of maintaining any mandated benefit as the State is responsible for any added cost from the mandate for those individuals enrolled in the exchange who receive a subsidy for their coverage.

- ***What type of mechanism for individual market reinsurance should be enacted? What form of risk adjustment should be adopted for the individual and small group market?***

The ACA requires states to establish one or more non-profit reinsurance entities (or enter into contracts with a reinsurance entity) not later than January 1, 2014 to make reinsurance payments to health insurers that cover high-risk individuals in the individual market over a 3-year period. The reinsurance entity must meet federal regulations that will be adopted after consultation with the National Association of Insurance Commissioners. In addition to a reinsurance entity for the individual market, the ACA requires that states implement a risk adjustment mechanism for individual and small group health plans. While the federal government will adopt criteria and methods to be used for risk adjustment, states will be responsible assessing and determining the appropriate charge for risk adjustment. The Joint Select Committee notes that there is an existing reinsurance mechanism enacted in Maine law that was not implemented. The 125th Legislature will make the policy decisions about individual market reinsurance and risk adjustment in accordance with expected federal regulation.

- ***Whether Maine should allow interstate sales of health insurance? With what states? With what standards and regulation?***

The ACA requires the Secretary of Health and Human Services to issue regulations no later than July 1, 2013 for the creation of health care choice compacts under which 2 or more states may agree to permit one or more qualified health plans to be offered in all states subject to the agreement but be subject only to the laws of the state in which the health plan is issued. The ACA provides that a state may not enter into an agreement with another state for a health care choice compact unless the state enacts a law that specifically authorizes the state to enter into such an agreement. The ACA also requires an agreement between 2 or more states to enter into a health care choice compact to have prior approval from the federal Secretary of Health and Human Services. A health care choice compact made pursuant to the ACA may not take effect before January 1, 2016. The Joint Select Committee also notes that, in 2014, the ACA will require 2 national plans to be offered through each state's exchange.

The Joint Select Committee recognizes that legislative proposals to allow interstate sales of health insurance have been introduced but not enacted in previous legislative sessions. While the ACA prescribes a state's authority to enter into a health care choice compact, the federal law is silent on whether a state may enact legislation to authorize the purchase of health insurance out-of-state in another manner. Although the deadline for federal regulations regarding health care choice compacts is not until 2013, the Joint Select Committee anticipates that this policy issue will be brought forward for consideration by the 125th Legislature.

An outline of the policy decisions related to insurance market reforms in the Affordable Care Act and current Maine law is included in Appendix F.

❑ Impact of ACA on Dirigo Health Assessment

Under current law, the Dirigo assessment, or health access payment paid by health insurers and third-party administrators on paid health claims, is a major source of funding for the Dirigo Health Agency and its health coverage programs. The Dirigo assessment, established in statute as 2.14 % on all paid claims, resulted in approximately $42.1 million total revenue in 2009. Preliminary analysis presented to the Governor's Steering Committee indicated that the federal premium tax credits available under the ACA for individuals receiving coverage through a health insurance exchange can replace the Dirigo assessment as the source of premium subsidies for

individuals. Based on information provided by the Governor's Steering Committee, the Joint Select Committee identified the following policy options relating to the Dirigo assessment:

- ***Repeal the assessment upon implementation of exchange in 2014***

The Dirigo assessment is currently used as the primary source of funding subsidies for eligible individuals enrolled in the DirigoChoice program. In 2014, those individuals receiving premium subsidies in the DirigoChoice program can transition to coverage through a health insurance exchange and qualify for federal premium tax credits.

- ***Use all or part of the assessment to provide subsidies for small business employers' share of premiums for employee health coverage after tax credits no longer available***

In 2014, the ACA will provide premium tax credits to purchase health coverage through a health insurance exchange to individuals and sole proprietors. While the ACA does include a limited 2-year income tax credit for small employers to support the costs of employee health coverage, the tax credit is not available to sole proprietors. Other than the limited 2-year income tax credit, the ACA does not provide funds to assist small employers with the costs of employee health coverage. Under current Maine law, small employers enrolled in the DirigoChoice program are eligible for subsidies.

- ***Use all or part of the assessment for subsidies for employees of small businesses***

Federal premium tax credits under the ACA are not available to employees of small businesses. Under current Maine law, employees of small employers enrolled in the DirigoChoice program are eligible for premium subsidies based on their income.

- ***Use all or part of the assessment for administrative costs of the exchange***

While the ACA does provide funding to states to support planning and initial implementation of health insurance exchanges, the federal law requires that state-operated exchanges have sustainable funding for administrative costs of the exchange starting in 2015. One option for funding identified in the ACA is an assessment on health insurance carriers. The Dirigo assessment may be a source of revenue to support the administrative costs of an exchange.

- ***Use all or part of the assessment for a reinsurance program to reduce premium costs for certain individuals***

A reinsurance program may be used to mitigate the impact of any health insurance premium increases in the individual and small group health insurance markets. The State may opt to implement a reinsurance program and use revenue from the Dirigo assessment to fund that program.

- ***Use all or part of the assessment to supplement federal tax credits to reduce premium costs for individuals purchasing coverage***

The ACA will give states that have expanded their Medicaid eligibility the option of transitioning those with incomes above 133% of the federal poverty level to an exchange in 2014. For individuals with low incomes, the availability of federal premium tax credits may not be sufficient to make health coverage through an exchange affordable.

- ***Use all or part of the assessment for quality improvement initiatives and health information exchange***

Under current law, revenue from the Dirigo assessment is used to support the Maine Quality Forum in addition to providing subsidies for those enrolled in the DirigoChoice program. The State may maintain a portion of the assessment to continue to support the Maine Quality Forum.

- ***Use all or part of the assessment for costs of additional mandated benefits not included in essential benefits package***

Beginning in 2014, the ACA will require that health insurance plans provide an essential benefits package as part of all policies. The ACA does not prohibit health plans from including benefits in excess of the minimum essential benefits. In fact, the ACA extends states the option of requiring health plans offered within the exchange to include benefits beyond the essential benefits package as long as the state provides the necessary funding for those benefits to those exchange members eligible for premium tax credits. If policymakers determine that additional mandated benefits are needed beyond the essential benefits package, revenue from the Dirigo assessment may be used to offset the costs of any additional mandated benefits.

- **State Option for Waiver –Alternatives to ACA**

Beginning in 2017, the ACA provides individual states the option to seek a waiver from the federal government from the requirements to provide health care coverage through a health insurance exchange. Although federal guidance on the waiver and waiver process has not yet been issued, it is expected that the provision can be used by states interested in alternative mechanisms to provide universal health care to their residents. States granted a waiver will receive federal funding for the aggregate amount of premium tax credits that would have been paid to individuals and small employers getting coverage through an exchange. States must demonstrate that the alternative plan for health care coverage must provide comprehensive coverage equal to that required for exchanges, must include cost-sharing protections against excessive out-of-pocket spending that is as affordable as required for exchanges and will provide coverage to a comparable number of its residents.

One of the Joint Select Committee's duties was to determine how the ACA affects the ability of the State to adopt a system of universal health care through an alternative mechanism like a single-payer plan or other plan for universal coverage. The Joint Select Committee identified the waiver provision within the ACA as a potential opportunity for Maine to develop an alternative system to an exchange for providing universal health care to all residents. The Joint Select Committee was also briefed by Dr. William Hsaio on a project working with Vermont to design and model alternative health care plans that might qualify for a waiver, including a public model, a single-payer model and another model.

VII. CONCLUSION

The Joint Select Committee is pleased to offer its input and guidance to the 125th Legislature on the State's role in implementing the federal health reform law.

While the Joint Select Committee recognizes the potential uncertainty regarding implementation of the federal health reform law, the Joint Select Committee worked diligently to study the ACA and the impact of its provisions on the State and State programs. The Joint Select Committee

agreed that the Legislature has a significant role in the implementation and oversight of a health insurance exchange and that the health insurance exchange would be the major focus of its deliberations. Based on input from stakeholders and its own discussions, the Joint Select Committee provides consensus recommendations for the goals and elements of a health insurance exchange to the 125th Legislature. The Joint Select Committee also includes in this report consensus recommendations relating to pilot programs and grant funding, consideration of legislation related to the federal law, and the State's overall approach to health care reform.

The Joint Select Committee considered additional provisions in the ACA that could have a direct impact on the State and on State programs, including MaineCare, health insurance statutory and regulatory provisions and the Dirigo Health program. While this report does not make specific policy recommendations in these areas, the Joint Select Committee summarizes the potential policy issues facing the 125th Legislature.

Although this report contains several appendices, additional resources and background materials from the Joint Select Committee's deliberations are available at the following website: http://www.maine.gov/legis/opla/healthcarereform.htm.

APPENDIX A

Joint Order, H.P. 1262, Establishing Joint Select Committee

PLEASE NOTE: Legislative Information ***cannot*** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

Joint Order Establishing a Joint Select Committee on Health Care Reform Opportunities and Implementation

ORDERED, the Senate concurring, that the Joint Select Committee on Health Care Reform Opportunities and Implementation is established as follows.

1. Joint Select Committee on Health Care Reform Opportunities and Implementation established. The Joint Select Committee on Health Care Reform Opportunities and Implementation, referred to in this order as "the committee," is established.

2. Membership. Notwithstanding Joint Rule 353, section 5, the committee consists of 17 members, appointed as follows:

A. Five members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature and with preference to members of the Joint Standing Committee on Insurance and Financial Services, Joint Standing Committee on Health and Human Services and Joint Standing Committee on Appropriations and Financial Affairs; and

B. Twelve members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature and with preference to members of the Joint Standing Committee on Insurance and Financial Services, Joint Standing Committee on Health and Human Services and Joint Standing Committee on Appropriations and Financial Affairs.

3. Committee chairs. The first-named Senator is the Senate chair of the committee and the first-named member of the House is the House chair of the committee.

4. Appointments; convening of committee. All appointments must be made by May 20, 2010. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been made. When the appointment of all members has been completed, the chairs of the committee shall call and convene the first meeting of the committee, which may not be held before May 20, 2010. If by May 20, 2010 a majority but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the committee to meet and conduct its business.

5. Duties. The committee shall study any federal health care reform legislation enacted by the United States Congress and determine the State's opportunities for health care reform and the State's role in implementation of federal legislation. In examining these issues, the committee shall consider:

A. The impact of federal legislation on existing state law and programs that provide access to health care to residents of this State;

B. The role of the State in the implementation and oversight of a health insurance exchange;

C. The opportunity for the State to conduct pilot projects, including, but not limited to, pilot projects related to cost containment, payment reform, use of health care technology or health care coverage, with federal funding;

D. The impact of federal legislation on the State's MaineCare program;

E. How federal legislation affects the ability of the State to adopt a system of universal health care through a single-payer plan or other mechanism, including the use of Medicare, MaineCare and other state money to provide funding for universal health care in the State; and

F. Any other issue related to implementation of the federal legislation.

If federal legislation is not enacted, the committee shall consider any other issue related to the State's options for health care reform.

6. Consultation with stakeholders. The committee shall consult with stakeholders including the Governor's Office of Health Policy and Finance; the Department of Health and Human Services; the Department of Professional and Financial Regulation, Bureau of Insurance; health insurance companies; hospitals; health care providers; business and labor representatives; and advocates for health care reform.

7. Staff assistance. The Legislative Council shall provide necessary staffing services to the committee.

8. Report. No later than November 3, 2010, the committee shall submit a report that includes its findings and recommendations, including suggested legislation, to the First Regular Session of the 125th Legislature.

APPENDIX B

Joint Select Committee on Health Care Reform Opportunities and Implementation Membership List

Joint Select Committee on Health Care Reform Opportunities and Implementation

Appointment(s) by the President of the Senate

Sen. Joseph C. Brannigan, Co-Chair
168 Concord Street
Portland, ME 04103

Sen. Justin Alfond
134 Sheridan Street
Portland, ME 04104

Sen. Margaret M. Craven
41 Russell Street
Lewiston, ME 04240

Sen. Kevin L. Raye
63 Sunset Cove Lane
Perry, Maine 04667

Sen. Earle L. McCormick
633 Hallowell Litchfield Road
West Gardiner, ME 04345

Appointment(s) by the Speaker of the House

Rep. Sharon Anglin Treat, Co-Chair
22 Page Street
Hallowell, ME 04347

Rep. Emily Ann Cain
103 Forest Avenue
Orono, ME 04473

Rep. Gary A. Connor
10 Patterson Drive
Kennebunk, ME 04043

Rep. Mark Eves
78 Madison Street
North Berwick, ME 03906

Rep. Patrick S. Flood
56 Wedgewood Drive
Winthrop, ME 04364

Rep. Leslie T. Fossel
P.O. Box 525
Alna, ME 04535

Rep. Adam Goode
PO Box 2681
Bangor ME 04402-2681

Rep. Elizabeth S. Miller
6 Hemlock Lane
Somerville, ME 04348

Rep. Charles Priest
9 Bowker Street
Brunswick, ME 04011

Rep. Wesley E. Richardson
893 North Pond Road
Warren, ME 04864

Rep. Linda S. Sanborn
170 Spiller Road
Gorham, ME 04038

Rep. Meredith N. Strang Burgess
155 Tuttle Road
Cumberland, ME 04021

Staff:

Colleen McCarthy Reid 287-1670
Office of Policy and Legal Analysis

Christopher Nolan 287-1635
Office of Fiscal and Program Review

APPENDIX C

Timeline for Implementation of Key Provisions of the Affordable Care Act

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2010 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Temporary High-Risk Pool Program	Monitor federal guidance and State application and participation	July 1, 2010
Early Retiree Reinsurance Program	Monitor federal guidance and State application and participation	July 1, 2010
Web Portal for Consumer Health Information	Monitor federal implementation	July 1, 2010 for phase I; October 2010 for phase II
Grant Opportunities: ▪ Maternal, Infant and Early Childhood Home Visiting Program *(announced)* ▪ Health Insurance Rate Review *(announced)* ▪ Health Insurance Consumer Assistance	Monitor federal guidance Review criteria and recommend priorities Monitor State applications and participation	FY 10 Home visiting grant and rate review grant announced—initial applications due during July 2010
Insurance Market Changes: ▪ Dependent Coverage up to age 26 ▪ Prohibitions on coverage limits and exclusions ▪ Limits on policy rescissions ▪ Coverage Required for Preventive Services ▪ Health plans Required to Report Medical Loss Ratio ▪ "Grandfathered" plans may be excluded from certain requirements	Review existing law for conformity with federal law Enact statutory changes as necessary	Plan years beginning September 23, 2010
Medicaid Provisions: ▪ State option to implement expansion to non-categorical adults with incomes up to 133% of FPL at State's regular FMAP rate (no enhanced FMAP until 2014) ▪ Maintenance of effort requirement regarding eligibility changes unless State meets hardship exemption—certification on or after 12/31/10 ▪ Changes to prescription drug rebates	Monitor federal guidance Determine State policy on options for coverage Enact statutory changes needed to implement policies Authorize State funding if necessary	▪ Beginning FY 10 unless specified otherwise below ▪ Option permitted beginning April 2010 ▪ State may apply for waiver from MOE on or after 12/31/10 (available from Jan.1, 2011 to Jan. 1, 2014)

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2010 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
▪ Coverage of tobacco cessation services for pregnant women *(October 2010)*		
Small business tax credit	Monitor impact	2010 tax year

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2011 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Medicaid provisions: ▪ Prohibit payments to States for Medicaid services for health care acquired conditions ▪ Options for community-based long-term care services, medical homes for individuals with chronic conditions, wellness and prevention of chronic disease	Monitor federal guidance Determine State policy on permitted options/demonstration projects Monitor State application and participation Enact statutory changes needed to implement policies Authorize State funding if necessary	▪ July 1, 2011 ▪ Funding available October 2011 for CBLTC option; January 2011 for medical homes and wellness and prevention
Grants available for medical liability demonstration projects/tort reform	Review criteria and recommend priorities Monitor State applications and participation	Available FY 2011
Grants available for planning establishment of state-based exchanges	Monitor federal guidance Determine State role in operation of exchange Determine governance and structure for exchange	Available by March 2011
Insurance market reforms: ▪ Health plans must issue rebates if medical loss ratio requirements not met (80% for individual and small group; 85% for large group)	Review existing law for conformity with federal law Enact statutory changes as necessary	Plan years beginning January 1, 2011
National voluntary long-term care insurance program created (CLASS)	Monitor impact on public programs and existing long-term care insurance laws	Effective January 1, 2011

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2012-2013 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
	2012	
Medicaid provisions: ▪ Demonstration projects for bundled payments *(limited to 5 states)* ▪ Pediatric accountable care organizations ▪ Emergency care treatment for adults with mental illness	Monitor federal guidance Determine State policy on permitted options/demonstration projects Monitor State application and participation Enact statutory changes if necessary Authorize State funding if necessary	Funding available beginning January 1, 2012 except emergency care demo project funding made available in October 2011
	2013	
Exchange ---State must notify federal government by January 1, 2013 of decision to operate exchange	Monitor federal guidance Determine State role in operation of exchange Determine governance and structure for exchange Monitor State application for planning grants and participation Enact statutory authorization for exchange Authorize State funding if necessary	Notification by State before December 31, 2012; State law/authorization must be in place
Medicaid provisions: ▪ 1% increase in FMAP for coverage of preventive services and immunizations without cost-sharing ▪ Increases payments for primary care services for 2013 and 2014 with 100% federal funds	Monitor federal guidance Determine State policy on permitted options/demonstration projects Monitor State application and participation Enact statutory changes if necessary Authorize State funding if necessary	Beginning January 1, 2013

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:

Key Provisions Affecting State Programs and State Law

2012-2013 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Insurance market reforms: ▪ Creation of nonprofit insurance companies in States (COOP) permitted ▪ Administrative simplification measures for insurance companies implemented (eligibility and claims handling)	Monitor federal guidance Review existing law and enact statutory changes if necessary	▪ COOP effective January 1, 2013 ▪ Rules to be adopted by July 1, 2011; effective date for plans beginning January 1, 2013

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2014 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Individual mandate to obtain health insurance	Monitor federal guidance Review existing law and enact statutory changes if necessary	Effective January 1, 2014
Employer mandate to offer coverage to employees	Monitor federal guidance Review existing law and enact statutory changes if necessary	Effective January 1, 2014
Exchange established for individuals and small employers with 100 or fewer employees; Subsidies made available for eligible individuals and families with incomes between 133% FPL and 400% FPL	Maintain oversight over exchange operation Make statutory changes to address Dirigo assessment as necessary	Effective January 1, 2014
State option to establish Basic Health Plan for uninsured individuals with incomes between 133% FPL and 200% FPL otherwise eligible for premium subsidy through exchange	Monitor federal guidance Determine State policy on options for coverage Review existing law and enact statutory changes if necessary	Effective January 1, 2014
Insurance Market Reforms: ▪ Guaranteed issue and renewal ▪ Rating changes ▪ Lifetime limits and preexisting condition exclusions prohibited ▪ Limits on out-of-pocket costs, deductibles and waiting periods ▪ National essential benefits package ▪ Option to merge individual and small group market ▪ Temporary reinsurance program for high-risk individuals in individual market	Review existing law for conformity with federal law Enact statutory changes as necessary	Plan years beginning January 1, 2014
State grant opportunity to permit financial rewards for cost of coverage for participating in wellness programs in individual market; standards to be developed	Review criteria and recommend priorities Monitor State applications and participation	By July 1, 2014 (10 states)

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:

Key Provisions Affecting State Programs and State Law

2014 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
Medicaid Provisions: ▪ Expands Medicaid to all non-Medicare eligible adults under age 65 with incomes up to 133% FPL; enhanced FMAP for new eligibles ▪ Coordination of eligibility and enrollment for Medicaid, CHIP and exchange ▪ Reduces DSH allotments	Monitor federal guidance Determine State policy Enact statutory changes as necessary Authorize State funding if necessary	Effective January 1, 2014

TIMELINE FOR IMPLEMENTATION OF HEALTH CARE REFORM:
Key Provisions Affecting State Programs and State Law

2015 -2018 Implementation		
Key Provision	**Legislative Role/Decision**	**Federal Due Date/Guidance**
	2015	
Annual Medicaid enrollment reporting	Monitor State response	Beginning January 1, 2015
Changes in CHIP funding; CHIP-eligible children may get tax credits to obtain coverage through exchange	Monitor federal guidance Determine State policy Enact statutory changes as necessary	Beginning FY 2016
Exchange must be self-supported; assessments and user fees permitted	Maintain oversight of exchange Enact statutory changes if necessary	Beginning January 1, 2015
	2016	
States may form health care choice compacts to allow insurance plans from out-of-state insurers	Monitor federal guidance Determine State policy Enact statutory authorization and make statutory changes as necessary	Rules adopted no later than July 1, 2013 Effective January 1, 2016
	2017	
Reduction in enhanced FMAP for Medicaid begins	Monitor federal guidance Determine State policy Enact statutory changes as necessary	Beginning FY 2017
State exchange can allow participation from large employers (more than 100 employees)	Monitor federal guidance Determine State policy Enact statutory authorization and make statutory changes as necessary	Beginning January 1, 2017
States may apply for waiver to operate alternative program for coverage	Monitor federal guidance Determine State policy Enact statutory authorization and make statutory changes as necessary	Rules adopted within 180 days of enactment (9/23/10) Effective January 1, 2017

APPENDIX D

Chart, Existing Functional Capability in State Programs for Health Insurance Exchange

Chart Prepared by Governor's Office of Health Policy and Finance,
Presented to Joint Select Committee on September 21, 2010

CURRENT STATE INFRASTRUCTURE: FUNCTIONAL CAPACITY FOR HEALTH INSURANCE EXCHANGES

	Dirigo	HHS	BOI	State Employee Plan	Exists in State
Eligibility					
Determine Public Program		X			X
Determine subsidies for private insurance	X				X
Determine employer vouchers					
Determine employee vouchers	X				X
Determine affordability waiver					
Determine affordability exemption					
Determine employer access	X				X
Refer applicants to other programs	X	X	X		X
Benefit and plan interaction					
Contract with carriers	X	X		X	X
Standardize benefit categories by actuarial value					
Certify qualified health plans	X		X		X
Reward quality through market-based incentives				X	X
Assign quality ratings to plans				X	X
Conduct risk adjustment	X				X
Customer service					
Call center	X	X			X
Enroll individuals	X				X
Enroll businesses	X				X
Maintain website with cost and quality info	X		X	X	X
Provide cost calculator	X				X
Premium Payment and Collection					
Pay brokers	X				X
Manage navigator program	X				X
Pay premiums to carriers	X			X	X
Aggregate premiums from multiple sources	X				X

APPENDIX E

Chart, Grant Funds Awarded to Maine under the Affordable Care Act

Presented to Joint Select Committee on November 29, 2010
by the Governor's Office of Health Policy and Finance

Funded Grants for Maine Under the Affordable Care Act (ACA)

11/24/10

Grant/Pilot/Demonstration	Amount	Recipient	Timeframe
Delivery System Reform:			
Helping States Establish Health Insurance Exchange	$1,000,000	GOHPF	2010-2011
High Risk Pool	$17,000,000	Dirigo Health Agency	2010-2014
Workforce Development-Early Retiree Reinsurance	This ACA funding is applied for and awarded to individual businesses. It is not a State of Maine grant.	Bowdoin College, Eastern Maine Healthcare Systems, Employees of Municipal and Other Public Employers, Iberdrola USA Management Corporation, Maine Education Association Benefits Trust, Maine Health, Portland Water District, Tex Tech Industries, Inc., University of Maine System, UNUM Group, Maine State Employees Health Plan, Bangor Hydro Electric Company.	2010-2014
Wellness/Public Health/Prevention:			
*Providing Technical Assistance to Community Health Centers	$86,434	Maine Primary Care Association	2010
Medicaid Money Follows the Person/Demonstration Grant	$199,990	OES/DHHS	2010/2011
Infrastructure: Expand Access to Care	Total amount unknown	Public Medical Schools	2010-2011
Infrastructure/Capacity Building/ Prevention	$8,793,930	CDC/DHHS	9/10-9/15
Epidemiology & Lab Capacity for Infectious Diseases	$674,823	CDC/DHHS	9/10-7/12
HIV/AIDS Enhancing Lab Reporting	$60,000	CDC/DHHS	2010
Tobacco Prevention and Control	$53,098	CDC/DHHS	2010
Education to Promote Responsibility Regarding Sex and Healthy Relationships	$250,000	CDC/DHHS	2010-2012
Aging and Disability Resource Centers Evidence-Based Transition Grants	$184,071	OES/DHHS	2010-2012
ARDC Options Counseling & Assistance Programs	$500,000	OES/DHHS	2010-2012
Home Visiting Program	$667,546	OES/DHHS	2010-2012
Funding outreach & assistance for low-income families	$396,394	ARDC's, OESI, SHIP, AAA	2009-2010

Grant/Pilot/Demonstration	Amount	Recipient	Timeframe
Therapeutic Discovery Project Grants	$77,770 $82,018 $71,997	Bar Harbor BioTechnology Sea Run Holdings	2010 2009 2010
Quality Improvement:			
Promoting Consumer Health Insurance Information	$135,000	Attorney General	2010
Health Insurance Premium Review	$1,000,000	Bureau of Insurance	2010-2011
Workforce:			
Grants to Medical Schools to train Physicians and other practitioners for family medicine	$990,000	UNE	2010-2014
Planning Grants State health care workforce	$150,000	ME Department of Labor	2010
Nursing Home Aides Demonstration projects to address professions workforce needs	$2,247,345	OES/DHHS	2010-2013
Personal and Home Care Aide State Training Program	$747,632	OES/DHHS	2010-2014
Geriatric Workforce Development	$208,111	UNE	2010-2014
Advanced Nursing Education Grants	$83,503	Husson College ($28,457), UNE ($8,641), University of Maine System, acting through University of Maine ($24,469), University of Southern Maine ($21,936)	2010

*NEW FUNDING:

***TA to CHC funds to provide training and technical assistance, supporting community development, expansion planning, patient-centered medical home development, and to adopting meaningful health information technology.**

***The Therapeutic Discovery Project is targeted to programs that show potential to produce new therapies, address unmet needs, reduce the long-term growth of health care costs, or to advance to the goal of curing cancer within the next 30 years.**

HRSA and DHHS News Release, 11/19/10: $8 million for existing Community Health Center Cooperative agreements to provide additional training and technical assistance on a national, regional and state basis to community-based organizations that support CHCs. Funding made available through ACA.

Over the next five years, the ACA will provide $11 billion in funding for the operation, expansion and construction of community health centers across the country. Of the $11 billion, $9.5 is targeted to creating new health center sites in medically underserved areas and expanding preventive and primary health care services, including oral health, pharmacy, vision, and enabling services at existing health center sites. An additional $1.5 billion will support major construction and renovation projects at health care centers nationwide.

DHHS News release, 11/22/10: $290 million in new funding to launch a new application cycle for the National Health Service Corps (NHCS) Loan Replacement Program. NHCS offers primary medical, dental and mental health clinicians up to $60,000 to repay student loans in exchange for two years of service at health care facilities in medically underserved areas.

APPENDIX F

Chart, Policy Issues Relating to Impact of ACA on Maine Health Insurance Laws

Policy Decisions Facing the 125th Legislature:
Insurance Market Reforms in the Federal Health Reform Law, Affordable Care Act

Note: Overview does not include provisions relating to health insurance exchanges or other related provisions, e.g. basic health plan option, waiver for alternative coverage

ACA Provision	Current Maine Law	Policy Decision
	Provisions Effective in 2010	
Prohibition on lifetime limits on essential benefits	Lifetime and annual limits on aggregate dollar amount of claims in provider network prohibited for plans beginning 1/1/11 (certain plans excluded)	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Coverage required for preventive services; cost-sharing prohibited	Certain mandated benefits for preventive services, e.g. mammograms. Pap tests, prostrate cancer screening, colorectal cancer screening, except cost-sharing is permitted	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Prohibition on preexisting coverage exclusion for individuals age 19 and under	Preexisting condition exclusion permitted for up to 12 months if person had no prior coverage for more than 90 days prior to enrollment; otherwise not permitted	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Extension of dependent care coverage to age 26	Offer of coverage extension for dependents up to age 25 to policyholders (individual and group)	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Provides choice of primary care provider, including OB/GYNs and pediatricians; prohibits referrals for OB/GYN services	Requires group plans to allow OB/GYNs to serve as primary care providers and allows self-referral to OB/GYN for annual exam	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Requires coverage of emergency services from nonparticipating providers (no cost-sharing)	Requires coverage of emergency services from nonparticipating providers, but cost-sharing is permitted	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Requirements for internal and external review of	Required for all health plans	*Technical drafting issue*: Should Maine law be

ACA Provision	Current Maine Law	Policy Decision
claims appeals		amended to conform to language of federal law to preserve Maine enforcement authority?
	Provisions Effective in 2011	
Establishes medical loss ratio standard of 80% in individual and small group market; 85% in large group market Requires rebates for plans with MLR below standards	65% MLR in individual market 75% MLR /78% avg. over 3 yrs in small group market No MLR standard in large group market	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority? Note that Maine Bureau of Insurance has requested waiver from federal MLR requirement for individual market as permitted by ACA. Is waiver appropriate?
	Provisions Effective in 2012	
States may authorize health care cooperatives	None	*Substantive policy issue:* Whether to enact enabling legislation? In what form?
	Provisions Effective in 2014	
Prohibition on preexisting condition exclusions for individuals 20 and older	Preexisting condition exclusion permitted for up to 12 months if person had no prior coverage for more than 90 days prior to enrollment; otherwise not permitted	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Prohibition on annual limits on essential benefits	Lifetime and annual limits on aggregate dollar amount of claims in provider network prohibited for plans beginning 1/1/11 (certain plans excluded)	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Adjusted community rating No rating based on health status Rate may only vary based on age (limited to 3:1 ratio); tobacco use (limited to 1.5:1); geography and family size in individual and small group markets	No rating based on health status or gender in individual and small group markets Ind: Rates may vary 1.5: 1 based on age and geography Sm grp: Rates may vary 1.5: 1 based on age,	*Substantive policy issue:* Should Maine law conform to federal law? Whether current Maine law (which is more protective than federal law) should be maintained? If Maine law should conform to federal law rating bands, should change be implemented before 2014 effective date?

ACA Provision	Current Maine Law	Policy Decision
	geographic area, group size and occupation or industry	
Defines small group as 1-100; States may delay change in 2014 and 2015	Defines small group as 1-50	*Substantive policy issue:* Should definition of small group be expanded in Maine before federal definition takes effect in 2014? Whether to delay or phase-in change in definition in 2014 and 2015?
States are permitted to merge individual and small group markets	None	*Substantive policy issue:* Whether to enact legislation? What impact on market competition and premiums?
Guaranteed issue in all markets	Required in individual market Required in small group market for all groups that meet minimum participation requirements (no more than 75%)	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Guaranteed renewal in all markets	Required in all markets	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
Health plans must cover essential benefits package	Coverage required for certain mandated benefits in individual and group health insurance policies	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve compliance by Maine health plans? *Substantive policy issue:* Are existing mandated benefits included or excluded from essential benefits? Whether to repeal some or all mandated benefits not included? What impact on State funding for costs of additional mandates?

ACA Provision	Current Maine Law	Policy Decision
Coverage for clinical trials	Required in all health plans offered by carriers	*Technical drafting issue*: Should Maine law be amended to conform to language of federal law to preserve Maine enforcement authority?
States shall establish reinsurance mechanism in individual market	Enacted but not implemented due to people's veto of funding mechanism	*Substantive policy issue:* Is statutory mechanism in current law appropriate? Should other mechanism for reinsurance be considered? In what form?
State shall establish individual and small market risk corridors and risk adjustment mechanism	None	*Substantive policy issue:* Whether to enact enabling legislation? In what form?
Provisions Effective After 2014		
States may establish interstate compacts with other states to allow interstate sales beginning in 2016 (federal regulations must be in place by 1/13)	None	*Substantive policy issue:* Whether to allow interstate sales of health insurance? With which states? With what standards and regulation?