

Maine Health Exchange Advisory Committee

Monday September 22, 2014

9:30 am

Appropriations Committee Room 228

Draft Agenda

- 9:30 am Welcome and introduction from chairs
- 9:45 am Update on Recent Developments
- Navigator Grants
 - Correspondence with federal officials
 - Letter of support for Consumer Assistance program grant application
 - D.C. Circuit decision to grant *en banc* hearing in Halbig v. Burwell case
 - Census Bureau data on uninsured
 - Marketplace Data matching
- Committee Staff*
- 10:30 am Bureau of Insurance Update
- 2015 Rates
 - Use of Composite Premiums
 - Automatic Renewal Process
- Eric Cioppa, Superintendent*
- 11:00 am Federal Update
- Christie Hager, Region One Director,
U.S. Department of Health and Human Services*
- 11:30 am Review of Draft Report Template and Potential Findings and Recommendations Discussion Draft
- Committee Staff*
- 12:00 pm Lunch
- 1:00 pm Basic Health Plan Program and Other Coverage Options under ACA
- Jessica Schubel, Center for Budget Policies and Priorities (conference call)*
- 2:00 pm Committee Discussion and Planning
- Continue review of draft findings and recommendations
 - Develop additional findings and recommendations
 - Planning for next meeting?
- 3:00 pm Adjourn

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201



August 29, 2014

Margaret M. Craven
Senate Chair
Sharon Anglin Treat
House Chair
State of Maine
126th Legislature
Maine Health Exchange Advisory Committee

Dear Senate Chair Craven and House Chair Treat:

Thank you for your letter regarding the Health Insurance Marketplace Navigator program. We appreciate your work implementing the Navigator program in Maine.

The Centers for Medicare and Medicaid (CMS) are still in the process of working through future funding options for the Navigator program and you will be able to find more information on our website, at <http://www.cms.gov/ccio/Resources/Funding-Opportunities/index.html>, once our plans have been finalized.

Again, thank you for your letter. Please do not hesitate to contact me with any further thoughts or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert Imes". The signature is fluid and cursive, with a large initial "R" and "I".

Robert Imes
Associate Deputy Director
Center for Consumer Information and Insurance Oversight

SEN. MARGARET M. CRAVEN, CHAIR
SEN. RODNEY L. WHITEMORE
CHRISTINE ALIBRANDI
JOHN BENOIT
JOHN COSTIN
BOB DAWBER
SARA GAGNE-HOLMES
DOUG GARDNER
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REP. SHARON ANGLIN TREAT, CHAIR
REP. MICHAEL D. MCCLELLAN
REP. LINDA F. SANBORN
KEVIN LEWIS
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DAVID SHIPMAN
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STATE OF MAINE

ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE

MAINE HEALTH EXCHANGE ADVISORY COMMITTEE

June 11, 2014

Christie L. Hager, J.D., M.P.H.
Regional Director
U.S. Department of Health and Human Services, Region One
John F. Kennedy Federal Building, Suite 2100
Boston, MA 02203

Dear Ms. Hager,

Thank you again for speaking with the Maine Health Exchange Advisory Committee on June 3rd to provide an update on Maine's federally-facilitated Marketplace following the close of the first open enrollment period. We want to extend our gratitude to the Department of Health and Human Services for its efforts to implement the Marketplace for the benefit of Maine individuals, families and small businesses. We recognize and appreciate the many improvements already made to the functionality of the Marketplace, but we believe that additional changes and resources are needed as we prepare for the 2015 open enrollment period. On behalf of the Maine Health Exchange Advisory Committee, we are writing to convey concerns brought to our attention during our recent meeting. We hope you share these concerns with others in the Department of Health and Human Services, Centers for Medicaid and Medicare Services and further hope the Department is willing to address the items noted below.

Use of federal marketing resources to promote the Marketplace

Given the limited federal resources being spent here, we request that the federal government grant permission for Maine to use previously produced marketing and media advertisements promoting healthcare.gov for outreach, education and enrollment leading up to the 2015 open enrollment period. The Maine Health Access Foundation has led Maine's marketing, outreach and education effort through the development of enroll207.com with limited resources to produce television, radio and other media marketing. Having the benefit and use of media materials already created and paid for would allow the foundation to avoid duplication of effort and instead increase its own outreach, education and enrollment activities.

Improvements to healthcare.gov enrollment identity verification process and SCHIP assessments

At the Advisory Committee's meeting on June 3rd, representatives of Marketplace carriers and navigators indicated that improvements are still needed to the healthcare.gov enrollment process. We understand the identity verification process used by healthcare.gov relies on individual credit reports maintained by a credit reporting agency. As a result, healthcare.gov has been unable to verify the identity of consumers with no or little credit history, disproportionately impacting low-income families. The current system for verifying immigration status has likewise created obstacles to enrollment for those who are eligible. Based on information we have received, there is also a particular issue for legal immigrants eligible for a subsidy whose incomes are below 100% FPL and who have been in the United States for less than 5 years. We are not aware of any immigrant living in Maine who has been granted a subsidy despite their eligibility and despite significant efforts to assist these individuals. Addressing these systems issues will make the online enrollment process easier and increase the number of successful enrollments.

We also understand that families seeking coverage through the Marketplace experience difficulties and delays in enrollment and subsidy eligibility determination due to the SCHIP eligibility assessment for their children. We believe improvements can be made to improve the interface and response time between the federally-facilitated Marketplace and Maine's eligibility determination system. In order to improve the consumer experience for those Maine individuals and small businesses seeking access to coverage through the Marketplace, we ask that these technical issues be addressed for the 2015 open enrollment period.

Additional federal resources for Maine's designated health insurance consumer assistance program

We understand that federal resources to support Maine's designated health insurance consumer assistance program have not been provided for 2015. Maine's consumer assistance program, which is operated by Consumers for Affordable Health Care, a local nonprofit organization, has been very successful in helping individuals and families resolve complaints about their health care coverage. We feel strongly that additional resources are needed to continue this valuable assistance in 2015. We are committed to exploring all options available to the State to provide funding for consumer assistance.

Early guidance on essential health benefits

Current guidance under which States have designated a medical and dental benchmark plan for the Essential Health Benefits applies through plan year 2015 and CMS has indicated that additional guidance may be provided for plan years beginning in 2016 and thereafter. If changes are expected to be made to the Essential Health Benefits package for 2016, we request that guidance be provided to Maine as soon as possible. As an Advisory Committee to the Maine Legislature, we need time to carefully consider any related policy options before making any recommendations to the Legislature and our Superintendent of Insurance.

Ms. Hager Letter
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Thank you for your consideration. We look forward to your reply and to discussing these issues with you further.

Sincerely,

Margaret M. Craven
(enc)

Margaret M. Craven
Senate Chair

Sharon Anglin Treat

Sharon Anglin Treat
House Chair

cc: Maine Health Exchange Advisory Committee members
Wendy Wolf, Maine Health Access Foundation
Joseph Ditre, Consumers for Affordable Health Care

SEN. MARGARET M. CRAVEN, CHAIR
SEN. RODNEY L. WHITTEMORE
CHRISTINE ALIBRANDI
JOHN BENOIT
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STATE OF MAINE

ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE

MAINE HEALTH EXCHANGE ADVISORY COMMITTEE

September 3, 2014

Christie L. Hager, J.D., M.P.H.
Regional Director
U.S. Department of Health and Human Services, Region One
John F. Kennedy Federal Building, Suite 2100
Boston, MA 02203

Dear Ms. Hager,

Thank you again for your speaking with us by conference call on August 26th to provide an update on Maine's federally-facilitated marketplace and other implementation efforts related to the federal Affordable Care Act. On behalf of the Maine Health Exchange Advisory Committee, we are writing to again stress the need for early guidance on potential changes to Essential Health Benefits. Please share our request with others in the Department of Health and Human Services, Centers for Medicaid and Medicare Services.

As you know, the current federal guidance under which States designated Essential Health Benefits medical and dental benchmark plans applies through plan year 2015. When the current benchmark plan selection process was announced, CMS indicated that additional guidance as to any changes in that selection process might be provided for plan years beginning in 2016 and thereafter. We urge CMS to issue immediate notification to States as to whether the current federal guidance permitting States to designate a benchmark plan for Essential Health Benefits will be continued without change or modified for the 2016 plan year. If changes are anticipated, guidance must be provided no later than in the last quarter of 2014 so that health insurance carriers are able to incorporate any changes into 2016 health plans submitted for approval to the Maine Bureau of Insurance in the spring of 2015. As an Advisory Committee to the Maine Legislature, we also want to have adequate time to consider any policy options carefully and receive public input on those options before making any recommendations to the Legislature and our Superintendent of Insurance.

Ms. Hager Letter
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Thank you for your consideration. We look forward to discussing these issues with you further.

Sincerely,

Margaret M. Craven
(CMC)

Margaret M. Craven
Senate Chair

Sharon Anglin Treat

Sharon Anglin Treat
House Chair

cc: Maine Health Exchange Advisory Committee members
Eric Cioppa, Superintendent, Maine Bureau of Insurance

SEN. MARGARET M. CRAVEN, CHAIR
SEN. RODNEY L. WHITTEMORE
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STATE OF MAINE

ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE

MAINE HEALTH EXCHANGE ADVISORY COMMITTEE

September 8, 2014

Shamia Blanks
Grants Management Specialist
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
Mailstop #770 Bethesda
5600 Fishers Lane
Rockville, MD 20857

RE: Limited Competition for Affordable Care Act Consumer Assistance Program Grants (CA-CAP-14-001)

Dear Ms. Blanks,

On behalf of the Maine Health Exchange Advisory Committee, we are writing in strong support of the Maine Hospice Council's grant proposal under the Limited Competition for Affordable Care Act Consumer Assistance Program Grants (CA-CAP-14-001), which proposes extending the contract with Consumers for Affordable Health Care Foundation (CAHCF), a Maine public charity organized under Internal Revenue Code §501(c) (3), to provide services under Maine's Consumer Assistance Program (CAP).

As Maine's CAP, Consumers for Affordable Health Care (CAHC) has been very successful in helping individuals and families resolve complaints about their coverage. Maine's navigators and other assisters also rely on CAHC for their legal and health insurance expertise, and their ability to advocate freely and vigorously on behalf of consumers. During the past open enrollment period, CAHC was a vital resource to Maine's assisters. Through their HelpLine, they provided information, referral services, and other enrollment assistance. CAHC also provided vital updates and supports to assisters through a series of regional roundtables, which helped Maine achieve great enrollment success despite limited resources.

As over 44,000 Mainers begin to use their new health insurance coverage and with more Mainers expected to join the Marketplace in the upcoming open enrollment period, CAHC's consumer assistance services are needed more than ever. Many people who are now covered have never

Ms. Blanks Letter
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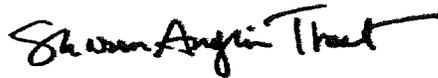
had health insurance before, and need help to understand their health care coverage and access the new protections that the federal Affordable Care Act has provided. Maine consumers also need help with navigating their coverage, including filing complaints and appeals if needed. CAHC is the only organization in Maine qualified to do this work.

Given the limited federal resources being spent in Maine, we feel strongly that this valuable assistance needs to continue in 2015. The Committee strongly supports this application.

Sincerely,



Margaret M. Craven
Senate Chair



Sharon Anglin Treat
House Chair



Navigator Grant Recipients for States with a Federally-facilitated or State Partnership Marketplace

Navigators will serve as an in-person resource for Americans who want additional assistance with Marketplace coverage in 2014-2015, including as they shop for and enroll in plans in the Health Insurance Marketplace this fall. Below are the recipients of the 2014 Navigator grants in Federally-facilitated and State Partnership Marketplaces, grouped by state. Recipients marked with an asterisk (*) are operating in more than one state. The anticipated grant amount listed in each case only applies to the amount going to that organization for that state's specific operations.

MAINE

Western Maine Community Action Anticipated grant amount: \$520,376 Western Maine Community Action, Inc. is a private non-profit community agency and serves as the lead for a state-wide consortium of eight community action agencies, collectively referred to as the WMCA Community Action Navigator Consortium. As a 2013 Navigator grantee, funds were used to create a statewide network of education, outreach and enrollment assistance available and accessible to every uninsured and under-insured individual in Maine. This year, it will build on this foundation to continue targeting low and moderate income individuals, including the under and uninsured and young adults.

Fishing Partnership Health Plan Anticipated grant amount: \$79,624 Fishing Partnership Health Plan (FPHP) served as a 2013 Navigator grantee and is a health plan developed to provide subsidized coverage to uninsured commercial fisherman, many of whom operate as small business owners or employees. FPHP will coordinate with the Maine Lobstermen's Association to undertake a series of community health navigation activities, including: outreach; social marketing; distribution of material describing the program, the Affordable Care Act, and the health insurance enrollment process.

Excerpt from larger document, "List of Navigator Grant Recipients",
<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-10-18-2013.pdf>

News

FOR IMMEDIATE RELEASE

September 8, 2014

Contact: HHS Press Office

202-690-6343

HHS announces \$60 million to help consumers navigate their health care coverage options in the Health Insurance Marketplace

The Affordable Care Act is working for millions of Americans who are able to access quality health coverage at a price they can afford, in large part because of the efforts of in-person assisters in local communities across the nation. People shopping for and enrolling in coverage through the Health Insurance Marketplace can get local help in a number of ways, including through Navigators.

Health and Human Services Secretary Sylvia M. Burwell today announced \$60 million in Navigator grant awards to 90 organizations in states with federally-facilitated and state partnership Marketplaces. These awards support preparation and outreach activities in year two of Marketplace enrollment and build on lessons learned from last year.

"In-person assisters have an impact on the lives of so many Americans, helping individuals and families across the country access quality, affordable health coverage," said Secretary Burwell.

"We are committed to helping Americans get covered and stay covered with in-person assistance in their own communities."

According to a recent outside survey, a variety of assisters, including Navigators, in both state-based and federally-facilitated Marketplaces were responsible for helping an estimated 10.6 million consumers apply for coverage in Marketplace plans, Medicaid, or the Children's Health Insurance Program (CHIP) during the first Open Enrollment period. Assistors tend to help those consumers in communities with the most challenging or complicated enrollments, and according to another poll, Latinos in particular valued the assistance of in-person help. Navigators provide unbiased information to consumers about the Marketplace and other public programs in a way that recognizes the cultures of the communities they serve. Navigators were selected to receive these awards through a competitive grant process based on their ties with the communities they will be serving and other standards such as effectiveness and program integrity.

In addition to helping eligible individuals and their families enroll in coverage, Navigators help consumers compare their health coverage options including helping them determine whether they are eligible for public programs such as Medicaid and CHIP and guide consumers- many of whom have never had insurance before- on accessing and using their new coverage, among other important functions.

These awards build on lessons learned from the first year of Marketplace operations.

- Navigator grantees must maintain a physical presence in the Marketplace service-area, so that consumers can easily access face-to-face assistance.
- Navigator grantees are required to be trained on and comply with strict security and privacy standards to ensure that consumers' personally identifiable information (PII) is protected, as was the case last year. In no case will Navigators obtain a consumer's PII without the consumer's consent.
- In addition to quarterly and annual reporting, Navigators will also be required to submit to HHS weekly progress reports detailing their progress and activities in the communities they serve.
- Based on feedback from the assister community, HHS is incorporating new elements into this year's required training, such as a course on advanced Marketplace issues with detailed information on topics such as how to help college-age students enroll in coverage and re-enrollment. HHS is committed to providing Navigators with on-going technical assistance and training opportunities throughout the year.

In addition to Navigators, Marketplaces make other resources available to consumers to help them access Marketplace coverage, such as certified application counselors, non-navigator assistance personnel (also known as in-person assisters), and agents and brokers. Consumers in federally-facilitated and state partnership Marketplaces can visit Find Local Help to find assistance in their area.

For a list of HHS Navigator awardees or more information about Navigators and other Marketplace resources, please visit: <http://cciio.cms.gov/programs/exchanges/assistance.html>

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Note: All HHS press releases, fact sheets and other news materials are available at <http://www.hhs.gov/news>.

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Last revised: September 8, 2014

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 14-5018**September Term, 2014****1:13-cv-00623-PLF****Filed On: September 4, 2014**

Jacqueline Halbig, et al.,

Appellants

v.

Sylvia Mathews Burwell, in her official
capacity as U.S. Secretary of Health and
Human Services, et al.,

Appellees

BEFORE: Garland, Chief Judge, and Henderson, Rogers, Tatel, Brown,
Griffith, Kavanaugh, Srinivasan, Millett, Pillard, and Wilkins,
Circuit Judges

ORDER

Upon consideration of appellees' petition for rehearing en banc, the response thereto, and the vote in favor of the petition by a majority of the judges eligible to participate, it is

ORDERED that the petition be granted. Case No. 14-5018 will be reheard by the court sitting en banc. It is

FURTHER ORDERED that the judgment filed July 22, 2014, be vacated. It is

FURTHER ORDERED that the oral argument before the en banc court be heard at 9:30 a.m. on Wednesday, December 17, 2014, in Courtroom #20, Sixth Floor. It is

FURTHER ORDERED that, in addition to filing briefs electronically, the parties file 30 paper copies of each of their briefs and the appendix, in accordance with the following schedule:

Brief for Appellants	October 3, 2014
Joint Appendix	October 3, 2014
Brief(s) for Amici Curiae for Appellants	October 3, 2014

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United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 14-5018**September Term, 2014**

Brief for Appellees	November 3, 2014
Brief(s) for Amici Curiae for Appellees	November 3, 2014
Reply Brief for Appellants	November 17, 2014

Parties are directed to hand deliver the paper copies of their briefs to the Clerk's office by the date due. To enhance the clarity of their briefs, the parties are urged to limit the use of abbreviations, including acronyms. While acronyms may be used for entities and statutes with widely recognized initials, briefs should not contain acronyms that are not widely known. See D.C. Circuit Handbook of Practice and Procedures 41 (2013); Notice Regarding Use of Acronyms (D.C. Cir. Jan. 26, 2010).

Because the briefing schedule is keyed to the date of oral argument, the court will grant requests for extension of time limits only for extraordinarily compelling reasons. The briefs and appendix must contain the date the case is scheduled for oral argument at the top of the cover. See D.C. Cir. Rule 28(a)(8).

A separate order will issue regarding allocation of oral argument time.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/
Michael C. McGrail
Deputy Clerk



Halbig v Burwell: Potential Implications for ACA Coverage and Subsidies

Linda J. Blumberg, John Holahan, and Matthew Buetgens

JULY 2014

A ruling from the U.S. Court of Appeals for the D.C. Circuit on *Halbig v. Burwell* is expected imminently. The case challenges the Obama Administration's interpretation of the Affordable Care Act (ACA), relying upon a single phrase in the law's text. The plaintiff claims the phrase prohibits residents of moderate income from receiving financial assistance (i.e., federal subsidies) for the purchase of private insurance coverage if their state does not run its own Health Insurance Marketplace (a.k.a. exchange), and has instead left this responsibility to the federal government. As of this writing, 34 states have chosen to leave administration of their Marketplaces to the federal government, with 15 of those states taking on some of the responsibilities of administering the law themselves via either formal or informal partnership with the federal government. As a result, a decision for the plaintiff could have widespread implications across the country.

As others have indicated, a ruling for the plaintiff at this time is far from a final decision in this case.¹ However, we can estimate the implications of an ultimate ruling in their favor using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).² Estimates are for 2016, assuming that individual and employer behavioral changes associated with the ACA's coverage provisions will be fully phased in, and taking into account current state decisions regarding the expansion of Medicaid. This analysis demonstrates that prohibiting individuals from receiving federal subsidies for health insurance coverage in states that rely on the federal government to administer their Marketplaces would broadly undermine implementation of the

ACA in those 34 states, with substantial coverage and financial implications for their residents.

Table 1 shows that 11.8 million individuals are expected to enroll in the 34 Federally Facilitated Marketplaces (FFMs) in 2016. Of those, 7.3 million people are estimated to receive federal subsidies to assist in the purchase of private insurance through the new Marketplaces. Many of the lowest income among those 7.3 million people also receive cost-sharing subsidies to lower their co-payments, deductibles and co-insurance. A decision in favor of *Halbig* translates into a loss of \$36.1 billion in 2016 of funds that would otherwise go to individuals and families with incomes below 400 percent of the federal poverty level, with spillover effects to state economies also expected from the sizable reduction in federal dollars flowing into these states. Losses would be as high as \$4.8 billion in Florida and \$5.6 billion in Texas.

Twenty-four of these 34 states also rejected the ACA's Medicaid expansion, meaning they are also foregoing large amounts of federal dollars while their providers are experiencing the Medicare and Medicaid payment cuts included in the law.³

Elimination of the financial subsidies would have a domino effect on other components of the ACA as well:

1. The individual mandate, which requires most Americans to have health insurance coverage or pay a penalty is predicated on the presence of financial support for the purchase of coverage for those who could not otherwise afford it. Eliminating the

subsidies means that many more residents of these states would face premium costs in excess of 8 percent of family income, exempting them from the penalties, making coverage unaffordable for many of them, and increasing the number of uninsured.

2. In turn, the regulatory reforms prohibiting insurance companies from discriminating against those with past, current, or anticipated health problems, along with other consumer protections, are predicated on the individual mandate. If almost everyone participates in the insurance pools, all types of individuals can be covered at essentially an overall average price. However, if the pool shrinks appreciably without the subsidies available to draw in many healthy individuals, insurers are likely to advocate strongly for the repeal of these new protections. And they would have a strong case to make.
3. FFM states have the option of taking over responsibility for running their state Marketplaces, transforming them into State Based Marketplaces (SBMs) and avoiding the consequences of a potential decision in favor of *Halbig*. In fact, a number of states continue to explore this as an option regardless of the case. As a practical matter, however, many of these states would find such a change extremely challenging from an administrative, resource, or political perspective.

Table 1. Estimated Enrollment and Subsidies for Purchase of Marketplace Plans in the 34 Federally Facilitated Marketplace States, 2016

State	Projected 2016 Total Marketplace Enrollment	Projected 2016 Subsidized Marketplace Enrollment	Estimated Subsidy Spending
Alabama	252,000	153,000	\$725,985,000
Alaska	51,000	36,000	\$156,420,000
Arizona	391,000	249,000	\$1,166,316,000
Arkansas	147,000	95,000	\$495,615,000
Delaware	34,000	21,000	\$93,975,000
Florida	1,437,000	931,000	\$4,756,479,000
Georgia	608,000	383,000	\$2,083,903,000
Illinois	566,000	315,000	\$1,420,965,000
Indiana	369,000	231,000	\$1,256,871,000
Iowa	145,000	78,000	\$396,084,000
Kansas	169,000	98,000	\$435,610,000
Louisiana	305,000	187,000	\$1,019,337,000
Maine	82,000	55,000	\$279,510,000
Michigan	467,000	290,000	\$1,271,070,000
Mississippi	162,000	106,000	\$641,512,000
Missouri	349,000	215,000	\$1,039,095,000
Montana	98,000	60,000	\$264,780,000
Nebraska	136,000	71,000	\$330,008,000
New Hampshire	79,000	47,000	\$183,770,000
New Jersey	396,000	229,000	\$969,815,000
North Carolina	615,000	376,000	\$1,792,392,000
North Dakota	54,000	29,000	\$144,884,000
Ohio	498,000	322,000	\$1,383,312,000
Oklahoma	235,000	152,000	\$797,240,000
Pennsylvania	677,000	402,000	\$2,138,640,000
South Carolina	283,000	183,000	\$871,446,000
South Dakota	66,000	37,000	\$206,756,000
Tennessee	378,000	225,000	\$1,216,575,000
Texas	1,683,000	1,092,000	\$5,582,304,000
Utah	208,000	127,000	\$630,047,000
Virginia	451,000	260,000	\$1,159,860,000
West Virginia	68,000	48,000	\$210,000,000
Wisconsin	269,000	164,000	\$882,976,000
Wyoming	45,000	27,000	\$139,644,000
Total FFM States	11,773,000	7,293,000	\$36,143,196,000

Source: Health Insurance Policy Simulation Model (HIPSM)

Notes:

1. Federally Facilitated Marketplace (FFM) states include states in which the federal government performs all Marketplace responsibilities, those with formal partnership agreements between the state and the federal government, and those taking on plan management responsibilities under informal or quasi-partnership arrangements.
2. Estimates assume individual and employer behavior is fully phased in by 2016.
3. Subsidy estimates include advanced premium tax credits and cost-sharing assistance.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Linda Blumberg is a senior fellow, John Holahan is an Institute fellow, and Matthew Buettgens is a senior research associate at the Urban Institute's Health Policy Center. The authors are grateful for research assistance by Jay Dev and the comments and suggestions of Genevieve Kenney and Stephen Zuckerman. The authors are grateful to the Robert Wood Johnson Foundation for supporting this research.

ABOUT THE URBAN INSTITUTE

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit <http://www.urban.org>. Follow the Urban Institute on Twitter www.urban.org/twitter or Facebook www.urban.org/facebook. More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at www.healthpolicycenter.org.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national Culture of Health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

Notes

- 1 See for example, Timothy Jost, "Courts won't void the Affordable Care Act over Semantics," Washington Post, July 9, 2014, http://www.washingtonpost.com/opinions/courts-wont-void-the-affordable-care-act-over-semantics/2014/07/09/5910c9d0-060b-11e4-a0dd-f2b22a257353_story.html.
- 2 For more information on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), see: "The Urban Institute's Health Microsimulation Capabilities," <http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf> for an overview and <http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf> for a more detailed description of the model's methodology.
- 3 John Holahan, Matthew Buettgens, Caitlin Carroll, Stan Dorn. November 2012. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Report prepared for the Kaiser Commission on Medicaid and the Uninsured. <http://www.urban.org/UploadedPDF/412707-The-Cost-and-Coverage-Implications-of-the-ACA-Medicaid-Expansion.pdf>.



S2701

HEALTH INSURANCE COVERAGE STATUS

2013 American Community Survey 1-Year Estimates

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the American Community Survey website in the Data and Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Subject	Maine				
	Total		Number Uninsured		Percent Uninsured
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Total civilian noninstitutionalized population	1,314,191	+/-575	147,015	+/-7,214	11.2%
AGE					
Under 18 years	259,827	+/-1,356	15,386	+/-2,520	5.9%
18 to 64 years	825,507	+/-1,778	131,236	+/-6,066	15.9%
65 years and older	228,857	+/-1,052	393	+/-271	0.2%
19 to 25 years	111,367	+/-2,418	23,949	+/-2,753	21.5%
SEX					
Male	641,305	+/-2,085	82,694	+/-4,989	12.9%
Female	672,886	+/-2,064	64,321	+/-4,240	9.6%
RACE AND HISPANIC OR LATINO ORIGIN					
One Race	N	N	N	N	N
White alone	1,247,632	+/-1,936	137,569	+/-7,009	11.0%
Black or African American alone	13,077	+/-1,230	1,720	+/-625	13.2%
American Indian and Alaska Native alone	8,035	+/-1,395	1,453	+/-702	18.1%
Asian alone	14,059	+/-1,403	1,793	+/-891	12.8%
Native Hawaiian and Other Pacific Islander alone	N	N	N	N	N
Some other race alone	3,795	+/-1,636	1,104	+/-829	29.1%
Two or more races	27,332	+/-2,235	3,339	+/-894	12.2%
White alone, not Hispanic or Latino	1,234,608	+/-1,462	135,354	+/-6,886	11.0%
Hispanic or Latino (of any race)	18,395	+/-512	3,244	+/-925	17.6%
NATIVITY AND CITIZENSHIP STATUS					
Native born	1,269,742	+/-3,232	141,793	+/-7,179	11.2%
Foreign born	44,449	+/-3,144	5,222	+/-1,276	11.7%
Naturalized	25,131	+/-2,799	2,143	+/-860	8.5%
Not a citizen	19,318	+/-2,812	3,079	+/-846	15.9%
EDUCATIONAL ATTAINMENT					
Civilian noninstitutionalized population 25 years and older	941,257	+/-1,875	110,259	+/-5,273	11.7%



Subject	Maine				
	Total		Number Uninsured		Percent Uninsured
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Less than high school graduate	74,732	+/-3,486	9,847	+/-1,691	13.2%
High school graduate, GED, or alternative	316,898	+/-8,052	47,635	+/-3,470	15.0%
Some college or associate's degree	281,479	+/-6,369	37,448	+/-3,545	13.3%
Bachelor's degree or higher	268,148	+/-6,419	15,329	+/-1,971	5.7%
EMPLOYMENT STATUS					
Civilian noninstitutionalized population 18 years and older	1,054,364	+/-1,396	131,629	+/-6,108	12.5%
In labor force	680,450	+/-6,376	107,238	+/-5,517	15.8%
Employed	634,921	+/-6,597	91,910	+/-4,978	14.5%
Unemployed	45,529	+/-3,448	15,328	+/-1,958	33.7%
Not in labor force	373,914	+/-6,133	24,391	+/-2,456	6.5%
WORK EXPERIENCE					
Civilian noninstitutionalized population 18 years and older	1,054,364	+/-1,396	131,629	+/-6,108	12.5%
Worked full-time, year round in the past 12 months	419,844	+/-6,679	49,290	+/-3,344	11.7%
Worked less than full-time, year round in the past 12 months	290,542	+/-6,607	59,960	+/-3,821	20.6%
Did not work	343,978	+/-6,249	22,379	+/-2,460	6.5%
HOUSEHOLD INCOME (IN 2013 INFLATION ADJUSTED DOLLARS)					
Civilian household population	1,291,176	+/-575	145,629	+/-7,247	11.3%
Under \$25,000	238,121	+/-9,533	35,373	+/-3,536	14.9%
\$25,000 to \$49,999	323,201	+/-11,753	47,464	+/-4,336	14.7%
\$50,000 to \$74,999	267,080	+/-10,131	35,882	+/-3,972	13.4%
\$75,000 to \$99,999	185,678	+/-7,816	11,355	+/-2,044	6.1%
\$100,000 and over	277,096	+/-9,304	15,555	+/-2,880	5.6%
RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS					
Civilian noninstitutionalized population for whom poverty status is determined	1,292,303	+/-1,341	145,791	+/-7,145	11.3%
Under 1.38 of poverty threshold	287,905	+/-10,667	44,780	+/-3,796	15.6%
1.38 to 1.99 of poverty threshold	161,080	+/-9,274	30,796	+/-3,773	19.1%
2.00 of poverty threshold and over	843,318	+/-10,471	70,215	+/-4,827	8.3%
HEALTH COVERAGE BY TYPE					
Private health insurance	(X)	(X)	(X)	(X)	(X)
Private health insurance alone	(X)	(X)	(X)	(X)	(X)
Employment-based health insurance	(X)	(X)	(X)	(X)	(X)
Employment-based health insurance alone	(X)	(X)	(X)	(X)	(X)
Direct-purchase health insurance	(X)	(X)	(X)	(X)	(X)
Direct-purchase health insurance alone	(X)	(X)	(X)	(X)	(X)
TRICARE/military health coverage	(X)	(X)	(X)	(X)	(X)
TRICARE/military health coverage alone	(X)	(X)	(X)	(X)	(X)
Public coverage	(X)	(X)	(X)	(X)	(X)
Public coverage alone	(X)	(X)	(X)	(X)	(X)
Medicare coverage	(X)	(X)	(X)	(X)	(X)
Medicare coverage alone	(X)	(X)	(X)	(X)	(X)
Medicaid/means-tested public coverage	(X)	(X)	(X)	(X)	(X)
Medicaid/means-tested public coverage alone	(X)	(X)	(X)	(X)	(X)
VA Health Care	(X)	(X)	(X)	(X)	(X)
VA Health Care alone	(X)	(X)	(X)	(X)	(X)
Uninsured	(X)	(X)	(X)	(X)	(X)
PERCENT IMPUTED					
Health insurance coverage	12.1%	(X)	(X)	(X)	(X)
Private health insurance	11.3%	(X)	(X)	(X)	(X)

Subject	Maine				
	Total		Number Uninsured		Percent Uninsured
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Employer-based health insurance	8.4%	(X)	(X)	(X)	(X)
Direct-purchase health insurance	9.1%	(X)	(X)	(X)	(X)
TRICARE/military health coverage	10.5%	(X)	(X)	(X)	(X)
Public coverage	11.6%	(X)	(X)	(X)	(X)
Medicare coverage	6.7%	(X)	(X)	(X)	(X)
Medicaid/means-tested public coverage	9.6%	(X)	(X)	(X)	(X)
VA Health Care	10.3%	(X)	(X)	(X)	(X)

Subject	Maine				
	Percent Uninsured	Number Insured by Coverage Type		Percent Insured by Coverage Type	
	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total civilian noninstitutionalized population	+/-0.5	1,167,176	+/-7,185	88.8%	+/-0.5
AGE					
Under 18 years	+/-1.0	(X)	(X)	(X)	(X)
18 to 64 years	+/-0.7	(X)	(X)	(X)	(X)
65 years and older	+/-0.1	(X)	(X)	(X)	(X)
19 to 25 years	+/-2.4	(X)	(X)	(X)	(X)
SEX					
Male	+/-0.8	(X)	(X)	(X)	(X)
Female	+/-0.6	(X)	(X)	(X)	(X)
RACE AND HISPANIC OR LATINO ORIGIN					
One Race	N	(X)	(X)	(X)	(X)
White alone	+/-0.6	(X)	(X)	(X)	(X)
Black or African American alone	+/-4.9	(X)	(X)	(X)	(X)
American Indian and Alaska Native alone	+/-6.9	(X)	(X)	(X)	(X)
Asian alone	+/-6.0	(X)	(X)	(X)	(X)
Native Hawaiian and Other Pacific Islander alone	N	(X)	(X)	(X)	(X)
Some other race alone	+/-17.8	(X)	(X)	(X)	(X)
Two or more races	+/-3.1	(X)	(X)	(X)	(X)
White alone, not Hispanic or Latino	+/-0.6	(X)	(X)	(X)	(X)
Hispanic or Latino (of any race)	+/-5.0	(X)	(X)	(X)	(X)
NATIVITY AND CITIZENSHIP STATUS					
Native born	+/-0.6	(X)	(X)	(X)	(X)
Foreign born	+/-2.8	(X)	(X)	(X)	(X)
Naturalized	+/-3.4	(X)	(X)	(X)	(X)
Not a citizen	+/-4.2	(X)	(X)	(X)	(X)
EDUCATIONAL ATTAINMENT					
Civilian noninstitutionalized population 25 years and older	+/-0.6	(X)	(X)	(X)	(X)
Less than high school graduate	+/-2.1	(X)	(X)	(X)	(X)
High school graduate, GED, or alternative	+/-0.9	(X)	(X)	(X)	(X)
Some college or associate's degree	+/-1.2	(X)	(X)	(X)	(X)
Bachelor's degree or higher	+/-0.7	(X)	(X)	(X)	(X)
EMPLOYMENT STATUS					
Civilian noninstitutionalized population 18 years and older	+/-0.6	(X)	(X)	(X)	(X)
In labor force	+/-0.8	(X)	(X)	(X)	(X)
Employed	+/-0.8	(X)	(X)	(X)	(X)
Unemployed	+/-3.2	(X)	(X)	(X)	(X)
Not in labor force	+/-0.6	(X)	(X)	(X)	(X)
WORK EXPERIENCE					
Civilian noninstitutionalized population 18 years and older	+/-0.6	(X)	(X)	(X)	(X)
Worked full-time, year round in the past 12 months	+/-0.8	(X)	(X)	(X)	(X)
Worked less than full-time, year round in the past 12 months	+/-1.2	(X)	(X)	(X)	(X)
Did not work	+/-0.7	(X)	(X)	(X)	(X)
HOUSEHOLD INCOME (IN 2013 INFLATION ADJUSTED DOLLARS)					
Civilian household population	+/-0.6	(X)	(X)	(X)	(X)
Under \$25,000	+/-1.4	(X)	(X)	(X)	(X)

Subject	Maine				
	Percent Uninsured	Number Insured by Coverage Type		Percent Insured by Coverage Type	
	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
\$25,000 to \$49,999	+/-1.3	(X)	(X)	(X)	(X)
\$50,000 to \$74,999	+/-1.4	(X)	(X)	(X)	(X)
\$75,000 to \$99,999	+/-1.1	(X)	(X)	(X)	(X)
\$100,000 and over	+/-1.0	(X)	(X)	(X)	(X)
RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS					
Civilian noninstitutionalized population for whom poverty status is determined	+/-0.6	(X)	(X)	(X)	(X)
Under 1.38 of poverty threshold	+/-1.2	(X)	(X)	(X)	(X)
1.38 to 1.99 of poverty threshold	+/-1.8	(X)	(X)	(X)	(X)
2.00 of poverty threshold and over	+/-0.6	(X)	(X)	(X)	(X)
HEALTH COVERAGE BY TYPE					
Private health insurance	(X)	852,796	+/-12,284	64.9%	+/-0.9
Private health insurance alone	(X)	638,109	+/-11,629	48.6%	+/-0.9
Employment-based health insurance	(X)	697,968	+/-13,029	53.1%	+/-1.0
Employment-based health insurance alone	(X)	568,512	+/-12,425	43.3%	+/-0.9
Direct-purchase health insurance	(X)	156,858	+/-6,271	11.9%	+/-0.5
Direct-purchase health insurance alone	(X)	55,442	+/-4,784	4.2%	+/-0.4
TRICARE/military health coverage	(X)	45,104	+/-4,313	3.4%	+/-0.3
TRICARE/military health coverage alone	(X)	14,155	+/-3,011	1.1%	+/-0.2
Public coverage	(X)	509,351	+/-9,541	38.8%	+/-0.7
Public coverage alone	(X)	255,334	+/-9,486	19.4%	+/-0.7
Medicare coverage	(X)	269,953	+/-3,691	20.5%	+/-0.3
Medicare coverage alone	(X)	59,167	+/-3,250	4.5%	+/-0.2
Medicaid/means-tested public coverage	(X)	295,577	+/-9,857	22.5%	+/-0.7
Medicaid/means-tested public coverage alone	(X)	190,457	+/-8,582	14.5%	+/-0.7
VA Health Care	(X)	45,058	+/-2,458	3.4%	+/-0.2
VA Health Care alone	(X)	5,710	+/-1,045	0.4%	+/-0.1
Uninsured	(X)	147,015	+/-7,214	11.2%	+/-0.5
PERCENT IMPUTED					
Health insurance coverage	(X)	(X)	(X)	(X)	(X)
Private health insurance	(X)	(X)	(X)	(X)	(X)
Employer-based health insurance	(X)	(X)	(X)	(X)	(X)
Direct-purchase health insurance	(X)	(X)	(X)	(X)	(X)
TRICARE/military health coverage	(X)	(X)	(X)	(X)	(X)
Public coverage	(X)	(X)	(X)	(X)	(X)
Medicare coverage	(X)	(X)	(X)	(X)	(X)
Medicaid/means-tested public coverage	(X)	(X)	(X)	(X)	(X)
VA Health Care	(X)	(X)	(X)	(X)	(X)

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

In data year 2013, there were a series of changes to data collection operations that could have affected some estimates. These changes include the addition of Internet as a mode of data collection, the end of the content portion of Failed Edit Follow-Up interviewing, and the loss of one monthly panel due to the Federal Government shut down in October 2013. For more information, see: User Notes

The health insurance coverage category names were modified in 2010. See ACS Health Insurance Definitions for a list of the insurance type definitions.

While the 2013 American Community Survey (ACS) data generally reflect the February 2013 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.

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Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2010 data. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2013 American Community Survey

Explanation of Symbols:

1. An '***' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '****' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.



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2013 American Community Survey 1-Year Estimates

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the American Community Survey website in the Data and Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Subject	Maine			
	Total Civilian Noninstitutionalized Population		Uninsured Population	
	Estimate	Margin of Error	Estimate	Margin of Error
Total population	1,314,191	+/-575	147,015	+/-7,214
AGE				
Under 18 years	19.8%	+/-0.1	10.5%	+/-1.5
Under 6 years	5.8%	+/-0.2	2.5%	+/-0.5
6 to 17 years	13.9%	+/-0.2	7.9%	+/-1.4
18 to 64 years	62.8%	+/-0.1	89.3%	+/-1.5
18 to 24 years	8.6%	+/-0.1	14.5%	+/-1.4
25 to 34 years	11.3%	+/-0.2	19.7%	+/-1.7
35 to 44 years	11.9%	+/-0.1	16.5%	+/-1.4
45 to 54 years	15.5%	+/-0.1	23.2%	+/-1.3
55 to 64 years	15.5%	+/-0.1	15.3%	+/-1.3
65 years and older	17.4%	+/-0.1	0.3%	+/-0.2
65 to 74 years	10.0%	+/-0.1	0.2%	+/-0.1
75 years and older	7.4%	+/-0.1	0.1%	+/-0.1
Median age (years)	43.9	+/-0.2	38.6	+/-1.1
SEX				
Male	48.8%	+/-0.2	56.2%	+/-2.0
Female	51.2%	+/-0.2	43.8%	+/-2.0
RACE AND HISPANIC OR LATINO ORIGIN				
One race	97.9%	+/-0.2	97.7%	+/-0.6
White alone	94.9%	+/-0.1	93.6%	+/-1.3
Black or African American alone	1.0%	+/-0.1	1.2%	+/-0.4
American Indian and Alaska Native alone	0.6%	+/-0.1	1.0%	+/-0.5
Asian alone	1.1%	+/-0.1	1.2%	+/-0.6
Native Hawaiian and Other Pacific Islander alone	0.0%	+/-0.1	0.0%	+/-0.1
Some other race alone	0.3%	+/-0.1	0.8%	+/-0.6
Two or more races	2.1%	+/-0.2	2.3%	+/-0.6
Hispanic or Latino (of any race)	1.4%	+/-0.1	2.2%	+/-0.6
White alone, not Hispanic or Latino	93.9%	+/-0.1	92.1%	+/-1.3

Subject	Maine			
	Total Civilian Noninstitutionalized Population		Uninsured Population	
	Estimate	Margin of Error	Estimate	Margin of Error
NATIVITY AND U.S. CITIZENSHIP STATUS				
Native born	96.6%	+/-0.2	96.4%	+/-0.9
Foreign born	3.4%	+/-0.2	3.6%	+/-0.9
Naturalized	1.9%	+/-0.2	1.5%	+/-0.6
Not a citizen	1.5%	+/-0.2	2.1%	+/-0.6
DISABILITY STATUS				
With a disability	16.3%	+/-0.5	9.4%	+/-1.1
No disability	83.7%	+/-0.5	90.6%	+/-1.1
RESIDENCE 1 YEAR AGO				
Civilian noninstitutionalized population 1 year and over	1,301,798	+/-1,729	146,651	+/-7,183
Same house	86.1%	+/-0.8	79.5%	+/-2.3
Different House in the U.S.	13.6%	+/-0.8	19.8%	+/-2.3
Same county	8.3%	+/-0.4	12.1%	+/-1.8
Different county	5.3%	+/-0.5	7.7%	+/-1.4
Same state	2.5%	+/-0.3	4.1%	+/-1.0
Different state	2.8%	+/-0.4	3.6%	+/-1.1
Abroad	0.3%	+/-0.1	0.6%	+/-0.4
EDUCATIONAL ATTAINMENT				
Civilian noninstitutionalized population 25 years and over	941,257	+/-1,875	110,259	+/-5,273
Less than high school graduate	7.9%	+/-0.4	8.9%	+/-1.6
High school graduate (includes equivalency)	33.7%	+/-0.9	43.2%	+/-2.5
Some college or associate's degree	29.9%	+/-0.7	34.0%	+/-2.7
Bachelor's degree or higher	28.5%	+/-0.7	13.9%	+/-1.5
EMPLOYMENT STATUS				
Civilian noninstitutionalized population 16 years and over	1,086,258	+/-2,422	134,067	+/-6,321
In labor force	63.6%	+/-0.6	80.6%	+/-1.7
Employed	59.2%	+/-0.6	69.0%	+/-1.9
Unemployed	4.4%	+/-0.3	11.6%	+/-1.3
Not in labor force	36.4%	+/-0.6	19.4%	+/-1.7
WORK EXPERIENCE				
Civilian noninstitutionalized population 16 to 64 years	857,401	+/-2,730	133,674	+/-6,273
Worked full-time, year round in the past 12 months	47.1%	+/-0.7	36.8%	+/-1.8
Worked less than full-time, year round in the past 12 months	31.1%	+/-0.7	45.5%	+/-2.0
Did not work	21.8%	+/-0.7	17.6%	+/-1.7
Civilian noninstitutionalized workers 16 years and over	643,378	+/-6,579	92,495	+/-5,051
CLASS OF WORKER				
Private for-profit wage and salary workers	63.5%	+/-0.8	70.5%	+/-2.3
Employee of private company workers	60.0%	+/-0.8	65.9%	+/-2.6
Self-employed in own incorporated business workers	3.5%	+/-0.4	4.6%	+/-1.6
Private not-for-profit wage and salary workers	13.9%	+/-0.6	6.8%	+/-1.3
Local government workers	7.0%	+/-0.5	2.6%	+/-1.0
State government workers	4.4%	+/-0.4	1.2%	+/-0.6
Federal government workers	2.7%	+/-0.3	0.8%	+/-0.4
Self-employed workers in own not incorporated business workers	8.4%	+/-0.5	17.8%	+/-2.2
Unpaid family workers	0.1%	+/-0.1	0.3%	+/-0.3
INDUSTRY				

Subject	Maine			
	Total Civilian Noninstitutionalized Population		Uninsured Population	
	Estimate	Margin of Error	Estimate	Margin of Error
Agriculture, forestry, fishing and hunting, and mining	2.6%	+/-0.3	5.3%	+/-1.1
Construction	7.1%	+/-0.5	15.0%	+/-2.2
Manufacturing	9.3%	+/-0.5	6.5%	+/-1.7
Wholesale trade	2.4%	+/-0.3	1.6%	+/-0.8
Retail trade	13.3%	+/-0.7	16.3%	+/-2.3
Transportation and warehousing, and utilities	3.5%	+/-0.3	3.0%	+/-0.7
Information	1.9%	+/-0.3	1.6%	+/-0.7
Finance and insurance, and real estate and rental and leasing	5.8%	+/-0.4	3.1%	+/-1.1
Professional, scientific, and management, and administrative and waste management services	8.4%	+/-0.5	9.0%	+/-1.3
Educational services, and health care and social assistance	27.6%	+/-0.8	13.9%	+/-1.9
Arts, entertainment, and recreation, and accommodation and food services	8.8%	+/-0.6	15.7%	+/-2.2
Other services (except public administration)	4.7%	+/-0.4	7.5%	+/-1.4
Public administration	4.7%	+/-0.4	1.6%	+/-0.8
OCCUPATION				
Management, business, science, and arts occupations	34.6%	+/-1.0	15.1%	+/-1.8
Service occupations	19.1%	+/-0.9	28.1%	+/-2.6
Sales and office occupations	23.4%	+/-0.8	21.6%	+/-2.2
Natural resources, construction, and maintenance occupations	11.1%	+/-0.6	22.2%	+/-2.5
Production, transportation, and material moving occupations	11.8%	+/-0.6	12.9%	+/-1.9
EARNINGS IN THE PAST 12 MONTHS (IN 2013 INFLATION ADJUSTED DOLLARS)				
Civilian noninstitutionalized population 16 years and over with earnings	723,255	+/-6,565	110,249	+/-5,700
\$1 to \$4,999 or less	12.5%	+/-0.6	11.6%	+/-1.6
\$5,000 to \$14,999	16.4%	+/-0.6	27.6%	+/-2.5
\$15,000 to \$24,999	16.7%	+/-0.6	28.6%	+/-2.3
\$25,000 to \$34,999	15.5%	+/-0.7	15.5%	+/-1.7
\$35,000 to \$49,999	15.6%	+/-0.6	8.9%	+/-1.2
\$50,000 to \$74,999	13.6%	+/-0.6	5.2%	+/-1.2
\$75,000 or more	9.6%	+/-0.5	2.6%	+/-0.7
Median earnings (dollars)	27,221	+/-424	17,869	+/-1,039
HOUSEHOLD INCOME (IN 2013 INFLATION ADJUSTED DOLLARS)				
Total household population	1,291,176	+/-575	145,629	+/-7,247
Under \$25,000	18.4%	+/-0.7	24.3%	+/-2.2
\$25,000 to \$49,999	25.0%	+/-0.9	32.6%	+/-2.4
\$50,000 to \$74,999	20.7%	+/-0.8	24.6%	+/-2.6
\$75,000 to \$99,999	14.4%	+/-0.6	7.8%	+/-1.3
\$100,000 and over	21.5%	+/-0.7	10.7%	+/-1.9
Median household income of householders	46,898	+/-797	32,129	+/-1,660
RATIO OF INCOME TO POVERTY LEVEL IN THE PAST 12 MONTHS				
Civilian noninstitutionalized population for whom poverty status is determined	1,292,303	+/-1,341	145,791	+/-7,145
Below 50 percent of the poverty level	5.1%	+/-0.5	8.3%	+/-1.3
50 to 99 percent of the poverty level	8.9%	+/-0.5	10.8%	+/-1.7
100 to 149 percent of the poverty level	10.5%	+/-0.6	15.7%	+/-1.7
150 to 199 percent of the poverty level	10.3%	+/-0.7	17.0%	+/-2.0
200 to 299 percent of the poverty level	18.5%	+/-0.9	22.5%	+/-2.2
At or above 300 percent of the poverty level	46.8%	+/-0.9	25.6%	+/-2.1

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

In data year 2013, there were a series of changes to data collection operations that could have affected some estimates. These changes include the addition of Internet as a mode of data collection, the end of the content portion of Failed Edit Follow-Up interviewing, and the loss of one monthly panel due to the Federal Government shut down in October 2013. For more information, see: User Notes

Occupation codes are 4-digit codes and are based on Standard Occupational Classification 2010.

The health insurance coverage category names were modified in 2010. See ACS Health Insurance Definitions for a list of the insurance type definitions.

While the 2013 American Community Survey (ACS) data generally reflect the February 2013 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.

Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2010 data. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2013 American Community Survey

Explanation of Symbols:

1. An '***' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

9/22/14 For MHEAC

REVIEW

Project Abstract

State of Maine Data Center Enhancement to Improve Health Cost Transparency

The Health Insurance Rate Review Grant Program: Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing, Cycle IV, Funding Opportunity Number: PR-PRP-14-001

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The Maine Health Data Organization (MHDO) is proposed as the lead agency for Maine's Rate Review Cycle IV grant to enhance their existing Data Center. The Maine Legislature established MHDO in 1996 as an independent executive agency to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens. MHDO created the nation's first All Payer Claims Database (APCD) and has been collecting medical, pharmacy and dental claims data from public and private insurers since 2003 as defined in Statute and rule and makes those data publicly available while protecting individual privacy. MHDO is also required in Statute to provide data on quality of care and price comparisons. The Agency does this through its publicly accessible HealthCost 2014 and MONAHRQ web pages. As described more fully in the proposal, Maine has a strong history of public/private collaboration in health care improvement initiatives. By communicating and working together MHDO and these groups are able to leverage each other's work and avoid duplication of effort.

Building upon the work being done under Maine's Rate Review Cycle III activities, MHDO intends to use grant funding to further integrate and enhance its cost and quality data to provide more comprehensive and useful information to consumers, providers, employers, and other key stakeholders. MHDO will develop ways to improve access to and dissemination of its wealth of data to further promote cost and quality transparency.

Specifically, MHDO intends to use funds for the following health cost and quality website activities as well as health data transparency and dissemination activities:

Health Cost and Quality Website Activities

- 1) Increase the number procedures displayed
 - a) Add additional medical procedures
 - b) Develop and implement an inpatient procedure category and affiliated procedures
 - c) Add mental health/substance abuse procedure category and affiliated procedures
 - d) Explore adding a dental procedure category and affiliated procedures
 - e) Explore adding and enhancing pricing information for pharmacy data (previous activities focused on researching and linking to external data sources)
- 2) Increase the number of non-hospital facilities displayed
- 3) Define clinical data to collect (such as laboratory results) and explore integration options
- 4) Enhance the consumer website experience on computers, tablets, and mobile devices
- 5) Enhance the procedure search function (possibilities include searching for facilities by a clickable county map and searching for procedures by clicking on relevant areas of the human body)
- 6) Enhance data display (possibilities include displaying color-coded price variation on a county map; reporting cost using symbols or words rather than numbers)

Health Data Transparency and Dissemination

- 1) Work with stakeholders to develop an online data request system to collect information required for data release and streamline the release process
- 2) Research and make recommendations on the best researcher and consumer payment model options that promote access and

From: Maine Health
Data Organization

sustainability

- 3) Research and make recommendations on options for self-service access to data

The State of Maine is requesting \$1,179,000 to complete this ambitious agenda.

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Stein- Health Affairs Blog - <http://healthaffairs.org/blog/> -**Implementing Health Reform: Complicated ACA Tax Forms Could Cause Problems**Posted By [Timothy Jost](#) On September 21, 2014 @ 5:48 pm In [All Categories](#), [Consumers](#), [Employer-Sponsored Insurance](#), [Health Reform](#), [Insurance](#), [Policy](#) | [No Comments](#)

Editor's note: *This post has been updated to clarify who must file IRS form 8965.*

In a few months, millions of Americans will be filing either [form 8962](#)^[1] to reconcile the advance premium tax credit they received with the tax credit they were actually due, or [form 8965](#)^[2] because they claim an exemption from the shared responsibility (individual mandate) provision of the Affordable Care Act.

By the close of open enrollment in April, [6.7 million Americans had chosen a qualified health plan with premium tax credits](#)^[3], and many more have since enrolled in a QHP through a special enrollment period and received tax credits. Each of them will need to file a form 8962. [The Congressional Budget Office estimates](#)^[4] that 30 million Americans are potentially subject to the shared responsibility requirement, and that 23 million of them may qualify for an exemption. Many of the 23 million will have to file a form 8965.

On September 15, 2014 the Internal Revenue Service released [draft instructions for form 8965](#)^[5]. On September 17, 2014, the IRS released [draft instructions for form 8962](#)^[6]. It is difficult to overstate how complicated these instructions are. The tax credit and individual responsibility provisions of the ACA were complicated to begin with, but have become ever more complex as new exceptions and special rules have been created as implementation of the legislation has proceeded. Many of the mostly low income Americans who will be completing these forms are marginally literate, at least in English, and have been accustomed to filing very simple tax forms like the 1040-EZ (which cannot be used by an individual claiming a tax credit) or perhaps not to filing taxes at all. They are likely to be confused, frustrated, even angry, and certainly bewildered, completing these forms. It is to be hoped that most of them will be assisted by well-trained tax preparers.

The form 8965 must be filed by any individual who claims an exemption from the shared responsibility payment, other than the exemption for having income below the filing limit. Most Americans who must file a tax return will simply check a box on their 1040, 1040A, or 1040-EZ indicating that they have had minimum essential coverage (MEC), either through their employer or a government program, for the entire year. Those who are required to file taxes, have not been covered for the full 12 months of 2014, and claim an exemption from the shared responsibility payment must file the 8965. Tax filers who themselves had MEC but have a member of their tax household (a spouse or a person who is or could be claimed as a tax dependent and is not claimed by another taxpayer as a tax dependent) who lacked MEC and who is eligible for an exemption must also file the form.

The instructions to both forms 8962 and 8965 generally refer to the person filling out the form as "you." In this post, I will generally use the term "tax filer" at any place where the instructions use the term "you."

The Form 8965 instructions begin with a list of types of coverage exemptions. Nineteen types of coverage exemptions are listed. This list is not exhaustive, however, as it does not list individually the [14 categories of hardship exemptions](#)^[7] currently available, rather lumping most of them together into one category: "You are experiencing circumstances that prevent you from obtaining coverage under a qualified health plan." Of the 19 exemptions listed, 10 may be claimed on the tax return. Five (including hardship exemptions) may be claimed only through the marketplace (exchange). Four may be claimed either through the marketplace or on the form.

The exemption for income below the filing limit may be claimed on the form if an individual decides to file anyway (to obtain a refund of withheld taxes, for example), but need not be claimed by individuals who do not file. In fact, the form has two boxes that can be checked for this exemption, one for tax filers with household income below the filing limit and the other for filers with gross income below the filing limit. Although there is a conceptual difference between the two (one is a statutory exemption, the other a hardship exemption), the distinction will make no sense to most filers, makes no practical difference, and is a needless complication. For 2014, the filing threshold is \$10,150 for single individuals, \$13,050 for heads of household, and \$20,300 for married couple filing jointly, with higher levels for individuals over age 65.

If an exemption can only be granted through the marketplace, the tax filer must obtain the exemption from the marketplace and then enter on the form the exemption certificate number provided by the marketplace for each member of the household. These include, among others,

- exemptions for membership in a religious sect that foregoes all forms of insurance coverage, including Medicare and Social Security;
- hardship;
- individuals who live in a state that failed to expand Medicaid who would have qualified for it because their household income was below 138 percent of the poverty level; or
- individuals whose 2013 health insurance policy was not renewed and who could not find affordable coverage.

If a tax filer has not yet received an exemption certificate from the marketplace, the tax filer must either do so before the 2014 tax filing deadline (April 15, 2015) or request an extension and get the certificate before filing.

Processing some of these exemptions should be straightforward. Most individuals who qualify for the religious exemption—primarily Amish, conservative Mennonites, and Hutterites—are used to filing exemption forms for Social Security or Medicare taxes, and have probably already requested an exemption. For hardship exemptions the filing of an individual application with the marketplace is probably necessary to determine if a hardship really exists.

But it makes no sense to require individuals who are excluded from Medicaid because their state failed to expand to apply for an exemption. Many of these individuals will be otherwise exempt because they have income below the filing limit or be unable to afford coverage, but for the rest of them, the fact necessary to determine an exemption — state of residence and household income — are apparent on the face of the tax form and requiring the extra step of filing for an exemption simply places an unnecessary burden on the individual and the marketplace.

The instructions next defines the various terms used in the form. Household income is the modified adjusted gross income (MAGI) of the tax filer plus the income of each dependent in the household who is required to file his or her own tax return. The first step in filling out the form, therefore, is to determine if any dependents are required to file taxes. Generally a single dependent must file if he or she has earned income over \$6,200 or unearned income over \$1,000.

MAGI is defined for purposes of the shared responsibility exception as adjusted gross income plus income claimed for the foreign earned income exclusion, housing exclusion, housing deduction, and tax-exempt interest. It does not include Social Security income, which is included in MAGI for purposes of determining eligibility for premium tax credits.

No penalty is owed by taxpayers whose entire household is covered by MEC. The different forms of MEC (mainly employer or individual coverage or coverage under government-sponsored programs) are listed on the form. MEC is determined on a monthly basis, but an individual is considered to have MEC for any month in which the individual had coverage for at least one day.

The form then proceeds to specific filing instructions. Tax filers granted an exemption by the marketplace, for hardship for example, must enter the name of each member of the household granted an exemption and the exemption certificate number. Members of health care sharing ministries, members of federally-recognized Indian tribes, individuals eligible for Indian health services provider services, or incarcerated individuals can apply for a marketplace exemption and enter their certificate number, or they can simply claim this status on the form 8965.

Coverage exemptions claimed on the return must be claimed separately for each individual in a household and the appropriate code entered for each month of the year for which the exemption applies. Some of these are quite straightforward and are simply claimed by entering the appropriate code for the specific individual and checking the months for which it applied. These include the exemptions for

- short gaps in coverage (less than 3 months),
- certain citizens living abroad,
- individuals not lawfully present in the United States,
- members of health care sharing ministries,
- members of federally-recognized Indian tribes,
- individuals who applied for CHIP or marketplace coverage during the 2014 open enrollment period but were uncovered before that coverage began,
- individuals covered by certain types of Medicaid or TRICARE coverage that is not MEC but is considered to be so for 2014, or
- individuals or are incarcerated other than those awaiting disposition.

There is apparently no list of recognized health care sharing ministries but there is a list of federally recognized Indian Tribes.

The affordability exception is more complicated. An individual is exempt from the shared responsibility requirement for any month in which his or her required contribution for the lowest-cost coverage through an employer-sponsored plan, or if the individual is not eligible for employer coverage, bronze plan purchased through the marketplace, (after available premium tax credits are applied) is more than 8 percent of household income. If an individual is eligible for self-only employer coverage, the required contribution for coverage is the cost of self-only coverage. If an individual in a household is not eligible for self-only employer coverage, but is eligible for employer-sponsored family coverage, the required contribution is the amount required to cover everyone in the household for whom a personal exemption is claimed on the tax return, for whom coverage is available, and who is not otherwise eligible for an exemption.

A separate exemption applies if two or more members of a tax household are each independently eligible for self-only employer coverage, but the combined cost of that coverage exceeds 8 percent of household income. If a household member changes employers or the cost of coverage from a single employer changes over the course of the year, affordability must be calculated on a monthly basis. It is not clear how individuals will determine the cost of the lowest-cost employer plan available to them, since employers have no obligation to report this information for 2014. It is hoped, apparently, that employers will be helpful in providing this information voluntarily.

If an individual, including a dependent, cannot purchase employer coverage, a determination must be made whether the individual could purchase the lowest-cost bronze plan in the marketplace for no more than 8 percent of household income. To make this determination, the instructions tell the tax filer to go to healthcare.gov or the marketplace website for his or her state and find out what the lowest cost bronze plan would have cost and how much of this cost could have been covered by premium tax credits.

This means that the marketplaces will have to make a retroactive financial eligibility determination for coverage for the lowest cost bronze plan for everyone who wants to claim this exemption. Premium tax credit eligibility depends on household income and the premium for the lowest-cost bronze plan will depend on the geographic location of the household and the age of every household member, so an individualized determination will have to be made for each tax filer. Moreover, if no one bronze plan will cover all household members, the premiums may need to be added together for two or more bronze plans.

The advantage of this approach is that it will drive everyone who wants to claim the affordability exception to the marketplace in the spring of 2015, where they may simply sign up for coverage — if, that is, they get there before open enrollment closes on February 15. If they sign up for a bronze plan, however, they may miss out on the cost-sharing reductions they might have received under a silver plan. Moreover, if they get there after February 15, which most probably will, they will no doubt be frustrated.

Moreover, this requirement imposes one more administrative burden on the exchanges, which have enough to do already without having to calculate retroactively the cost of bronze plans and premium tax credits available for 2014. As a practical matter, everyone with household income below 250 percent of poverty, and probably most older individuals with incomes below 400 percent of poverty, will not need to spend more than 8 percent of their income to purchase coverage, so this determination could be simplified considerably, and I hope will be.

Finally, the penalty must be calculated for anyone who does not qualify for an exemption. For 2014, the per-month penalty is the greater of,

- the sum of 1/12 of \$95 for each adult and one half that amount for each minor dependent up to a maximum of 1/12 of \$285, or
- 1 percent of household income over the filing limit up to a maximum of \$204 per month for each member of the household.

This amount is added to taxes otherwise owed by the taxpayer on his or her tax return. It will, no doubt, be subtracted for many tax filers from refunds otherwise due.

Form 8962, the premium tax credit form, is no less complicated. This form must be filed together with a 1040 or 1040A (not a 1040-EZ) by any tax filer who wishes to claim a premium tax credit, who received an advance premium tax credit (APTC) during 2014, who claims a personal exemption for an individual who received an APTC, or who told the marketplace he or she intended to claim a tax personal exemption for an individual who received an APTC if no other taxpayer claims a personal exemption for that dependent. An individual is eligible for an APTC if he or she, for one or more months of the year,

- was enrolled in a qualified health plan through a marketplace,
- was not eligible for MEC during the same month,
- had a household income between 100 and 400 percent of the federal poverty level,
- was not claimed as a dependent by another tax filer for 2014,
- was not incarcerated (unless pending disposition of charge) or unlawfully present in the United States (although such persons may claim tax credits for members of their tax family who are properly covered by a QHP), and
- if married, files jointly, unless the tax filer lives separately and meets the requirements for filing singly or as head of household, or is a victim of spousal abandonment or domestic abuse ^[8]. (A victim of spousal abandonment or domestic abuse can simply certify this status and does not need to file documentation.)

The Form 8962 instructions begin by defining terms. Household income includes the MAGI for the tax filer and spouse, as well as for any members of the tax filer's tax family required to file a return. For purposes of tax credit determination, MAGI is defined as it is for purposes of the shared responsibility requirement, except that Social Security benefits not otherwise included in income are added. The monthly tax credit amount is the lesser of the premiums actually paid during a month for coverage through a qualified health plan (QHP) in which the tax filer or a member of the tax filer's tax family is enrolled, or the monthly premium for the second lowest-cost silver plan (SLCSP) that would have covered the tax filer and the tax filer's coverage family, minus the household's monthly contribution amount.

The monthly contribution amount is one twelfth of the annual contribution amount. The annual contribution amount is a percentage of the household's MAGI, the size of which is determined by relationship between the household's MAGI and the federal poverty level. For example, a tax filer that has a MAGI equal to 200 percent of the federal poverty level for a family the tax filer's size would have to pay 6.3 percent of MAGI as an annual contribution amount, while the tax credit would cover the amount above that for the lesser of the actual cost

the tax filer paid for coverage or the cost of the SLCSPP. A tax filer can only claim a credit for premiums actually paid by the due date of the tax return (without extensions).

The tax filer's tax family is defined as the tax filer and all individuals for whom a personal exemption is claimed. The coverage family consists of all individuals in the tax family who are enrolled in a QHP through a marketplace and who are not otherwise eligible for MEC. QHPs include bronze, silver, gold, and platinum plans but not catastrophic plans.

MEC is generally defined as it is for the shared responsibility requirement, except that employer coverage only counts "if the premiums are affordable and the deductibles and co-pays are no more than a certain amount." The tax filer is referred to "Pub. 974", which is as far as I can tell is not yet available, to find out more about MEC. Affordability and adequacy of employer coverage are defined terms under the statute and regulations (although the IRS has not yet issued final regulations on adequacy, which is to say minimum value).

It is simply unacceptable that the instructions do not provide directions for the tax filer to figure out whether offered employer coverage counts as MEC or not. But even with directions, it is not clear how a tax filer is supposed to figure out whether employer coverage is affordable and adequate, since employers are not required to provide any information on coverage to the taxpayer (or to the IRS) for 2014.

The form proceeds to specific line-by-line filing instructions. The instructions include worksheets for calculating MAGI; they also include tables showing the federal poverty level for different sized households and for calculating what percentage of MAGI a household must spend on premiums to determine the monthly contribution amount, based on household MAGI ranging from less than 133 percent of the federal poverty level to 400 percent of the FPL.

Tax filers with MAGI below 100 percent of the poverty level are only eligible for an APTC 1) if they are aliens lawfully present in the United States but not eligible for Medicaid, or 2) if they were determined to be eligible for a QHP because the marketplace estimated that their income would be between 100 and 400 percent of poverty at the time they enrolled, if they in fact enrolled and got APTCs. Households with incomes above 400 percent of the FPL are not eligible for premium tax credits and must pay back all APTCs received.

Tax filers who married during the tax year and whose income went above 400 percent because of the marriage may not have to pay back all APTCs for months of the year that preceded the marriage if they would have been eligible for those months. Moreover, if a tax filer enrolled an individual in his or her coverage who in fact is claimed by another tax filer for a personal exemption, the other tax filer may be responsible for paying back excess APTCs.

The instructions contain long and complicated directions and worksheets for "shared policy allocation" situations

- involving divorces or legal separations during 2014,
- where an individual in a tax filer's tax family was enrolled in a QHP by someone outside the tax family, or
- where an individual outside of the tax filer's tax family was enrolled in a QHP by someone in the taxpayer's tax family.

The instructions also refer the tax filer to publication 974 to deal with alternative calculations for tax filers who were married during 2014 and spent part of the year single. These situations will not be analyzed here.

Tax filers who are eligible for premium tax credits must proceed to reconcile the amount of APTC they received and the amount of premium tax credits for which they are actually eligible. To do this, they will need the form 1095-A which is supposed to be sent to tax filers by their marketplace as of January 31, 2014^[9]. If the 1095-A shows that the tax filer had the same coverage for all 12 months of 2014, paid the same premium for each month, and had the same applicable SLCSPP cost for each month, and no exception applies, the tax filer can simply compute the premium tax credit due for the whole year and reconcile this with the APTC actually received, the amount of which will be shown on the 1095-A. (This assumes that marketplaces can actually determine how much APTC was paid for each tax filer, which may be difficult given the limitations of the back-end process in place to date).

A tax filer cannot simply use the actual premium and SLCSPP premium amounts reported on the 1095-A, however, if the tax filer's coverage family changed over the year — for example, because an individual joined or left the tax family, an individual ceased enrollment in a QHP, an individual lost tax credit eligibility by becoming eligible for MEC, or an individual enrolled in coverage died, and the tax filer failed to report the change. Actual premium tax credit eligibility must then be calculated for each month.

To determine the actual SLCSPP amount for each month given the tax filer's actual coverage family, where a change was not reported to the marketplace (or reported but not acted on by the marketplace), the tax filer is directed to publication 974. ***Apparently the tax filer is supposed to be able to figure out retrospectively what the SLCSPP would have cost for each month of coverage had the membership of the tax family been correctly reported. Since the premiums for the SLCSPP vary based on geographic rating area and the age of family members, I cannot imagine how this cost will be computed by the tax filer.***

Since it was difficult or impossible to report changes to some marketplaces for part of 2014, situations where the coverage family changed over the year and the 1095-A does not actually reflect actual APTC due will be common. It must be possible to simplify this calculation, perhaps through a web-based calculator that can determine an approximation of the exact SLCSPP for the tax family.

If, as will often be the case, the tax filer's tax family did not have the same coverage for the entire twelve months — because, for example, the tax filer did not enroll until late in the open enrollment period — or if the amounts reported on the 1095-A by the marketplace for actual premiums and second-lowest cost plan premiums otherwise vary from month to month, the tax filer must calculate the allowed premium tax credit for each month; this calculation will be based on the actual premium paid and SLCSPP for the month as reported on the 1095-A, as well as the monthly contribution amount. The actual premium tax credit due must then be reconciled with the APTC actually received, as shown on the 1095-A.

If any shared policy allocation calculations are relevant, they are applied at this point to the reported premium amount paid and SLCSPP. If the tax filer receives more than one 1095-A, the SLCSPP amounts from the two forms may need to be added together. The monthly contribution amount for each month of coverage will normally be the annual contribution amount divided by 12. If QHP coverage was terminated in the middle of a month, the credit amount must be prorated. For each month, the tax credit actually due and the reported APTC received must be reconciled.

If the premium tax credit due arrived at through the annual calculation or by summing the monthly calculations exceeds the APTC received, the excess amount is subtracted from taxes otherwise due and may result in an additional refund. If the premium tax credit due is less than the APTC received, the tax filer must pay the difference as an additional tax. It will often be subtracted from a refund otherwise due. The amount that must be repaid, however, is subject to the repayment limitation, which varies from \$300 for individuals filing as single with MAGI below 200 percent of poverty to \$2,500 for married couples filing jointly with incomes between 300 and 400 percent of poverty.

Married couples who file separately and do not qualify for the domestic abuse or abandonment exceptions or meet the requirements for married people who live apart to file as single or head of household must also pay back APTC received subject to the limitations. Again, if the taxpayer's MAGI exceeds 400 percent of the poverty level, the taxpayer must pay all APTC received without limitation, subject to the complications mentioned above.

These instructions are so far only in draft form. They need serious rethinking, however, or we may be heading into a disaster in the spring of 2015 as bad as that we experienced in the fall of 2013. Of course, the problems presented by these forms are inherent in any health care reform that uses the tax system to finance insurance coverage^[10]. Republican proposals would present the same complexities^[11]. But health care reform does not need this distraction. Some way must be found to simplify this process.

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URLs in this post:

- [1] form 8962: <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCAQFjAA&url=http%3A%2F%2Fwww.irs.gov%2Fpub%2Firs-dft%2F8962--dft.pdf&ei=KmEdVLHKBKSUsQSduYGwCg&usg=AFQjCNEu8edR-UNhcK9o5J8dS7Y6K8JvOQ&bvm=bv.75775273,d.cWc>
- [2] form 8965: <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCAQFjAA&url=http%3A%2F%2Fwww.irs.gov%2Fpub%2Firs-dft%2F8965--dft.pdf&ei=1GEEdVPvQNaW1sQS3joCwDQ&usg=AFQjCNGct-NZW7vkW6uUIPNaDtLRT95e3g&bvm=bv.75775273,d.cWc>
- [3] 6.7 million Americans had chosen a qualified health plan with premium tax credits: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCAQFjAA&url=http%3A%2F%2Faspe.hhs.gov%2Fhealth%2Freports%2F2014%2Fmarketplaceenrollment%2Fapr2014%2Fib_2014apr_enrollment.pdf&ei=OGIdVJLrIqT9sATEhIGYBg&usg=AFQjCNHmIU91hi7NGigQsaCz3yLm9Wgn1w&bvm=bv.75775273,d.cWc
- [4] The Congressional Budget Office estimates: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CDAQFjAC&url=http%3A%2F%2Fwww.cbo.gov%2Fsites%2Fdefault%2Ffiles%2Fcbfiles%2Fattachments%2F45397-IndividualMandate.pdf&ei=yV8dVP7pDcnmyQP644KgDQ&usg=AFQjCNH6rTLNU_55QDydBzoMrv2RvnL0Yw&bvm=bv.75775273,d.bGQ
- [5] draft instructions for form 8965: <http://www.irs.gov/pub/irs-dft/i8965--dft.pdf>
- [6] draft instructions for form 8962: <http://www.irs.gov/pub/irs-dft/i8962--dft.pdf>
- [7] 14 categories of hardship exemptions: <https://www.healthcare.gov/exemptions/>
- [8] if married, files jointly, unless the tax filer lives separately and meets the requirements for filing singly or as head of household, or is a victim of spousal abandonment or domestic abuse: <http://healthaffairs.org/blog/2014/07/25/implementing-health-reform-irs-releases-premium-tax-credit-rules-and-draft-forms/>
- [9] they will need the form 1095-A which is supposed to be sent to tax filers by their marketplace as of January 31, 2014: <http://healthaffairs.org/blog/2014/08/29/implementing-health-reform-tax-form-instructions/>
- [10] the problems presented by these forms are inherent in any health care reform that uses the tax system to finance insurance coverage: <http://healthaffairs.org/blog/2014/07/14/income-verification-on-the-exchanges-the-broader-policy-picture/>
- [11] Republican proposals would present the same complexities: <http://healthaffairs.org/blog/2014/09/02/transcending-obamacare-analyzing-avik-roys-aca-replacement-plan/>



DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION

**Bureau of
Insurance**

STATE OF MAINE



**2015 Rates, Auto-Reenrollment and Small Group
Rating Structure**

September 22, 2014

Eric Cioppa, Superintendent of Insurance

2015 HEALTH INSURANCE MARKET

2

- **Individual Marketplace/Exchange:**
 - Maine Community Health Options:
 - ✦ Average Rates decreased 0.8%
 - Anthem Health Plans of Maine:
 - ✦ Average Rates decreased 1.1%
 - Harvard Pilgrim Health Care:
 - ✦ Average Rates increased 2.2% from off-exchange last year

MEGA is non-renewing approximately 6,800 lives in 2014 and 2015

2015 Individual Off-Exchange Market

3

- **Individual Off-Exchange:**
 - All the Marketplace plans will also be available off the Marketplace.
 - HPHC Insurance Co.
 - ✦ Average rates increased 1.5%
 - Aetna Health Inc. will offer 4 off-exchange plans in a new HMO Whole Health Product line, in:
 - ✦ Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Waldo, and York.

Second Lowest Silver Plan Rate Change

4

Below is an analysis of the change to the second lowest silver plan on-exchange for age 21.
The impact for each consumer will differ depending on their age and plan.

Age 21-Rates	2014		2015		Difference
	Carrier-Plan	Premium	Carrier-Plan	Premium	
Area 1- Cumberland, Sagadahoc, York	Community Health Options-Value Plan	\$230.81	Maine Community Health Options-Community Value Plan	\$220.60	-4.42%
Area 2- Kennebec, Knox, Lincoln, Oxford	Maine Community Health Options-Community Choice Plan	\$250.26	Anthem Blue Cross Blue Shield-Silver X HMO 3500/20%	\$249.93	-0.13%
Area 3- Androscoggin, Franklin, Penobscot, Piscataquis, Somerset, Waldo	Community Health Options-Community Choice Plan	\$264.53	Maine Community Health Options-Community Choice Plan	\$267.08	0.96%
Area 4- Aroostook, Hancock, Washington		\$306.02		\$308.97	0.96%

Example: Rates of 45-year-old living in Kennebec County

5

Carrier	Metal Level				Availability
	<i>Bronze</i>	<i>Silver</i>	<i>Gold</i>	<i>Catastrophic</i>	
Maine Community Health Options	\$294.54	\$345.40	\$443.82	\$243.48	On & Off Exchange
Anthem Health Plans of Maine	\$286.32	\$360.60	\$480.20	\$227.35	On & Off Exchange
Harvard Pilgrim Health Care Inc.	\$344.94	\$459.74	\$548.85	N/A	On & Off Exchange
HPHC Insurance Co.	\$366.47	N/A	N/A	N/A	Off Exchange
Aetna Health Inc.	Rates Under Review				Off Exchange

All rates for different ages and areas are available on BOI's website via our Rate Calculator:

http://www.maine.gov/pfr/insurance/ACA/Price_compare/Individual_Health_Index.html

Auto Enrollment General

6

- If the consumer authorized the Marketplace to review their final 2013 tax data and their income is below the 500% Federal Poverty Level (FPL), the Marketplace will continue the APTC at the same level in 2015.
- If it is above the 500% FPL, the Marketplace will notify the consumer to go onto healthcare.gov and take action regarding renewal. If no action is taken the Marketplace will re-enroll the consumer without APTC or Cost Sharing Reductions (CSR).
- If a consumer goes onto the Marketplace and updates their tax information, the Marketplace will make a new determination of the consumer's APTC eligibility.

Auto Enrollment for Maine

7

- Consumers will be auto-enrolled in the same plan, or the plan closest to their old plan, if their old plan is no longer available.
- Crosswalks of old and new plans have been submitted by the carriers and reviewed by the Bureau.
- In Maine the only plans discontinued are the duplicate Anthem plans already offered by OPM. 1,573 consumers will be mapped to the identical Anthem plans administered by OPM.

Auto Enrollment Timeline

8

- A health insurer must provide the policyholder written notice of renewal before the first day of open enrollment, but after they have signed issuer agreements which may be as late as November 3rd, 2014.
- The Marketplace must provide notices to consumers before November 15, 2014 advising of the open enrollment period, the consumer's coverage in 2015, and the opportunity for the consumer to obtain an updated eligibility determination.

Consequences of Auto Enrollment

9

- It is critical that individuals whose income has changed significantly since their eligibility determination for 2014 contact the Marketplace for redetermination.
- If income has decreased the individual may be entitled to greater APTC or CSR plans.
- If income has increased the individual should seek a redetermination for an accurate APTC determination to minimize potential tax liabilities.

Individual Dental Plans Available 2015

10

- **On Exchange:**
 - Anthem, Delta Dental and Denteegra are offering pediatric plans and family plans.
- **Off Exchange**
 - Anthem, Delta Dental, Denteegra and Renaissance are offering pediatric plans and family plans.
- **Rates**
 - Dental rates range from \$25-\$50 monthly depending on the plan benefits, carrier, and area in which the consumer lives.

2015 Small Group Market

11

- **On/Off-SHOP exchange:**
 - Anthem Health Plans of Maine- PPO, HMO, HMO/POS
 - ✦ Average rates increased 6.7%
 - Maine Community Health Options-PPO
 - ✦ Average rates decreased 10%
 - Harvard Pilgrim Health Care Inc.-HMO
 - ✦ Average rates increased 6.2%

2015 Small Group Market

12

- **Only Off-SHOP exchange:**
 - HPHC Insurance Co.-PPO
 - ✦ Average Rates increased 6.2%
 - Aetna Health Inc.-HMO, PPO
 - ✦ Average PPO Rates increased 7.8%
 - United Healthcare-PPO
 - ✦ Average Rates decreased 2.9%

Small Group Dental Plans Available 2015

- **On Exchange:**
 - Anthem, Delta Dental, Guardian Life and Denteegra are offering pediatric plans and family plans.
- **Off Exchange**
 - Anthem, Delta Dental, Guardian Life, Lincoln National Life Ins., Ameritas Life Ins., Standard Insurance Co., Reliance Standard Co., Companion Life, Kansas City Life, Metropolitan Life, Principal Life, Denteegra and Renaissance.
- **Rates**
 - Dental rates range from \$25-\$50 monthly depending on the plan benefits, carrier, and area in which the consumer lives.

Example of Small Group Rate Structure Tiers Prior to Affordable Care Act

(14)

- Example: Monthly rates for a small group plan in Kennebec County with an average age 45-49 and a group size 3-4.
 - Employee Only Rate- \$533
 - Employee and Spouse Rate- \$1,226
 - Family Rate- \$1,600
 - Employee and Children Rate- \$960

Small Group per member rating beginning in 2014

15

- **Member rating:** The total premium charged to the group is determined by summing the premiums of each employee and their dependents for their individual ages. Premium for dependent children is limited to a maximum of 3 children under age 21.
- Each employee is charged the premium for their coverage minus any employer contribution.

Example of Small Group per member rating beginning in

2014

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Employee 1	Employee 2	Employee 3	Employee 4
<u>Employee Only</u>	<u>Employee & Spouse</u>	<u>Family</u>	<u>Employee & Children</u>
Employee Age- 45 Rate-\$570	Spouse Employee Age-55 Rate-\$881	Employee Age-49 Rate-\$674	Employee Age-43 Rate-\$536
Total <u>Rate=\$570</u>	Spouse Age-51 Rate-\$736 Total <u>Rate=\$1,617</u>	Spouse Age-39 Rate-\$499 Children Age-10 Rate-\$251 Age- 5 Rate-\$251 Total <u>Rate=\$1,675</u>	Adult Children Age-22 Rate-\$395 Age-23 Rate-\$395 Children Age 13 Rate-\$251 Age-15 Rate-\$251 Total Rate= \$1,828

Composite Premium Rating

17

- HHS Notice of Benefit and Payment Parameters for 2015 (finalized March 11, 2014) outlined requirements for composite rating.
- The notice defined a two-tiered federal compositing methodology that states could adopt, or it allowed states to propose and submit to Health and Human Services (HHS) an alternate tiered-composite methodology for use in that state.

Composite Premium Rating

18

- Composite premiums are calculated based on the average derived from the per-member rating of all “participants and beneficiaries” at the beginning of the plan year. They may not vary until renewal.
- The average rate cannot include children under the age of 21. The enrollees under age 21 will all have the same child rate (capped at 3 for each family).
- The average rate cannot include tobacco loads. These loads must be added to an individual’s premium and must be based on the individual’s original premium amount, not the composite premium.

How to calculate Composite Premium Monthly Rate

Employee 1	Employee 2	Employee 3	Employee 4
<u>Employee Only</u> Employee Age- 45 Rate-\$570 <u>Total Adult Rate=\$570</u>	<u>Employee & Spouse</u> Employee Age-55 Rate-\$881 Spouse Age-51 Rate-\$736 <u>Total Adult Rate=\$1,617</u>	<u>Family</u> Employee Age-49 Rate-\$674 Spouse Age-39 Rate-\$499 Children Age-10 Rate-\$251 Age- 5 Rate-\$251 <u>Total Adult Rate=\$1,173</u> <u>Total Child Rate=\$502</u>	<u>Employee & Children</u> Employee Age-43 Rate-\$536 Adult Children Age-22 Rate-\$395 Age-23 Rate-\$395 Children Age 13 Rate-\$251 Age-15 Rate-\$251 <u>Total Adult Rate=\$1,326</u> <u>Total Child Rate=\$502</u>

Composite Premium Rate Calculation

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- **Composite Premium =**
 - Adult rates include participants and beneficiaries
 - (Sum of adult rates) / (# of adults)
 - $(\$570 + \$1,617 + \$1,173 + \$1,326) / 8 = \$586$ Per Adult
 - Final Composite Premium Monthly Rates for group
 - ✦ \$586 Per Adult
 - ✦ \$251 Per Child (capped at 3 children under the age of 21)

Example of Small Group Composite Premium Monthly Rate

Employee 1	Employee 2	Employee 3	Employee 4
<u>Employee Only</u>	<u>Employee & Spouse</u>	<u>Family</u>	<u>Employee & Children</u>
Employee Age- 45	Employee Age-55 Spouse Age-51	Employee Age-49 Spouse Age-39 Child Age-10 Child Age- 5	Employee Age-43 Adult Child Age-22 Adult Child Age-23 Child Age-13 Child Age-15
<u>Final Rate=</u> <u>\$586</u>	<u>Final Rate= \$1,172</u>	<u>Final Rate=\$1,674</u>	<u>Final</u> <u>Rate=\$2,260</u>

Comparison of Small Group Monthly Rating

Different Rating Groups	Pre-ACA	Current Per Family Member Rating	Composite Premium Rating
Employee Only	\$533	\$570	\$586
Employee & Spouse	\$1,226	\$1,617	\$1,172
Family	\$1,600	\$1,675	\$1,674
Employee & Children	\$960	\$1,828	\$2,260



DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION

Bureau of Insurance

STATE OF MAINE



Toll Free Line 1-800-300-5000

TTY for hearing impaired: Please call Maine relay 711

207-624-8475

www.maine.gov/insurance

Insurance.PFR@maine.gov

Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034



DEPARTMENT OF

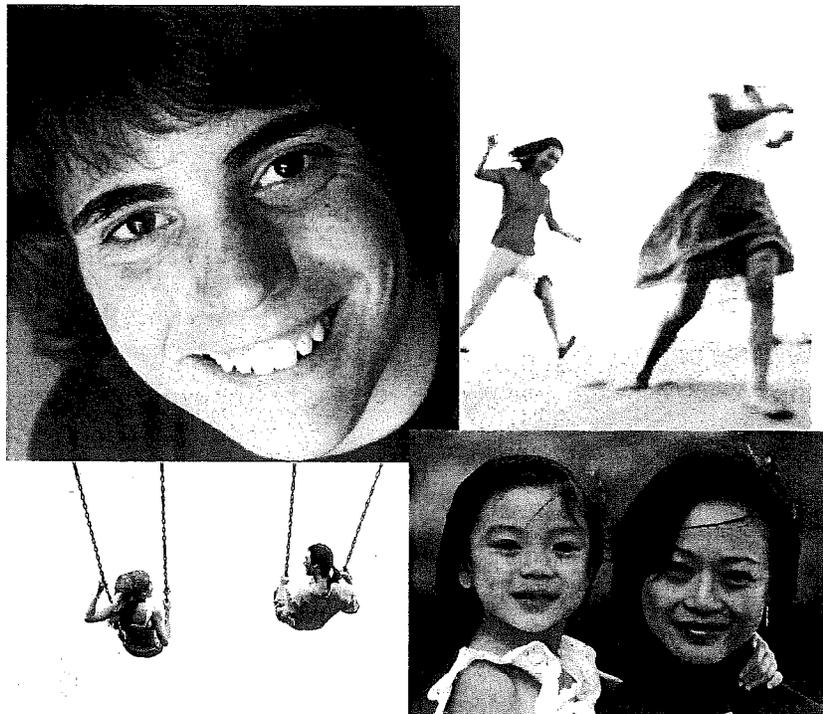
**Professional &
Financial Regulation**

STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF AND OCC REGULATION

A Consumer's Guide To...

INDIVIDUAL HEALTH INSURANCE IN MAINE



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Superintendent

A GUIDE TO INDIVIDUAL HEALTH INSURANCE IN MAINE

The Affordable Care Act (ACA) and the federally facilitated Healthcare Marketplace has brought about changes in the insurance plans offered in the state of Maine.

The ACA's Individual Mandate and Pre-Existing Conditions

- As of 2014 the ACA requires individuals to have health insurance or pay a tax penalty.
- Any Maine resident not eligible for Medicare can buy an individual health insurance policy. (Individuals who need to pay for Medicare Part A can also buy an individual policy). *Some people can get help with the cost of a plan on the Marketplace, depending on their income, household size, and whether they are eligible for another kind of coverage.*
- For insurance issued on or after January 1, 2014, plans cannot exclude coverage for pre-existing conditions.

If you are eligible for group coverage that meets the ACA's standards (either through your employment or your spouse's or parents' employment, or through membership in an association), you will not be able to get help with the cost of a plan through the Marketplace. You can still buy individual coverage on or off the Marketplace, but you will want to carefully consider whether the group coverage available to you has better benefits, or costs less.

Mandated Benefits

Ten essential health benefits must now be included in all health insurance plans:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health & substance use disorder services
- prescription drugs
- rehabilitative and habilitative service and devices
- laboratory services
- preventative/wellness services/chronic disease mgt.
- pediatric services, including dental and vision

- **Preventive services:** Individuals do not pay co-pays, coinsurance or deductibles for certain preventive health services that are provided by network providers including routine immunizations and routine physical exams, such as:

- gynecological exams
- pediatric eye exams
- mammograms
- digital rectal exams and
- routine and medically necessary colorectal cancer screenings

Check with your insurance company before your appointment to see which services are covered without additional cost to you.

A GUIDE TO INDIVIDUAL HEALTH INSURANCE IN MAINE

“Metal Levels”

The ACA creates standardized levels of coverage, called “metal levels” — Bronze, Silver, Gold and Platinum — which allow you to compare plans, offered by different insurance companies. In general, plans with lower cost-sharing will have higher premiums, and vice versa.

- **Cost-sharing:** This refers to the portion you will have to pay (or “share”) for covered services, at least until you reach the annual out-of-pocket (OOP) limit. *Deductibles, co-pays* and *co-insurance* are all types of cost-sharing. (See page 6 for a glossary of terms.).

Plan Level	Actuarial Value ¹ (This is the estimated % of total costs your plan will pay)	Your Expected Cost Share
Gold	80%	20%, up to maximum OOP
Silver ²	70%	30%, up to maximum OOP
Bronze	60%	40%, up to maximum OOP
Catastrophic ³	Not applicable	100% up to maximum OOP

¹ Actuarial Value is the average amount of total cost the plan will cover for your care.

² When purchasing a Silver plan, individuals who qualify for a premium subsidy may also qualify for assistance with out-of-pocket cost-sharing.

³ Catastrophic plans are only available to individuals age 30 and younger, or to those who qualify for a “hardship exemption.”



Dependent Coverage - Young Adults:

Insurance companies generally must offer to cover your dependent child up to his or her 26th birthday. Eligibility is not limited if your dependent child is married or has his or her own dependents or files his or her own taxes. Your dependent child also is not required to be a student to qualify for coverage under your plan.

A GUIDE TO INDIVIDUAL HEALTH INSURANCE IN MAINE

2015 Individual Plans Offered in Maine

For plan-specific questions and additional information, please use the phone numbers or website addresses below (current as of September 2014). You may also contact a local independent agent, broker or Marketplace navigator (see page 5 for more information). As always, the plans and rates insurance companies offer in Maine are reviewed and approved by the Bureau of Insurance. You are welcome to call the Consumer Health Care Division of the Bureau at 800-300-5000 (in Maine), or TTY 711, with any health insurance-related questions.

2015 Plans By Metal Level Offered By Each Carrier							
Insurance Carrier	Bronze	Silver	Gold	Catastrophic	Network Types	On Exchange	Off Exchange
Aetna Health Inc. * (800) 694-3258 www.aetna.com	✓	✓	✓		HMO		X
Anthem Blue Cross Blue Shield (including OPM) (800) 547-4317 www.anthem.com	✓	✓	✓	✓	HMO (South) POS (North)	X X	X X
Maine Community Health Options (MCHO) (855) 624-6463 www.maineoptions.org	✓	✓	✓	✓	PPO	X	X
Harvard Pilgrim Health Care/ HPHC (888) 333-4742 www.harvardpilgrim.org	✓	✓	✓		HMO PPO	X	X X

* As of 9/17/14 Aetna's rates are pending approval by the Bureau of Insurance.

If you use the rate calculator at the Bureau of Insurance website, it will automatically screen out the options that are not available to you, based on you county where you live. You can find the calculator at www.maine.gov/insurance. See more information on page 4 under "Premium Rates."



A GUIDE TO INDIVIDUAL HEALTH INSURANCE IN MAINE

Check with your insurance company before you purchase your plan to see if your provider and hospital are in the plan network.

Health Care Provider Networks

The networks available to you are determined in part on where you live. The insurance companies offering plans in Maine offer the following network types:

- **Preferred Provider Organization (PPO)** - The insurer contracts with a network of doctors, hospitals, and other medical providers (“preferred providers”) who agree to accept lower fees. You receive a higher level of benefits if you go to a preferred provider than if you go to a non-preferred provider or an out-of-network provider.
- **Health Maintenance Organization (HMO)** - You must choose a primary care provider (the provider you would see for your annual physical) from a list of participating providers. For any non-emergency hospital or specialty care you must get a referral from your primary care provider first. The insurer or HMO reviews treatment recommendations to determine whether the hospitalization or treatment is medically necessary. Typically, out-of-network providers are not covered under this type of policy.
- **Point of Service (POS)** - This has characteristics of both HMOs and PPOs. Like an HMO, you must choose a primary care provider from a list of participating providers, and for any non-emergency hospital or specialty care you must get a referral from your primary care provider first. Like a PPO, you can see an out-of-network provider but you will probably have to pay more than you would to see an in-network provider. Out-of-state providers may or may not be covered.

Premium Rates

Rates for insurance premiums vary, based on three factors: geographic area, smoking status, and age.

- For a premium estimate of each plan currently available to you use visit maine.gov/pfr/insurance/ACA/Price_compare/Instructions.html. (This calculator does not apply any potential subsidies.)
- For an estimate of your potential subsidy or tax credits visit kff.org/interactive/subsidy-calculator.
- For an exact quote, you will need to contact the insurance company or an insurance agent.

Benefits and Exclusions

Compare benefits, exclusions and premiums carefully when considering different policies. Service is also important to consider. A company who gives superior service may be worth some additional cost.

A GUIDE TO INDIVIDUAL HEALTH INSURANCE IN MAINE

Comparing Plans

Some questions to consider when comparing plans:

- What medical providers are part of the network? Is my preferred doctor and hospital in the plan?
- Are out-of-state providers covered?
- What is the formulary (cost) for different prescription drugs I may need? Are my drugs covered?
- What are the limits on services or on the number of visits to certain types of providers?
- What is the annual out-of-pocket cost?
- Is the plan compatible with a Health Savings Account (if applicable)?
- Does the insurer sell their plan on the Marketplace? Am I eligible for a subsidy?
- Are some services exempted from the deductible?
- Is there a separate deductible for prescriptions?
- What is the out-of-network deductible?
- Will I be covered if I travel?
- Is there one deductible for an individual and another for a family?

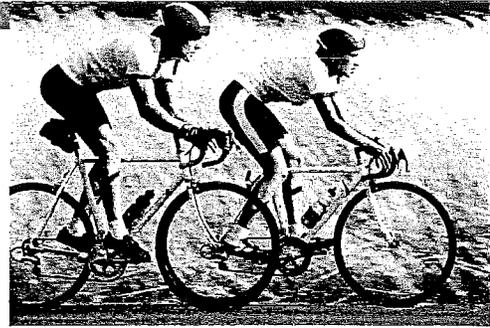
Getting Help

- **Call an insurance broker or agent** to compare plans and rates. Note, not all brokers and agents represent all insurers.*
- **Contact the insurance companies offering plans in Maine.** You can call the insurance companies directly to ask questions or to buy your insurance. However, to have a subsidy applied, you must purchase your plan through the Marketplace rather than directly from the insurance carrier. Please see insurance company contact information on page 3.
- **Call the Maine Bureau of Insurance** at 800-300-5000, (TTY, please use Maine Relay 711), or visit the Bureau's website at www.maine.gov/insurance for more information about your options.
- **Visit www.healthcare.gov** or call 1-800-318-2596 for answers to questions about the Marketplace and subsidies. Online chat is also available on HealthCare.gov 24 hours a day.
- **Call Consumers for Affordable Health Care** at 1-800-965-7476 (TTY:1-877-362-9570) for additional support in understanding the Affordable Care Act and the Marketplace, or visit www.maine cahc.org.
- **Find a Marketplace "Navigator"** who can assist you with your application, at www.enroll207.com/locator.

* The National Association of Health Underwriters provides a list of NAHU-member agents, including those certified to sell plans on the Marketplace, at <http://www.nahu.org/consumer/findagent2.cfm> and use their search tool. In addition to listing Navigators, the web-based tool www.enroll207.com/locator also provides names of Market-place certified brokers. (These are provided as resources, not endorsements.)

A GUIDE TO INDIVIDUAL HEALTH INSURANCE IN MAINE

A GLOSSARY OF TERMS



Catastrophic Coverage	A health insurance policy with a high deductible.
Coinsurance	A percentage of each claim, above the deductible, that is paid by the policyholder.
Copay	The payment that is due at the time you receive a health care service, such as a visit to a doctor's office, or when you pick up a prescription drug. The copayment is usually a fixed amount (\$10, \$20, or \$30, for example) and may only be part of what you will owe for the service.
Deductible	The amount that you are responsible to pay before benefits from the insurance company are payable. Choosing a plan with a higher deductible will lower your premium.
Effective Date	The date on which an insurance policy coverage starts.
Expiration Date	The date on which the policy ends.
Guaranteed Renewal	Once you obtain an individual policy it is renewable as long as premiums continue to be paid. If premiums are not paid the insurer can end the policy.
Indemnity Plan	A health insurance plan that has no network of providers. The insurance company pays a set amount for services and the enrollee pays the rest.
Individual Policy	All Maine residents who are not eligible for Medicare can buy health insurance policies for themselves and/or their families, regardless of their employment or health status. (May also be purchased by those needing a Medicare Part A plan.)
Limit	Maximum amount a policy will pay either overall or for a particular benefit.
Network	The doctors, hospitals, therapists, and other health care providers who have signed contracts to provide services to a health plan's members. Members who obtain services from providers outside the network will have to pay more.
Premium	The amount of money an insurance company charges for insurance coverage.
Usual And Customary Charges	Usual and customary — also called reasonable and customary — is the fee charged by most of the providers in a given geographical area for a particular service. Most insurance companies pay claims based on a percentage of these fees.

A GUIDE TO INDIVIDUAL HEALTH INSURANCE IN MAINE

Open Enrollment

In general, you only can purchase individual insurance during Open Enrollment periods.

Next Open Enrollment:

Start date: November 15, 2014

End date: February 15, 2015



Other publications are available through:
Maine Bureau of Insurance
34 State House Station, Augusta, Maine 04333

(207) 624-8475 or (800) 300-5000 [in state]
TTY: Please use Maine Relay 711

Visit the Bureau's website:
www.maine.gov/insurance

Special Enrollment Period (SEP)

Even when Open Enrollment is closed, you can purchase a new policy if you do so within 60 days from experiencing one of these events:

- Loss of eligibility for other coverage (due to quitting a job or a lay off, a reduction in hours, loss of student health coverage upon graduation, etc.). **Note: Loss due to failure to pay premiums does NOT trigger a special enrollment opportunity.**
- Gaining a dependent (due to marriage, birth or adoption of a child, etc.). **Note: Pregnancy does NOT trigger a special enrollment opportunity.**
- Divorce or legal separation that results in loss of coverage.
- Loss of dependent status (for example, "aging off" a parent's plan at age 26).
- Moving to another state, or within a state if you move outside of your health plan service area.
- Exhaustion of COBRA coverage.
- Losing eligibility for Medicaid or the Children's Health Insurance Program (CHIP).
- For people enrolled in a Marketplace plan, income increases or decreases that change eligibility for subsidies.
- Change in immigration status.
- Enrollment or eligibility error made by the Marketplace or another government agency or somebody acting on behalf of the individual enrollee, such as a Marketplace Assistor.



RENEWING YOUR INDIVIDUAL HEALTH CARE PLAN FOR 2015

IMPORTANT THINGS TO KNOW ABOUT RENEWAL AND AUTO-ENROLLMENT

- If you purchased a health insurance plan for yourself or your family between October 2013 and March 2014, **your time to renew or change that plan begins on November 15.**
- Your insurance company will send you information this fall about your policy and any changes that have been made to your provider network and premium amount for 2015.
- **Carefully review the information from your insurance company to be sure the plan still meets your needs.** Make sure the provider(s) you plan to see and the hospital you plan to use, if needed, are part of the network and that the prescriptions you need are covered. **Call your insurance company with any questions.**
- **Compare your plan with others being offered for 2015.** There are new plans to choose from this year.
- If you decide to keep your insurance plan and you continue to pay your premium you will be automatically re-enrolled for 2015.
- **If you purchased your plan through the Marketplace and your income and/or household size HAS changed, you need to report those changes at www.healthcare.gov to get the correct premium tax credit and avoid owing money at tax time.** (The basis for determining tax credits has changed, so it is possible you may see an increase in the portion you are required to pay.)
- If you want to change insurance plans you can purchase another plan on or off the Marketplace from your insurance company or another company. If you think you qualify for tax credits purchase your plan through the Marketplace to have the tax credits applied.
- You may find your current plan is not being offered in 2015. If that happens, your insurance company will automatically enroll you in a similar plan so you don't have a gap in coverage. You can choose another plan if you don't want the plan your insurance company has substituted.

2015 Open Enrollment

KEY DATES

November 15, 2014

Open Enrollment begins. Apply for, keep, or change your coverage for 2015.

December 15, 2014

Enroll or change your plan by this date to have coverage on Jan 1, 2015.

December 31, 2014

Coverage ends for 2014 plans.

January 1, 2015

Earliest date for coverage under a 2015 plan.

February 15, 2015

Last day of Open Enrollment for 2015.



34 State House Station

Augusta ME 04333

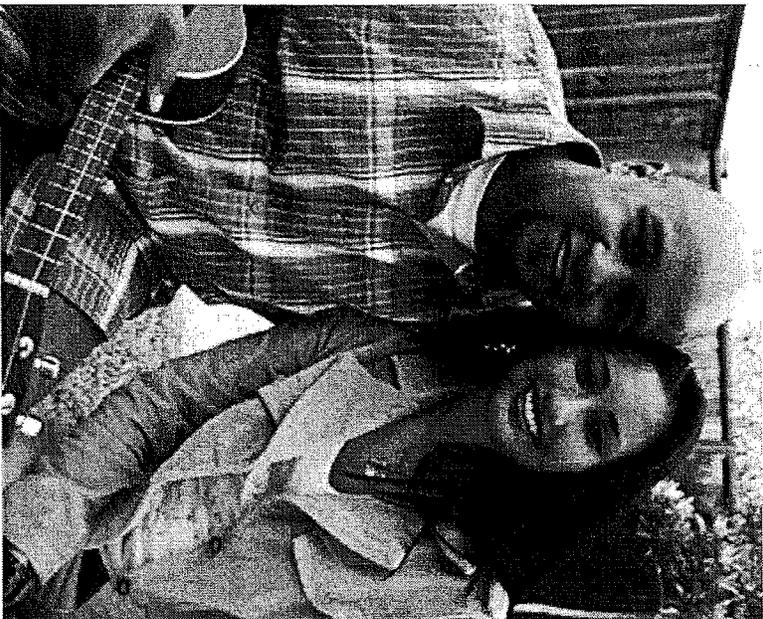
(207) 624-8475 or (800) 300-5000 (in Maine)

TTY: Please use Maine Relay 711

www.maine.gov/insurance



Coverage Affordability Programs – How States Can Make Coverage Even More Affordable



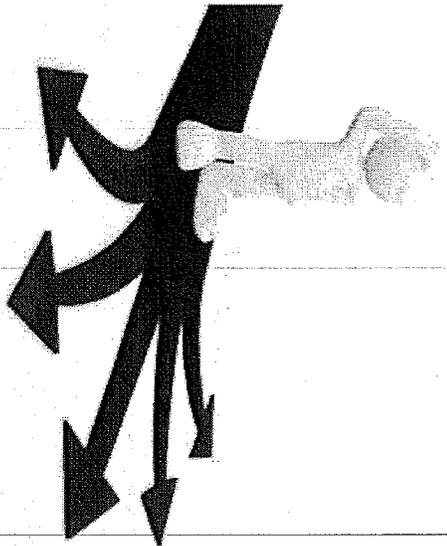
Jessica Schubel
Senior Policy Analyst
Center on Budget and Policy Priorities

September 22, 2014

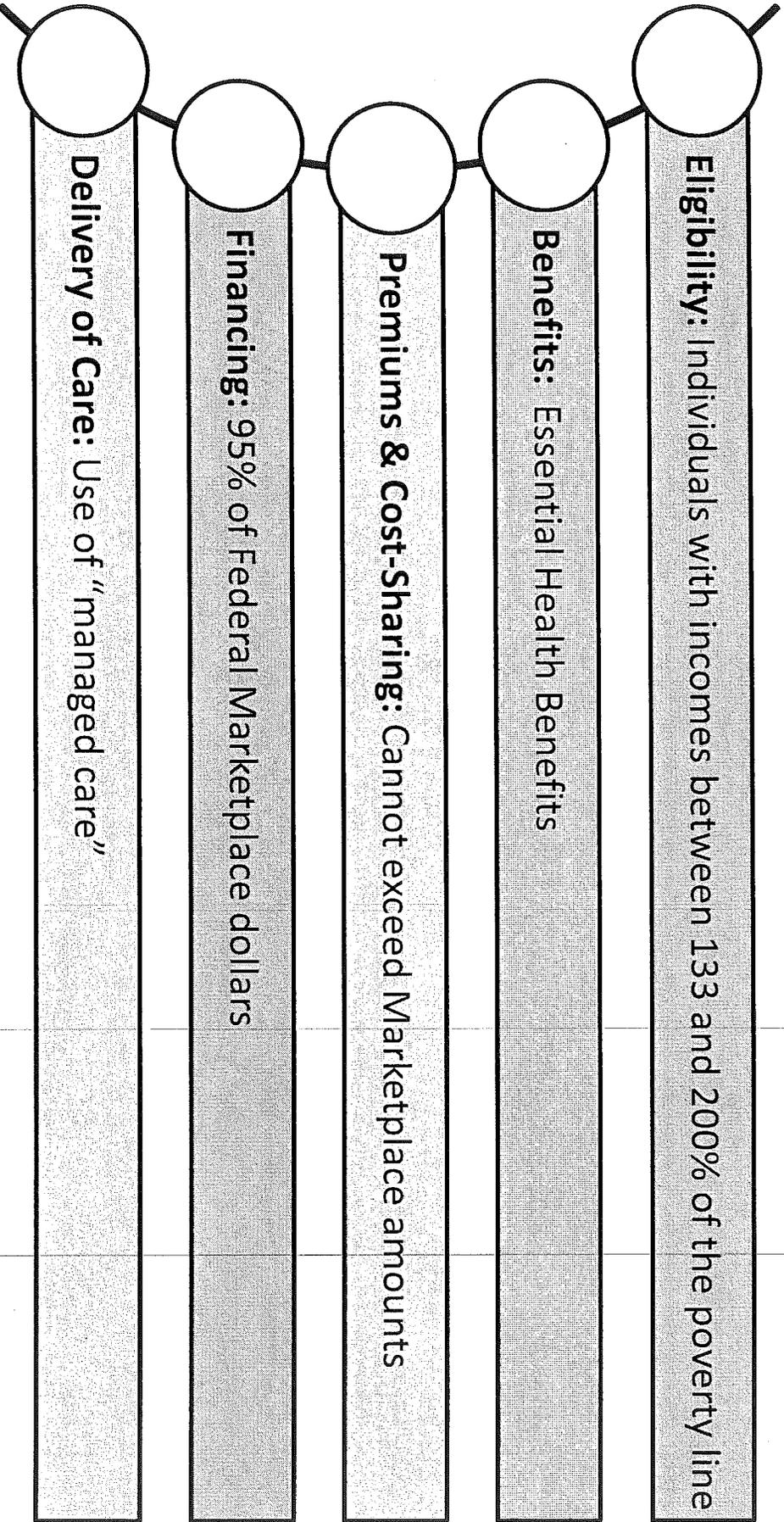


Menu of Options

- 1) Basic Health Program
- 2) “XX” Group
- 3) 2017 State Innovation Waiver



Option 1: Basic Health Program





Option 2: Optional Medicaid State Plan “XX” Group

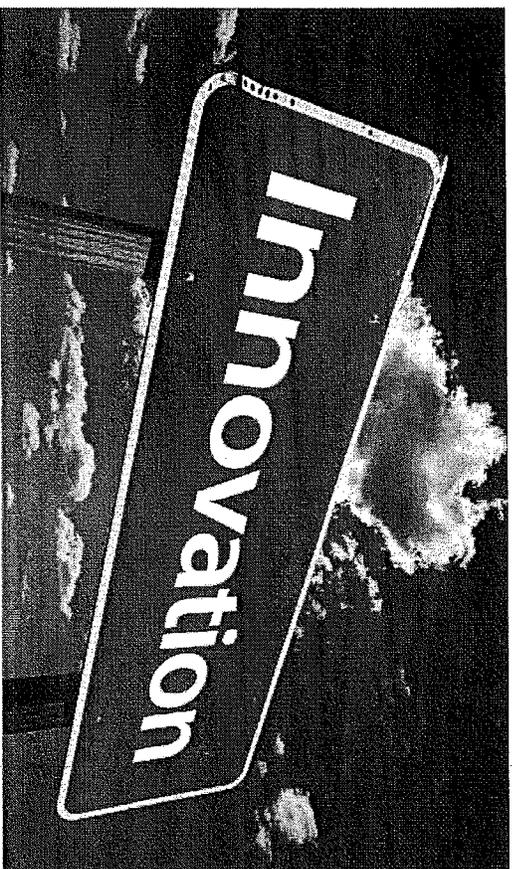
- Individuals with incomes above 133% of the poverty line
- State receives regular Federal match rate
- State cannot have higher income limits for this group than for children or pregnant women





Option 3: State Innovation Waivers

- Available January 1, 2017
- Can vary terms of Marketplace subsidies and coverage
- Can use to implement a BHP-like program





Consideration of the Menu of Options

Financial: Amount of Federal dollars

Timing: NOW vs. 2017?

Administrative Burden: Leverage & streamline

Marketplace impact

Recommendation: Feasibility study



Resources

- Oregon Legislation and RFP
- Statutory and Regulatory Citations
 - **BHP**
 - Section 1331 of ACA
 - 42 CFR part 600
 - **“XX” Group**
 - 1902(a)(10)(A)(ii)(XX) of the Social Security Act
 - 42 CFR 435.218
 - **Innovation Waiver**
 - Section 1332 of ACA
 - 31 CFR part 33 and 45 CFR part 155

Contact Information

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FACT SHEET

FOR IMMEDIATE RELEASE

Contact: CMS Media Relations

March 7, 2014

(202) 690-6145

FINAL RULE FOR ESTABLISHMENT OF THE BASIC HEALTH PROGRAM AND 2015 PAYMENT NOTICE

Today, the Centers for Medicare & Medicaid Services (CMS) issued the final rules establishing the standards for the Basic Health Program. The program provides states with the option to establish a health benefits coverage program for lower-income individuals as an alternative to Marketplace coverage under the Affordable Care Act. This program, which is voluntarily for states, enables them to create a program for individuals with incomes that are too high to qualify for Medicaid under the Medicaid expansion in the Affordable Care Act, but are in the lowest income bracket of individuals who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. These final rules set forth a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, state administration and federal oversight, and funding methodology. States can implement the Basic Health Program starting in 2015.

CMS also published the 2015 payment notice providing states the final funding methodology for the Basic Health Program and information about the 2015 payment rates.

Overview

Section 1331 of the Affordable Care Act provides states with a new coverage option, the Basic Health Program, for individuals who are citizens or lawfully present non-citizens, who do not qualify for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage and generally have income between 133 percent and 200 percent of the federal poverty level (FPL).

Benefits will include at least the ten essential health benefits specified in the Affordable Care Act; states can add benefits at their option. The monthly premium and cost sharing charged to eligible individuals will not exceed what an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace, including cost-

sharing reductions and advance premium tax credits; a state can lower premiums and other out of pocket costs at their option. A state that operates a Basic Health Program will receive federal funding equal to 95 percent of the amount of the premium tax credit and the cost sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the Marketplace.

Wherever possible, the final rule aligns Basic Health Program rules with existing rules governing coverage through the Marketplace, Medicaid, or CHIP. This will simplify administration for states and promote coordination between the Basic Health Program and other insurance affordability programs.

The final rule establishes: (1) the procedures for certification of a state-submitted Basic Health Program Blueprint, and standards for state administration of the Basic Health Program consistent with that Blueprint; (2) eligibility and enrollment requirements for standard health plan coverage offered through the Basic Health Program; (3) the benefits covered by standard health plans as well as requirements of the plans; (4) federal funding of certified state Basic Health Programs; (5) the purposes for which states can use such federal funding; (6) the parameters for enrollee financial participation; and (7) federal oversight of Basic Health Program funds.

The companion 2015 payment notice provides the methodology and data sources necessary to determine federal payment amounts made to states that elect to establish a Basic Health Program (BHP) for the 2015 operational year. The methodology in this payment notice is for CY 2015, and we anticipate updating the funding methodology annually with subsequent payment notices as we gain more experience with the Marketplace.

The final rule and final 2015 payment notice are intended to enable states to implement programs effective on or after January 1, 2015.

Key Provisions of the Final Rule

State establishment of a Basic Health Program. The regulation establishes the “Basic Health Program Blueprint” as the vehicle by which states will seek Secretarial certification to implement a Basic Health Program, consistent with the process for State-based Marketplaces. The regulation establishes fundamental elements of a Basic Health Program consistent with the statute, including statewide operation, and enrollment of all eligible individuals and prohibition on enrollment caps and waiting lists. The rule provides some flexibility around enrollment for states implementing in the first year.

Eligibility and Enrollment. The regulation lays out the eligibility criteria tying most standards to those used to determine eligibility for advance premium tax credits and cost sharing reductions. Additionally, it provides a state option to use the annual open enrollment model as in the Marketplace or the continuous enrollment model as in Medicaid and most CHIP programs. It

also provides a state option to use 12 month continuous eligibility. States are required to use the single streamlined application, to ensure coordination among other insurance affordability programs and to have government agencies determine eligibility.

Standard Health Plan. The regulation codifies the statutory provision requiring standard health plans and outlines the competitive contracting process and other contracting requirements. It defines the types of entities that can contract with the state to provide a standard health plan to Basic Health Program enrollees and ensures a choice of at least two standard health plan offerors while offering flexibility where choice is not feasible such as in rural areas. The rule defines the minimum benefit standard (the essential health benefits) and makes provisions for additional benefits at state option.

Enrollee Financial Responsibilities. Consistent with the statute, the rule provides that monthly premiums may not exceed the monthly premium the individual would have paid had he/she enrolled in the second lowest cost Marketplace silver plan. It establishes cost-sharing standards consistent with the Marketplace's, including protections for American Indian/Alaskan Natives and the prohibition of cost sharing for preventive health services.

Financing of Basic Health Program. The final rule establishes state Basic Health Program trust funds for receipt of federal deposits, sets the parameters on the permitted uses of funding, and establishes the process through which HHS will annually develop and finalize the Basic Health Program funding methodology and state payment amounts.

Oversight. The rule promotes program integrity and establishes standards for both state and federal oversight of the Basic Health Program. Standards are set for voluntary program termination by the state as well as Secretarial termination of Basic Health Program certification.

Key Provisions of the Final Payment Notice

Funding formula. The final 2015 payment notice describes the formula that will be used to determine the federal 2015 BHP payment rates, the final values for each of the factors relied on, and the data sources and methodologies used to develop the factors included in the formula. The payment methodology includes factors used to calculate the value of PTC and CSR for persons enrolled through the Marketplace, as well as several factors specific to the BHP payment (including those to estimate the impacts of tobacco rating factors, income reconciliation, and differences in the health status of BHP enrollees relative to persons enrolled through the Marketplace).

Use of 2014 or 2015 Marketplace Premiums. The final 2015 payment notice provides states with the option to use either 2014 premium data (trended forward) as the basis for the 2015 payment rate calculation, or actual 2015 premium data. (The actual 2015 data will serve as the "default" for calculation purposes unless a state elects otherwise). States must notify CMS by May 15, 2014 if they elect to use 2014 premium data as the basis for the payment calculation.

Risk Adjustment. The final 2015 payment notice establishes a process by which a state interested in a retrospective risk adjustment could propose a methodology that would reconcile its federal 2015 BHP payments to reflect the risk profile of its BHP population relative to persons enrolled through the Marketplace. This methodology is subject to approval by CMS and the Chief Actuary of CMS. While the reconciliation process is optional for the states, the payment notice includes a general description of the process, including timeframes for proposing and finalizing the risk adjustment methodology.

National Data Used to Determine Factors in the Methodology. CMS will use national data for other factors in the funding methodology. As we gain more experience in the Marketplace and as more data become available, future payment methodologies and factors used in the methodology may be revised, as appropriate. Any future adjustments will be announced in future years' payment notices and the public will have an opportunity to comment on the changes.

This final rule and final payment notice can be found at <http://www.ofr.gov/inspection.aspx>.

A

CHAPTER 96

AN ACT

HB 4109

Relating to studying alternative approaches to financing health care; appropriating money; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) As used in this section:

(a) "Basic health program" means the program described in 42 U.S.C. 18051.

(b) "Continuity of care" means continuing to receive care from an individual's primary provider after enrolling in a health care plan, changing a health care plan, or withdrawing from a health care plan.

(c) "Exchange" has the meaning given that term in ORS 741.300.

(d) "Medical assistance" has the meaning given that term in ORS 414.025.

(2) The Oregon Health Authority shall commission an independent study of the feasibility of operating a basic health program in Oregon. The study must produce estimates of the:

(a) Number and characteristics of individuals who would be eligible to enroll in the basic health program, including legal resident aliens who are barred for five years from participation in the medical assistance program by 8 U.S.C. 1613;

(b) Federal funds available to operate the basic health program;

(c) State expenses and administrative costs to operate the basic health program;

(d) Impact of the basic health program on the number of individuals enrolled in qualified health plans through the exchange;

(e) Impact of the basic health program on the rates at which individuals with incomes below 200 percent of the federal poverty guidelines lack health insurance coverage compared to such rates in the absence of a basic health program;

(f) Extent to which individuals would be expected to:

(A) Cycle in and out of the basic health program and the exchange due to changes in income; and

(B) Maintain continuity of care;

(g) Premium and out-of-pocket costs of health care to consumers with and without the basic health program; and

~~(h) Impact of the basic health program on premiums charged in the private insurance market.~~

(3) The study must evaluate the financial feasibility of operating a basic health program using at least two alternative options for:

(a) Health benefit packages, including packages that mirror the medical assistance program benefit package and the essential health benefits package adopted by the Oregon Health Insurance Exchange Corporation;

(b) Provider reimbursement rates, including rates that mirror provider reimbursement rates in the medical assistance program and the private insurance market in this state; and

(c) Premium and out-of-pocket cost limits.

(4) The authority shall solicit input using a public process to determine the factors and assumptions on which the study will be based.

(5) The authority shall report the findings of the study to the Legislative Assembly no later than November 30, 2014.

SECTION 2. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2013, out of the General Fund, the amount of \$60,000, which may be expended for contract costs to conduct the study required by section 1 of this 2014 Act.

SECTION 3. Section 1 of this 2014 Act is repealed on January 2, 2015.

SECTION 4. This 2014 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2014 Act takes effect on its passage.

Approved by the Governor April 1, 2014

Filed in the office of Secretary of State April 2, 2014

Effective date April 1, 2014

Solicitation: OHA-3766-14

Title: Oregon Basic Health Plan Study

Status: Expired

Purchase Agency: Oregon Procurement Information Network

Publish Date: 4/23/2014

Due Date: 5/13/2014 12:00 PM PST

Contact: ~~Heather J Mowry (OHA) @ (971) 673-0514, heather.j.mowry@state.or.us~~

Description: REQUEST FOR PROPOSALS (RFP) #3766

The State of Oregon Health Authority (OHA) requests proposals from qualified individuals or firms hereinafter "Proposers," to prepare a comprehensive assessment of the Oregon Basic Health Plan in Oregon including potential policy options for consideration by the Legislature, Oregon policy makers and stakeholders

OHA prefers to award a single resulting contract. Single RFP responses will be given preference in the evaluation process. Proposers wishing to undertake only a portion of this work should arrange appropriate, high-quality subcontractor arrangements for the other portions of the work and indicate how the subcontractors' results will be integrated with other study components included in the Section 4. Scope of Work. The resulting Contract is for the period starting approximately June 16, 2014, through December 1, 2014.

1. Background and Overview

In March 2014, the 77th Oregon Legislative Assembly passed House Bill 4109. The legislation requires the Oregon Health Authority (OHA) to commission an independent study of costs and impacts of operation of a Basic Health Program (BHP) in Oregon. The legislation further requires OHA to report to the Legislative Assembly by November 30, 2014. Pursuant to the legislation, OHA is issuing a Request for Proposal (RFP) to perform the independent study.

The purpose of the RFP is to develop a series of analyses and report documents that will enable Oregon policymakers to assess the potential opportunities and impacts if Oregon were to implement the Basic Health Program (BHP) option available under Section 1331 of the federal Affordable Care Act (ACA). Specifically, the study must estimate:

- The population eligible and likely to enroll in the BHP including the rate of uptake of the BHP option and percent of eligible insured compared to a non-BHP environment;
- Available federal funding, and state implementation and administrative cost;
- Impact to Oregon's health insurance exchange; and
- Impacts to affected populations regarding affordability and continuity of coverage.

Working within the health insurance coverage framework provided by the Affordable Care Act (ACA), Oregon has established its own health insurance Exchange for the individual and small-group markets, and has expanded the Oregon Health Plan (OHP) Medicaid program for low-income individuals. As of March 2014, approximately 39,000 and 227,000 individuals have enrolled in a) private coverage through Exchange Qualified Health Plans (QHP), and b) Oregon's Medicaid program, respectively. The majority of Medicaid enrollees receive care through Coordinated Care Organizations (CCOs). CCOs are networks of all types of health care providers who have agreed to work together in their local communities to improve outcomes and reduce costs for people who receive health care coverage under the Oregon Health Plan (Medicaid). As of Nov. 1, 2012, there are 16 CCOs in operation, serving about 90 percent of OHP members.

Beginning January 1, 2015, states have an additional option under the ACA to establish a Basic Health Program (BHP) to provide coverage for low-income individuals, who meet the following eligibility requirements:

- Residents of the State who: Are under age 65, and have incomes between 138% and 200% FPL;
- Are U.S. citizen or lawfully present immigrants (in the U.S. for five or more years);
 - Are not eligible for coverage under the State's Medicaid program, the Children's Health Insurance Program (CHIP), or Military/CHAMPUS-TRICARE;
 - Do not have access to Employer-Sponsored Insurance (ESI) that meets ACA standards for comprehensiveness and affordability, or other forms of minimum essential coverage (MEC);
 - Lawfully present immigrants up to 138% FPL,
 - who are not eligible for Medicaid due to their immigration status (have lived in the U.S. less than five years)

The final federal rule allows states to operate their BHP

Documents:

Bid Submission:

This solicitation center is courtesy of Find RFP which maintains a nationwide database of all Bids and RFP's. If you'd like to learn more about Find RFP and its services, please visit our website at www.findrfp.com

**MAINE HEALTH EXCHANGE ADVISORY COMMITTEE
DRAFT REPORT TEMPLATE**

EXECUTIVE SUMMARY

{TO BE ADDED}

I. INTRODUCTION

The Maine Health Exchange Advisory Committee was established by joint order, H.P. 1136, to advise the Legislature regarding the interests of individuals and employers with respect to any health benefit exchange that may be created for this State pursuant to the federal Patient Protection and Affordable Care Act. A copy of the Joint Order, H.P. 1136 is included as Appendix A.

Senator Margaret M. Craven and Representative Sharon Anglin Treat served as the Senate and House chairs of the Advisory Committee. As required by the Joint Order, the Advisory Committee has 18 members: 5 Legislators representing the Joint Standing Committees on Insurance and Financial Services, Appropriations and Financial Affairs and Health and Human Services; 6 members appointed by the President of the Senate; and 7 members appointed by the Speaker of the House of Representatives. While the Joint Order directed the President of the Senate and the Speaker of the House of Representatives to invite the Superintendent of Insurance and Commissioner of Health and Human Services or their designees to participate as ex officio nonvoting members, the Governor declined to appoint any representatives of the Administration to serve on the Advisory Committee.

The Advisory Committee members are:

Sen. Margaret M. Craven	<i>Senate Chair, Member of the HHS Committee ;appointed by the President of the Senate</i>
Rep. Sharon Anglin Treat	<i>Chair, House Member of the IFS Committee; appointed by the Speaker of the House</i>
Sen. Rodney L. Whittemore	<i>Senate Member of the IFS Committee; appointed by the President of the Senate</i>
Rep. Michael D. McClellan	<i>House Member of the IFS Committee; appointed by the Speaker of the House</i>
Rep. Linda F. Sanborn	<i>House Member of the AFA Committee; appointed by the Speaker of the House</i>
Christine Alibrandi	<i>Representing dental insurance carriers; appointed by the Speaker of the House</i>
John Benoit	<i>Representing insurance producers; appointed by the President of the Senate</i>

John Costin	<i>Representing individuals expected to purchase coverage through exchange; appointed by the President of the Senate</i>
Bob Dawber	<i>Employee of an employer expected to purchase coverage through exchange; appointed by the Speaker of the House</i>
Sara Gagne-Holmes	<i>Representing Medicaid recipients; appointed by the Speaker of the House</i>
Doug Gardner	<i>Advocate for enrolling hard-to-reach populations; appointed by the President of the Senate</i>
Laurie Kane-Lewis	<i>Representing federally-qualified health centers; appointed by the Speaker of the House</i>
Kevin Lewis	<i>Representing health insurance carriers; appointed by the Speaker of the House</i>
Elizabeth Neptune	<i>Representing a federally-recognized Indian tribe; appointed by the President of the Senate</i>
Kristine Ossenfort	<i>Representing health insurance carriers; appointed by the President of the Senate</i>
David Shipman	<i>Representing an employer expected to purchase coverage through exchange; appointed by the Speaker of the House</i>
Gordon Smith	<i>Representing health care providers; appointed by the Speaker of the House</i>
Mitchell Stein	<i>Representing navigators or entities likely to be navigators; appointed by the President of the Senate</i>

The complete membership of the Advisory Committee, including contact information, is included as Appendix B. The Office of Policy and Legal Analysis provided staffing support to the Advisory Committee.

With authorization from the Legislative Council, the Advisory Committee met 5 times: September 23, October 21, November 18, December 2 and December 9. All of the meetings were held in the Room 228 at the State House in Augusta and open to the public. Live audio of each meeting was made available through the Legislature's webpage.

The Advisory Committee also established a website which can be found at <http://www.maine.gov/legis/opla/healthexchangeac.htm>. The website includes agendas, meeting materials, links to related resources and audio recordings of all committee meetings.

II. ADVISORY COMMITTEE DUTIES

In its role as adviser to the Legislature regarding the interests of individuals and small businesses with respect to Maine's health benefit exchange, the Advisory Committee's specific duties are to:

- ◆ Advise the Legislature regarding the interests of individuals and employers with respect to any exchange that may be created for this State;
- ◆ Serve as a liaison between any exchange and individuals and small businesses enrolled in the exchange;
- ◆ Evaluate the implementation and operation of any exchange with respect to the following:
 - The essential health benefits benchmark plan designated in this State under the federal Patient Protection and Affordable Care Act, including whether the State should change its designation;
 - The impact of federal and state laws and regulations governing the health insurance rating for tobacco use and coverage for wellness programs and smoking cessation programs on accessibility and affordability of health insurance;
 - The consumer outreach and enrollment conducted by the exchange and whether the navigator program is effective and whether navigators or other persons providing assistance to consumers are in compliance with any federal or state certification and training requirements;
 - The coordination between the state Medicaid program and the exchange;
 - Whether health insurance coverage through the exchange is affordable for individuals and small businesses, including whether individual subsidies are adequate;
 - Whether the exchange is effective in providing access to health insurance coverage for small businesses;
 - The implementation of rebates under the federal Patient Protection and Affordable Care Act and the Maine Revised Statutes, Title 24-A, section 4319; and
 - The coordination of plan management activities between the Department of Professional and Financial Regulation, Bureau of Insurance and the exchange, including the certification of qualified health plans and rate review;
- ◆ Following the release of guidance or regulations addressing the basic health program option, conduct a study, and make recommendations as appropriate, that examines the potential for establishing a basic health program for eligible individuals in order to ensure continuity of care and that families previously enrolled in Medicaid remain in the same plan; and
- ◆ Make recommendations for any changes in policy or law that would improve the operation of an exchange for consumers and small businesses in the State.

III. ADVISORY COMMITTEE PROCESS

The Advisory Committee monitored the operations of Maine's federally-facilitated marketplace (FFM) and the coordination between the FFM, the Medicaid program, the Bureau of Insurance and the qualified health plans operating in Maine on and off the FFM. The Advisory Committee also focused on the consumer outreach and assistance resources available to individuals and small businesses and the effectiveness of those resources.

The Advisory Committee received an update at each meeting from Christie Hager, Region One Director for the United States Department of Health and Human Services. Ms. Hager was a valuable resource to the Advisory Committee and an important link for information on federal implementation efforts for the FFM in Maine and other provisions of the federal Affordable Care Act.

The Superintendent of Insurance, Eric Cioppa, provided updates at each meeting on the regulatory activities of the Bureau of Insurance with regard to the FFM and oversight of qualified health plans. The Advisory Committee also received presentations on the health and dental plans available through the FFM in 2014 (and expected in 2015) from representatives of Anthem Health Plans of Maine, Maine Community Health Options, Northeast Delta Dental and Harvard Pilgrim Health Care.

The Advisory Committee discussed consumer outreach and enrollment assistance issues with the following individuals:

- ◆ Jacob Grindle, Western Maine Community Action;
- ◆ Wendy Wolf and Morgan Hynd, Maine Health Access Foundation, on the enroll207.com;
- ◆ Emily Brostek, Consumers for Affordable Health Care; and
- ◆ Robyn Merrill, Maine Equal Justice Partners,

Finally, the Advisory Committee discussed the Basic Health Program and other coverage options with Jessica Schubel from the Center for Budget Policies and Priorities.

The Advisory Committee was disappointed that representatives of the Department of Health and Human Services did not attend any meetings or make presentations as requested. Although DHHS did submit written information in response to requests from the Advisory Committee, the lack of full participation affected the Advisory Committee's discussions.

IV. ADVISORY COMMITTEE FINDINGS AND RECOMMENDATIONS

[TO BE ADDED FOLLOWING REVIEW OF DISCUSSION DRAFT ON SEPT. 22ND AND COMMITTEE DISCUSSIONS AT SEPT. 22 AND OCT. 16 MEETINGS]

V. CONCLUSION

{TO BE ADDED}

**Maine Health Exchange Advisory Committee
Discussion Draft---Potential Findings and Recommendations**

Pursuant to H.P. 1136, the Maine Health Exchange Advisory Committee was directed by the Legislature to consider the issues described below. Based on its review and discussions, the Advisory Committee makes the following findings and recommendations.

1. Whether Maine's federally-facilitated marketplace is effective for individuals and small businesses and whether the State should transition to a partnership exchange or state-based exchange in the future.

The Advisory Committee recommends that the State continue with a Federally-Facilitated Marketplace in Maine in 2016. More than 44,000 people selected qualified health plans through Maine's Marketplace; 90% of those selecting health plans qualified for premium assistance. Despite the initial problems with the healthcare.gov website, Maine's first year in the Marketplace was very successful for individuals and families. In contrast, states that chose to establish state-based Marketplaces were not as successful in implementing their Marketplaces and a few states will be reverting to a Federally-Facilitated model for 2015. While the 2015 enrollment period may present different challenges, the Advisory Committee believes the FFM has provided those individuals enrolled with comprehensive health care coverage and critical financial assistance to those eligible for that assistance.

Because full implementation of the SHOP Marketplace through healthcare.gov was delayed in FFM states like Maine until 2015, it is premature for the Advisory Committee to assess the effectiveness of the FFM model for small businesses. During its meetings in 2013, the Advisory Committee did discuss the potential for the State to establish a state-based SHOP Marketplace to serve small businesses. The Advisory Committee received a briefing on Kentucky's health benefit exchange, "kynect." After the first year, Kentucky's Marketplace appears to be one of the most successful state-based Marketplaces in terms of small business enrollment. The Advisory Committee was impressed with Kentucky's approach to its small business Marketplace and the broad involvement of health insurance brokers. The Advisory Committee may be interested in exploring this potential model if the Federally-Facilitated SHOP Marketplace fails to attract enrollment from small businesses in Maine.

Legal challenges to the validity of premium subsidies in states with Federally-Facilitated Marketplaces may affect the future operation of Maine's marketplace and cause policymakers to reconsider Maine's current model. At this time, however, the Advisory Committee does not believe that changes to Maine's Federally-Facilitated Marketplace model are necessary.

The Legislature should continue to monitor the operations of the FFM and, after the 2015 enrollment period, assess whether any changes can be made to make the Marketplace more effective for individuals and small businesses.

2. Evaluate the continued necessity of a state health exchange advisory committee, including, including the staffing and funding needs of such an advisory committee and recommend, whether such an advisory committee should be established by the 127th Legislature and whether any changes should be made to the Maine Revised Statutes governing such an advisory committee.

(to be added after Advisory Committee discussion at Sept. 22 and Oct. 16th meetings)

3. Evaluate the implementation and operation of any exchange with respect to the essential health benefits benchmark plan designated in this State under the federal Patient Protection and Affordable Care Act, including whether the State should change its designation.

Maine Health Exchange Advisory Committee
Discussion Draft---Potential Findings and Recommendations

The current federal guidance under which States designated Essential Health Benefits medical and dental benchmark plans applies through plan year 2015. When the current benchmark plan selection process was announced, CMS indicated that additional guidance as to any changes in that selection process might be provided for plan years beginning in 2016 and thereafter. The Advisory Committee wrote letters in June and August 2014 urging CMS to issue immediate notification to States as to whether the current federal guidance permitting States to designate a benchmark plan for Essential Health Benefits will be continued without change or modified for the 2016 plan year. If changes are anticipated, the Advisory Committee believes guidance must be provided no later than in the last quarter of 2014 so that health insurance carriers are able to incorporate any changes into 2016 health plans submitted for approval to the Maine Bureau of Insurance in the spring of 2015. In addition, if changes to Maine's designation of Essential Health Benefits will be permitted for the 2016 plan year, the Legislature will need adequate time to consider any policy options carefully and receive public input on those options before making any recommendations.

4. Evaluate the impact of federal and state laws and regulations governing the health insurance rating for tobacco use and coverage for wellness programs and smoking cessation programs on accessibility and affordability of health insurance.

(to be added after Advisory Committee discussion at Sept. 22 and Oct. 16th meetings)

5. Evaluate the consumer outreach and enrollment conducted by the exchange and whether the navigator program is effective and whether navigators or other persons providing assistance to consumers are in compliance with any federal or state certification and training requirements.

The Advisory Committee believes that consumer outreach and enrollment efforts in Maine have been successful despite limited federal resources. 44,258 Maine residents selected health care plans during the open enrollment period. It is a remarkable achievement that would not have been possible without the coordinated effort of Maine's recognized navigators, certified application counselors and other community partners. In addition, the Maine Health Access Foundation provided significant leadership and resources as well as the enroll207.com website.

However, the Advisory Committee believes additional resources are needed to enhance the consumer education, outreach and assistance efforts currently being provided. The Advisory Committee believes consumer education and outreach efforts must continue for both individuals and small businesses. The delays in full implementation of the SHOP marketplace highlight the continued need for assistance to small businesses. Individuals and small businesses must be informed of regulatory changes and other implementation developments so they are able to make good decisions based on current information about their health coverage options. The Advisory Committee supports the Navigator program and was pleased that federal resources for Maine's two recognized navigators has been extended for 2015. Funding should be available to support the Navigator program as long as Maine's FFM is operating.

As over 44,000 Mainers begin to use their new health insurance coverage and with more Mainers expected to join the Marketplace in the upcoming open enrollment period, the Advisory Committee also believes that consumer assistance programs are needed more than ever. Many people who are now covered have never had health insurance before, and need help to understand their health care coverage and access the new protections that the federal Affordable Care Act has provided. Maine consumers also

Maine Health Exchange Advisory Committee
Discussion Draft---Potential Findings and Recommendations

need help with navigating their coverage, including filing complaints and appeals if needed. The Advisory Committee sent a letter in support of Consumer for Affordable Health Care's application for continued federal funding for its consumer assistance program. Given the limited federal resources being spent in Maine, the Advisory Committee feels that this valuable assistance needs to continue in 2015.

6. Evaluate the coordination between the state Medicaid program and the exchange.

The Advisory Committee has had limited information about the coordination of the Medicaid program and Maine's FFM. While the Maine Department of Health and Human Services (DHHS) has responded to written requests for information, DHHS representatives have not attended any meetings or accepted the Advisory Committee's invitations to make presentations. Based on input provided by Christie Hager, the Advisory Committee understands that the FFM and DHHS are working to improve the coordination and exchange of information needed to determine eligibility of individuals for health coverage through Medicaid or the FFM.

The Advisory Committee has reviewed sample notices used by DDHS and believes that these notices can be improved. The Advisory Committee recommends that notices sent by DHHS provide accurate information on all of the coverage options, all of the ways consumers can apply for coverage and all of the resources available to the consumer for assistance in evaluating health coverage options.

7. Evaluate whether health insurance coverage through the exchange is affordable for individuals and small businesses, including whether individual subsidies are adequate.

In its preliminary report from December 2013, the Advisory Committee recommended that the State take action to close the coverage gap to ensure individuals have access to affordable health insurance coverage. As changes in MaineCare eligibility have been implemented, individuals have lost eligibility for MaineCare and will not qualify for subsidies to provide assistance to access private health coverage through the Marketplace. In addition to the individuals who lost eligibility for coverage, there are individuals who are also ineligible for subsidies due to their low incomes. These individuals are described as being in the "coverage gap."

Since the implementation of the ACA only began on January 1, 2014, the Advisory Committee has not had an opportunity to gather data about the impact of the coverage gap on "churn". Churning is the movement of consumers between systems of health coverage. Churn can occur between public and private health coverage and between private health plans in and outside of the Marketplace. Churning makes programs more complicated and costly to administer and interrupts continuity of coverage and care. It can also create gaps in coverage when consumers need to move between programs or health plans, and interfere with accurate and comprehensive quality measurement. The coverage gap and churn can also have an effect on the financial stability of federally-qualified health centers, hospitals and other health care providers depending on reimbursement for services provided to individuals enrolled in public and private health plans. The Advisory Committee is concerned about the effects of the coverage gap and churn on the effectiveness of the Marketplace and believes these effects should be monitored.

The Advisory Committee supports providing access to affordable health care coverage for all Maine people as well as the goal of reducing the uninsured and would support policy changes that would close the coverage gap as soon as possible and expand access to affordable health coverage. For the Advisory Committee, affordable health coverage means the availability of the appropriate health care at the right time, at the right place and at the right price. While individuals may be eligible to purchase private health care coverage through the marketplace, the affordability of that coverage is a significant issue for those with limited income.

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All policy options should be explored, including amendments to the ACA to expand the availability of premium tax credits to individuals with lower income levels and expanded eligibility for MaineCare, an option which is currently available to the State in accordance with federal law and regulation. The Advisory Committee acknowledges that this recommendation is significant because it represents the consensus of its members; individual members of the Advisory Committee have differing opinions on specific policy options available to address the coverage gap, but all support this recommendation in the interest of achieving consensus.

The Advisory Committee also notes that the design and structure of the ACA has had an effect on affordability of coverage. Current IRS guidelines interpret the ACA in a manner that prevents an employee's family from being eligible for premium subsidies and other financial assistance through the Marketplace even if the cost of coverage for the family is unaffordable. These rules state that an employer's offer of *individual* coverage is used to determine if that coverage is affordable (costs less than 9.5 percent of the employee's income). Even if that employer also offers the employee's family members coverage in its plan, the cost of the family coverage is not used to determine the affordability of the employee's coverage. While the employee's family may purchase coverage through the FFM, they will not be eligible for financial assistance. The Advisory Committee supports efforts at the federal level to address the "family glitch."

8. Evaluate whether the exchange is effective in providing access to health insurance coverage for small businesses.

Because full implementation of the SHOP Marketplace through healthcare.gov was delayed in FFM states like Maine until 2015, it is premature for the Advisory Committee to assess the effectiveness of the FFM model for small businesses. During its meetings in 2013, the Advisory Committee did discuss the potential for the State to establish a state-based SHOP Marketplace to serve small businesses. The Advisory Committee received a briefing on Kentucky's health benefit exchange, "kynect." After the first year, Kentucky's Marketplace appears to be one of the most successful state-based Marketplaces in terms of small business enrollment. The Advisory Committee was impressed with Kentucky's approach to its small business Marketplace and the broad involvement of health insurance brokers. The Advisory Committee may be interested in exploring this potential model if the Federally-Facilitated SHOP Marketplace fails to attract enrollment from small businesses in Maine.

For 2015 open enrollment, improvements in functionality are expected for the SHOP Marketplace, including enrollment through the healthcare.gov website (which was not available in 2014). However, due to an additional delay permitted by the federal government and agreed to by Maine's Superintendent of Insurance, Maine's small employers will not be able to offer their employees a choice of qualified health plans through the SHOP Marketplace in 2015.

The Legislature should monitor the operations of the SHOP in Maine and, after the 2015 enrollment period, assess whether any changes can be made to make the Marketplace more effective for small businesses.

9. Evaluate the implementation of rebates under the federal Patient Protection and Affordable Care Act and the Maine Revised Statutes, Title 24-A, section 4319.

(to be added after Advisory Committee discussion at Sept. 22 and Oct. 16th meetings; please see attached summary of MLR rebate results prepared by Advisory Committee member, Christine Alibrandi)

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10. Evaluate the coordination of plan management activities between the Department of Professional and Financial Regulation, Bureau of Insurance and the exchange, including the certification of qualified health plans and rate review.

Through an exchange of letters, the Bureau of Insurance has assumed certain plan management functions for the FFM. The Bureau oversees the regulation of health insurance carriers participating in the FFM, including review of premium rates. The Advisory Committee believes current coordination of plan management activities by the Bureau of Insurance with the FFM has been effective for the health plans operating in Maine as well as Maine insurance consumers. The Advisory Committee does not recommend any changes to this oversight model, but the Legislature's Joint Standing Committee on Insurance and Financial Services should monitor the relationship of the FFM with the Bureau of Insurance and determine whether a future transition to a formal partnership model would provide any added benefit. The Advisory Committee also supports the outreach efforts undertaken by the Bureau of Insurance and urges the State, through the Bureau of Insurance, to apply for any available federal grant funds to leverage the available resources to help pay the costs of the Bureau's plan management and consumer outreach activities.

11. Study the basic health program option, as set forth in the federal Affordable Care Act and make recommendations as appropriate, that examine the potential for establishing a basic health program for eligible individuals in order to ensure continuity of care and that families previously enrolled in Medicaid remain in the same plan.

(to be added after Advisory Committee discussion at Sept. 22 and Oct. 16th meetings)

12. Recommend other changes in policy or law that would improve the operation of an exchange for consumers and small businesses in the State?

- ◆ Whether changes should be considered in federal law or regulation to address dental health coverage available through the marketplace, including but not limited to, premiums and out-of-pocket costs;
- ◆ Whether the State should consider changes to its designated rating areas for geographic area to the extent permitted by federal law and regulation
- ◆ The impact of "churn" on the effective operation of the marketplace, public health programs and the private health insurance market
- ◆ The impact of federal requirements to provide employer-sponsored health coverage on the health care workforce

(to be added after Advisory Committee discussion at Sept. 22 and Oct. 16th meetings)

ⁱ Health Insurance Marketplace: Summary Enrollment Report, October 1, 2013 – April 19, 2014, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS); May 1, 2014. http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf

The Affordable Care Act's Medical Loss Ratio Rebate Results for 2011-2013

Beginning in 2011, the Affordable Care and Patient Protection Act “requires insurance companies in the individual and small group markets to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurance companies in the large group market must spend at least 85 percent of premium dollars on medical care and quality improvement activities. Insurance companies must report their MLR data to HHS on an annual basis so that residents of every State will have information on the value of health plans offered by different insurance companies in their State. Insurance companies that do not meet the MLR standard will be required to provide rebates to their consumers. Insurers [made] the first round of rebates to consumers in 2012. Rebates must be paid by August 1st each year”.ⁱ

For those enrolled in large group plans, “the final [administrative] rule directs issuers to provide rebates to the group policyholder (usually the employer) through lower premiums or in other ways that are not taxable. This process will vary by plan type. Policyholders must ensure that the rebate is used for the benefit of subscribers. The final rule also requires that issuers provide notice of rebates to enrollees and the group policyholder. All enrollees must be given information about the MLR and its purpose, the MLR standard, the issuer’s MLR, and the rebate provided”.ⁱⁱ

Rebates totaled \$1.3 billion in 2011 [paid in 2012], including \$426 million in the individual market, \$377 million in the small group market, and \$541 million in the large group market. While total rebates are highest for large employers and their workers, many more people are also covered in that market segment.ⁱⁱⁱ For Maine in 2011, only the large group market was touched by the rebates, with Connecticut General Life Insurance Co. required to pay a rebate of \$2,579,922.^{iv}

In 2012, 8,517,869 consumers saved \$504,157,712 with an average rebate per family of \$98.^v For Maine in 2012, CMS reported \$501,240 in rebates in the large group market with 8,796 consumers benefitting from the rebates which averaged \$106 per family.^{vi} As with 2011, there were no rebates reported for the small group or individual market.

In 2013, the effects of the MLR were more dramatically evidenced by the reduced amount of rebate dollars nationwide. A total of \$332,152,474 in rebates in the three impacted markets benefitting 6,816,423 consumers with an average family rebate of \$80.^{vii} For the 2013 claim year in Maine, a total of \$1,845,006 in rebates were due in the small group (\$237,887 benefitting 6,002 consumers, \$50 average rebate) and large group (\$1,607,119 benefitting 13,540 consumers, \$211 average rebate).^{viii}

ⁱ CMS, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html>

ⁱⁱ Id.

ⁱⁱⁱ <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8305.pdf>, page 2

^{iv} Consumers Union, <http://yourhealthsecurity.org/health-insurance-refund-list-2011>

^v <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-rebates-by-state-and-market.pdf>

^{vi} <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-rebates-by-state-and-market.pdf>

^{vii} http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2013_MLR_Refunds_by_State.pdf

^{viii} http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2013_MLR_Refunds_by_State.pdf