

RECOMMENDATIONS REGARDING THE MAINE  
HEALTH BENEFIT EXCHANGE

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Report to the Governor and the Joint Standing  
Committee on Insurance and Financial Services

From the Advisory Committee on Maine's Health  
Insurance Exchange

**September 20, 2011**

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## **I. Background**

The 125th Maine State Legislature adopted a Resolve to establish the Advisory Committee on Maine's Health Insurance Exchange (the "Advisory Committee") "to develop and provide recommendations, including suggested enabling legislation, to the Governor and the Legislature for a health insurance exchange."<sup>1</sup> Specifically, the Resolve required the Advisory Committee to:

1. Review and consider the recommendations issued by the 124th Legislature's Joint Select Committee on Health Care Reform with respect to a health insurance exchange;
2. Consider the rules issued by the Federal Government subsequent to the passage of the Patient Protection and Affordable Care Act and their impact on the creation and operations of a health insurance exchange;
3. Review the work products of other states to consider whether any elements of their health insurance exchanges can be used in implementing Maine's health insurance exchange;
4. Establish technical committees or seek the advice of technical experts when necessary to execute the Advisory Committee's duties; and
5. Seek input from and report regularly to legislative leadership, the Joint Standing Committee on Insurance and Financial Services, and the Governor's office throughout the Advisory Committee's deliberations.

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<sup>1</sup> Resolve Chapter 105, LD 1582, 125th Maine State Legislature. Attached as Appendix C.

## **II. Advisory Committee Members**

In July 2011, the Governor appointed the members of the Advisory Committee in accordance with the nominating process and composition required in the Resolve.

The members of the Advisory Committee are:

- Joel Allumbaugh  
CEO, National Worksite Benefit Group, Inc.
- Dan Bernier  
The Law Office of Daniel Bernier
- Jamie Bissonette Lewey  
Chair, Maine Indian Tribal State Commission
- Joseph Bruno (Chair of Advisory Committee)  
Chair, Dirigo Health Agency Board of Trustees
- David R. Clough  
Maine State Director, NFIB
- Edward Kane  
Vice President for Maine, Harvard Pilgrim Health Care
- Dan McCormack  
CEO, Intermed
- Steve Michaud  
President, Maine Hospital Association
- Kristine Ossenfort, Esq.,  
Director of Government Relations, Anthem Blue Cross Blue Shield

### **III. Issues Considered by the Advisory Committee**

In meetings of the Advisory Committee conducted in public in accordance with Section 5 of the Resolve on August 16th and 23rd and September 8th and 14th the Advisory Committee considered a number of items that must be decided by the State in establishing a health insurance exchange in accordance with the Patient Protection and Affordable Care Act (“ACA”) (an “Exchange”).

These items were based on questions presented by the National Association of Insurance Commissioners in its American Health Benefit Exchange Model Act (the “NAIC Model Act”) for states to consider in establishing an exchange and drafting its enabling legislation for an exchange.<sup>2</sup>

For each item, the Advisory Committee considered any relevant narrative included within each of the two bills establishing a health insurance exchange that were introduced during the 125th Legislative session-- LD 1497 and LD 1498-- in addition to any applicable recommendations in the final report by the 124th Legislature’s Joint Select Committee on Health Care Reform Opportunities and Implementation (the “JSC Report”), and the proposed regulations issued by the Federal Government subsequent to the passage of ACA. In addition, for certain issues the Advisory Committee considered testimony by appropriate experts. For example, for issues relating to the structure of the Exchange, the Advisory Committee considered testimony by Linda Pistner, Chief Deputy Attorney General, and for issues relating to the potential effect of ACA’s changes on Maine’s insurance markets, the Advisory Committee considered testimony and actuarial analysis provided by Gorman Actuarial, LLC.

The items considered by the Advisory Committee appear in the Appendix A to this report. In addition, materials considered by the Advisory Committee during its meetings are available at [http://www.dirigohealth.maine.gov/Pages/hix\\_ac.html](http://www.dirigohealth.maine.gov/Pages/hix_ac.html).

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<sup>2</sup> The NAIC Model Act is available at [http://www.naic.org/documents/committees\\_b\\_exchanges\\_adopted\\_health\\_benefit\\_exchanges.pdf](http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf) (November 22, 2010)

## IV. Advisory Committee Recommendations

This section of the report is organized into two parts: Part A summarizes the recommendations that are reflected in the suggested legislation and Part B summarizes the additional recommendations by the Advisory Committee (purposefully not reflected in the suggested legislation) for the Legislature to consider during the drafting process.

The Advisory Committee's recommendations on the items that it has considered in establishing an Exchange appear in Appendix A to this report. The Advisory Committee's recommended suggested legislation establishing the Exchange is attached as Appendix B to this report.

### A. *Recommendations Reflected in Suggested Legislation*

The following recommendations are reflected in the Advisory Committee's suggested legislation for establishing the Exchange, which is attached to this report as Appendix B.

1. Exchange Structure: The Legislature should establish the Exchange as a state agency within the Department of Professional and Financial Regulation.

The ACA requires the Exchange to be structured as either a governmental agency or a non-profit entity.<sup>3</sup> If structured as a governmental agency, ACA permits the Exchange to be established as part of an existing executive branch agency or an independent public agency.<sup>4</sup> The Advisory Committee recommends that the Legislature structure the Exchange as a governmental agency for three reasons:

- First, ACA requires an Exchange to perform several regulatory functions that affect the welfare of Maine's citizens, including the power to determine an individual's eligibility to purchase coverage through the Exchange and to determine whether a health insurance issuer or health plan meets minimum requirements to be offered on the Exchange.<sup>5</sup>
- Second, the Exchange must coordinate closely with both the Maine Bureau of Insurance and the Department of Health and Human Services. The coordination is likely to be more efficient and effective if the Exchange also operates as a state agency.
- Third, ACA requires the Exchange to be financially self-sustaining by 2015 such that the Exchange will need both governmental authority and oversight in imposing fees or other revenue-raising measures and in spending these revenues.<sup>6</sup>

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<sup>3</sup> ACA § 1311(d)(1).

<sup>4</sup> ACA § 1311(d)(1); 76 *Fed. Reg.* 41866, 41870 (July 15, 2011).

<sup>5</sup> ACA § 1311(d)(4).

<sup>6</sup> ACA § 1311(d)(5)(A).

The regulatory functions that ACA requires an Exchange to perform, including the power to collect fees, are inherently governmental functions that a non-profit entity may not be able to perform if it wishes to have tax-exempt status under the federal Internal Revenue Code. In reaching this recommendation, the Advisory Committee took into account recommendations by the Governor, recommendations in the JSC Report, and testimony by Linda Pistner, Chief Deputy Attorney General.

The Advisory Committee also considered the differences between establishing the Exchange as a pure state agency within the executive branch or as a quasi-governmental agency. Ms. Pistner testified before the Advisory Committee on August 23, 2011, and explained that, in contrast to a state agency, a quasi-governmental agency is generally not financially supported by the full faith and credit of the state and the officers and directors of the agency, while typically appointed by the Governor, serve for a specified term and are not subject to removal except for cause. Ms. Pistner also testified that an agency governed by a board is typically a quasi-governmental agency. She explained that it was uncommon to establish a governmental agency governed by an independent board, and that such a structure could raise issues of improper ex parte communication between board members and the officers and directors of the agency. However, she identified other instances in Maine where a governmental agency was governed by an independent board operating within a larger department.

The Advisory Committee recommends that the Exchange be housed within the Department of Professional and Financial Regulation. Some of the functions related to the Exchange, including determining whether issuers and health plans meet certain licensing requirements, will need to be performed by the Bureau of Insurance in order to ensure that issuers and plans remain subject to consistent licensing requirements regardless of whether they are offered through the Exchange. Moreover, the Bureau of Insurance will play an important role in helping the Exchange to establish standards for “navigators” who will be responsible for creating public awareness of the Exchange and assisting individuals in enrolling in qualified health plans in the Exchange. Currently, the Commissioner of Professional and Financial Regulation oversees the Bureau of Insurance, the Bureau of Financial Institutions, and other similar agencies and coordinates efforts among these agencies when necessary. Because of the shared responsibilities between the Bureau of Insurance and the Exchange, the Advisory Committee recommends that the Exchange be housed within the Department of Professional and Financial Regulation so that the Commissioner can administer and oversee the Exchange and coordinate any shared responsibilities between the two agencies. In response to the Advisory Committee’s request the Commissioner of Professional and Financial Regulation submitted a written recommendation to the Advisory Committee regarding the Administration’s preference for the structure and governance of the State’s health insurance exchange. See Appendix D.

2. Exchange Governance:

a) Governance.

The Advisory Committee recommends that a commission be established to advise the Executive Director and the Commissioner of Professional and Financial Regulation on technical

matters such as critical issues or matters that require a particular expertise, knowledge, or skill.<sup>7</sup> The Advisory Committee's suggested legislation does not include recommendations regarding the allocation of governing powers. The Advisory Committee recommends that the Legislature determine the allocation of these powers and, in making such determination, consider existing state models.

- b) The Executive Director should be appointed by the Governor, subject to confirmation by the Legislature. The Executive Director should serve at the pleasure of the Governor.

The Advisory Committee recommends that the legislation establishing the Exchange authorize the Exchange commission to recommend candidates for Executive Director to the Commissioner of Professional and Financial Regulation and to the Governor. The Executive Director should be appointed by the Governor subject to confirmation by the Legislature and should serve at the pleasure of the Governor.

- c) The members of the commission should be appointed by the Governor, subject to confirmation by the Legislature.

The Advisory Committee recommends that the voting members of the commission be appointed by the Governor and subject to confirmation by the Legislature. Moreover, the Advisory Committee recommends that the Legislature adopt legislation establishing the Exchange promptly so that members of the commission can be appointed by the Governor no later than October 2012.

The Advisory Committee observed that the stability that would be provided by a governing board whose members turn over at fixed intervals rather than with a change in Governor would be beneficial to the Exchange. Accordingly, the Advisory Committee recommends that the enabling legislation provide for the voting members of the commission to serve three-year terms, but no more than two consecutive terms. The initial terms of the voting members should be staggered to provide continuity in governance as members' terms expire and they are replaced.

- d) The members of the commission should represent stakeholders to the Exchange and meet certain qualification requirements.

The Advisory Committee considered the federal proposed regulations on the establishment of exchanges and qualified health plans<sup>8</sup>, which require the governing board of an exchange to represent consumer interests by ensuring that the majority of the voting members do not have a conflict of interest and that a majority of the voting members have relevant experience in the health insurance or health care delivery industry. Under proposed federal rules, a voting member has a conflict of interest if he or she is a representative of a health insurance issuer,

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<sup>7</sup> The Advisory Committee's members do not unanimously agree that the commission's authority should be limited to advising on technical matters.

<sup>8</sup> 76 *Fed. Reg.* 41866 (July 15, 2011).

health insurance producer, or is licensed to sell health insurance.<sup>9</sup> The Advisory Committee recommends that the composition of the commission be consistent with the federal proposed regulations. The Advisory Committee further recommends that the commission consist of eleven members in order to remain a manageable size. Nine of the members will have voting rights and be appointed by the Governor subject to confirmation by the Legislature. These voting members will represent stakeholders to the Exchange as follows:

- one member representing insurers,
- one member representing health insurance producers,
- one member representing healthcare providers,
- one member representing employers that employed an average of not more than 50 employees during the calendar year preceding the member's appointment,
- one member representing employers that employed an average of not less than 51 employees and not more than 100 employees during the calendar year preceding the member's appointment,
- one member representing consumers,
- one member representing federally recognized Indian tribes in the State, and
- two additional members, who may be drawn from any of the above categories, or any other category.

In order to satisfy federal requirements, the voting members must have relevant experience in the following areas: health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. The Advisory Committee recommends that these requirements be included in the state legislation.

The Advisory Committee recommends that the Governor appoint the Chair of the commission.

The Advisory Committee also recommends that two of the eleven members of the commission be non-voting ex-officio members: the Commissioner of the Department of Professional and Financial Regulation and the Commissioner of the Department of Health and Human Services or their designees. Many of the functions performed by the Exchange will require input and resources of both the Department of Health and Human Services and the Department of Professional and Financial Regulation. Accordingly, the Advisory Committee thought it important for the commission to receive input from these agencies in its decision-making process.

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<sup>9</sup> Prop. 45 C.F.R. § 155.110(c)(3) (76 *Fed. Reg.* at 41914).

- e) The enabling legislation should permit the Exchange to establish advisory committees who represent stakeholder interests.

The ACA requires the Exchange to regularly consult with stakeholders.<sup>10</sup> Under the statute, stakeholders may include educated health care consumers, individuals and entities with experience in facilitating enrollment in health coverage, advocates for enrolling hard to reach populations, small businesses and self-employed individuals, state Medicaid and CHIP agencies, federally-recognized tribes, public health experts, health care providers, large employers, health insurance issuers, and agents and brokers.<sup>11</sup>

Although some of these stakeholders will be represented on the commission, their representation is limited to one member and not all of the categories of stakeholders are represented. Accordingly, the Advisory Committee proposes that the enabling legislation allow the Exchange to establish advisory committees representing the various stakeholders to advise the Exchange on issues of importance to these stakeholders.

Moreover, the proposed rules and existing state and federal Executive Orders require the Exchange to seek input from all federally-recognized tribal organizations within the State.<sup>12</sup> Accordingly, the Advisory Committee recommends that the enabling legislation require the Exchange to establish an advisory committee that includes representatives who are appointed by the chief and council for each of the federally-recognized tribes within the State.

3. Duties of Exchange: The enabling legislation should require the Exchange to perform only the duties required by ACA with some state-specific clarifications.

The ACA requires the Exchange to perform approximately twenty duties, including certification of qualified health plans to participate on the Exchange, determining eligibility of individuals to participate in the Exchange, and maintaining toll-free hotlines and other services to assist individuals in purchasing coverage on the Exchange.<sup>13</sup> The Advisory Committee recommends that the enabling statute include the duties that the Exchange is required to perform as described in the NAIC Model Act with the following modifications to reflect existing requirements under Maine statutes:

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<sup>10</sup> ACA § 1311(d)(6); Proposed 45 C.F.R. § 155.130 (76 Fed. Reg. at 41914).

<sup>11</sup> *Id.*

<sup>12</sup> 76 Fed. Reg. at 41873; *Consultation and Coordination with Federal Indian Tribes* U.S. Executive Order 1375 (Nov. 6, 2000); *An Order Recognizing the Special Relationship Between the State of Maine and the Sovereign Native American Tribes Located Within the State of Maine* (Aug. 26, 2011).

<sup>13</sup> ACA § 1311(c). One of these duties includes establishing a Small Business Help Options Program (also referred to as a SHOP Exchange) to assist small employers in enrolling their employees in qualified health plans offered to their employees through the Exchange. Therefore, the Exchange will serve not only individuals but also, through the SHOP program, small employers.

- The Exchange is required by federal law to establish a navigator program to raise awareness of the Exchange, facilitate enrollment in qualified health plans, and perform other customer service-oriented functions.<sup>14</sup> To protect consumers, the Advisory Committee recommends that navigators be required to meet any registration or licensing requirements established by the Bureau of Insurance in consultation with the Exchange and the Department of Health and Human Services. While the Advisory Committee was of the view that navigators must be adequately trained, the Committee did not recommend that the legislation specify a training component for registration or licensure, leaving this to the discretion of the Bureau of Insurance and the Exchange.
- The Advisory Committee recommends that the enabling legislation require the Exchange to allow health insurance producers to enroll individuals and employers in qualified health plans. Insurance producers play an important role in assisting small employers with the purchase of small group health insurance for their employees. To increase the likelihood that small employers will participate in the Exchange, it is important for insurance producers with whom small employers already have professional relationships to be permitted to assist these employers in obtaining coverage for their employees through the Exchange.
- The Exchange must allow employers to select a level of coverage (*e.g.*, bronze, silver, gold or platinum) from which employees may select a qualified health plan in which to enroll.<sup>15</sup> However, federal proposed regulations permit an Exchange to allow employers to make other choices, such as selecting one or more specific plans in which employees may enroll.<sup>16</sup> The Advisory Committee recommends allowing the Exchange to determine whether to make additional choices available to employers and that the Exchange not preclude an employer from choosing a single qualified health plan.

Moreover, the Advisory Committee recommends that the issuer of a health benefit plan and any health benefit plans offered by the issuer that meet licensing or other minimum requirements established by the Exchange (in order to meet federal requirements) or the Superintendent of the Bureau of Insurance (as applicable) be eligible to participate in the Exchange. In other words, the Advisory Committee also recommends that all qualified health plans be eligible to participate on the Exchange, so that the Exchange functions as an open marketplace. The Advisory Committee recommends against permitting the Exchange to require an issuer or plan to meet requirements to participate in the Exchange that are not required under federal law or by the Superintendent of the Bureau of Insurance, including any requirements for qualified health plans to provide benefits in addition to essential health benefits.

4. Exchange Funding: The Exchange should be required to submit a budget for approval to the Commissioner of the Department of Professional and

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<sup>14</sup> ACA § 1311(d)(4)(K).

<sup>15</sup> ACA § 1312(a)(2).

<sup>16</sup> Proposed 45 C.F.R. § 705(b)(2) (76 *Fed. Reg.* at 41918).

Financial Regulation and any assessments or fees charged by the Exchange to raise revenue must be subject to Legislative approval.

The ACA requires the Exchange to be self-sustaining by 2015 and permits the Exchange to charge assessments or user fees to health carriers or adopt other measures to generate funding to support its operations.<sup>17</sup> The Advisory Committee recommends including a provision in the legislation that requires (1) the Exchange to submit a budget for approval to the Commissioner of the Department of Professional and Financial Regulation and (2) the initial budget to include recommendations for the Exchange to be self-sustaining by 2015. In addition, as required by the State's existing laws, the enabling legislation should provide that any revenue-raising initiatives that will be undertaken by the Exchange must be enacted by the Legislature.<sup>18</sup>

The Advisory Committee also recommends that the State include in its application to the Federal Government for an Exchange establishment grant a request for funds that the State may use to engage qualified consultants to analyze and make recommendations to the State regarding how the Exchange can generate sufficient revenue to be self-sustaining by 2015.

The suggested legislation proposed by the Advisory Committee includes the NAIC Model Act provisions that permit the Exchange to impose assessments or user fees on health carriers. The Advisory Committee heard testimony from the public expressing concern that these provisions would permit the Exchange to charge assessments or user fees to health carriers that do not (1) offer health benefit plans inside or outside of the Exchange (such as carriers offering only disability, life, and long-term care insurance) and/or (2) offer any health benefit plans in the Exchange. If the Legislature wishes to limit the Exchange's ability to assess user fees on health carriers that either do not offer health benefit plans or do not offer health benefit plans in the Exchange, the funding provisions of the suggested legislation must be revised accordingly. The Legislature should also consider whether it wishes to explore other sources of funding, in addition to those referenced in the NAIC Model Act.

5. Automatic Repeal: If the U.S. Supreme Court overturns all or part of the ACA, the Exchange should be required to recommend to the Legislature whether to continue the Exchange.

The ACA's "individual mandate" to purchase health insurance coverage and the expansion of Medicaid have been subject to legal challenges in federal courts. In June, the U.S. Court of Appeals for the Sixth Circuit upheld the constitutionality of the individual mandate and in August, the U.S. Court of Appeals for the Eleventh Circuit declared the individual mandate unconstitutional.<sup>19</sup> It is expected that the U.S. Supreme Court will rule on the constitutionality

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<sup>17</sup> ACA § 1311(d)(5)(A).

<sup>18</sup> 5 MRSA §§ 8071 and 8072.

<sup>19</sup> Thomas More Law Center et al. v. Barack Obama et al. (Sixth Circuit, Case No. 10-2388, (June 29, 2011) at <http://www.ca6.uscourts.gov/opinions.pdf/11a0168p-06.pdf>; Florida v. HHS, 11th Cir., No. 11-11021, (August 12, 2011) at <http://www.uscourts.gov/uscourts/courts/ca11/201111021.pdf>.

of these provisions of ACA in order to resolve the circuit split; however, this ruling may not occur for another year or two.

Accordingly, the Advisory Committee recommends that the enabling legislation provide that if the U.S. Supreme Court overturns all or part of ACA, or if ACA is otherwise repealed (in whole or in part), the Exchange will be required to recommend to the Legislature and the Governor, within 60 days of the Supreme Court decision, whether to continue the Exchange.

***B. Additional Recommendations for Legislature to Consider***

The Advisory Committee also makes the following recommendations related to establishing an Exchange that are not reflected in the suggested enabling legislation.

1. The Advisory Committee recommends against merging the risk pools for the individual and small group insurance markets.

Beginning in 2014, ACA requires all enrollees in all health plans (other than grandfathered health plans) offered by a health insurance issuer in the individual market both inside and outside of the Exchange to be members of a single risk pool.<sup>20</sup> Likewise, all enrollees in health plans offered by an issuer in the small group market (other than grandfathered plans) must be members of a single risk pool.<sup>21</sup> The ACA permits a state to merge the individual and small group insurance markets within a state if the state determines that the merger is appropriate.<sup>22</sup>

The Advisory Committee considered a report prepared by Gorman Actuarial, LLC for the Maine Bureau of Insurance and testimony by Bela Gorman to the Advisory Committee on August 23, 2011, that merging the individual and small group insurance markets will cause small group insurance premiums to increase and this increase, in turn, will subsidize a decrease in insurance premiums in the individual insurance market.<sup>23</sup> The original Gorman study, completed before recent changes in State law, including the State's recently enacted reinsurance program<sup>24</sup> which is designed to limit increases in premiums in the individual insurance market, is being updated and will be available to the Legislature for their deliberations in 2012.

The Advisory Committee believes that the State has already adopted measures to limit increases in premiums in the individual insurance market through the adoption of its reinsurance program that will become effective in 2012. The effectiveness of the reinsurance program should be evaluated before additional measures, such as merging the risk pools, are

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<sup>20</sup> ACA § 1311(c)(1).

<sup>21</sup> ACA §1311(c)(2).

<sup>22</sup> ACA § 1311(c)(3).

<sup>23</sup> The Impact of the ACA on Maine's Health Insurance Markets, Gorman Actuarial, LLC (May 31, 2011). See also, Appendix E, which includes a slide provided by Ms. Gorman to the Advisory Committee in connection with her testimony regarding effects of merging the individual and small group markets.

<sup>24</sup> 24-A MRS Chapter 54-A.

implemented. Accordingly, the Advisory Committee recommends against merging the individual and small group risk pools.

Beginning in 2016, ACA requires the small group market to be expanded from employers who employ up to 50 employees to employers who employ up to 100 employees.<sup>25</sup> The Advisory Committee does not recommend expanding the small group market to include employers with 51 to 100 employees before 2016.<sup>26</sup> The effects of other changes in the State's insurance laws are not yet known and merging these two markets before the markets have adjusted to these changes could be disruptive and may have unintended consequences.<sup>27</sup>

2. The Advisory Committee recommends that any decision to allow large group health insurance plans to participate in the Exchange be made closer to 2017.

Beginning in 2017, ACA permits the State to allow issuers of large group health insurance to participate in the Exchange, at which time large employers-- *i.e.*, employers who employ an average of at least 101 employees-- would be eligible to purchase coverage for their employees through the Exchange.<sup>28</sup>

The Advisory Committee expects the insurance market to undergo several changes between now and 2017. In particular, the individual and small group insurance markets will be subject to new rating requirements and starting in 2016, the small group market must be expanded to include employers who have up to 100 employees. Moreover, reinsurance programs under both state and federal laws will impact the individual insurance market.

Accordingly, the Advisory Committee recommends that the State evaluate whether to allow larger employers to participate in the Exchange at a later date after premiums in the insurance markets have adjusted to reflect changes in the law.

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<sup>25</sup> ACA § 1304(b)(2) and (b)(3).

<sup>26</sup> Federal proposed rules published at 76 Fed. Reg. 41866 (July 15, 2011) propose that in determining the size of an employer, part-time and seasonal employees must be counted and sole proprietors must be excluded. Part-time workers would be counted in the same manner as full-time workers while seasonal employees would be counted proportionately to the number of days they work in a year. Under Maine's existing law (24-A MRSA § 2808-B), full-time employees and sole-proprietors are counted, but seasonal and part-time workers are not. The Advisory Committee understands that the U.S. Department of Health and Human Services has received several comments from states objecting to the proposed method of counting employees for purposes of determining whether an employer is a small employer. Accordingly, the suggested legislation reflects the Advisory Committee's recommendation that Maine's statutory provisions apply unless and until a Federal regulation is finalized that is contrary to and preempts Maine's statute.

<sup>27</sup> See Appendix F which includes a slide provided by Ms. Gorman in connection with her testimony showing that (without taking into account the changes made by P.L. 90) merging the small and large group markets would cause small group market premiums to decrease by one percent and large group market premiums to increase up to five percent.

<sup>28</sup> ACA § 1312(f)(2)(B).

3. The Advisory Committee recommends that the Exchange and the Department of Health and Human Services evaluate whether the State should provide a basic health program.

The Affordable Care Act allows the State to establish one or more basic health programs to provide health coverage to low-income individuals instead of offering those individuals coverage through the Exchange.<sup>29</sup> Individuals eligible to participate in a basic health program are those who are not eligible for Medicaid and who have household incomes that exceed 133 percent but do not exceed 200 percent of the federal poverty level.<sup>30</sup> The Federal Government would provide financial support for the operation of a basic health program. This financial support would equal 95 percent of premium tax credits and cost-sharing reductions that would have been provided to individuals if they were covered through the Exchange, but who are instead covered through the basic health program.<sup>31</sup>

States are considering establishing a basic health plan to provide individuals who are most likely to churn between Medicaid and the Exchange with a less dramatic transition between Medicaid and the Exchange. The basic health program would provide benefits, including provider networks, that are similar to Medicaid so that these individuals can maintain coverage that is similar to Medicaid until they reach higher, more stable, income levels that would support purchasing coverage through the Exchange for a more sustained period of time. The federal funding for the basic health program may be more advantageous to the State than covering higher-income individuals in Medicaid or having them cycle in and out of Medicaid.

The Advisory Committee recommends that, in consultation with stakeholders, the Exchange and the Department of Health and Human Services evaluate whether a basic health program would be in the best interests of the State and its citizens and make a recommendation to the Legislature regarding the same.

4. The Advisory Committee recommends against establishing a regional exchange at this time.

The ACA permits states to establish a regional or interstate exchange, subject to the approval of the United States Department of Health and Human Services.<sup>32</sup> The Advisory Committee recommends against establishing a regional exchange at this time. However, the state should monitor how other states are implementing ACA's requirements and seek opportunities for the Exchange to perform its functions more efficiently by collaborating with other states.

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<sup>29</sup> ACA § 1331.

<sup>30</sup> ACA § 1331(e).

<sup>31</sup> ACA § 1331(d)(3).

<sup>32</sup> ACA § 1311(f).

5. The Advisory Committee recommends that the State, and not the Federal Government, establish and maintain an Exchange.

The ACA provides that if a state fails to establish an exchange, the federal government will establish and operate an exchange within the state.<sup>33</sup> The Advisory Committee recommends that the State establish the Exchange to retain control over, and accountability for, its operations.

6. The Advisory Committee recommends that the Exchange leverage existing State infrastructure. See Appendix G, which was presented to the Advisory Committee. The Advisory Committee leaves to the Governor and Legislature the issue of how existing State infrastructure should be inserted into the proposed new Exchange entity.

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<sup>33</sup> ACA § 1321(c)(1).

**Appendix A  
Exchange Integration Decision Points**

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498 *	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
<b>A. Exchange Structure</b>				
<p>1. <b>Exchange Structure:</b> Whether to structure the Exchange as a governmental agency or a non-profit entity. ACA § 1311(d)(1). <i>Either is permissible, 45 C.F.R. § 155.100(b) (prop.), but HHS notes that:</i></p> <ul style="list-style-type: none"> <li>• States should consider costs and benefits of using accountability structure in an existing agency versus the need to establish a governing body for an independent public agency.</li> <li>• Non-profits may operate without some restrictions but could face limitations in performing typically governmental functions.</li> <li>• HHS notes suggestions by commenters that States establish independent public or governmental agencies with flexible hiring &amp; operational practices, or non-profit entities with governing bodies appointed and overseen by States.</li> </ul>	<p>Independent executive agency governed by a Board (<i>i.e.</i>, governmental agency). The members of the Board are appointed by the Governor (subject to review by the joint standing committee of the Legislature and confirmation by the Senate) and represent key stakeholders. §§ 7003(1) and 7004.</p>	<p>Independent executive agency (a) governed by a Board (<i>i.e.</i>, governmental agency). Nine members of which are appointed by either the Governor (5 members) or the Legislature (4 members) (subject to review by the joint standing committee of the Legislature and confirmation by the Senate) and 4 members of which are commissioners of related executive agencies, and (b) advised by a business advisory council whose members represent key stakeholders. §§ 7003(1); 7004; and 7013.</p>	<p>Independent or quasi-governmental agency, accountable to board and legislature, allowing the necessary interface with other state agencies. No recommendation about where to house the Exchange, but report notes that one logical place would be to house the Exchange in the Dirigo Health Agency since it already performs many of the required functions of the Exchange. (ACHSD p. 42-45) The Exchange should have strong legislative oversight (whether administered by an independent state agency or quasi-state agency) (JSC p. 5)</p>	<ul style="list-style-type: none"> <li>• Establish Exchange as a governmental agency within the Department of Professional and Financial Regulation. Proposed Legislation § 7003(1).</li> <li>• Exchange Commission should be appointed by the Governor and subject to confirmation by the Senate. Proposed Legislation § 7005(1).</li> <li>• Executive Director should be appointed by and serve at the pleasure of the Governor. Proposed Legislation § 7004.</li> <li>• Legislature should adopt legislation establishing the Exchange promptly so that Commission members can be appointed by the Governor no later than October 2012.</li> </ul>

\* In accordance with ACA § 1321(c)(1)(B), the Secretary of Health and Human Services (“HHS”) must determine by January 1, 2013, whether the State’s Exchange will be fully operational by January 1, 2014. Regulations recently proposed by HHS provide standards and processes for this determination, as well as guidance on other aspects of Exchange design. *See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans*, 76 Fed. Reg. 41,866 (proposed July 7, 2011) (to be codified at 45 C.F.R. pts. 155 and 156). Key provisions of the proposed regulations that are relevant to each of the decision points are discussed in this chart. In addition, a key part of the determination process is an Exchange Plan, which must be submitted to HHS in a form and manner that HHS will describe in later guidance. The Exchange Plan must include detailed information on how the Exchange will meet federal requirements. 45 C.F.R. § 155.105(b) (prop.). The Exchange will need to notify HHS in writing before making any significant changes to its Exchange Plan. 45 C.F.R. § 155.105(e) (prop.).

† Unless otherwise indicated, section numbers in the columns for the proposed legislation and the Washington legislation refer to sections of the respective bill or law. Citations elsewhere indicate whether they refer to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) (“ACA”) or to the appropriate section of 45 C.F.R. part 155 (prop.), as proposed in *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans*, 76 Fed. Reg. 41,866 (proposed July 7, 2011) (to be codified at 45 C.F.R. pts. 155 and 156).

‡ “ACHSD” refers to *Options and Opportunities for Implementing the Affordable Care Act in Maine*, Advisory Council on Health Systems Development (Dec. 17, 2010). “JSC” refers to *Final Report of the Joint Select Committee on Health Care Reform Opportunities and Implementation* (Dec. 2010).

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498 *	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
76 Fed. Reg. at 41,870.				
<p>2. <b>Interstate Exchanges:</b> Whether to form regional exchanges or establish interstate coordination for certain functions. ACA § 1311(f).</p> <p><i>Regional exchanges are permissible, but--</i></p> <ul style="list-style-type: none"> <li>• the regional exchange must “span two or more States” (that need not be contiguous). 45 C.F.R. § 155.140(a)(1) (prop.).</li> <li>• a single plan for the regional Exchange must be submitted and approved by HHS prior to operation. 45 C.F.R. § 155.140(a)(2) (prop.).</li> <li>• the regional exchange must perform the functions of a SHOP for its area. 45 C.F.R. § 155.140(c)(2) (prop.).</li> </ul> <p>The entire geographic area of a state must be covered by one or more Exchanges but only one Exchange may operate in each geographically distinct area. 76 Fed. Reg. at 41,871.</p>	Does not provide for any regional exchange or interstate coordination.	Does not provide for any regional exchange or interstate coordination.	Operate own exchange initially but explore opportunities for regional exchange or coordination of back office functions with other New England states. (JSC p. 5, 14) Regional exchange unlikely to be initially desirable because more difficult to tailor to needs of Maine residents, synchronize the exchange with existing insurance market and Medicaid programs, and timely implement the exchange. However, regionalization of certain aspects of the exchange (e.g., administrative “back office” functions) may be initially feasible and beneficial. (ACHSD p. 40-42)	No regional Exchange.  However, recommend that the state continue to participate in multi-state collaboratives to learn how other states are implementing ACA requirements.
<p>3. <b>Single or Dual Exchange(s) for Individuals &amp; Small Employers:</b> Whether to operate a unified Exchange for individuals &amp; businesses or two separate exchanges: the SHOP Exchange for small employers and the Exchange for individuals. If operating a single exchange, it must have adequate resources to assist both the individuals &amp; employers. ACA § 1311(b).</p> <p><i>A state may elect to create an independent governance and administrative structure for the SHOP if the state ensures that the SHOP coordinates and shares relevant information for the individual Exchange operating in the same area. 45 C.F.R. § 155.110(e)(1) (prop.).</i></p> <p><i>If a state chooses one governance/ administrative structure for both the individual Exchange and SHOP, it must ensure that the Exchange has adequate resources to assist individuals and small employers. ACA § 1311(b)(2); 45 C.F.R. § 155.110(e)(2) (prop.).</i></p>	Authorizes Exchange to establish SHOP Exchange. § 7008(2)(I).	Authorizes Exchange to establish SHOP Exchange. Also authorizes Exchange to use access payments (currently, the Dirigo assessment) to provide subsidies for small businesses to purchase coverage through the SHOP exchange. § 7008(2)(N).	One exchange for individuals, families, and small employers, but recognize different needs of the groups. (JSC p. 5) Separate lines of business should be established within the unified exchange to serve individuals and businesses to ensure the viability of both programs and that the priorities of each group are met. (ACHSD p. 38-40) Identify as a policy option using Dirigo assessment to assist sole proprietors and small businesses in purchasing coverage for employees (JSC p. 15; ACHSD p. 67)	State should establish one unified Exchange that includes a SHOP program to meet the needs of small employers. Proposed Legislation § 7008(2)(I).

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498 *	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
<i>HHS indicates a preference for Exchange to use same governance for both Exchange and SHOP. 76 Fed. Reg. at 41,872-73.</i>				
<p><b>4. <u>Separate Risk Pools for Individual and Small Group Markets:</u></b> Whether to merge risk pools for rating the individual and small group markets. ACA § 1312(c). <i>If risk pools are <u>not</u> merged, SHOP must permit each qualified employee to enroll only in qualified health plans in the small group market. 45 C.F.R. § 155.705(b)(8) (prop.). HHS notes that the purpose of this requirement is to help prevent adverse selection. 76 Fed. Reg. at 41,887.</i></p>	--	--	Consider merging risk pools that are currently separate for these markets, depending on outcome of actuarial study. (JSC p. 13)	The risk pools for rating the individual and small group markets should not be merged.
<p><b>5. <u>Insurance Options Available to Employers:</u></b> SHOP must allow employers to select a level of coverage, from which employees may choose any qualified health plan at that level (<i>i.e.</i>, employee choice within a tier). 45 C.F.R. § 705(b)(2) (prop.); <i>see also</i> ACA § 1312(a)(2).<sup>§</sup> Whether SHOP should allow employers to make other choices, such as to select specific plans in which employees may enroll. <i>The state must determine whether the Exchange will also allow:</i></p> <ul style="list-style-type: none"> <li>• <i>employees to choose any qualified health plans offered in SHOP at any level;</i></li> <li>• <i>employers to select specific levels from which an employee may choose a qualified health plan;</i></li> <li>• <i>employers to select specific qualified health plans from different levels of coverage from which an employee may choose; or</i></li> <li>• <i>employers to select a single qualified health</i></li> </ul>	Allows an employer only to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage. § 7008(2)(I).	Allows an employer only to specify a level of coverage <u>or amount of contribution toward coverage</u> so that any of its employees may enroll in a qualified health plan offered through the SHOP exchange at the specified level of coverage or cost of coverage. § 7010(2)(N). <sup>††</sup>	--	The Exchange should have the authority to determine whether any additional options should be made available to employers, and the Exchange should not preclude an employer from selecting a single qualified health plan for its employees. Proposed Legislation § 7008(2)(I).

<sup>§</sup> The proposed regulations require the Exchange to provide aggregate billing for insurance premiums and allocate the employer's payments among the insurers whom its employees have selected. *See* 45 C.F.R. § 155.705(b)(4) (prop.); 76 Fed. Reg. at 41,879, 41,887. In addition, employers will want the coverage options that are available in the SHOP to also be available in the individual market to facilitate the frequent enrollments/dis-enrollments that occur in the small group market.

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<p><i>plan to offer employees. See 76 Fed. Reg. at 41,886 (but inviting comment on whether allowing the last option is permissible under ACA).** ACA § 1312(f)(2).</i></p>				
<p><b>6. Small Employers:</b> Whether to use the ACA definition of small employer (1-100 employees) or elect the option to use 50 employees as the cut-off for small group market plans until 2016. ACA §§ 1312(f)(2)(A); 1304(b)(2)-(3).</p>	<p>Uses 50 employees as the cut-off; does not provide for an automatic increase to 100 effective January 1, 2016. § 7002(13).</p>	<p>Uses 50 employees as the cut-off; does not provide for an automatic increase to 100 employees effective January 1, 2016. § 7002(13).</p>	<p>Identifies issue and notes that under current Maine law, small group is defined as an employer with 50 or fewer employees. No recommendation regarding whether to change definition to 100 now or wait until 2016. (JSC p. 12)</p>	<p>The State should continue to define the small group market as employers with up to 50 employees until 2016. Proposed Legislation § 7002(15).</p>
<p><b>7. Counting Employer Size:</b> What legal standard to use for counting employer size, and whether this standard should be included in the State legislation or delegated to the Exchange. ACA § 1304(b); HHS Bulletin 99-03. <i>All employees, including part-time and seasonal employees, would need to be counted. 76 Fed. Reg. at 41,887-88. Part-time workers would be counted in the same manner as full-time workers, while seasonal employees would be counted proportionately to the number of days they work in a year. Id. HHS requests comments regarding whether states should be permitted to impose more specific rules for determining the number of employees. See id.</i> <i>Exchange is permitted to either rely on employer self-reporting or require more stringent determination of employer size. See 76 Fed. Reg. at 41,888.</i></p>	<p>Uses NAIC model language based on HHS guidance which provides for all employees to be counted, including part-time employees and employees who are not eligible for coverage through the employer. § 7002(13).</p>	<p>Uses NAIC model language based on HHS guidance which provides for all employees to be counted, including part-time employees and employees who are not eligible for coverage through the employer. § 7002(13).</p>	<p>--</p>	<p>The enabling legislation should provide for the size of an employer to be determined in accordance with Maine law except to the extent federal law requires a different standard to be used. Proposed Legislation § 7002(15)(C).</p>

<sup>††</sup> The approach in LD 1498 with regard to insurance options available to employers appears permissible, so long as the Exchange *at least* allows the employer to specify the level of coverage.

<sup>\*\*</sup> ACA includes conflicting provisions, but it appears to also allow Exchanges to offer group health plans to employers through the SHOP exchange. HHS agrees that it is probably permissible for Exchanges to offer employers a single group health plan but invites comment on this question. 76 Fed. Reg. at 41,886. This option is attractive to employers because it would allow an employer to select one health plan for its employees that would be rated solely on its own employee group.

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498 *	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
<p><b>8. Large Employers:</b> Beginning in 2017, the State may allow issuers of large group health insurance to participate in the Exchange. If so, the exchange must allow large employers—<i>i.e.</i>, employers who employ an average of at least 101 employees--to participate in the Exchange. ACA § 1312(f)(2)(B).</p>	--	--	--	The State should not consider allowing insurers of large group plans to participate in the exchange until closer to 2017.
<p><b>9. Automatic Repeal:</b> Whether the Exchange will continue to exist if the provisions of the Federal Act relating to health benefit exchanges are repealed.</p>	--	--	--	If there is a U.S. Supreme Court decision overturning all or part of ACA or if the ACA is otherwise repealed in whole or in part, the Exchange should be required to recommend to the Legislature and the Governor, within 60 days of the decision, whether to continue the Exchange.  Proposed Legislation, Section 5.
<b>B. Board Structure and Operations<sup>‡‡</sup></b>				
<p><b>10. Exchange Governance—Duties:</b> The duties and other responsibilities of any board that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange. ACA § 1311.</p>	<p><u>Board Authority:</u> Responsible for operation of Exchange and exercising duties and powers of Exchange (described below in “Exchange Duties”). Within 6 months of appointment, must submit to the Superintendent of the Bureau of Insurance (the “Superintendent”) a plan of operation for the Exchange that will not take effect until it is approved by the Superintendent. If Board fails to submit a plan of operation, the Superintendent may, after notice and hearing, determine a plan of operation for the Exchange that will remain in effect until the Board submits a plan of operation that is approved by the Superintendent. § 7006.</p>	<p><u>Board Authority:</u> Responsible for operation of Exchange and exercising duties and powers of Exchange (described below in “Exchange Duties”).</p>	<p>Recommendation that, at a minimum, the Board of Directors operates in the public interest and no board member realizes personal financial gain. Notes that balance should be struck between the Board and government’s policy-setting responsibilities and the Exchange staff’s administrative responsibilities. Also notes that if the Exchange is operated by an executive agency, an advisory board could provide input and advice on exchange polices. (ACHSD p. 43-44)  Exchange should have strong legislative oversight (JSC p. 5)</p>	<p>The powers and duties of the Exchange should be specified in the enabling statute.  Proposed Legislation § 7008.</p>

<sup>‡‡</sup> HHS indicates that changes to Exchange governance structure and operations would be a “significant change” to an Exchange plan that would require advance notice and approval by HHS in writing. See 45 C.F.R. § 155.105(e) (prop.); 76 Fed. Reg. at 41,871.

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<p><b>11. Exchange Governance—Board Appointment and Reappointment Process:</b></p> <p>The process for appointing members of the board or other entity that will govern the Exchange. ACA § 1311.</p>	<p><b>Board Member Appointment Process.</b> Ten members appointed by Governor subject to Senate confirmation and review by joint standing committee of Legislature with health insurance jurisdiction.</p> <p><b>Board Term.</b> 6 years, up to 2 consecutive terms; may serve until replacement appointed and qualified. § 7004(2).</p> <p><b>Chair.</b> Governor appoints 1 member as chair. § 7004(3).</p>	<p><b>Board Member Appointment Process.</b> Nine voting members. Five appointed by Governor and 1 appointed by each the President of Senate, Speaker of House, President of Senate from Senate Minority Leader recommendation, and Speaker of House by House Minority Leader recommendation. § 7004(1)(A).</p> <p><b>Board Term.</b> 3 years, although to achieve a staggered board, 2 of the members will serve an initial term of 1 year, 3 members will serve initial terms of 2 years, and 4 members will serve initial terms 3 years. §§ 7004(3); B-3.</p> <p>Voting members may serve up to 2 consecutive terms and may serve until a replacement is appointed and qualified. § 7004(3).</p> <p><b>Chair.</b> Governor appoints 1 voting member as chair. § 7004(4).</p>	<p>--</p>	<ul style="list-style-type: none"> <li>• The Exchange should be governed by an Executive Director. A Commission should advise on technical matters, such as critical issues or matters that require a particular expertise, knowledge, or skill. (Note: The Advisory Committee’s members do not unanimously agree that the Commission’s authority should be limited to advising on technical matters.)</li> <li>• The Commission should include 9 voting members appointed by the Governor and subject to confirmation by the Senate. Proposed Legislation § 7005(2).</li> <li>• The Commission should also include 2 ex officio, non-voting members: Commissioner of PFR and the DHHS Commissioner (or their designees). Proposed Legislation § 7005(2).</li> <li>• The Commission members should be permitted to serve 3-year terms but should be prohibited from serving more than 2 terms. Proposed Legislation § 7005(4).</li> <li>• Initial terms of Commission members will be staggered. Proposed Legislation § 7005(4).</li> </ul>
<p><b>12. Exchange Governance—Board Member Composition:</b></p> <p><i>Board may not be made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers, agents, brokers, or any other individual licensed to sell health insurance. See 45 C.F.R. § 155.110(c)(3) (prop.).</i></p> <p><i>HHS invites comment on whether categories of potential conflicts should be further specified and what types of representatives have potential conflicts of interests. 76 Fed. Reg. at 41,872.</i></p> <p><i>A State may adopt more stringent or specialized conflict of interest requirements than those used in connection with regular governmental operations. 76 Fed. Reg. at 41,872.</i></p>	<p><b>Board Member Composition.</b> Two members representing each insurers and insurance producers; 1 member representing each hospitals, physicians, nurses, large employers, and small employers; and one member who purchases individual health insurance (total of 10 members). § 7004(1).</p>	<p><b>Nonvoting Members.</b> Four nonvoting ex officio members (Commissioner of Professional and Financial Regulation, Commissioner of HHS, Commissioner of Admin. and Financial Services, and State Treasurer). § 7004(1)(B).</p> <p><b>Voting Members.</b></p> <ul style="list-style-type: none"> <li>• One member must serve as chair of the Medicaid advisory committee within DHHS. § 7004(2)(B)(1).</li> <li>• Two members must represent consumers selected from stakeholder nominations. § 7004(2)(B)(2).</li> <li>• Voting members may not be: <ul style="list-style-type: none"> <li>• employed by, a consultant to, a member of the board of directors of,</li> </ul> </li> </ul>		<p>The Commission should be comprised of the following representatives:</p> <ul style="list-style-type: none"> <li>• employer with not more than 50 employees</li> <li>• employer with more than 50 but not more than 100 employees</li> <li>• insurer</li> <li>• broker</li> <li>• provider</li> <li>• federally recognized Indian tribe</li> <li>• consumer</li> <li>• 2 at large (subject to federal conflict of interest rules)</li> </ul> <p>Proposed Legislation § 7005(2)(B).</p>

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		<p>affiliated with or otherwise a representative of a carrier, insurer, agent or broker, health care provider, health care facility, health clinic;</p> <ul style="list-style-type: none"> <li>• a member, board member, or employee of a trade association of carriers, health facilities, health clinics or health care providers; or</li> <li>• a health care provider, unless the member receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice. § 7004(2)(C).</li> <li>• Notwithstanding any other provision, a current or former member of Board of Trustees of Dirigo may also be member of Board. § 7004(2)(D).</li> </ul>		
<p><b>13. <u>Exchange Governance—Board Member Qualifications:</u></b>  <u>Whether to specify qualification requirements for the Board in the enacting legislation.</u></p> <p><i>A majority of the voting members must have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. 45 C.F.R. § 155.110(c)(4) (prop.); see also 76 Fed. Reg. at 41,872 (inviting comment on the types of representatives that should be on the Board to ensure necessary technical expertise).</i></p>	<p>LD 1497 does not include experience requirements for Board members that would be necessary to comply with 45 C.F.R. § 155.110(c)(4) (prop.).</p>	<p><u>Voting Members.</u></p> <ul style="list-style-type: none"> <li>• Six voting members must be qualified in at least 2 of the following areas: health care purchasing, individual health coverage, small group coverage, MaineCare program; health benefit plan administration, administering a public or private health care delivery system, health care financing, or health policy and law. § 7004(2)(A).</li> </ul>		<p>The Commission composition should comply with federal requirements for experience. Proposed Legislation § 7005(3).</p>

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498*	Recommendations By Committee Reports <sup>††</sup>	Advisory Committee Recommendation
<p><b>14. Exchange Governance—Operations:</b>  Rules regarding how the Board will operate. ACA § 1311.</p> <p><b><i>Meetings: Board must hold regular public meetings that are announced in advance. 45 C.F.R. § 155.110(c)(2) (prop.).</i></b></p> <p><b><i>Conflicts of Interest:</i></b></p> <ul style="list-style-type: none"> <li>• Exchange must have in place and make publicly available a set of governance principles that includes ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest. 45 C.F.R. § 155.110(d)(1) (prop.).</li> <li>• Exchange must implement procedures for disclosure of financial interests by members of the Board. § 155.110(d)(2); <i>see also</i> 76 Fed. Reg. at 41,872 (inviting comment on this proposal and whether additional detail should be proposed).</li> </ul>	<p><b><u>Voting.</u></b> Quorum of 6, and 6 affirmative votes required for any board action. § 7004(5).</p> <p><b><u>Meetings:</u></b> Monthly or at times called by Chair or Executive Director. All meetings public. § 7004(7).</p> <p><b><u>Other.</u></b><sup>§§</sup></p> <ul style="list-style-type: none"> <li>• Members compensated for expenses incurred in performance of their duties. § 7004(6).</li> <li>• Members’ personal liability is limited if acted in accordance with scope of power and duties, and members are indemnified for expenses actually and necessarily incurred in defense of any action or proceeding to which they are made a party by reason of their authority with respect to the Exchange. §§ 7005(1), (2).</li> </ul>	<p><b><u>Voting.</u></b> Quorum of 5 voting members, and majority vote of members required for any board action. § 7004(6).</p> <p><b><u>Meetings:</u></b> Monthly or at times called by Chair or Executive Director. All meetings public. § 7004(8).</p> <p><b><u>Other.</u></b><sup>§§</sup></p> <ul style="list-style-type: none"> <li>• Members compensated for fulfilling board duties in accordance with board bylaws. § 7004(7).</li> <li>• Members’ personal liability is limited if acted in accordance with scope of power and duties, and members are indemnified for expenses actually and necessarily incurred in defense of any action or proceeding to which they are made a party by reason of their authority with respect to the Exchange. § 7005.</li> <li>• Members and employees of the Exchange and their spouses and children may not receive any direct personal benefit from the activities of the Exchange in assisting any private entity, except they may participate in the Exchange on the same terms as others. Provision does not apply to any entities that employ members and staff (and their families) if the relationship is made known to the Board and the member does not vote on matters relating to the entity’s participation in the Exchange. § 7006.</li> </ul>	<p>--</p>	<p>The Commission should be required to operate in accordance with federal and state law. Proposed Legislation § 7005(10).</p>

<sup>§§</sup> Note that LD 1497 does not provide for conflict of interest standards for the Exchange or its Board.

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498*	Recommendations By Committee Reports <sup>††</sup>	Advisory Committee Recommendation
<p><b>15. Exchange Governance—Advisors:</b></p> <p>Whether the Board is required or permitted to appoint advisors. ACA § 1311. Whether the legislation should specify how the Exchange is to take into account stakeholder interests.</p> <p><i>ACA provides that Board must regularly consult with certain stakeholders. ACA § 1311(d)(6). In addition to the statutorily listed stakeholders (educated health care consumers who are enrollees, enrollment facilitators, advocates for hard-to-reach populations, small businesses and self-employed individuals, and State Medicaid and CHIP agencies), HHS would add the following:</i></p> <ul style="list-style-type: none"> <li>• federally-recognized tribes,</li> <li>• public health experts,</li> <li>• health care providers,</li> <li>• large employers,</li> <li>• health insurance issuers, &amp;</li> <li>• agents and brokers.</li> </ul> <p>45 C.F.R. § 155.130 (prop.).</p> <p>(Note: the Board need not necessarily appoint advisory committees to meet this requirement, but it is one avenue for compliance.)</p>	<p>--</p>	<p><u>In General.</u> Board may appoint advisory committees (with no compensation but reimbursed for necessary expenses). § 7010(10).</p> <p><u>Business Advisory Council.</u></p> <ul style="list-style-type: none"> <li>• Council to advise and support the Exchange on matters referred to it by the Board or the Executive Director and serve as a liaison between Exchange and consumers. § 7013(7).</li> <li>• Volunteer members appointed by Governor with 3 members representing providers (1 physician, 1 hospital rep, and 1 non-physician health care practitioner) and 1 member representing each consumers, large employers, small employers, carriers, and producers (total of 8 members). § 7013(1).</li> <li>• Council members serve 5 year terms, except to achieve a staggered Council, 3 of the members will serve an initial term of 3 years, 3 members will serve initial terms of 4 years, and 2 members will serve initial terms of 5 years. § 7013(2); B-4.</li> <li>• Council members serve as volunteers without compensation. § 7013(3)</li> <li>• Council will meet at least 4 times a year; a quorum is a majority of the members of the Council. § 7013(4), (6).</li> <li>• The Council shall annually choose one of its members to serve as chair for a one year term. § 7013(5).</li> </ul>	<p>--</p>	<p>The enabling legislation should allow the Exchange to establish advisory committees and should require the Exchange to establish an advisory committee for federally-recognized Indian tribes within the state. Proposed Legislation § 7008(2)(P).</p>

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498*	Recommendations By Committee Reports <sup>†</sup>	Advisory Committee Recommendation
<p><b>16. Staff and Leadership:</b>            Authority and procedures for hiring staff and procurement resources. ACA § 1311.</p>	<p>Requires Exchange Board to submit to Superintendent a plan of operation for the Exchange, including, <i>inter alia</i>, procedures for selecting and hiring an Executive Director. § 7006(2)(B).            Executive Director shall prepare budget at Board's direction. § 7008(3).</p>	<p>Board to appoint Executive Director to:</p> <ul style="list-style-type: none"> <li>• serve as liaison between Board and Exchange, secretary and treasurer to the Board;</li> <li>• manage Exchange's programs and services;</li> <li>• employ or contract for personnel or services;</li> <li>• approve accounts; and</li> <li>• perform other duties prescribed by Board.</li> </ul> <p>§ 7008.</p> <p>Executive Director shall prepare budget at Board's direction. § 7010(3).</p> <p>Executive Director of Dirigo Health will provide initial staffing assistance to the Exchange, until the appointment of the Executive Director. § B-5(2).</p> <p>In hiring and contracting, preference may be given to Dirigo Health employees. § B-5(2).</p> <p>Board must submit application to HHS for Exchange planning and implementation grant funding. § B-5(3).</p>	<p>--</p>	<p>The Commission should recommend candidates for Executive Director to the Commissioner of PFR and the Governor. The Governor should have the authority to appoint an Executive Director, subject to confirmation by the Legislature. Proposed Legislation § 7004.</p>

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498 *	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
<b>C. Exchange Functions</b>				
<p><b>17. Exchange Operating Model:</b>            What operating model to choose (e.g., “active purchaser” model, “open marketplace” model, etc.) for certifying plans to participate on Exchange.<sup>***</sup>            § 1311. Whether the operating model should be specified in the legislation or delegated to the Exchange.</p> <p><i>HHS identifies different models for choosing qualified health plans and gives Exchanges the “discretion” to choose strategy for certifying plans. Exchange need not be limited to one strategy. See 76 Fed. Reg. at 41,891-92.</i></p>	<p>Requires Exchange Board to submit to Superintendent a plan of operation for the Exchange. § 7006(2).</p>	<p>Requires Exchange Board to selectively contract for health care coverage and “seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.” § 7010(2)(I).</p>	<p>Exchange should take active role in selecting plans to contain costs and ensure quality. Exchange has role in standardizing plans to make consumer selection easier. (JSC p. 5)</p>	<p>The Exchange should be an open marketplace – if issuer/QHP meets minimum standards, it will be permitted to participate on Exchange.</p>
<p><b>18. Exchange Duties:</b>            Whether to assign additional duties to the Exchange beyond the minimum required in the Act. § 1311(d)(4). The minimum required duties appear in the “Appendix” to this chart.</p> <p><i>HHS “encourage[s] States to consider supplemental standards or functionality for their Exchanges that benefit consumers and businesses” and invites comments regarding such functions. 76 Fed. Reg. at 41,875.</i></p>	<p>Specifies Exchange powers and duties, which are limited to those minimum duties required by ACA (as reflected in ACA § 1311(d)(4) and the NAIC model legislation). § 7008(2). However, an initial duty of the Exchange Board is to submit to Superintendent a plan of operation for the Exchange that includes procedures for:</p> <ul style="list-style-type: none"> <li>• operation of the Exchange,</li> <li>• selecting and hiring an Executive Director,</li> <li>• creating a fund, managed by the Board, for administrative expenses,</li> <li>• handling, according and auditing of money and other assets of the Exchange,</li> <li>• a program to foster public awareness of the Exchange and to publicize the eligibility requirements and enrollment procedures for coverage and subsidies under the Exchange,</li> </ul>	<p>Specifies minimum Exchange powers and duties (as reflected in ACA § 1311(d)(4) and the NAIC model legislation). § 7010(2). In addition to minimum duties:</p> <ul style="list-style-type: none"> <li>• Moves the Maine Quality Forum (currently within Dirigo Health) to within the Exchange. § A-38.</li> <li>• Requires Exchange to coordinate eligibility/enrollment process with other health care coverage programs, including MaineCare and the basic health program, if established. § 7010(2)(H).</li> <li>• Requires Exchange to determine minimum requirements for carrier participation and standards &amp; criteria for selecting qualified plans offered through Exchange. § 7010(2)(I).</li> <li>• Requires Exchange to consider establishment of basic health program for eligible individuals. § 7010(2)(O).</li> <li>• Prohibits Exchange toll-free telephone</li> </ul>	<p>The exchange must be more than just a website—individuals and small businesses seeking assistance must have opportunity for face-to-face interaction. Local access and consumer outreach are important functions for the exchange. The exchange should be accessible for providers and minimize their costs and administrative burden. (JSC p. 5-6)</p>	<p>No additional duties should be assigned to the Exchange beyond the minimum federal required duties. Proposed Legislation § 7008.</p>

\*\*\* The more active of a role the Exchange plays in administering plans, the more attractive the Exchange will be to small employers. Small employers will be more inclined to purchase coverage through the Exchange if it is convenient and shoulders administrative burdens that would normally need to be performed by the employer, such as processing enrollments and dis-enrollments and ensuring compliance with applicable laws, such as ERISA and the ADEA. The Exchange will also be more likely to attract small employers if it facilitates an employer’s receipt of the federal tax credit.

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498*	Recommendations By Committee Reports <sup>††</sup>	Advisory Committee Recommendation
	<ul style="list-style-type: none"> <li>requirements that only licensed producers may enroll individuals and small employers in qualified health plans offered through the Exchange</li> <li>requirements to assist individuals in applying for premium-tax credits and cost-sharing reductions, and</li> <li>any matters necessary and proper for the execution of the Board's powers, duties, and obligations.</li> </ul> § 7006(1).	hotline from being automated. § 7010(2)(B). <ul style="list-style-type: none"> <li>Requires Exchange to provide, in each region of the State, a choice of qualified health plans at each of the five levels. § 7010(2)(J)</li> <li>Requires each participating carrier to offer at least one product in all five coverage levels. § 7010(2)(K)</li> <li>Requires carriers to offer same products outside Exchange as those offered inside Exchange. § 7010(2)(L).</li> </ul>		
<b>19. <u>Inter-agency Coordination:</u></b> Responsibilities of State agencies coordinating with the Exchange. ACA § 1311. <i>HHS invites comments on how to implement or construct a partnership model for state and federal exchanges to share information and ideas. 76 Fed. Reg. at 41,871.</i> <i>HHS “encourage[s] the Exchange and the State department of insurance to collaborate in” rate increase justification process. See 76 Fed. Reg. at 41,892.</i>	Authorizes the Exchange to enter into information sharing agreements with federal and state agencies and other states' exchanges (with adequate protections for confidentiality). § 7003(3). Requires other State agencies to provide technical assistance, § 7008(7), and Attorney General to provide legal assistance. § 7008(8).	Authorizes the Exchange to enter into information sharing agreements with federal and state agencies and other states' exchanges (with adequate protections for confidentiality). § 7003(3). Requires other State agencies to provide technical assistance, § 7010(7), and Attorney General to provide legal assistance. § 7010(8). Superintendent authorized to coordinate with Exchange. § C-3.	Recognizes that ACA requires coordination with state agencies and that overall coordination may be less complex if the exchange is located within a state or quasi-state agency. (ACHSD p. 43)	Exchange should be established under the Commissioner of Professional and Financial Regulation. Accordingly, it will be subject to current rules and practices that exist for coordination among state agencies. Proposed Legislation § 7003(4).
<b>20. <u>Exchange Subject to State Licensing:</u></b> Whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange or its employees need to obtain such a license.	Does not exempt the Exchange from any licensing requirements that would apply to the Exchange in performing duties typically performed by an insurance producer or consultant. Exchange does not have the authority to exempt any carriers from state licensure or solvency requirements. § 7009(4).	Does not exempt the Exchange from any licensing requirements that would apply to the Exchange in performing duties typically performed by an insurance producer or consultant. Exchange does not have the authority to exempt any carriers from state licensure or solvency requirements. To the contrary, Bill expressly provides that licensing requirements continued to apply to issuers of health plans that are certified to participate in the Exchange. § 7011(4); § 4319(1).	--	Exchange itself should not be subject to licensing requirements. However, employees of the Exchange should not be permitted to engage in activities that would otherwise require state licensing. Proposed Legislation § 7009(4).

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498*	Recommendations By Committee Reports <sup>†</sup>	Advisory Committee Recommendation
<p><b>21. Entities Eligible to Contract with Exchange:</b></p> <p>(a) Whether to authorize the Exchange to enter into agreements with “eligible entities” to carry out one or more of the responsibilities of the Exchange. ACA § 1311(f)(3).</p> <p>(b) Whether to define “eligible entities” by reference to ACA § 1311(f)(3)(B) or by using the less precise NAIC model legislation definition: ACA prohibits entities who are within the same controlled group of corporations as (under common control with) a health insurance issuer within the meaning of IRC § 52(a) or (b). The NAIC model legislation uses the term “affiliates.”</p> <p><i>Exchange remains responsible for ensuring that all federal requirements related to contracted functions are met. 45 C.F.R. § 155.110(b) (prop.).</i></p> <p><i>HHS invites comment on</i></p> <ul style="list-style-type: none"> <li>• extent regulation should place conflict of interest requirements on contracted entities. 76 Fed. Reg. at 41,872.</li> <li>• coordination with web-based entities for performing outreach and enrollment functions of the Exchange. 76 Fed. Reg. at 41,878.</li> </ul>	<p>Allows the Exchange to contract with “eligible entities” to perform one or more of the responsibilities of the exchange. Defines “eligible entities” to include the MaineCare program or any entity that has experience in individual and small group health insurance. Uses the NAIC model legislation definition to carve out a health carrier or an “affiliate” of a health carrier from the definition of eligible entity. § 7003(2).</p>	<p>Allows the Exchange to contract with “eligible entities” to perform one or more of the responsibilities of the exchange. Defines “eligible entities” to include the MaineCare program or any entity that has experience in individual and small group health insurance. Uses the NAIC model legislation definition to carve out a health carrier or an “affiliate” of a health carrier from the definition of eligible entity. § 7003(2).</p>	<p>--</p>	<p>The Exchange should be permitted to outsource functions to eligible entities. Proposed Legislation § 7003(3).</p>

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498 *	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
<p><b>22. Navigators:</b></p> <p>Whether to impose any additional requirements on Navigators in the Exchange beyond the minimum in ACA. § 1311(i). Whether such decisions can or should be delegated to the Exchange.</p> <p><i>Navigators must not be a health insurance issuer or receive direct or indirect consideration from an issuer in connection with enrollment of individuals. 45 C.F.R. § 155.210(c) (prop.).</i></p> <p><i>In order to receive grant:</i></p> <ul style="list-style-type: none"> <li>• Navigators must have relationships with employers, employees, or consumers likely to be eligible; and be capable of carrying out duties. 45 C.F.R. § 155.210(b)(1) (prop.).</li> <li>• Navigator must not have conflict of interest during term. 45 C.F.R. § 155.210(b)(1)(iv) (prop.). HHS invites comment on whether there should be additional requirements. 76 Fed. Reg. 41,877.</li> <li>• Exchange must include as Navigators entities from at least two categories (community and consumer-focused groups, trade and professional organizations, commercial fishing, ranching and farming organizations, chambers of commerce, unions, resource partners of the SBA, agents and brokers, or other entities). 45 C.F.R. § 155.210(b)(2) (prop.).</li> </ul>	<p>Requires any navigator to be licensed as a producer. § 7012.</p>	<p>Exchange will select entities qualified to serve as navigators, in accordance with federal standards. However, an individual licensed as an insurance producer may serve as a navigator in the SHOP Exchange, but not in the individual Exchange. § 7010(2)(T).</p>	<p>Navigators must be accountable and qualified with consideration of the need for licensing. Should consider role for insurance producers, especially small businesses, but need to avoid conflict of interest and determine compensation. (JSC p. 6)</p>	<p>Navigators should be required to meet any training and registration or licensing requirements established by the Bureau of Insurance in consultation with the Exchange and DHHS. Proposed Legislation § 7008(2)(N).</p>

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498 *	Recommendations By Committee Reports <sup>††</sup>	Advisory Committee Recommendation
<p><b>23. Participation by Brokers and Agents:</b> Whether to allow agents and brokers to assist individuals enrolling in plans through the Exchange.<sup>†††</sup> ACA § 1312(e).</p> <p><i>Exchange may allow agents and brokers to enroll qualified individuals, employers, or employees in plans and to assist individuals with advance payments of the premium tax credit and cost-sharing reductions. However, an agent/broker serving as a Navigator may not receive any financial compensation from an issuer for helping an individual or small group select a specific plan. 45 C.F.R. § 155.210 (prop.); 76 Fed. Reg. at 41,878.</i></p>				Agents/brokers should be permitted to participate in the Exchange. Proposed Legislation § 7008(2)(T).
<p><b>24. Auditing and Reporting:</b> Whether to grant specific authority to the insurance commissioner (in Maine, Superintendent of the Bureau of Insurance) to investigate the affairs of the Exchange, examine the properties and records of the Exchange, or require the Exchange to provide periodic reporting on its activities. ACA § 1311.</p>	<p>Subjects Exchange to annual audit by State Auditor with a copy of the audit to be provided to the Superintendent (among others). Also requires Board to provide annual report (beginning Feb. 1, 2015) regarding operation of the Exchange to Governor and joint committees of Legislature with jurisdiction. § 7008(4), (6).</p> <p>Does not give specific authority to Superintendent to investigate the affairs of the Exchange, but it does give Superintendent the authority to approve plan of operation for the Exchange. § 7006(2).</p>	<p>Subjects Exchange to annual audit by State Auditor with a copy of the audit to be provided to the Superintendent (among others). Also requires Board to provide annual report (beginning Feb. 1, 2015) regarding operation of the Exchange to Governor and joint committees of Legislature with jurisdiction. § 7010(4), (6).</p> <p>Requires website publication of average costs of licensing, regulatory fees, and other payments required by the Exchange; the administrative costs to the Exchange; and money lost to waste, fraud, and abuse. § 7010(11).</p> <p>Does not give specific authority to Superintendent to investigate the affairs of the Exchange.</p>	--	The Exchange will be subject to the oversight of the Commissioner of Professional and Financial Regulation. Proposed Legislation § 7003(1).

<sup>†††</sup> The Exchange should ensure that it allows brokers and agents who currently market to (and have relationships with) small employers to participate in the Exchange because small employers are likely to look to their existing agents and brokers to advise them on whether to purchase coverage through the Exchange.

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498*	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
<p><b>25. <u>Finances/Revenues:</u></b> Whether to give the Exchange authority to charge assessments or user fees to health carriers or otherwise generate funding necessary to support its operations, to ensure that the Exchange is self-sustaining by 2015. ACA § 1311(d)(5)(A). Whether legislation should impose a cap on the amount the Exchange may collect.</p> <p><i>In order to be self-sustaining, may charge assessments or user fees on participating issuers; any user fees must be announced in advance of the plan year. 45 C.F.R. § 155.160(b)(4) (prop.). HHS invites comment on whether there should be other limitations on how and when user fees are charged. See 76 Fed. Reg. at 41,874.</i></p> <p><i>The Exchange also “may otherwise generate funding for Exchange operations.” 45 C.F.R. § 155.160(b)(2) (prop.). HHS contemplates “broad flexibility to generate funds.” 76 Fed. Reg. at 41,874.</i></p> <p><i>The State must develop a plan for ensuring that the Exchange will have sufficient funding. 76 Fed. Reg. at 41,874; 45 C.F.R. § 155.105(c)(1) (prop.).</i></p>	<p>Exchange has authority to charge assessments or user fees to health carriers or otherwise generate funding necessary to support its operations. § 7010(1). Revenues and expenditures of the Exchange are subject to legislative approval. § 7008(3).</p>	<p>Requires monthly access payments to the Exchange (currently 2.14% of claims to Dirigo), which may be used to support the following:</p> <ul style="list-style-type: none"> <li>• administration and operations expenses;</li> <li>• Maine Quality Forum;</li> <li>• consumer assistance and navigator programs;</li> <li>• coverage subsidies for sole proprietors and small businesses;</li> <li>• if funds available (after meeting above 4 uses), subsidies for benefits in addition to the minimum essential health benefits, or reductions to the access payments.</li> </ul> <p>§§ A-35, A-37.</p> <p>Creates Maine Health Benefit Exchange Enterprise Fund for deposit of Exchange funds. § 7012.</p> <p>Revenues and expenditures of the Exchange are subject to legislative approval. § 7010(3).</p>	<p>Outlines pros and cons of 8 policy options originally presented by Governor’s Steering Committee with respect to the current access payments to Dirigo. The 8 policy options include using the access payments for subsidies of small business, subsidies for employees of small business, administrative costs of the exchange, a reinsurance program, subsidies for individuals purchasing coverage, quality improvement initiatives, or subsidies for benefits in addition to federal minimum essential health benefits. (JSC p. 14-16; ACHSD p. 66-69)</p>	<ul style="list-style-type: none"> <li>• Exchange should recommend to the Commissioner of Professional and Financial Regulation a budget for being self-sustaining by 2015. Budget will include a recommendation regarding the source for the revenue. Any revenue-raising initiatives must be enacted by the Legislature. Proposed Legislation § 7008(3).</li> <li>• The State should apply to the federal government for funds to study funding options for the Exchange.</li> </ul>
<p><b>26. <u>Rulemaking Authority:</u></b> Whether the Exchange or the agency responsible for administration or oversight of the Exchange will have rulemaking authority.</p>	<p>Exchange has rulemaking authority. § 7008(5).</p>	<p>Exchange has rulemaking authority. § 7010(5).</p>	<p>--</p>	<p>The Exchange should have rulemaking authority governed by state Administrative Procedures Act. Proposed Legislation § 7008(4). Any Exchange adjudication shall be conducted in accordance with the state Administrative Procedures Act and the ACA. Proposed Legislation § 7008(6).</p>
<b>D. Plans Offered By Exchange</b>				
<p><b>27. <u>Qualified Plan Certification:</u></b> Whether to impose any certification standards for qualified health plans beyond the minimum in ACA, considering factors such as consumer choice and additional costs, in light of the value to enrollees provided by the proposed standards. ACA § 1311(c)(1).</p>	<p>Follows the minimum certification standards required under ACA § 1311(c)(1) and reflected in the NAIC model legislation. § 7009(1).</p>	<p>Follows the minimum certification standards required under ACA § 1311(c)(1) and reflected in the NAIC model legislation. § 7011(1).</p>	<p>--</p>	<p>The enabling legislation should include only the minimum certification standards. Proposed Legislation § 7009(1).</p>

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498*	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
<p><b>28. <u>Qualified Plan Certification:</u></b> Whether the Exchange should delegate all or part of the plan certification function to the insurance commissioner pursuant to the commissioner’s rate and form review responsibilities. ACA § 1311(c)(1).</p>	<p>Exchange may certify health benefit plan as a qualified health plan only if premium rates and contract language have been approved by Superintendent. § 7009(1)(B). No provision of Bill intended to preempt or supersede the Superintendent’s authority to regulate. § 7011.</p> <p>Exchange retains authority to make rules regarding certification requirements and make determination whether plan is in interest of individuals and employers. § 7009(1)(F), (G).</p>	<p>Exchange may certify health benefit plan as a qualified health plan only if premium rates and contract language have been approved by Superintendent. § 7011(1)(B). Superintendent retains this authority. § C-3. No provision of Bill intended to preempt or supersede the Superintendent’s authority to regulate. § 7014.</p> <p>Exchange retains authority to make rules regarding certification requirements and make determination whether plan is in interest of individuals and employers. However, Superintendent is authorized to enter into agreements with Exchange to assume authority relating to certification of qualified plans or authorization of a carrier to participate in the Exchange. § 7011(1)(F), (G), § 4319 of C-2 .</p>	<p>--</p>	<ul style="list-style-type: none"> <li>• Rates and forms should be subject to existing requirements of Title 24-A. Proposed Legislation § 7009(1)(B).</li> <li>• Exchange should otherwise retain responsibility for certifying issuers and plans. Proposed Legislation § 7009(1).</li> </ul>
<p><b>29. <u>Additional Benefits:</u></b> Whether to require additional benefits in the Exchange beyond the essential health benefits (and, if so, how the State will assume those costs). ACA § 1311(d)(3).</p>	<p>--</p>	<p>Requires the Dep’t of Insurance to review and evaluate the HHS minimum essential health benefits package; hold a public hearing on whether to include additional benefits; and submit a report and recommendations to the legislature. § D-1.</p> <p>Provides that if funds are available (after supporting the administration and operation of the Exchange), the access payments (2.14% of claims) may be used to subsidize benefits in addition to the minimum essential health benefits. § A-35.</p>	<p>Noting that current state law may require health benefits not mandated by federal law, identifies issue and potential factors to consider once federal regulations released. (JSC p. 13; ACHSD p. 20-21)</p>	<p>The state should not require qualified health plans to provide benefits in addition to essential health benefits.</p>
<p><b>30. <u>Basic Health Program:</u></b> Whether the Exchange should establish a basic health program to provide health coverage to individuals between 133-200% of FPL instead of offering these individuals coverage through the Exchange. ACA § 1331.</p>	<p>--</p>	<p>Requires Exchange to consider establishment of basic health program for eligible individuals. § 7010(2)(O).</p>	<p>Without making specific recommendations, provides pros and cons of providing basic health plan to individuals between 133-200% of FPL. (JSC p. 9-10; ACHSD p. 48-49)</p>	<p>Exchange and DHHS should evaluate whether Basic Health Program is in best interests of State and its citizens.</p>

Decision Point(s) *	LD 1497 <sup>†</sup>	LD 1498 *	Recommendations By Committee Reports <sup>‡</sup>	Advisory Committee Recommendation
<b>31. Regulation Beyond Exchange Plans:</b> Whether to extend any of the Exchange requirements to the outside insurance market, beyond what is required in ACA.	--	As a condition to participation in Exchange, carriers that sell products outside of Exchange must offer outside of the Exchange any products available in the Exchange. § 7010(2)(K).	Supports requiring health plans in and out of the exchange to be subject to the same insurance rules. (JSC p. 5)	Exchange requirements should not be extended to the outside insurance market beyond what is required in ACA.

**Appendix A: Section 1311(d)(4) of ACA**

**(4) FUNCTIONS.—** An Exchange shall, at a minimum—

- (A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;
- (B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- (C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;
- (D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);
- (E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;
- (F) in accordance with section 1413, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;
- (G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;

- (H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because—
  - (i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
  - (ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;
- (I) transfer to the Secretary of the Treasury—
  - (i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;
  - (ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—
    - (I) the employer did not provide minimum essential coverage; or
    - (II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
  - (iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified

- health plan during a plan year (and the effective date of such cessation);
- (J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and
- (K) establish the Navigator program described in subsection (i).

## Appendix B

### Suggested Legislation

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA c. 89 is enacted to read:

### CHAPTER 89

#### **MAINE HEALTH BENEFIT EXCHANGE ACT**

##### **§ 7001. Short title**

This *chapter* may be known and cited as “the *Maine Health Benefit Exchange Act*.”

##### **§ 7002. Definitions**

*As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.*

- 1. Commission.** “*Commission*” means the *Maine Health Benefit Exchange Commission* established in section 7005.
- 2. Commissioner.** “*Commissioner*” means the *Commissioner of the Department of Professional and Financial Regulation* within the meaning of chapter 901 of Title 10.
- 3. Educated health care consumer.** “*Educated health care consumer*” means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical and scientific matters.
- 4. Exchange.** “*Exchange*” means the *Maine Health Benefit Exchange* established in section 7003.
- 5. Executive Director.** “*Executive Director*” means the *Executive Director of the Maine Health Benefit Exchange*.
- 6. Federal Affordable Care Act.** “*Federal Affordable Care Act*” has the meaning given to this term in section 14.
- 7. Federally Recognized Indian Tribe.** “*Federally Recognized Indian Tribe*” means the *Passamaquoddy Tribe, the Penobscot Nation, the Houlton Band of Maliseet Indians* as defined in 25 U.S.C. sections 1722(a) and (h), the *Aroostook Band of Micmacs* as defined in Pub. L. 102-171, section 3(1).
- 8. Health benefit plan.** “*Health benefit plan*” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

- A. “Health benefit plan” does not include:
- (1) Coverage only for accident or disability income insurance or any combination thereof;
  - (2) Coverage issued as a supplement to liability insurance;
  - (3) Liability insurance, including general liability insurance and automobile liability insurance;
  - (4) Workers’ compensation or similar insurance;
  - (5) Automobile medical payment insurance;
  - (6) Credit-only insurance;
  - (7) Coverage for on-site medical clinics; or
  - (8) Insurance coverage *similar to any coverage listed in subparagraphs (1) to (7), as specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.*
- B. “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (1) Limited-scope dental or vision benefits;
  - (2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or
  - (3) Limited benefits *similar to those listed in subparagraphs (1) and (2) as specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.*
- C. “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

D. “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance as defined under the *United States Social Security Act, section 1882(g)(1)*;

(2) Coverage supplemental to the coverage provided under *10 United States Code, chapter 55*; or

(3) Supplemental coverage *similar to coverage listed in subparagraphs (1) and (2)* provided under a group health plan.

**9. Health carrier.** “Health carrier” or “carrier” means:

A. *An insurance company licensed in accordance with this Title to provide health insurance;*

B. *A health maintenance organization licensed pursuant to chapter 56;*

C. *A preferred provider arrangement administrator registered pursuant to chapter 32;*

D. *A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24;*

E. *An insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance as defined in section 707, subsection 1, paragraph C-1; or*

F. *Any other entity providing a plan of health insurance, health benefits, or health services that may lawfully provide such benefits under state and federal law.*

**10. Health insurance producer.** “Health insurance producer” means a person required to be licensed under the laws of this State to sell, solicit or negotiate a health benefit plan.

**11. Qualified dental plan.** “Qualified dental plan” means a limited-scope dental plan that has been certified in accordance with section 7009, subsection 5.

**12. Qualified employer.** “Qualified employer” means a small employer that elects to make its full-time employees, and, at the option of the employer, some or all of its part-time employees, eligible for one or more qualified health plans offered through the SHOP Exchange, provided that the employer:

- A. Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or
- B. Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

**13. Qualified health plan.** “Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the *federal Affordable Care Act* and section 7009.

**14. Qualified individual.** “Qualified individual” means an individual, including a minor, who:

- A. Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;
- B. Resides in this State *within the meaning of the federal Affordable Care Act*;
- C. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and
- D. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

**15. Secretary.** “Secretary” means the Secretary of the *United States* Department of Health and Human Services.

**16. SHOP exchange.** “SHOP Exchange” means the Small Business Health Options Program established pursuant to section 7008, *subsection 2, paragraph I*.

**17. Small employer.** “Small employer” means an employer that employed an average of not more than 100 employees during the preceding calendar year, *provided that for plan years beginning before January 1, 2016, “small employer” means an employer that employed an average of not more than 50 employees during the preceding calendar year*. For purposes of this subsection:

- A. All persons treated as a single employer under Section 414(b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as a single employer;
- B. An employer and any predecessor employer shall be treated as a single employer;
- C. *Employees for purposes of determining the number of employees employed shall mean “eligible employees” as defined under section 2808-*

*B, unless Federal law requires a different rule to be used to determine the number of employees and such Federal law preempts state law, in which case the number of employees shall be determined in accordance with Federal law;*

- D. If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer must be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and
- E. An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, must continue to be treated as a small employer for purposes of this *chapter* as long as the employer continuously makes enrollment through the SHOP Exchange available to its employees.

### **§ 7003. Maine Health Benefit Exchange established; declaration of necessity**

**1. Exchange established.** The Maine Health Benefit Exchange is hereby established as a governmental agency within the Department of Professional and Financial Regulation.

**2. Exchange Functions.** The Exchange shall facilitate the purchase and sale of qualified health plans; provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans; and meet the requirements of this *chapter* and any regulations implemented under this *chapter*.

**3. Contracting authority.** The Exchange may contract with an eligible entity for any of its functions described in this *chapter*. For the purposes of this subsection, “eligible entity” includes, but is not limited to, the MaineCare program or any entity that has experience in individual and small group health insurance or benefit administration, or has other experience relevant to the responsibilities to be assumed by the entity, *except that an eligible entity does not include* a health carrier or an affiliate of a health carrier.

**4. Intergovernmental Agreements and Coordination.** The Exchange may enter into information-sharing agreements with federal and other state agencies and other state exchanges to carry out its responsibilities under this *chapter*; such agreements shall include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws, rules and regulations.

### **§ 7004. Executive Director**

**1. Appointment.** The Commission shall recommend candidates for Executive Director to the Commissioner and the Governor. The Executive Director shall be appointed by the Governor subject to review by the joint standing committee of the Legislature having jurisdiction over insurance and financial services and to confirmation by the Legislature. The

*position of Executive Director is a major policy-influencing position as designated in Title 5, section 934. The Executive Director serves at the pleasure of the Governor.*

*2. Duties. The Executive Director shall supervise and manage the Exchange in consultation with the Commission and the Commissioner.*

**§ 7005. Maine Health Benefit Exchange Commission**

*1. Duties. There shall be established a Commission to advise the Executive Director and the Commissioner regarding technical issues related to the Exchange.*

*2. Appointments. The Commission consists of 9 voting members and 2 ex officio, nonvoting members as follows:*

- A. The 9 voting members of the Commission are appointed by the Governor subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters, and confirmation by the Senate.*
- B. The Governor shall appoint the voting members as follows:*
  - (1) At least one member representing insurers;*
  - (2) At least one member representing health insurance producers;*
  - (3) At least one member representing health care providers;*
  - (4) At least one member representing employers with an average of not more than 50 employees during the calendar year preceding the member's appointment;*
  - (5) At least one member representing employers with an average of not less than 51 but not more than 100 employees during the calendar year preceding the member's appointment;*
  - (6) At least one member representing consumers; and*
  - (7) At least one member representing federally recognized Indian tribes in the State.*
- C. The appointments of all voting members shall be made in accordance with state conflicts of interest laws. The appointments of voting members shall also be made in accordance with the federal Affordable Care Act so that a majority of the voting members of the Commission do not have conflicts of interest, as defined in regulations implementing the federal Affordable Care Act.*
- D. The 2 ex officio, nonvoting members of the Commission are:*

- (1) *The Commissioner or the commissioner's designee; and*
- (2) *The Commissioner of the Department of Health and Human Services or the commissioner's designee.*

**3. Qualifications of voting members.** *A majority of the voting members of the Commission must have relevant experience in the following areas:*

- A. *Health benefits administration;*
- B. *Health care finance;*
- C. *Health plan purchasing;*
- D. *Health care delivery system administration;*
- E. *Public health;*
- F. *Health policy issues related to the small group and individual markets and the uninsured; or*
- G. *Any additional areas of relevant experience identified in the federal Affordable Care Act.*

**4. Terms of office.** *Voting members of the Commission serve 3-year terms. Any vacancy for an unexpired term must be filled in accordance with subsections 1 and 2. A member may serve until a replacement is appointed and qualified. Of the initial members, 3 members serve an initial term of one year, 3 members serve an initial term of 2 years, and 3 members serve an initial term of 3 years in order to achieve a staggered set of terms. Voting members may serve up to 2 consecutive terms, not including any initial term of less than 3 years.*

**5. Chair.** *The Governor shall appoint one of the voting members of the Commission as the chair of the Commission.*

**6. Quorum.** *Five voting members of the Commission constitute a quorum.*

**7. Affirmative vote.** *An affirmative vote of 5 members is required for any action taken by the Commission.*

**8. Compensation.** *A member of the Commission is entitled to compensation according to the provisions of Title 5, section 12004-G, subsection 14-H; a member must receive compensation whenever that member fulfills any Commission duties in accordance with Commission bylaws.*

**9. Meetings.** *The Commission shall hold regular public governing meetings that are announced in advance. All meetings of the Commission are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.*

**10. Governance.** *The Commission shall adopt rules in accordance with section 7008, subsection 4 that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest, including disclosure of financial interests by members of the Commission, that meet the requirements of the federal Affordable Care Act and any applicable state law to the extent not inconsistent with the federal Affordable Care Act.*

#### **§ 7006. Records**

*Except as provided in this section, information obtained by the Exchange under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.*

**1. Financial information.** *Any personally identifiable financial information, supporting data or tax return of any person obtained by the Exchange under this chapter is confidential and not open to public inspection.*

**2. Health information.** *Health information obtained by the Exchange under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information covered by chapter 24 or Title 22, section 1711-C is confidential and not open to public inspection.*

#### **§ 7007. General Requirements**

**1. Coverage.** The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

**2. Qualified health plan required.** The Exchange shall not make available any health benefit plan that is not a qualified health plan.

**3. Dental benefits.** The Exchange shall allow a health carrier to offer a plan that provides limited-scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the *federal Affordable Care Act*.

**4. No fee or penalty for termination of coverage.** Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

#### **§ 7008. Powers and duties of the Maine Health Benefit Exchange**

**1. Powers.** *Subject to any limitations contained in this chapter or in any other law, the Exchange shall have and may exercise all powers necessary or convenient to effect the purposes for which the Exchange is organized or to further the activities in which the Exchange may lawfully be engaged, including the establishment of the Exchange.*

2. **Duties.** The Exchange shall:
- A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the *federal Affordable Care Act* and pursuant to section 7009, of health benefit plans as qualified health plans;
  - B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
  - C. Provide for enrollment periods, as provided under Section 1311(c)(6) of the *federal Affordable Care Act*;
  - D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;
  - E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the *federal Affordable Care Act* and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the *federal Affordable Care Act*;
  - F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under the *federal Public Health Service Act*, 42 *United States Code*, Section 300gg-15 (2010);
  - G. In accordance with Section 1413 of the *federal Affordable Care Act*, inform individuals of eligibility requirements for the Medicaid program under the *United States Social Security Act*, Title XIX, or the *State Children's Health Insurance Program* under the *United States Social Security Act*, Title XXI, or of *eligibility requirements* for any applicable state or local public program and if, through screening of *an* application by the Exchange, the Exchange determines that *an* individual is eligible for any such program, enroll the individual in that program;
  - H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the *federal Affordable Care Act*;
  - I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, enabling any qualified employer to specify a level of coverage that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified

level of coverage; and determine whether to provide other ways for the SHOP Exchange to allow a qualified employer to offer one or more plans to its employees, provided that the SHOP Exchange shall not preclude a qualified employer from selecting a single qualified health plan to offer to its employees;

J. Subject to Section 1411 of the *federal Affordable Care Act*, issue a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that Section because:

- (1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
- (2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty;

K. Transfer to the *United States* Secretary of the Treasury the following:

- (1) A list of the individuals who are issued a certification under paragraph J, including the name and taxpayer identification number of each individual;
- (2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because:
  - (a) The employer did not provide the minimum essential coverage; or
  - (b) The employer provided the minimum essential coverage, but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value; and
- (3) The name and taxpayer identification number of:
  - (a) Each individual who notifies the Exchange under Section 1411(b)(4) of the *federal Affordable Care Act* that the individual has changed employers; and
  - (b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

- L. Provide to each employer the name of each employee of the employer described in paragraph K, *subparagraph 2* who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
- M. Perform duties required of the Exchange by the Secretary or the United States Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost sharing or individual responsibility requirement exemptions;
- N. Select entities, *through the award of grants or contracts*, to serve as navigators *who meet the requirements of* Section 1311(i) of the *federal Affordable Care Act*, standards developed by the Secretary, *and any registration or licensing requirements established by the Bureau of Insurance in consultation with the Exchange and the Department of Health and Human Services*; and award grants *or contracts* to enable navigators to:
  - (1) Conduct public education activities to raise awareness of the availability of qualified health plans;
  - (2) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B(c)(2)(C) of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the *federal Affordable Care Act*;
  - (3) Facilitate enrollment in qualified health plans;
  - (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under federal Public Health Service Act, 42 United States Code, Section 300gg-93 (2010) or any other appropriate state agency or agencies, for an enrollee with a grievance, complaint or question regarding a health benefit plan or coverage or a determination under that plan or coverage; and
  - (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;
- O. Review the rate of premium growth within the Exchange and outside the Exchange and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;
- P. Consult with stakeholders *regarding* carrying out the activities required under this *chapter*, including, but not limited to:

- (1) Educated health care consumers who are enrollees in qualified health plans;
- (2) Individuals and entities with experience in facilitating enrollment in qualified health plans;
- (3) Representatives of small businesses and self-employed individuals;
- (4) *Representatives of the MaineCare program;*
- (5) Advocates for enrolling hard-to-reach populations; and
- (6) *any other groups or representatives required by the federal Affordable Care Act;*

*The Commission shall consult with an advisory committee, the members of which are appointed by the chief and council for each tribe of the federally recognized Indian tribes in the State. The Commission may appoint other advisory committees that include stakeholders to advise and assist the Commission in discharging its responsibilities under this chapter. Members of any advisory committee serve without compensation but may be reimbursed by the Exchange for necessary expenses while on official business of the advisory committee.*

- Q. Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the *Commissioner* a report concerning such accountings;
- R. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the *federal Affordable Care Act* and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:
- (1) Investigate the affairs of the Exchange;
  - (2) Examine the properties and records of the Exchange; and
  - (3) Require periodic reports in relation to the activities undertaken by the Exchange;
- S. In carrying out its activities under this *chapter*, *avoid* using any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications; and
- T. *Allow health insurance producers to enroll individuals and employers in any qualified health plans and to assist individuals in applying for*

*premium tax credits and cost-sharing reductions for plans sold through the Exchange.*

**3. Budget.** *The Exchange shall submit a budget for its administration and operation to the Commissioner. The Exchange shall conduct an analysis of, and make recommendations to be included in the initial budget regarding, how the Exchange can be self-sustaining by 2015.*

**4. Rulemaking.** *The Exchange may adopt rules as necessary for the proper administration and enforcement of this chapter pursuant to the Maine Administrative Procedure Act. Unless otherwise specified or required by the Maine Administrative Procedure Act, rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Rules adopted pursuant to this subsection shall be consistent with the federal Affordable Care Act.*

**5. Funding; Publication of costs**

- A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this *chapter*.
- B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on a *publicly accessible* website to educate consumers on such costs. This information must include information on money lost to waste, fraud and abuse.

**6. Adjudications.** *Any adjudications by the Exchange shall be conducted in accordance with the Maine Administrative Procedure Act and the federal Affordable Care Act and shall be considered final agency actions for purposes of the Maine Administrative Procedure Act.*

**§ 7009. Health benefit plan certification**

**1. Certification.** The Exchange may certify a health benefit plan as a qualified health plan if:

- A. The *health benefit* plan provides the essential health benefits package described in Section 1302(a) of the *federal Affordable Care Act*, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection 5, if:
  - (1) The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and
  - (2) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric *dental* benefits and that

qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

- B. *The forms for the health benefit plan meet the requirements of chapter 27, and the rates for the health benefit plan meet the requirements of chapter 33 or chapter 35, as applicable;*
- C. *The health benefit plan provides at least a bronze level of coverage, as determined pursuant to section 7008, subsection 2, paragraph E unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal Affordable Care Act for catastrophic plans, and will be offered only to individuals eligible for catastrophic coverage;*
- D. *The health benefit plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the federal Affordable Care Act and, if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the federal Affordable Care Act;*
- E. *The health carrier offering the health benefit plan:*
  - (1) *Is licensed and in good standing to offer health insurance coverage in this State;*
  - (2) *Offers at least one qualified health plan in the silver level and at least one plan in the gold level as described in Section 1302(d)(1)(B) and Section 1302(d)(1)(C) of the federal Affordable Care Act through each component of the Exchange in which the carrier participates. As used in this subparagraph, "component" means the SHOP Exchange and the Exchange;*
  - (3) *Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;*
  - (4) *Does not charge any cancellation fees or penalties in violation of section 7007, subsection 4; and*
  - (5) *Complies with the regulations developed by the Secretary under Section 1311(c) of the federal Affordable Care Act and such other requirements as the Exchange may establish; and*
- F. *The health benefit plan meets the requirements of certification established by regulation promulgated by the Secretary under Section 1311(c) of the federal Affordable Care Act and by the Exchange pursuant to section 7008, subsection 4 and, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential*

community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance.

**2. Authority to exclude health benefit plans.** The Exchange shall not exclude a health benefit plan:

- A. On the basis that the *health benefit* plan is a fee-for-service plan;
- B. Through the imposition of premium price controls by the Exchange; or
- C. On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances *in which* the Exchange determines the treatments are inappropriate or too costly.

**3. Carrier requirements.** The Exchange shall require each health carrier seeking certification of a *health benefit* plan as a qualified health plan to:

- A. Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the *superintendent* under the *federal Public Health Service Act, 42 United States Code, Section 300gg-94 (2010)* into consideration when determining whether to allow the carrier to make plans available through the Exchange;
- B. Make available to the public and submit to the Exchange, the Secretary and the *superintendent* accurate and timely disclosure of the following:
  - (1) Claims payment policies and practices;
  - (2) Periodic financial disclosures;
  - (3) Data on enrollment;
  - (4) Data on disenrollment;
  - (5) Data on the number of claims that are denied;
  - (6) Data on rating practices;
  - (7) Information on cost sharing and payments with respect to any out-of-network coverage;
  - (8) Information on enrollee and participant rights under Title I of the *federal Affordable Care Act*; and
  - (9) Other information as determined appropriate by the Secretary;

The information required in this paragraph *must* be provided in plain language, as that term is defined in Section 1311(e)(3)(B) of the *federal Affordable Care Act*; and

- C. Permit *an* individual to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including deductibles, copayments and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through a *publicly accessible* website and through other means for *an* individual without access to the Internet.

**4. *Application of licensing or solvency requirements.*** The Exchange *may* not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that ensures fairness between or among health carriers participating in the Exchange. *The Exchange shall not be subject to state licensure or solvency requirements. No employee of the Exchange shall be permitted to engage in activities that require state licensure unless such employee is licensed to engage in such activities in accordance with state licensure requirements.*

**5. *Application to qualified dental plans.*** The provisions of this *chapter* that are applicable to qualified health plans also apply to the extent relevant to qualified dental plans except as modified in this subsection or by *rules* adopted by the Exchange.

- A. The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.
- B. The *qualified dental* plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to Section 1302(b)(1)(J) of the *federal Affordable Care Act* and such other dental benefits as the Exchange or the Secretary may specify by *rule or regulation*.
- C. Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, if the plans are priced separately and are also made available for purchase separately at the same price.

#### **§ 7010. Relation to other laws**

Nothing in this *chapter*, and no action taken by the Exchange pursuant to this *chapter*, shall be construed to preempt or supersede the authority of the *superintendent* to regulate the business of insurance within this State. Except as expressly provided to the contrary in this *chapter*, all health carriers offering qualified health plans in this State shall comply fully with all

applicable health insurance laws of this State and *rules* adopted and orders issued by the *superintendent*.

**Sec. 2.** *5 MRSA § 934, sub-§ 1, paragraph F is enacted to read:*

*F. Executive Director, Maine Health Benefit Exchange;*

**Sec. 3.** *5 MRSA § 12004-G, sub-§ 14-H is enacted to read:*

**14-H.**

*Health Care, Maine Health Benefit Exchange Commission, \$100 per diem and expenses, 24-A MRSA § 7005.*

**Sec. 4.** *10 MRSA § 8001 , sub-§39 is enacted to read:*

*39. The Maine Health Benefit Exchange*

**Sec. 5. Repeal of 24-A MRSA c. 89.** *If the U.S. Supreme Court overturns all or part of the federal Affordable Care Act or the federal Affordable Care Act is repealed (in whole or in part) after the date of enactment of this chapter, within 60 days of such decision the Exchange shall recommend to the Legislature and the Governor whether to continue the Exchange.*

## APPENDIX C

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

### **Resolve, Creating the Advisory Committee on Maine's Health Insurance Exchange**

**Emergency preamble. Whereas,** acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

**Whereas,** to be eligible for health insurance exchange funding, the Federal Government requires the states to make substantial progress in the following core areas: background research; stakeholder consultation; legislative and regulatory action; governance; program integration; exchange information technology systems; financial management; oversight and program integrity; health insurance market reforms; providing assistance to individuals and small businesses, coverage appeals and complaints; and business operation; and

**Whereas,** the deadlines for applying for the next round of federal funding are September 30, 2011 and December 31, 2011; and

**Whereas,** in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

**Sec. 1 Advisory Committee on Maine's Health Insurance Exchange established. Resolved:** That the Advisory Committee on Maine's Health Insurance Exchange, referred to in this resolve as "the advisory committee," is established to develop and provide recommendations, including suggested enabling legislation, to the Governor and the Legislature for a health insurance exchange that addresses the core areas specified by the Federal Government and consider the views of the health care industry and other stakeholders; and be it further

**Sec. 2 Membership of the advisory committee. Resolved:** That the advisory committee consists of no more than 9 members appointed by the Governor, after consultation with the chairs and lead minority members of the Joint Standing Committee on Insurance and Financial Services. The Governor shall appoint members that represent the diverse interests of stakeholders related to the establishment of a health insurance exchange. The members must include representatives of key constituencies, including, but not limited to, health care providers, insurers, health insurance producers, consumers, employers with more than 50 employees, employers with 50 or fewer employees and the Board of Trustees of Dirigo Health. Prior to making appointments to the advisory committee, the Governor shall seek nominations from statewide associations representing the interests of stakeholders identified in this section and other entities as appropriate; and be it further

**Sec. 3 Chair. Resolved:** That the Governor shall appoint a chair from among the members of the advisory committee; and be it further

**Sec. 4 Duties of the advisory committee. Resolved:** That the advisory committee

shall:

1. Review and consider the recommendations issued by the 124th Legislature's Joint Select Committee on Health Care Reform with respect to a health insurance exchange;
2. Consider the rules issued by the Federal Government subsequent to the passage of the Patient Protection and Affordable Care Act and their impact on the creation and operations of a health insurance exchange;
3. In an effort to create efficiencies, review the work products of other states to consider what elements of their health insurance exchange activities might be used in this State;
4. Establish technical committees or seek the advice of technical experts when necessary to execute the duties included in this resolve; and
5. Seek input from and report regularly to legislative leadership, the Joint Standing Committee on Insurance and Financial Services and the Governor's office throughout the advisory committee's deliberations; and be it further

**Sec. 5 Meetings. Resolved:** That meetings of the advisory committee must be conducted in public in accordance with the Maine Revised Statutes, Title 1, chapter 13. The advisory committee shall provide notice of its meetings to the Joint Standing Committee on Insurance and Financial Services; and be it further

**Sec. 6 Consultation with Legislature. Resolved:** That the Joint Standing Committee on Insurance and Financial Services is authorized to hold 3 meetings before the Second Regular Session of the 125th Legislature for the purpose of consulting with the advisory committee; and be it further

**Sec. 7 Staffing. Resolved:** That Dirigo Health shall provide staffing services to the advisory committee. As necessary, the Department of Professional and Financial Regulation, Bureau of Insurance; the Department of Administrative and Financial Services, Office of Information Technology; the Department of Health and Human Services; and the State Coordinator for Health Information Technology shall also provide staffing assistance to the advisory committee; and be it further

**Sec. 8 Report. Resolved:** That the advisory committee shall submit a report, including its recommendations and suggested legislation, to the Governor and the Joint Standing Committee on Insurance and Financial Services no later than September 1, 2011.

**Emergency clause.** In view of the emergency cited in the preamble, this legislation takes effect when approved.

## Appendix D



Paul R. LePage  
Governor

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

Anne L. Head  
Commissioner

### MEMORANDUM

**To:** Advisory Committee on Health Exchange Legislation

**From:** Anne L. Head

**Subject:** Administration Recommendation on Structure/Governance

**Date:** September 13, 2011

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This memorandum responds to the Committee's request that I submit a written recommendation regarding the Administration's preference for the structure and governance of a health exchange entity for Maine. I am happy to discuss the recommendation below at the Committee's convenience.

#### **Administration Recommendation:**

- State agency within existing executive branch department (Professional and Financial Regulation)
- Supported by advisory committee
- Directed by staff (Director) employed by the Department after consultation with advisory committee

#### **Advantages:**

Full accountability and transparency to administration, policy makers, stakeholders and the public for activities/finances through commissioner;

Direct link to State administration, direct ability to coordinate with other state agencies

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(Medicaid, Bureau of Insurance);

Full participation of stakeholders through advisory committee without raising conflict of interest issues;

Department familiarity with state administrative procedures, open meetings, freedom of access and privacy requirements, personnel rules, etc.;

Start up costs associated with exchange could be lower than other options;

Dedicated revenue environment

**Disadvantages:**

Exchange would be assessed proportional share of department overhead costs based on budget;

Exchange decision-making subject to political pressure from internal and external sources;

Subject to state procurement and personnel rules

cc: Kathleen Newman, Governor's Office  
Katrín Teel, Governor's Office

# Maine Individual + Small Group Merged Markets

Premium Change	June 2010		CY 2019	
Merge IND + SG	IND	-15%	IND	-9%
	SG	+7%	SG	+12%

- Premium change due to merging Individual & Small Group Markets
  - Individual Market premiums decrease: 9% to 15%
  - Small Group Market premiums increase: 7% to 12%
  - Results independent of medical trends
  - Modeling does not reflect PL90

\* Note that the modeling does not reflect the federal transition reinsurance program

# Maine Small Group + Large Group (51 to 100)

Premium Change	June 2010		CY 2019	
Merge SG + LG	SG	0%	SG	-1%
	LG	0%	LG	+5%

- Premium change due to merging Small Group Market & Large Group (51 to 100)
  - Small Group Market premiums decrease up to 1%
  - Large Group (51 to 100) Market premiums increase up to 5%
  - Results independent of medical trends
  - Modeling does not reflect PL90

## Appendix G

### Current State Infrastructure<sup>44</sup>

Required Functions of an Exchange	Citation	DHA	HHS	BOI	State Employee Plan
<b>Eligibility and Enrollment</b>					
- Determine Medicaid and CHIP	ACA §§ 1311(d)(4)(F), 1413		X		
- Determine subsidies for Private Insurance	ACA §§ 1311(d)(4)(F), 1413	X			
- Determine Affordability Exemption	ACA § 1311(d)(4)(H)				
- Determine Employer Eligibility	Prop. 45 CFR § 155.715.	X			
- Provide for open enrollment periods	ACA § 1311(c)(6)	X			X
<b>Benefit and Plan Interaction</b>					
- Standardize benefit categories by actuarial value	ACA § 1301(d)(1)	X <sup>45</sup>			
- Certify Qualified Health Plans	ACA §§ 1311(d)(4)(A), 1301, 1301(d)(1)	X		X	
- Reward quality through market based incentives	ACA § 1311(g)	X <sup>46</sup>			X
- Assign quality rating to plans	ACA § 1311(c)(6)				X
- Post enrollee satisfaction survey results	ACA § 1311(c)(4)	X			
- Conduct risk adjustment (if state does not establish, federal government will)	ACA § 1343, Prop. 45 CFR § 153.310				
<b>Customer Service</b>					
- Operation of a toll-free hotline	ACA § 1311(d)(4)(B)	X	X		
- Enroll individuals	ACA §§ 1311(d)(4)(F), 1413	X	X		X
- Enroll businesses	ACA § 1311(b)(1)(B)	X			
- Maintain website with cost and quality information	ACA § 1311(d)(4)(C)	X		X	X
- Provide cost calculator	ACA § 1311(d)(4)(G)	X			
<b>Premium Payment and Collection</b>					
- Establish and manage navigator program	ACA § 1311(d)(4)(K)				
- Pay premiums to carriers	Prop. 45 CFR §§ 155.240, 155.705(b)(4)	X			X
- Aggregate premium from multiple sources	Prop. 45 CFR §§ 155.240, 155.705(b)(4)	X			

<sup>44</sup> An earlier version of this chart was prepared for the Advisory Council on Health Systems Development (“ACHSD”) by Dirigo Health Agency in consultation with the Department of Health and Human Services, the Bureau of Insurance, and staff of the state employee plan. The chart was included in the JSC Report and ACHSD report to the Legislature. The chart has been modified primarily to include citations to the relevant provisions of ACA.

<sup>45</sup> Agency has experience in procurement and plan design based on actuarial value.

<sup>46</sup> The Maine Quality Forum provides tools to the market to assist them with rewarding quality through market based incentives.