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**Final Report
of the**

**JOINT SELECT COMMITTEE TO STUDY
THE CREATION OF A PUBLIC/PRIVATE
PURCHASING ALLIANCE TO ENSURE ACCESS
TO HEALTH CARE FOR ALL MAINE CITIZENS**

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Staff:

**Colleen McCarthy Reid, Esq.
Legislative Analyst**

**Office of Policy and Legal Analysis
13 State House Station
Augusta, Maine 04333
(207) 287-1670**

Members:

**Sen. Jill M. Goldthwait, Senate Chair
Rep. Jane W. Saxl, House Chair
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Sen. Peter S. Mills
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Rep. Benjamin F. Dudley
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Executive Summary

The Joint Select Committee to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for All Maine Citizens was established by Joint Order, House Paper 1857, on April 24, 2000 during the Second Regular Session of the 119th Legislature. A copy of the Joint Order is included as Appendix A. The Joint Select Committee was charged with examining the public policy, regulatory and legislative issues related to creating a public/private purchasing alliance and with examining the possibility of creating a pilot project for a community-based health plan.

The Joint Select Committee consists of 12 legislative members: 3 Senate members and 9 House members. Sen. Jill M. Goldthwait and Rep. Jane W. Saxl served as co-chairs. The Joint Select Committee convened on September 19 and met five more times on September 26, October 10, October 24, November 9 and November 28. Public comment was accepted at the October 24th meeting in Bangor. During its deliberations, the Joint Select Committee also invited the participation of experts and interested parties, including the Bureau of Insurance, the Bureau of Medical Services in the Department of Human Services, the State Employee Health Commission and the University of Southern Maine, Muskie School of Public Service. The Joint Select Committee wishes to acknowledge the valuable assistance of these experts as well as the significant contributions of all those individuals who made presentations to the select committee.

The joint study order creating the Joint Select Committee was drafted by the Joint Standing Committee on Banking and Insurance. During the Second Regular Session, the Committee considered LD 2423, Resolve, to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for All Maine Citizens. LD 2423 was sponsored by Rep. Jane Saxl and presented as a concept draft. In its consideration of LD 2423, the Committee decided the specific duties and membership needed for such a study. In drafting the Committee's recommendations, the Committee followed Legislative Council Study Guidelines and chose to use a joint study order as the legislative instrument to create the study instead of a resolve. While LD 2423 was voted "Ought Not to Pass", Rep. Jane Saxl introduced the joint study order on behalf of the Committee.

Subsequently, the duties provision in the original joint study order drafted by the Banking and Insurance Committee was amended to include a requirement that the Joint Select Committee examine the possibility of creating a pilot project for a community-based health plan. This amendment was initiated as a result of the Banking and Insurance Committee's consideration of LD 2627, An Act to Create the Community Health Plan Demonstration Project. The bill proposed to establish a pilot project to provide coverage for comprehensive health care services of small employers and self-insured employers on Mount Desert Island. The pilot project proposal would have authorized the development of a purchasing alliance exempt from provisions of the Maine Insurance Code. The proposal would have also appropriated 1.5 million of State funds to create a Guaranty Fund for the purpose of covering potential losses of an alliance not covered by reinsurance. Due to the limited time remaining in the previous legislative session, the

Banking and Insurance Committee deferred further consideration of the pilot project proposal to the interim by adding an examination of the issue to the duties of the Joint Select Committee.

The Joint Select Committee was charged with the following duties in the joint order:

- Examine the public policy, regulatory and legislative issues related to the creation of a public/private purchasing alliance, including but not limited to:
 - the priorities and objectives of a purchasing alliance;
 - the critical mass needed for an alliance to be effective and the possible public entities that could be included in an alliance;
 - the ability of private payers such as individuals, small employers and large employers to be included in an alliance;
 - the use of community rating, separate risk pools or other risk adjustment mechanisms in an alliance;
 - the governance and administrative structure of an alliance; and
 - the benefit structure and choice of health plans that should be offered through an alliance
- Review the experience of other states or entities that have established purchasing alliances
- Recommend a model and strategies for the establishment of purchasing alliances in this State
- Examine the possibility of creating a pilot project for a community-based health plan, including the statutory and regulatory framework for such a project and the need for state funds to cover potential losses incurred by the plan
- Invite the participation of experts and interested parties, including the Bureau of Insurance, the Bureau of Medical Services, the State Employee Health Commission, the Maine Health Management Coalition and the Muskie School of Public Service

Early in its deliberations, the Joint Select Committee broadened the scope of its work to include group-purchasing mechanisms for health insurance and other strategies to increase purchasing power for individuals and small employers. While the Joint Select Committee fulfilled each of its duties specified in the joint study order, the Joint Select Committee believed it was appropriate to expand its focus to include multiple employer welfare arrangements (MEWAs), association group plans and the Medicaid program in

its discussions. Given the current problems with affordability of health insurance, especially individual health insurance policies, the Joint Select Committee felt it was important to examine the purchasing alliance and community-based health plan concepts as well as other approaches.

The Joint Select Committee makes the following recommendations.

The Joint Select Committee does not recommend a model for establishing a public/private purchasing alliance in the State.

The Joint Select Committee recommends that the current law relating to private purchasing alliances be amended to remove obstacles to the establishment of a voluntary private purchasing alliance.

The Joint Select Committee recommends that the Legislature establish a program for local, regional or statewide community-based health plans.

The Joint Select Committee recommends that the State apply for a Medicaid waiver to create a Medicaid “buy-in” program for individuals and small groups.

The Joint Select Committee recommends that the Legislature advocate at the national level for changes in Medicare reimbursement and regulatory reform to alleviate the cost shifting among Maine’s health care providers from public insurance programs to private health insurance payers.

The Joint Select Committee recommends that policymakers examine whether amendments to the law governing multiple employer welfare arrangements are needed to allow more flexibility for the formation of a multiple employer welfare arrangement.

The Joint Select Committee recommends that policymakers consider a reinsurance mechanism for commercial health insurers and health maintenance organizations in the individual and small group health insurance market.

Draft legislation to implement the recommendations of the Joint Select Committee contained in this report is included in Section V.

I. Introduction

The Joint Select Committee to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for All Maine Citizens was established by Joint Order, House Paper 1857, on April 24, 2000 during the Second Regular Session of the 119th Legislature. A copy of the Joint Order is included as Appendix A. The Joint Select Committee was charged with examining the public policy, regulatory and legislative issues related to creating a public/private purchasing alliance and with examining the possibility of creating a pilot project for a community-based health plan.

The Joint Select Committee consists of 12 legislative members: 3 Senate members and 9 House members. Sen. Jill M. Goldthwait and Rep. Jane W. Saxl served as co-chairs. A complete list of committee members is included as Appendix B. During its deliberations, the Joint Select Committee also invited the participation of experts and interested parties, including the Bureau of Insurance, the Bureau of Medical Services in the Department of Human Services, the State Employee Health Commission and the University of Southern Maine, Muskie School of Public Service. The Joint Select Committee wishes to acknowledge the valuable assistance of these experts as well as the significant contributions of all those individuals who made presentations to the select committee.

The Joint Select Committee convened on September 19 and met five more times on September 26, October 10, October 24, November 9 and November 28. Public comment was accepted at the October 24th meeting in Bangor. Summaries of the Joint Select Committee meetings are included as Appendix C.

A. Creation of Joint Select Committee

The joint study order creating the Joint Select Committee was drafted by the Joint Standing Committee on Banking and Insurance. During the Second Regular Session, the Committee considered LD 2423, Resolve, to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for All Maine Citizens. LD 2423 was sponsored by Rep. Jane Saxl and presented as a concept draft. In its consideration of LD 2423, the Committee decided the specific duties and membership needed for such a study. In drafting the Committee's recommendations, the Committee followed Legislative Council Study Guidelines and chose to use a joint study order as the legislative instrument to create the study instead of a resolve. While LD 2423 was voted "Ought Not to Pass", Rep. Jane Saxl introduced the joint study order on behalf of the Committee.

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for comprehensive health care services of small employers and self-insured employers on Mount Desert Island. The pilot project proposal would have authorized the development of a purchasing alliance exempt from provisions of the Maine Insurance Code. The proposal would have also appropriated 1.5 million of State funds to create a Guaranty Fund for the purpose of covering potential losses of an alliance not covered by reinsurance. Due to the limited time remaining in the previous legislative session, the Banking and Insurance Committee deferred further consideration of the pilot project proposal to the interim by adding an examination of the issue to the duties of the Joint Select Committee.

B. Duties of the Joint Select Committee

The Joint Select Committee was charged with the following duties in the joint order:

- Examine the public policy, regulatory and legislative issues related to the creation of a public/private purchasing alliance, including but not limited to:
 - the priorities and objectives of a purchasing alliance;
 - the critical mass needed for an alliance to be effective and the possible public entities that could be included in an alliance;
 - the ability of private payers such as individuals, small employers and large employers to be included in an alliance;
 - the use of community rating, separate risk pools or other risk adjustment mechanisms in an alliance;
 - the governance and administrative structure of an alliance; and
 - the benefit structure and choice of health plans that should be offered through an alliance
- Review the experience of other states or entities that have established purchasing alliances
- Recommend a model and strategies for the establishment of purchasing alliances in this State
- Examine the possibility of creating a pilot project for a community-based health plan, including the statutory and regulatory framework for such a project and the need for state funds to cover potential losses incurred by the plan
- Invite the participation of experts and interested parties, including the Bureau of Insurance, the Bureau of Medical Services, the State Employee Health

II. Committee Process

A. Committee's Scope and Focus

Early in its deliberations, the Joint Select Committee broadened the scope of its work to include group-purchasing mechanisms for health insurance and other strategies to increase purchasing power for individuals and small employers. While the Joint Select Committee fulfilled each of its duties specified in the joint study order, the Joint Select Committee believed it was appropriate to expand its focus to include multiple employer welfare arrangements (MEWAs), association group plans and the Medicaid program in its discussions. Given the current problems with affordability of health insurance, especially individual health insurance policies, the Joint Select Committee felt it was important to examine the purchasing alliance and community-based health plan concepts as well as other approaches.

B. Report and Legislation

The joint study order requires that the Joint Select Committee submit a report, including any necessary legislation, on or before December 1, 2000. Draft legislation to implement the recommendations of the Joint Select Committee contained in this report is included in Section V.

III. Background Information

A. Current Law relating to the Group Purchasing of Health Insurance

◇ Private Purchasing Alliances

Generally, a purchasing alliance is an entity organized solely for the purpose of purchasing health insurance on behalf of its members, most often unrelated employers. Current Maine law authorizes the voluntary establishment of a private purchasing alliance. Under the law, an alliance must be licensed by the Bureau of Insurance and may be organized as a nonprofit or for-profit organization. A purchasing alliance is required to contract with health insurance carriers to provide coverage to its members through participating unaffiliated multiple carriers. Alliances are authorized to set their own standards for membership in the alliance. Individual enrollees in an alliance have a choice of health plans. The current law requires that an alliance offer at least 3 different carriers in each portion of its service area unless the Superintendent of Insurance waives the requirement. Although no private purchasing alliances have been licensed to operate in Maine, these entities are designed to provide additional options for the purchase of insurance by small employers.

◇ *Group Health Insurance: Employee Groups*

The Maine Insurance Code allows a single employer to purchase group health insurance on behalf of its employees. The term “employees” includes dependents. Under the group policy, coverage may be provided to retirees and directors of a corporate employer and to affiliated corporations if the corporations are under common control.

◇ *Group Health Insurance: Associations, Labor Unions and Other Groups*

The Maine Insurance Code also permits the issuance of group health insurance to non-employers, such as associations, labor unions, trustee groups, debtor groups and credit union groups. See 24-A MRSA §§ 2804- 2809. The specific entities that may offer group health insurance are prescribed in statute. These group plans must be fully insured, i.e. the association, labor union or other entity is the policyholder for the entire group. The law requires that the association, labor union or other group have been formed for a bona fide purpose other than the purchasing of group health insurance.

◇ *Multiple Employer Welfare Arrangements*

Although the federal Employee Retirement Income Security Act (ERISA) generally preempts states from regulating employer welfare benefit plans, states have been given specific authority under ERISA to regulate multiple employee welfare arrangements. Maine law governing multiple employee welfare arrangements was enacted in 1995. The law requires a multiple employee welfare arrangement, also known as a MEWA, to be licensed by the Bureau of Insurance and to meet requirements that include fiscal soundness. By organizing as a MEWA or participating in a MEWA, an employer or group of employers is able to self-insure health care coverage. Since it was enacted, Maine has only licensed one MEWA. The MEWA of the Maine Bankers' Association began operating in July 2000.

B. Past Legislative Proposals Related to Purchasing Alliances

In 1996, the Legislature considered 2 bills that would have established purchasing alliances: LD 1477, An Act to Provide for the Creation of a Health Purchasing Cooperative and LD 1753, An Act to Control Health Care Costs and Improve Access to Health Care. LD 1477 would have established a mechanism for the establishment of 5 regional purchasing alliances open to small employers. The alliances would have each been a state-chartered, nonprofit entity governed by a State Purchasing Alliance Board within Bureau of Insurance. The major proposal, LD 1753, was presented by the Health Care Reform Commission (HCRC), as part of its package of recommended incremental health insurance reforms. The HCRC proposal would have created a state-chartered, private, non-profit purchasing alliance for individuals and small employers. The alliance would have been required to contract with health insurance carriers to provide 10 different health plans to enrollees. General fund revenues of \$1.5 million were provided for start-up funds and assessments on premiums sold through the alliance would have provided on-going funding. The State Employee Health Commission would have also

been required to jointly negotiate with the alliance as part of the contracting process with carriers. While the State Employee Health Commission was only required to jointly negotiate with the alliance and state employees would have been placed in a separate risk pool, the perception of many legislators and the Maine State Employees Union was that the State Employee plan would be forced into the alliance. That perception led to the failure of the proposal.

At the suggestion of several interested parties, including the Maine Chamber and Business Alliance, the Joint Standing Committee on Banking and Insurance drafted legislation to establish a statutory framework for the formation of voluntary private purchasing alliances. This legislation was later enacted as Public Law 1995, chapter 672 and is described above in Section III, paragraph A.

C. Other States' Experience with Purchasing Alliances

◇ Legislation

30 states allow the establishment of purchasing alliances through legislation. These states include: Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Washington, and Wyoming. A number of states, including Maine, have based their legislation in whole or in part on model laws developed by the National Association of Insurance Commissioners (NAIC) for the establishment of voluntary purchasing alliances.

◇ Current Status of Purchasing Alliances in Other States

Although 30 states allow the establishment of purchasing alliances, only 15 alliances are currently operational. Alliances in Florida, Texas, Kentucky and Iowa have been disbanded because of loss of participation by health plans, declining enrollment from small employers and increased premium costs. The chart on the next page outlines the purchasing alliances operating in other states.

Purchasing Alliances Currently Operating in Other States

State	How sponsored or established	Eligibility	Date coverage available
California –Pacific Health Advantage	Originally state agency, now transitioning to private oversight and management	Employers of 2-50; Employers of any size if purchased through qualifying association	7/93
Colorado- The Cooperative for Health Insurance Purchasing	Private, non-profit	Any size employer	10/95
Connecticut-CIBA Health Connections	Private association of employers	Employers of 3-50	1/95
Kansas- Alliance Employee Health Access, Inc.	Private, non-profit	Employers of 2-50; larger employers may be accommodated	1/00
Montana- Community Health Options	Taxable, state not-for-profit mutual benefit corporation	Employers of 2 +	1/98
New York- New York Health Purchasing Alliance (5 boroughs of NYC)	Private, non-profit	Employers of 2-50	Mid-99
New York- LIA Health Alliance (Long Island, Brooklyn, Queens, Nassau and Suffolk counties)	Private, non-profit	Employers of 2-50	2/95
North Carolina- Caroliance	State chartered, non-profit	Self-employed individuals; employers with fewer than 50 employees	11/95
Ohio-Council of Small Enterprise (NE Ohio)	Private association	Employers of 1-250; firms must be member of Greater Cleveland Growth Association, regional chamber of commerce	1974
Oregon- HealthChoice	Private, non-profit	Employers of 2-50	8/97
Utah-Care of Utah	Private, for-profit	Employers of 2-50	10/94
Washington- HealthChoice	Private, non-profit	Employers of 3 or more employees; focus on employers with 100 or fewer employees	6/96

◇ *Benefits of Purchasing Alliances*

The major benefits of purchasing alliances have been identified as (1) administrative simplicity; (2) choice of both health plans and benefit packages; and (3) leverage in negotiating lower premiums. In evaluating the success of purchasing alliances, studies¹ have noted that alliances have been able to achieve two of those three goals for small employers. Alliances have made it easier for employers to offer health coverage to their employees and have provided employees a choice among health plans. However, alliances have not been able to negotiate lower premiums. Generally, the premiums for health plans offered through alliances have not been significantly lower than premiums for plans with similar benefits offered to small employers outside the alliance.

◇ *Problems Experienced by Purchasing Alliances*

Recent studies identify a number of problems experienced by purchasing alliances.

Limited market share: Alliances have not been able to attract significant market share in the small group market. Alliances have been unable to gain market share above 5 percent, except in Cleveland where the COSE has an 80% market share for its area. In terms of numbers, the California alliance has a steady enrollment of 150,000, but because of the large population, the alliance only has about a 2% market share. Alliances in Texas and Florida failed due to serious problems with enrollment and, in North Carolina, the alliance's enrollment is rapidly declining.

Clearly, the ultimate success of an alliance depends on achieving "critical mass." In terms of market share, the Economic and Social Research Institute Report identified that "critical mass" for the small group market is a 15-20% market share.

Changes in the health insurance environment: With the passage of the federal Health Insurance Portability and Accountability Act (HIPAA) and other state law small group reforms, small employers now have access to health insurance on a more equitable basis without the need for joining an alliance. Reforms like guaranteed issuance and renewal, portability of coverage, limits preexisting condition exclusions and rate restrictions have improved access to health insurance for small employers. Although alliances are often the only way to provide employee choice of individual plans, these reforms may have reduced the pressure to develop alliances.

Problems with implementation: Many alliances have experienced problems with adverse selection that grew out of policies to make coverage attractive to higher risk groups. Some states established excessive numbers of alliances on a regional basis rather than as a single statewide basis, which led to administrative inefficiencies and made it harder to establish a coherent statewide policy. Additionally, the consumer-driven orientation of

¹ GAO Report "Cooperatives Offer Small Employers Plan Choice and Market Prices", March 2000; and Economic and Social Research Institute Report "Barriers to Small Group Purchasing Cooperatives", March 2000.

alliances sometimes led to an adversarial relationship with health plans and an inability to respond quickly to plans' concerns.

Resistance or opposition from interest groups: Resistance from both health plans and insurance agents has been a significant barrier for alliances. Health plans generally did not like serving very small groups and especially feared adverse selection by higher-risk individuals because of the employee choice feature. Plans also contended there was little or no savings on administrative costs with participation in an alliance. In several states like Texas and Florida, the withdrawal of health plan participation has contributed to the failure of those alliances. Insurance agents have also been wary of alliances because many early efforts sought to eliminate or reduce agent commissions as a way of saving on administrative costs. As a result, many agents were unwilling to promote alliances. Since small employers rely heavily on agents for the purchase of insurance products, alliances cannot succeed without being sold and marketed by agents.

D. Innovative Models under Discussion

As part of its deliberations, the Joint Select Committee broadened its scope to include discussion of innovative models at work or in development in the public and private sector. These models include the Mount Desert Island Community Health Plan, the Maine PrimeCare program and a regional Small Group Purchasing Alliance.

◇ Mount Desert Island Community Health Plan

The Mount Desert Island Community Health Plan was formed in 1996 and is a nonprofit tax-exempt organization. Currently, the plan provides community health and education services and local Medical Management services and local Member Services assistance to area employers. The plan is also working to develop a comprehensive locally-based health insurance plan. Its primary goal is to provide more options for health insurance.

The Mount Desert Island (MDI) Community Health Plan identified two major problems with the current health system as: (1) the lack of local medical management that emphasizes early intervention, preventive and wellness services; and (2) the lack of an integrated health data information system that gives physicians and other health care providers and consumers access to information to effectively control costs. In response to the problem of little or no local medical management, the MDI Community Health Plan has developed its own medical management model and has begun marketing this model to area employers.

The MDI Community Health Plan has also been working actively to develop a local health insurance plan. It has explored many different avenues, such as a partnership with a private health insurer, the formation of a local insurance company, the development of a demonstration project with waivers from existing insurance law, and the formation of a multiple employer welfare arrangement (MEWA). Recently, the MDI Community Health Plan met with the Commissioner of Human Services to explore the development

of a Medicaid “buy-in” program for individuals and micro-employers with the ability for local medical management.

A chart outlining the MDI Community Health Plan model is included as Appendix E.

◇ *Maine’s Medicaid Managed Care Program –Maine PrimeCare*

Maine PrimeCare, the State’s Medicaid managed care program began as a voluntary program in Kennebec and Somerset counties in 1994. It became a mandatory program in July 1996 in Aroostook, Piscataquis and Washington counties with 10,500 enrollees and is now a mandatory program for certain Medicaid enrollees in Androscoggin, Aroostook, Cumberland, Hancock, Kennebec, Oxford, Penobscot, Piscataquis, Somerset, Washington and York counties. By the end of 2000, the program hopes to expand to all 16 counties in Maine. In October 2000, the enrollment in Maine PrimeCare was 71, 677; 78% of the Medicaid eligible population is enrolled in Maine PrimeCare. Under federal law, mandatory participation is prohibited for those individuals dually eligible for both Medicaid and Medicare. Mandatory enrollees include those who reside in a mandatory county and who: receive TANF (Temporary Aid for Needy Families); are TANF-related, who have children, are pregnant or are under 21 years of age; is a child in foster care that receives TANF; or receive Cub Care or Medicaid expansion.

The PrimeCare program’s goals are to: comply with the Medicaid rules; establish a medical home for the Medicaid beneficiary; provide continuity of care; strengthen the provider/patient relationship; and to reduce unnecessary utilization. Providers enrolled as PrimeCare providers are responsible for comprehensive primary care, patient education, authorization for managed services and 24-hour coverage. PrimeCare providers receive a Medicaid fee for direct services and are paid a monthly management fee of \$3.00 per month per patient. There is also a Primary Care Physician Incentive Program (PC-PIP) that provides additional payments to providers that meet program incentives. The services requiring authorization from the PrimeCare provider include ambulatory surgery services, chiropractic services, durable medical equipment services, home health services, inpatient and outpatient hospital services, laboratory and X-ray services and physical and occupational therapy services. Those services that do not require prior approval under the PrimeCare program include ambulance services, annual gynecological exam, emergency room services, dental services, prescriptions, mental health and substance abuse services.

◇ *Small Group Purchasing Alliance Model*

The Joint Select Committee was given a presentation by John Benoit of the Holden Insurance Agency in Portland and Gino Nalli of the USM Muskie School of Public Service on a model for a private purchasing alliance they have developed and hope to implement in southern Maine. Their model is designed for small employers of less than 50 employees. The alliance would be a non-profit entity and would not bear insurance risk. In the model, the alliance would offer one indemnity plan option and one managed care option in a particular geographic area. Employee contributions to either option

would cost the same to address the potential for adverse selection. As a result, an employee's choice of plans would be based on the different coverage levels and provider network of a particular plan rather than the employee's out-of-pocket contribution. In developing this model, several potential regulatory barriers to the creation of such an alliance have been identified as: (1) the restrictions on travel time and distance requirements for tertiary services in the preferred provider organization act; (2) the benefit differential requirements in the ppo act; (3) the "any willing provider"-type requirements for a select network in the ppo act; and (4) the requirement in the private purchasing alliance chapter to offer at least 3 different health insurance carriers.

A chart outlining the small group purchasing alliance model is included as Appendix F.

IV. Committee Recommendations

The Joint Select Committee makes the following recommendations.

The Joint Select Committee does not recommend a model for establishing a public/private purchasing alliance in the State.

Although the primary charge of the Joint Select Committee was to recommend a model and strategies for the establishment of purchasing alliances in Maine, the Joint Select Committee does not recommend a model for a public-private purchasing alliance. The experience of other states that have established purchasing alliances demonstrates that purchasing alliances have had limited success nationally. Those alliances that have had some success clearly show that having a "critical mass" of individuals enrolled in a purchasing alliance is crucial to survival. The Joint Select Committee believes that it is unlikely that critical mass can be developed in Maine on a voluntary basis. As a result, the Joint Select Committee does not recommend that the Legislature establish a state-chartered purchasing alliance.

Past legislative proposals suggested that the State Employee Health Insurance Plan be used as the critical mass to assist a purchasing alliance in the negotiation of its premium with health insurers. At this time, the Joint Select Committee believes that State employees should be voluntary participants in a purchasing alliance. Historically, the State Employee Health Commission and the Maine State Employees Union opposed mandatory participation in an alliance.

The Joint Select Committee recommends that the current law relating to private purchasing alliances be amended to remove obstacles to the establishment of a voluntary private purchasing alliance.

While no voluntary private purchasing alliances have been formed since enactment of the law, the Joint Select Committee believes that a statutory and regulatory framework should be available for purchasing alliances. As part of its deliberations, the Joint Select Committee received a presentation on the ongoing development of a purchasing alliance model for small employers in southern Maine. The requirement that a private purchasing

alliance offer at least 3 different carriers as part of the alliance was cited as a potential barrier to the establishment of a private alliance. The Joint Select Committee recommends that this requirement be eliminated and draft legislation to implement this recommendation is included in Section V. By recommending this amendment to the current law, the Joint Select Committee hopes to remove obstacles to the establishment of a private purchasing alliance.

The Joint Select Committee also considered amendments to the Preferred Provider Arrangement Act to remove potential barriers to the formation of a private purchasing alliance. The potential barriers were identified as the restrictions on travel time and distance requirements for tertiary services and the benefit differential requirement. The Joint Select Committee discussed the ramifications of making changes to public policy that would give private purchasing alliances a regulatory advantage over other types of purchasing arrangements involving preferred provider networks. However, the Joint Select Committee was unable to reach consensus on this issue and declines to make a recommendation for changes to the current law.

The Joint Select Committee recommends that the Legislature establish a program for local, regional or statewide community-based health plans.

The Joint Select Committee recommends that the Legislature support innovation at the community level targeted at providing affordable health insurance and access to health care. The Joint Select Committee believes the State's current rates of uninsured and underinsured individuals are unacceptable. The most recent estimate provided by the Governor's Year 2000 Blue Ribbon Commission on Health Care indicates that 14% of Maine's population is uninsured. While it is difficult to accurately document the percentage of underinsured individuals, it is widely believed that there are individuals that carry high-deductible insurance policies with limited benefits that affects their access to preventive care. The Joint Select Committee believes the Legislature should establish the Community Health Access program on a local, regional and statewide basis for community-based health plans. Further, the Joint Select Committee believes the Department of Human Services should apply for a Medicaid waiver to allow the participation of Medicaid enrollees in community-based health plans. While the Joint Select Committee is most familiar with the efforts of the Mount Desert Island Community Health Plan to create a community-based health plan, the Joint Select Committee is also aware of innovative programs in Franklin County and Kennebec County to improve access to health care in those areas. The Joint Select Committee feels that management of care at the local level works well to address the particular health needs of a community and continuity of care. The Joint Select Committee recognizes that the current methods of managing risk by a central insurer or health maintenance organization may be at odds with a community's health goals or the health needs of community members. The Joint Select Committee recommends that the Insurance Code be amended to allow the development of pilot projects for community-based health plans.

Draft legislation to implement this recommendation is included in Section V.

The Joint Select Committee recommends that the State apply for a Medicaid waiver to create a Medicaid “buy-in” program for individuals and small groups.

The Joint Select Committee recommends that the State establish a Medicaid “buy-in” for individuals and small groups with no health insurance. The Joint Select Committee believes the State should apply for a waiver from the federal government to allow these changes to the State’s Medicaid program. Information presented to the Joint Select Committee suggests that the current Medicaid plan has administrative costs of 4-7% and is more affordable than private market health insurance plans with a cost of approximately \$1100- \$1300 annually. By opening up eligibility to the Medicaid program and allowing individuals and small employers to purchase coverage, the Joint Select Committee hopes to provide another option for coverage. The Joint Select Committee also believes State funds should be used to subsidize premiums for certain individuals based on their income levels. Further, the waiver should allow for the establishment of demonstration projects for the management of care by community-based health plans.

Draft legislation to implement this recommendation is included in Section V.

The Joint Select Committee recommends that the Legislature advocate at the national level for changes in Medicare reimbursement and regulatory reform to alleviate the cost shifting among Maine’s health care providers from public insurance programs to private health insurance payers.

In its review of the current health insurance market, the Joint Select Committee discovered that federal law and regulations limit the ability to control costs by State action alone, especially with regard to the Medicare program. Information provided by the Maine Hospital Association demonstrates that Maine ranks 50th in Medicare reimbursement. One of the primary reasons for Maine’s low level of reimbursement is the State’s rural nature. Federal Medicare policy reimburses “rural” hospitals and other health care providers at a lower rate than “urban” providers for the same services. Fifty-eight percent of Maine’s hospitals are classified as “rural.” The low level of reimbursement from the Medicare program results in a cost shifting of those losses to the private health insurance market. The Joint Select Committee believes the Medicare reimbursement issue is a contributing factor to the high health insurance premiums in Maine and also jeopardizes the financial health of Maine’s hospitals and other health care providers. While certain federal programs like the Critical Access Hospital designation have brought some relief to Maine hospitals, the Joint Select Committee believes advocacy for better reimbursement and other changes to the Medicare program is needed. The Joint Select Committee also believes that the Medicare program should allow the private marketplace to develop more targeted insurance products as supplements to Medicare coverage, especially for prescription drug coverage.

The Joint Select Committee recommends that policymakers examine whether amendments to the law governing multiple employer welfare arrangements are

needed to allow more flexibility for the formation of a multiple employer welfare arrangement.

Current law permits the establishment of a multiple employer welfare arrangement as means for employers to group together to self-insure health benefits for their employees. Under normal circumstances, an employer must have a large employee base to assume the financial risks associated with self-insurance. The multiple employer welfare arrangement is a mechanism that allows employers that are not large enough to self-insure on an individual basis to join with other employers and self-insure health benefits on a group basis. Although Maine's MEWA law was first enacted in 1996, the first MEWA was established by the Maine Bankers Association and approved by the Bureau of Insurance in July, 2000. The Maine Bankers Association suggested in its presentation to the Joint Select Committee that there were some provisions in the current law that could be amended to provide more regulatory flexibility to groups of employers seeking to form a MEWA. These provisions include the requirements for a MEWA's sponsoring organization and the requirement that a MEWA maintain a positive fund balance. Accordingly, the Joint Select Committee recommends that policymakers examine whether greater flexibility in the statute will make multiple employer welfare arrangements a viable option for employers.

The Joint Select Committee recommends that policymakers consider a reinsurance mechanism for commercial health insurers and health maintenance organizations in the individual and small group health insurance market.

The Joint Select Committee believes that State policymakers should consider a reinsurance mechanism that will offer insurers and health maintenance organizations limited financial relief for individual high-cost claims. The Joint Select Committee believes that the complex public policy, legal and regulatory issues involved in the creation of a reinsurance mechanism need more thoughtful consideration. It is hoped that the availability of reinsurance would reduce the volatility in rates in the individual and small group health insurance markets and stabilize the number of health insurers offering coverage in these markets. Because of time constraints, the Joint Select Committee was unable to resolve these issues. However, the Joint Select Committee offers draft legislation (included as Appendix D) as a starting point for discussion by the 120th Legislature.

V. Recommended Legislation

The Joint Select Committee recommends that the current law relating to private purchasing alliances be amended to further encourage the establishment of a voluntary private purchasing alliance.

Sec. 1. 24-A MRS § 1951, sub-§ 2 is amended to read:

2. Private purchasing alliance. "Private purchasing alliance" or "alliance" means a corporation licensed pursuant to this section established under Title 13-A or

Title 13-B to provide health insurance to its members through ~~multiple-unaffiliated~~ one or more participating carriers.

Sec. 2. 24-A MRSA § 1954, sub-§ 2 is amended to read:

2. Enrollee choice. Ensure that enrollees have a choice among a reasonable number of competing carriers and types of health benefit plans, ~~in accordance with the following.~~

~~A. In every portion of the alliance's service area, the alliance must offer at least 3 different carriers. When 3 participating carriers are not reasonably available in some or all of the alliance's service area, the superintendent may waive this requirement in accordance with standards and procedures established by rule pursuant to this chapter.~~

The Joint Select Committee recommends that the Legislature establish a program for local, regional or statewide community-based health plans.

Sec. 1. 22 MRSA § 3193 is enacted to read:

§ 3193. Community Health Access Program

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Benefit Design" means the health care benefits package provided through the Community Health Access Program.

B. "Community Board" means the local governing board of a community health plan corporation.

C. "Community Health Access program excess insurance" means insurance that protects a program against higher than expected obligations at retention levels that do not have the effect of making the plan and insured plan. The issuance of Community Health Access program excess insurance does not constitute the business of reinsurance.

D. "Complementary Health Care Provider" means a health care professional, including a massage therapist, naturopath, chiropractor, physical therapist or acupuncturist, who provides care or treatment to a person that complements the care or treatment provided by a primary care physician and is credential by a community board.

E. “Health Quality Measures” means statistical data that provides information on the quality of health care outcomes for individuals and groups with similar health problems.

F. “Medical Data Collection System” means the computerized, systematic collection of individual medical data, including the cost of medical care, which when analyzed provides information on the quality and costs of health care outcomes.

G. “Micro-employer” means an employer that has an average of 4 or fewer employees eligible for health care benefits in the 12 months preceding its enrollment in the Community Health Access Program.

H. “Out-of-Area Medical Services” means medical care services provided outside of the geographic region of a community health plan corporation.

2. Program established. The Community Health Access Program, referred to in this section as the “program”, is established within the department to provide comprehensive health care services through local non-profit community health plan corporations governed by a local community board. The program’s primary goal is to provide access to health care services to persons without health care insurance or who are underinsured for health care services. The purpose of the program is to demonstrate the economic and health care benefits of a locally managed, comprehensive health care delivery model. The program’s emphasis is on preventive care, healthy lifestyle choices, primary health care and an integrated delivery of health care services supported by a medical data collection system.

3. Service areas. The department may establish service areas for a program in different geographic regions of the State. A service area established by the department must be an area that serves residents who seek regular primary health care services in conjunction with support from a hospital located in the same geographic region.

4. Eligible population. These provision govern eligibility.

A. The following population may enroll in the program:

(1) Micro-employers and their employees;

(2) Medicaid recipients;

(3) Self-insured employers and their employees to the extent allowed under the federal Employee Retirement Income Security Act;

(4) Self-employed persons; and

(5) Individuals without health care insurance.

B. Individuals eligible for group health care benefits through an individual's employment or spouse's employment may not enroll in the program.

5. Community boards. A program established pursuant to this section shall be governed by a local board composed of community members. The board membership must include representation of primary and complementary health care providers, mental health care providers, micro-employers and individuals enrolled in the Community Health Access Program. The community boards shall establish bylaws and operating procedures.

6. Authorized powers. The program may:

A. Develop a comprehensive health care benefit package that may include but is not limited to, primary and tertiary health care services, mental health services, complementary health care services, preventive health care services, healthy lifestyle services, and pharmaceutical services;

B. Develop medical data collection systems that will provide the program with the information necessary to support medical management strategies and will determine the costs and quality outcomes for the services provided;

C. Establish a fee structure sufficient to cover the actuarially determined costs of the comprehensive health care benefit package offered;

D. Develop a sliding fee schedule based on income to ensure the fees are affordable for individuals covered by the plan. The plans are further authorized to establish mandatory minimum contributions by employers;

E. Collect fees from individuals and employers enrolled in the program;

F. Solicit and accept funds from private and public sources to subsidize the plan;

G. Develop community preventive care education and wellness programs. The plans may coordinate its programs with schools, employers and other community institutions;

H. Enter into agreements with the Department of Human Services to provide care for individuals covered by the Department's medical assistance programs in its geographic region and to develop methods to share access to medical information necessary for the program's medical data collection system; and

I. Enter into agreements with third parties to provide needed services to programs, including but not limited to administration, claims processing, customer services, stop-loss insurance, education, out-of-area medical services, and other related program services and products.

7. Community Health Access Program excess insurance. In order to ensure for adequate financial resources, to pay for medical services allowed in the benefit plans developed by community health plan corporations, a community health care corporation is required to enter into agreements with insurers licensed in this State to obtain Community Health Access Program excess insurance and to provide coverage for those portions of the health care benefit package that exposes the corporations to financial risks beyond the resources of the corporation.

8. Continuity. Enrollment in a program authorized under this section is not considered prior coverage for the purposes of Title 24-A, Section 2849-B, subsection 2, paragraph A.

9. Cost-sharing agreements. A program may enter into agreements with private health insurance carriers or the Medicaid program in accordance with the following.

A. A program may enter into agreements with private health care insurers to cover individual medical costs associated with all or a portion of the costs resulting from the benefit plan or benefit plans offered by the program.

B. A program may enter into agreements with the department to access Medicaid coverage for all or a portion of the individual medical costs resulting from the benefit plans offered by the program.

C. No later than January 1, 2002, the department shall seek a waiver from the Federal Government as necessary to permit the use of the Medicaid program for the intended purposes of the program.

10. Medical and cost data. The department shall provide medical and cost data to the each program at the program's request in a format usable by the program's medical data collection system for the analysis of health care costs and health care outcomes.

11. Dissolution or sale. Upon the dissolution, sale or other distribution of assets of a community health plan corporation, the community board may convey or transfer the assets of the corporation only to one or more domestic corporations engaged in charitable or benevolent activities substantially similar to those of the community health plan corporation.

12. Annual reports. A program established pursuant to this section shall submit a written report to the Commissioner on or before January 21 annually. The report must address the financial feasibility, fee structure, and benefit design of the program; the health quality measures, health care costs and quality of health care outcome under the program; and number of lives enrolled in the program. The Commissioner may require more frequent reports and additional information. Annually, before March 15 of each year, the Department of Human Services must submit an annual report summarizing the program's demonstrated effectiveness by March 15 to the joint standing committee of the

Legislature having jurisdiction over health care insurance matters and human services matters.

13. Not subject to Title 24 or Title 24-A. A program established pursuant to this section or a community health plan corporation organized pursuant to this section is not subject to Title 24 or Title 24-A.

14. Rules. The department shall adopt rules establishing minimum standards for financial solvency, benefit design, enrollee protections, disclosure requirements, conditions for limiting enrollment and procedures for dissolution of a program. The department may also adopt any rules necessary to carry out the purposes of this section. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

{the draft provisions presented below would be presented as separate legislation to the Appropriations Committee}

Sec. 1 22 MRSA § 3195 is enacted to read:

§ 3195. Affordable Health Care Fund

The Affordable Health Care Fund is established to assist individuals with the costs of participation in the Community Health Access Program. The fund is a nonlapsing fund and any excess funds may only be used for the purposes of this section. The fund may only be used to subsidize the costs of the Community Health Access Program's fees. The department shall establish subsidies on a sliding scale based on income for eligible individuals enrolled in the Community Health Access Program. Individuals eligible for health coverage under the Medicaid or Medicare programs are not eligible to receive a subsidy from this fund.

Sec. 2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

2001-2002

HUMAN SERVICES, DEPARTMENT OF

Affordable Health Care Fund

All Other	\$ 1, 500, 000
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Provides funds to establish the Affordable Health Care Fund to provide subsidies for individuals enrolled in the Community Health Access Program

The Joint Select Committee recommends that the State apply for a Medicaid waiver to create a Medicaid “buy-in” program for individuals and small groups.

Sec. 1. Department of Human Services to apply for a waiver. The Department of Human Services shall apply by January 1, 2002 to the Federal Government for a waiver to permit funding under the Medicaid program to allow individuals and small employers to purchase coverage under the Medicaid program. The waiver must provide for a sliding scale fee based upon income and must be revenue-neutral. The waiver must provide that any savings be used to increase coverage for individuals and small employers. The department may adopt rules required to implement the waiver program in accordance with this section. Rules adopted pursuant to this section are major substantive rules for purposes of the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

APPENDIX A:

JOINT ORDER, HOUSE PAPER 1857

APPENDIX B:

MEMBERS OF JOINT SELECT COMMITTEE

APPENDIX C:

SUMMARIES OF JOINT SELECT COMMITTEE MEETINGS

**Joint Select Committee to Study Creation of a Public/Private Purchasing Alliance to Ensure
Access to Health Care for All Maine Citizens
Meeting Summary – September 19, 2000**

Joint select committee members in attendance: Sen. Jill Goldthwait (Senate chair) Sen. Neria Douglass, Sen. Peter Mills, Rep. Jane Saxl (House chair), Rep. Arthur Mayo III, Rep. John Richardson, Rep. Sumner Jones, Rep. Ben Dudley and Rep. Chris O’Neil. Rep. Nutting, Glynn and Rep. Perry were absent. Rep. Nancy Sullivan who was originally named as a member of the committee has withdrawn because of scheduling conflicts and has not been replaced yet. Colleen McCarthy Reid, staff to the joint select committee, was also in attendance.

The meeting began with an introduction from the committee chairs and the interested parties in attendance.

Duties and Background of Joint Select Committee

The committee briefly reviewed the duties from Joint Order HP 1857 that created the joint select committee. The joint order requires the committee to do the following:

- Examine the public policy, regulatory and legislative issues related to the creation of a public/private purchasing alliance, including but not limited to:
 - the priorities and objectives of a purchasing alliance;
 - the critical mass needed for an alliance to be effective and the possible public entities that could be included in an alliance;
 - the ability of private payers such as individuals, small employers and large employers to be included in an alliance;
 - the use of community rating, separate risk pools or other risk adjustment mechanisms in an alliance;
 - the governance and administrative structure of an alliance; and
 - the benefit structure and choice of health plans that should be offered through an alliance
- Review the experience of other states or entities that have established purchasing alliances
- Recommend a model and strategies for the establishment of purchasing alliances in this State
- Examine the possibility of creating a pilot project for a community-based health plan, including the statutory and regulatory framework for such a project and the need for state funds to cover potential losses incurred by the plan
- Invite the participation of experts and interested parties, including the Bureau of Insurance, the Bureau of Medical Services, the State Employee Health Commission, the Maine Health Management Coalition and the Muskie School of Public Service

Public Hearing/ Budget Discussion

HP 1857 requires the committee to submit a budget and work plan to the Legislative Council for its approval within 10 days of its first meeting. The proposed budget of \$8890 prepared by the

Office of Fiscal and Program Review includes money for per diem and expenses of legislators and printing and mailing costs only. No money has been included for the costs associated with a public hearing. Sen. Goldthwait asked for the committee's thoughts on whether a public hearing would be helpful at the mid-point of the committee's work. It was suggested and agreed to by the committee that the decision to hold a public hearing should be deferred until the 3rd meeting, but that the proposed budget submitted to the council should include the funds needed for a public hearing. The committee also decided that a future meeting should be held outside of Augusta in Bangor. The October 10th meeting was selected, although staff has not yet confirmed space in Bangor for the 10th. A final decision on the location of the October 10th meeting will be made by September 26th.

Current law related to purchasing alliances and past legislative proposals related to purchasing alliances

Staff outlined the prior proposals on purchasing alliances considered during the 117th Legislature and the origin of the current law related to purchasing alliances.

There were 2 bills considered in the 117th that would have established purchasing alliances. The major proposal, LD 1753, was presented by the Health Care Reform Commission (HCRC), as part of its package of recommended incremental health insurance reforms. The HCRC proposal would have created a state-chartered, private, non-profit purchasing alliance for individuals and small employers. The alliance would have been required to contract with health insurance carriers to provide 10 different health plans to enrollees. General fund revenues were provided for start-up funds and assessments on premiums sold through the alliance would have provided on-going funding. The State Employee Health Commission would have also been required to jointly negotiate with the alliance as part of the contracting process with carriers. Opposition from the Maine State Employees Union and the State Employee Health Commission led to the creation of a committee bill, LD 1882, which was later enacted as PL 1995, chapter 672, proposing a statutory framework for the formation of voluntary private purchasing alliances.

Under current law, an alliance must be licensed by the Bureau of Insurance and may be organized as a nonprofit or for-profit organization. A purchasing alliance is required to contract with health insurance carriers to provide coverage to its members through participating unaffiliated multiple carriers. Individual enrollees in an alliance have a choice of health plans. Under Maine law, an alliance must offer at least 3 different carriers in each portion of its service area unless the requirement is waived by the Superintendent of Insurance. To date, there have not been any private purchasing alliances formed in Maine although there has been interest from various groups.

Other states' experiences with purchasing alliances; problems experienced in other states

Staff reviewed the status of purchasing alliances in other states and the problems experienced in other states. While 30 states have legislation allowing the establishment of purchasing alliances, the data available indicates that there are only 12 alliances in operation in California, Connecticut, Colorado, Kansas, Montana, , New York (2), North Carolina, Ohio, Oregon, Utah and Washington. Alliances in Florida, Kentucky, Iowa and Texas have been disbanded. All of the alliances in operation are open to employer, mostly small employers from 2-50 employees.

The primary benefits of purchasing alliances have been identified as: 1) administrative simplicity; 2) multiple choice of health carriers and health plans; and 3) leverage in negotiation lower premiums. Studies seem to demonstrate that the alliances that have been formed have been able

to deliver the first two benefits, but haven't been able to negotiate lower premiums compared to the outside small group market.

The problems experienced by purchasing alliances have been generally identified as:

- limited market share
- changes in the health insurance environment, especially the small group market
- problems with implementation
- resistance or oppositions from interest groups, namely health plans and insurance agents

Several studies have suggested that if alliances could increase their market share to “critical mass” (identified by one study as 15-20% market share for the small group market), the alliance would be able to gain the leverage needed to negotiate lower premiums.

Committee discussion: Where do we go from here?; Planning for future meetings

The committee discussed the framework and focus for its remaining meetings and the public policy issues that need further discussion. It was suggested that despite the problems experienced in other states purchasing alliances could work in Maine but the issues of “critical mass”, participations of existing risk pools like the State employees or Medicaid enrollees, state funding and structure, and tax or other incentives need to be explored and addressed in greater detail. It was also suggested that other models for health care financing should be explored, including the prescription drug model, a regional hospital-based delivery system for health care coverage, the MDI Community Health Plan's pilot project, MEWA's and association plans, and the creation of a state-chartered, “MEMIC-style” health insurer should be discussed. The committee decided to focus on presentations and discussion of the purchasing alliance model for the September 26th meeting and to look at other models at the October 10th meeting.

The committee requested the following information:

- copies of prior bills related to the formation of purchasing alliances
- the start-up funding or on-going funding provided by other states that formed purchasing alliances
- proposals related to tax incentives, credits or other subsidies for participation in a purchasing alliance
- enrollment figures for individual and small group markets in Maine and size of existing publicly funded risk pools

Staff will provide as much of the requested information as possible at the September 26th meeting.

**Joint Select Committee to Study Creation of a Public/Private Purchasing Alliance to Ensure
Access to Health Care for All Maine Citizens
Meeting Summary – September 26, 2000**

Joint select committee members in attendance: Sen. Jill Goldthwait (Senate chair) Sen. Neria Douglass, Sen. Peter Mills, Rep. Jane Saxl (House chair), Rep. Arthur Mayo III, Rep. Sumner Jones and Rep. Chris O’Neil. Rep. Nutting, Rep. Richardson, Rep. Dudley, Rep. Glynn and Rep. Perry were absent. Rep. Nancy Sullivan who was originally named as a member of the committee has withdrawn because of scheduling conflicts and will not be replaced. Colleen McCarthy Reid, staff to the joint select committee, was also in attendance.

The focus of the meeting presentations was the purchasing alliance model—why it hasn’t worked in Maine and can it work in Maine. The committee heard from 3 presenters: Ellen Schneiter, Executive Director of the former Maine Health Care Reform Commission; Peter Gore, Maine Chamber and Business Alliance; and Alessandro Iuppa, Superintendent of the Maine Bureau of Insurance.

Ellen Schneiter, Maine Health Care Reform Commission

Ellen outlined the purchasing alliance proposal put forward by the Maine Health Care Reform Commission in the 117th Legislature. She explained that while the state employee health plan was only required to jointly negotiate with the alliance and would be a separate risk pool, the perception of many legislators and the Maine State Employees Union was that the state plan would be part of the alliance. That perception led to the failure of the proposal. She expressed her opinion that she thought consumers would be better off today if the alliance had been formed. The Commission had projected an 8% reduction in premium costs for health plans sold through the alliance. She also stated that the creation of an alliance now would probably not be successful because of the scarcity of insurers and decreasing competition in the small group and individual health insurance market in Maine. If the goal of an alliance is to use group buying power to leverage lower premiums, that goal is more difficult to achieve if there are a low number of carriers interested in bidding. “Critical mass” remains the key to the success of an alliance.

Peter Gore, Maine Chamber and Business Alliance

Peter explained the process undertaken by the Maine Chamber to study the feasibility of a private purchasing alliance under the current law. He stated that while the Chamber was committed to the idea and worked very hard on the issue there were three primary reasons why they concluded a private alliance was not feasible for them. The reasons he gave were: 1) the long-term success of an alliance was unlikely due to the volatility of the market and the lack of continuity among members; 2) the administrative start up costs would require significant capital investment for the Chamber (approximately \$250,000 - \$500,000) and if those costs were passed on, alliance products would not offer significantly lower premiums than the open market; and 3) the Chamber did not have a “critical mass” sufficient to bargain with carriers and market the alliance to its members.

However, Peter did explain that the Chamber has developed a new insurance product with Anthem Blue Cross Blue Shield for its members through an association plan. The new product offers high deductible choices of \$5000 and \$7500 along with an option of medical expense reimbursement accounts to allow employees to save funds to meet the deductible on a pre-tax basis.

In response to questions and comments from committee members, Peter agreed that today's market has changed significantly since 1997 and may be a less favorable climate for the establishment of an alliance.

Al Iuppa, Maine Bureau of Insurance

The Superintendent provided committee members with current information on the status of the individual and small group market in Maine. He outlined the carriers doing business in each market and the number of lives covered under individual and small group plans. He also provided recent financial information on HMO plans in Maine that demonstrates that only one HMO, Cigna, showed a small profit in the second quarter of this year. The remaining HMOs are operating with fairly significant losses.

On the topic of purchasing alliances, he commented that he didn't know that anything was wrong with the current law. He noted that since it was enacted the law was amended to allow the establishment of for-profit alliances to further encourage their establishment. In response to the question of whether an alliance could work in Maine, he noted that an alliance operates on the assumption of competition among carriers and service providers. With few carriers doing business in Maine currently, it would be difficult to develop an alliance that would meet Maine's needs and demographics. He also handed out a chart showing the increase in health care expenses for Maine insurers. These expenses for medical costs are a significant factor for the increased costs of health insurance premiums. He noted that an alliance may not be able to affect those costs.

Follow Up from Staff: Questions and Information Requests

Staff provided copies of past proposed legislation related to purchasing alliances, including LD 1753 that contains the Maine Health Care Reform Commission proposal. Staff also provided information in response to the following questions from committee members:

1. What type of State funding has been provided for purchasing alliances established in other states?

Based on the preliminary information I have been able to gather on alliances that are currently operating, there are no alliances that receive ongoing funding from the State. State resources are required, however, to provide regulatory oversight and monitoring of alliances by the state insurance department.

In terms of start-up funding, Florida provided start-up funds for administration of its regional purchasing alliances. The grants were capped at \$275,000 each for its 11 regional alliances. California's alliance originally began with state agency oversight so significant State funding was provided at its inception.

Note: The Maine Health Care Reform Commission's proposal to create a purchasing alliance would have provided \$1.5 million in General Fund money for start-up costs and would have funded the alliance on an ongoing basis through an assessment on products sold through the alliance.

2. What type of tax incentives or subsidy programs have been used in other states to encourage small employers to provide health insurance coverage or to participate in purchasing alliances?

Staff provided some examples from other states.

Tax incentives: Ohio law allows small employers that purchase health insurance coverage under a qualified alliance program to fully deduct the premiums or other charges paid by the employer in determining the state income tax.

Subsidy programs: New York law provides eligible small employers assistance in purchasing health insurance coverage for their full-time employees and their dependents. *(The subsidies were available to employers that purchased coverage from any insurer.)* Small employers of fewer than 50 full-time employees who have not provided group health insurance benefits to any employee in a prior 12-month period were eligible for the program. Employers could receive a voucher for up to 45% of the premiums costs paid by the employer; the contribution that could be required from employees was capped at 10%. The program began in 1997 and was phased out in January 2000.

3. For purposes of getting “critical mass”, how many lives are covered under existing publicly funded insurance pools?

State Employee Health Insurance Program: Based on information from the SEHIP, the total number of contracts for health insurance under the program, including active employees and retirees, is 22, 644. *The estimated number of covered lives under the program (employees, retirees and dependents) is 47,552.*

Medicaid and Cub Care programs: Based on information from the Medicaid program, there were approximately 170,259 individuals enrolled in Medicaid; of that number, approximately 63,000 were enrolled in Primecare and 2,000 with Aetna. Of that total number of 170,259, there were approximately 3,410 individuals enrolled in Cub Care. *** A newspaper report in the 9/27 edition of the Portland Press Herald noted that 9,510 individuals were enrolled in the CubCare program. Staff has contacted the Bureau of Medical Services for more information on the discrepancy.* Past studies indicated that there were 21,000 potentially eligible children with incomes under 200% of the federal poverty level.

Committee discussion: Where do we go from here?; Planning for future meetings

The committee discussed plans for the next meeting to be held in Augusta instead of Bangor due to scheduling conflicts for presenters. The October 24th meeting will be held in Bangor. At the October 10th meeting, presenters will include the State Employee Health Insurance Plan (tentative), Rep. Mike Saxl, Commissioner Longley and the Governor’s Blue Ribbon Commission on Health Care. The committee will also hear from the Bureau of Insurance on MEWAs and association plans and the bankers’ associations about their group health insurance arrangements. Lastly, the committee will hear a presentation from John Benoit and Gino Nalli on a private purchasing alliance model that they are developing.

At the October 24th meeting in Bangor, the committee will hear presentations from the MDI Community Health Plan, Anthem Blue Cross and Blue Shield and the insurance agents’ association. Invited presenters who haven’t yet been confirmed include the Bureau of Medical Services and Norman Ledwin of Eastern Maine Medical Center. Staff will update the planned agenda for the 24th at the next meeting.

In taking stock of how the committee felt about its work so far, the committee decided to broaden its charge somewhat to addressing ways to combine purchasing power for health coverage and to

leave the purchasing alliance model on the table for discussion along with other alternative financing mechanisms and delivery systems. It was noted that health insurance began at the community level and the committee should explore ways to retain and encourage community-level decision-making about health care. It was also noted that the idea of government reinsurance should be explored.

The committee requested information whether or not there are tax benefits to employers for paying out-of-pocket health care expenses for employees covered under high deductible health plans.

Staff will try to provide the requested information at the October 10th meeting as well as additional information related to earlier requests.

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**Joint Select Committee to Study Creation of a Public/Private Purchasing Alliance to Ensure
Access to Health Care for All Maine Citizens
Meeting Summary – October 10, 2000**

Joint select committee members in attendance: Sen. Jill Goldthwait (Senate chair), Sen. Neria Douglass, Rep. Jane Saxl (House chair), Rep. Arthur Mayo III, Rep. Sumner Jones, Rep. Ben Dudley and Rep. Chris O'Neil. Colleen McCarthy Reid, staff to the joint select committee was also in attendance. Absent: Sen. Peter Mills, Rep. Robert Nutting, Rep. John Richardson, Rep. Kevin Glynn, Rep. Nancy Sullivan, and Rep. Joseph Perry.

The focus of the meeting presentations was different group health insurance purchasing models, including purchasing alliances.

Housekeeping Matters

While the Legislative Council approved the committee's budget request for newspaper advertising for a public hearing, the committee decided not to hold a formal public hearing. Instead, it was decided that time will be set aside at the October 24th meeting in Bangor for public comment. Committee staff will send press releases to area newspapers about the meeting.

Multiple Employer Welfare Arrangements (MEWAs) and Association Plans

Tom Record and Rick Diamond, Maine Bureau of Insurance

Tom Record provided a historical background for the creation of the MEWA and an outline of the regulatory framework for MEWAs under Maine law. Although ERISA generally preempts states from regulating employer welfare benefit plans, states have been given specific authority under ERISA to regulate multiple employee welfare arrangements. Maine law governing MEWAs was enacted in 1995. The law requires MEWAs to be licensed by the Bureau of Insurance and to meet requirements that include fiscal soundness. Under a MEWA arrangement, an employer or group of employers is able to self-insure health care coverage. Since it was enacted, Maine has only licensed one MEWA. The MEWA of the Maine Bankers' Association began operating in July 2000. See outline of Mark Walker's presentation.

Rick Diamond provided a list of the group association plans approved by the Bureau of Insurance. He noted that association plans must be fully insured, i.e. the association is a policyholder for a group health insurance contract for association members. He also noted that Maine law prohibits an association from being formed solely for the purpose of purchasing group health insurance.

Rep. Michael Saxl

Rep. Saxl outlined some purchasing strategies for health insurance that he is exploring for the upcoming legislative session. He cautioned the committee about the huge health care crisis and that one solution will not solve the problem. He said that several incremental initiatives will be needed to solve the problem in the long-term. He is focusing on a strategic plan for the next 2-8 years to meet the goal of providing access to health care for all Maine citizens. He reminded the committee that it must be aware of a "death spiral" in the private insurance market in developing strategies.

Rep. Saxl described a two-pronged set of proposals addressing the public and private provision of health care coverage. On the public side, he suggested that the Medicaid program be expanded to provide access to more individuals through a buy-in program for individuals and small groups. He noted that the Medicaid plan has low administrative costs (4-7%) and is more affordable than private market plans (approx. \$1100-1300 annually). With the private health insurance market, Rep. Saxl described the creation of a reinsurance mechanism for small employers providing a defined benefit package. He drew a comparison between this model to create a "Rainy Day Fund" with General Fund monies to assist small employers who provide health insurance and the model under workers' compensation law that allows employers to join workers' compensation group self-insured risk pools.

State Employee Health Insurance Program

Frank Johnson, Director, Office of Employee Health and Benefits

Frank Johnson gave the committee background information on the current state employee health plan. He told the committee that eligibility for coverage and the requirement for state contribution to the plan is governed by statute, 5 MRSA § 285. The State Employee Health Commission, a labor-management group, serves as trustee of both the state health and dental plans. Currently, the state offers a POS plan through Anthem Blue Cross and Blue Shield to all active employees and their dependents; pre-Medicare age retirees and their dependents are also covered by the POS plan; and a Companion Plan product to all Medicare-eligible retirees to Supplement Medicare Parts A and B. Frank also briefed the committee on the plan's recent premium history, including a 28.8% increase in rates from April 1, 1999 to April 1, 2000.

On the topic of purchasing alliances, Frank noted that SEHIP's past opposition to the purchasing alliance model proposed by the Maine Health Care Reform Commission. The main reasons cited by the State Employee Health Commission (SEHC) at that time included:

- the requirement that only the state employee plan was mandated to participate;
- the governance of the alliance and admonished autonomy for the SEHC in its purchasing decisions;
- the provisions related to coverage of retiree populations; and
- the introduction of multiple plan offerings to individual enrollees and that effect on risk selection.

Frank noted that there has been considerable turnover in the membership of the SEHC since 1995. He speculated whether the SEHC would take a similar position today.

With regard to the state plan's participation in a public/private purchasing alliance, Frank offered some comments as the plan administrator with the disclaimer that his comments did not represent the views of the SEHC. He noted that a large health plan like the state plan can serve as the foundation for an alliance but that there were several practical factors that should be considered. These factors included the demographics of the state employee plan – an older population that includes pre-Medicare retirees – and the high premium costs for the plan. With a single rate of \$362.76 per month, he opined that the plan would not be affordable or attractive to many small group or individual purchasers. He mentioned different approaches to mitigate these factors, including establishing separate risk pools and changes in benefit plan design and offerings.

Maine Association of Community Banks' Insurance Trust

Chris Pinkham, MACB

Chris Pinkham gave an overview of the Association's benefits trust which offers a full cafeteria benefits to its members banks, including health insurance. The Association provides administrative support to its members including billing and research; claims administration is done under contract with a third-party administrator. The trust has 32 members and approximately 3500 covered lives in the health plan. He noted that the trust provides economies of scale to the members and greater choice to both employers and employees. The group plan is healthy – 2 new entities have joined in the past year.

Maine Bankers' Association MEWA

Mark Walker, Maine Bankers' Association

Mark provided an overview of the recently established MEWA of the Maine Bankers' Association. As previously noted, it is the first in operation in the state. It began offering self-insured health benefits to its members in July 2000. Since it is early, it is too soon to comment on the MEWAs long-term success. However, things are going well so far. The MEWA has 13 member banks and 800 employees with approximately 1300 covered lives under the plan. Prior to July 2000, the Banker's Association had a benefits trust similar to the MACB that offered health insurance through a fully-insured arrangement with Blue Cross Blue Shield. Now, the MEWA is a self-insured arrangement with the plan coordinated by a benefits administrator. The primary motivation was the benefit of group power with self-funding option to smaller employers that would be unable to self-fund alone. The outlook for the plan is that costs and claims will be the same and no changes in benefit packages have been made. Over time, the hope is that the arrangement will control increases in costs. The arrangement reinsures single claims after \$100,000 and also puts caps on overall amounts expended by employer members. He noted that there were some statutory hurdles and suggested that the committee explore making changes to the "sponsoring organization" language and the requirement that the arrangement be fiscally solvent at all times to make the statutory provisions more flexible.

Katy Longley, Commissioner of Professional and Financial Regulation

Commissioner Longley outlined the efforts of a Tri-state Coalition (Maine, New Hampshire and Vermont) at consolidating administrative functions for pharmacy benefit costs to reduce overall prescription drug costs for the states. The Coalition is developing an RFP to pharmacy benefits management companies for the management of the pharmacy benefits for the Medicaid programs in these states. Implementation is planned for Spring 2001. State employee plans will be phased-in at a later date as will options for small employers. Consultants have projected a 12-15% savings in administrative costs through the implementation of this type of program. Commissioner Longley said the participants in the Coalition are hopeful and are exploring ways to streamline regulation on a regional basis.

Governor's Year 2000 Blue Ribbon Commission on Health Care

Robert Woodbury, Chair and Joseph Carleton

Bob Woodbury and Joe Carleton gave an overview of the Commission's work, notably the preliminary report and options. They outlined the areas of recommendation as (1) the creation of a health policy council; (2) increased awareness and expenditure for public health; (3) increased access and affordability to health insurance and coverage; and (4) increased efficiency from both a clinical and an administrative standpoint. The final report and recommendations is expected

November 20. They noted that the concept of a purchasing alliance has been given some thought and study by the Commission, but that they have not devoted time to the issue because of the creation of this legislative study.

Small Group Purchasing Alliance Model

John Benoit, Holden Insurance Agency and Gino Nalli, USM Muskie School of Public Service

John and Gino outlined a model for a private purchasing alliance they have developed and hope to implement in southern Maine. Their model is designed for small employers of less than 50 employees. The alliance would be a non-profit entity and would not bear insurance risk. In the model, the alliance would offer one indemnity plan option and one managed care option in a particular geographic area. Employee contributions to either option would cost the same to address the potential for adverse selection. The choice of the employee would not be based on cost but on different coverage levels and provider network of each option. They outline the potential regulatory barriers currently in place to the development of such an alliance. The regulatory barriers they identified included: (1) the restrictions on travel time and distance requirements for tertiary services in the preferred provider organization act; (2) the benefit differential requirements in the ppo act; (3) the "any willing provider"-type requirements for a select network in the ppo act; and (4) the requirement in the private purchasing alliance chapter to offer at least 3 different carriers.

**Joint Select Committee to Study Creation of a Public/Private Purchasing
Alliance to Ensure Access to Health Care for All Maine Citizens
Meeting Summary – October 24, 2000**

Joint select committee members in attendance: Sen. Jill Goldthwait (Senate chair), Rep. Jane Saxl (House chair), Sen. Peter Mills, Rep. Arthur Mayo III, Rep. Sumner Jones and Rep. Chris O'Neil. Colleen McCarthy Reid, staff to the joint select committee was also in attendance. Absent: Sen. Neria Douglass, Rep. Ben Dudley, Rep. Robert Nutting, Rep. John Richardson, Rep. Kevin Glynn, Rep. Nancy Sullivan, and Rep. Joseph Perry.

The meeting was held in Bangor at Bangor City Hall. The meeting presentations focused on community-based health care delivery, provider involvement in health care delivery and Maine's Medicaid managed care program. A portion of the meeting was reserved for public comment.

Mount Desert Island Community Health Plan

John Cleveland, Robert Dworak, Joseph Robinson and Julian Kuffler, M.D.

The presentation began with an overview of the MDI Community Health Plan. The plan was formed in 1996 and is a nonprofit tax-exempt organization. Currently, the plan provides community health and education services and local Medical Management services and local Member Services assistance to area employers. The plan is also working to develop a comprehensive locally-based health insurance plan. Its primary goal is to provide more options for health insurance.

The presenters identified two major problems with the current health system as the lack of local medical management that emphasizes early intervention, preventive and wellness services and the lack of an integrated health data information system that gives physicians and other health care providers and consumers access to information to effectively control costs. In response to the problem of little or no local medical management, the MDI Community Health Plan has developed its own medical management model and has begun marketing this model to area employers.

The MDI Community Health Plan has also been working actively to develop a local health insurance plan. It has explored many different avenues, such as a partnership with a private health insurer, the formation of a local insurance company, the development of a demonstration project with waivers from existing insurance law, and the formation of a multiple employer welfare arrangement (MEWA). Recently, the MDI Community Health Plan met with the Commissioner of Human Services to explore the development of a Medicaid "buy-in" program for individuals and micro-employers with the ability for local medical management.

While the MDI Community Health Plan will go forward with its efforts, the presenters recommended that the committee and the Legislature support demonstration projects such as a Medicaid "buy-in" program that would allow participation by the MDI CHP. A "buy-in" program for the Maine Medicaid program would require a waiver from the federal government. They also urged the committee to support funding to supplement the premium for the Medicaid "buy-in" for the neediest individuals and to support funding and programs that emphasize the use of local medical management structures to control costs and manage care.

Maine's Medicaid Managed Care Program – Maine PrimeCare

Jude Walsh, Director, Division of Quality Improvement, Bureau of Medical Services

Ms. Walsh gave the committee an overview of the managed care program. The program began as a voluntary program in Kennebec and Somerset counties in 1994. It became a mandatory program in July 1996 in Aroostook, Piscataquis and Washington counties with 10,500 enrollees and is now a mandatory program for certain Medicaid enrollees in Androscoggin, Aroostook, Cumberland, Hancock, Kennebec, Oxford, Penobscot, Piscataquis, Somerset, Washington and York counties. By the end of 2000, the program hopes to expand to all 16 counties in Maine. In October 2000, the enrollment in Maine PrimeCare was 71, 677; 78% of the Medicaid eligible population is enrolled in Maine Primecare. Under federal law, mandatory participation is prohibited for those individuals dually eligible for both Medicaid and Medicare. The Department also has a contract with Aetna that has an additional 1879 enrollees. Mandatory enrollees include those who reside in a mandatory county and who: receive TANF (Temporary Aid for Needy Families); are TANF-related, who have children, are pregnant or are under 21 years of age; is a child in foster care that receives TANF; or receive Cub Care or Medicaid expansion.

The PrimeCare program's goals are to: comply with the Medicaid rules; establish a medical home for the Medicaid beneficiary; provide continuity of care; strengthen the provider/patient relationship; and to reduce unnecessary utilization. Providers enrolled as PrimeCare providers are responsible for comprehensive primary care, patient education, authorization for managed services and 24-hour coverage. PrimeCare providers receive a Medicaid fee for direct services and are paid a monthly management fee of \$3.00 per month per patient. There is also a Primary Care Physician Incentive Program (PC-PIP) that provides additional payments to providers that meet program incentives. The services requiring authorization from the PrimeCare provider include ambulatory surgery services, chiropractic services, durable medical equipment services, home health services, inpatient and outpatient hospital services, laboratory and X-ray services and physical and occupational therapy services. Those services that do not require prior approval under the PrimeCare program include ambulance services, annual gynecological exam, emergency room services, dental services, prescriptions, mental health and substance abuse services.

Blue Hill Memorial Hospital, affiliate of Eastern Maine Health

Bruce Cummings, CEO, Blue Hill Memorial Hospital

Mr. Cummings spoke to the committee about the hospital's efforts to form a community health plan with a health insurance component similar to the model being developed by the Mount Desert Island Community Health Plan. Ultimately, the hospital did not pursue the formation of its own health plan for a several reasons: legal reasons related to the formation of a multiple employer welfare arrangement (MEWA); capital reserves needed to qualify under the insurance laws; problems associated with segmenting risks in different pools and the shrinking population base in their geographical area; and financial instability of the hospital. Since the time that the community health plan idea was explored in the early 1990's, Blue Hill Memorial is on better financial ground as it has been designated a critical access hospital under Medicaid. This designation makes the hospital eligible for higher rates of reimbursement for its services.

Mr. Cummings suggested several possible steps for the committee to address problems in the health insurance market. These included the funding and development of demonstration projects at the local, regional and state level; and the formation of a state-chartered nonprofit mutual health insurance company. He noted the funding potentially available from the health care trust fund established after the sale of Blue Cross and Blue Shield of Maine.

Anthem Blue Cross and Blue Shield

Sharon Roberts and Rick Morrone

Ms. Roberts briefly outlined the Maine Partners and Central Maine Partners plans which were formed and owned jointly by Blue Cross and Maine Health and Central Maine Health, respectively. The Maine Partners plan has been successful in terms of enrollment with approximately 60,000 enrollees and serves members in 7 counties. It has not been financially profitable and continues to operate at a loss. Ms. Roberts noted that the “jury is still out” as to whether the plan will success long-term, but indicated that Anthem and Maine Health have benefited from the partnership. Anthem recently acquired the ownership share of Central Maine Partners plan and has applied to the Bureau of Insurance to merge the plan back into the parent company.

Mr. Morrone outlined the product design of the new product offered by Anthem with the Maine Chamber and Business Alliance. The product is a high deductible plan (\$5000 and \$7500 deductible options are available) with a medical reimbursement account component. In terms of premium, the products are priced 35-40% less than similar plans with lower deductible options.

Public Comment

The following individuals provided public comment: Jean Hay, Peter Rees, Jessie Greenbaum, Robin Wade and Andrew MacLean, Maine Medical Association. Ms. Hay, a State Senate candidate outlined her proposal for health care reform and distributed an op-ed piece on the topic she authored in the Bangor Daily News. The remaining presenters spoke in support of the Mount Desert Island Community Health Plan and state funding for demonstration projects involving MDICHP.

Planning for Next Meeting

At the request of the chairs, the committee spent ten minutes brainstorming to compile a list of ideas/topics/findings/recommendations based on all of the information provided to them. Staff will work to develop this list as a starting point for discussion of findings and recommendations at the November 9th meeting. At that meeting, there may be some short presentations, but the focus of the meeting will be the development of the committee’s findings and recommendations.

NEXT MEETING

**Thursday, November 9th
10:00 am – 4:00 pm
Room 427, State House**

DRAFT FINDINGS AND RECOMMENDATIONS
For Discussion Purposes Only
November 9th

Listed below are the potential findings and recommendations brought out in committee discussion on October 24th:

DRAFT FINDINGS	DRAFT RECOMMENDATIONS
<ul style="list-style-type: none"> • purchasing alliances have had limited success • purchasing alliance model is incremental health care reform • requirement that purchasing alliances contract with at least 3 different carriers has inhibited establishment of alliances by private sector • State employees should not be mandatory participants in purchasing alliance • the State has unacceptable levels of uninsured/underinsured individuals • critical mass for spreading risk is necessary • insurance industry still knows best how to insure/manage risk • local management of care works very well • federal law and regulations limit ability to control costs with State action • high-deductible policies are not long-term solution • high-deductible policies are disincentive to preventive care • underlying health care costs need to be controlled to control increases in health insurance premiums • effects of health insurance costs on small businesses and individuals retard economic growth 	<ul style="list-style-type: none"> • eliminate requirement that private purchasing alliances offer at least 3 different carriers • establish pilot projects and demonstration projects • create Medicaid buy-in program as option to decrease numbers of uninsured • use state funding to subsidize premiums for Medicaid “buy-in” • consider reinsurance mechanism with State funding • need one state-wide risk pool ? • establish better system for data collection • advocate on federal level for universal health care/national health care reform • advocate for better Medicare reimbursement • provide better health education/preventive to control chronic illness • provide prescription drug coverage as part of health insurance policies

Listed below are other potential recommendations suggested to the committee by interested parties appearing before the committee:

Suggested by Rep. Michael Saxl:

- create a Medicaid “buy-in” program for individuals and small groups with a defined benefit package
- establish a defined benefit package for individuals and small groups in the private insurance market that offer insurers a reinsurance mechanism for catastrophic claims

Suggested by John Benoit, Holden Insurance Agency and Gino Nalli, Muskie School of Public Service:

- broaden the restrictions on travel time and distance requirements for tertiary services in the preferred provider organization act
- broaden the benefit differential requirements in the Preferred Provider Organization act
- change the "any willing provider"-type requirements for a select network in the Preferred Provider Organization act
- eliminate the requirement in the private purchasing alliance law that alliance offer at least 3 different carriers

Suggested by Mount Desert Island Community Health Plan:

- legislate and support a State Medicaid “buy-in” program
- provide funding to supplement “buy-in” premiums for individuals
- support demonstration projects that emphasize the use of local medical management systems

Suggested by Bruce Cummings, Blue Hill Memorial Hospital:

- establish local, regional and statewide demonstration projects for a community-based health plan
- create a State-chartered nonprofit mutual health insurance company with State funds

APPENDIX D:

**DRAFT LEGISLATION RELATING TO
REINSURANCE MECHANISM**

Draft Legislation to implement a reinsurance mechanism

Sec. 1. 24-A MRSA § _____ are enacted to read:

§ _____. Individual and small group health insurance market reinsurance mechanism

1. Individual and small group health insurance market reinsurance mechanism. The individual and small group health insurance market reinsurance mechanism, referred to in this section as the “reinsurance mechanism”, is established as a nonprofit voluntary unincorporated legal entity to create an assessment mechanism and a mandatory risk sharing plan for the individual and small group health insurance market as a mechanism to distribute the risks associated within the individual and small group markets. All carriers, including health maintenance organizations, authorized to transact health insurance are members of the reinsurance mechanism and shall remain members of the association as a condition of their authority to transact insurance in this State. The reinsurance mechanism shall perform its functions under a plan of operation established and approved under subsection 3 and exercise its powers through a board of directors established under subsection 2.

2. Reinsurance mechanism board of directors. The board of directors of the reinsurance mechanism shall consist of not less than 7 persons serving terms as established in the plan of operation. The members of the board must be selected by member insurers subject to the approval of the superintendent. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the superintendent. In approving selections to the board, the superintendent shall consider among other things whether all member insurers are fairly represented. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

3. Plan of operation. The board of directors shall adopt a plan of operation and submit the plan of operation for approved by the superintendent. Any amendments to the plan of operation must be approved by the superintendent. The plan of operation must be in accordance with the following.

A. Risks must be shared through a risk adjustment and subsidization mechanism for carriers in the individual and small group health insurance market.

B. Subsidies must be determined on a calendar year basis and calculations of a subsidy in a given calendar year must be based on the claims experience of a carrier in the prior year. In calculating the subsidy, only claims in excess of \$75,000 may be considered. Only writers of individual and small group health insurance who are actively marketing individual and small group health insurance during the year in which the subsidy is distributed are eligible for a subsidy.

C. Assessments against members of the reinsurance mechanism must be calculated based on the number of covered lives in the individual and small group

health insurance markets. The number of covered lives must be determined each month during the calendar year. The assessment must be calculated as the number of covered lives multiplied by a specific amount. The specific amount is fixed throughout each calendar year and must be determined by the board of directors no later than the first day of November preceding the calendar year for which the amount is to be used. The specific amount is subject to approval by the superintendent. The board of directors shall establish procedures by which affiliated carriers calculate their assessment on an aggregate basis and to ensure that no covered life is counted more than once.

D. The plan of operation shall address the responsibility for the handling and accounting of funds and other assets of the reinsurance mechanism, the financial and other records required to be kept by the reinsurance mechanism and such other administrative provisions as are necessary for the execution of the powers and duties of the reinsurance mechanism.

4. Powers and duties of the reinsurance mechanism. The reinsurance mechanism shall:

A. Conduct activities in accordance with the plan of operation as approved by the superintendent;

B. Determine and collect assessments and distribute subsidy payments as provided in the plan of operation and approved by the superintendent;

C. Enter into contracts as necessary and proper to administer the plan of operation;

D. Sue or be sued, including taking any legal action necessary or proper for the recovery of any unpaid assessments for, on behalf of, or against members of the reinsurance mechanism;

E. Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the reinsurance mechanism, including the hiring of independent legal consultants as necessary; and

F. Perform any other functions within the authority of the reinsurance mechanism as may be necessary and proper in carrying out the plan of operation.

5. Superintendent's powers and duties. The superintendent is authorized to do the following:

A. Demand that a member of the reinsurance mechanism pay an assessment within a reasonable time at the request of the board of directors;

B. Levy a forfeiture on any member that fails to pay an assessment when due. Such forfeiture may not exceed 5 % of the unpaid assessment per month, but no forfeiture may be less than \$100 per month;

C. Suspend or revoke, after notice and hearing, the certificate of authority to transact business in the State of any member that fails to pay an assessment when due or fails to comply with the plan of operation; and

D. Decide an appeal made by a member of any action by the board of directors if the appeal is made within 30 days of the final action being appealed. If a member is appealing an assessment, the amount assessed must be paid to the reinsurance mechanism and available to meet reinsurance mechanism obligations during the pendency of the appeal. If the appeal on the assessment is upheld, the amount paid in excess or in error must be returned to the member from available funds of the reinsurance mechanism. Any final action of the superintendent of an appeal is subject to judicial review pursuant to Title 5, chapter 375.

6. Examination and annual report. The reinsurance mechanism is subject to examination by the superintendent. The board of directors shall submit to the superintendent not later than 120 days after the close of the reinsurance mechanism's fiscal year a financial report in a form approved by the superintendent and a report of its activities during the preceding fiscal year. The reinsurance mechanism's fiscal year is the calendar year.

7. Immunity for members and employees. The reinsurance mechanism, its board of directors or employees, a member insurer, its agents or employees, or the superintendent or the superintendent's designees is immune from any cause of action of any nature for any action or omission by them in the performance of their powers and duties under this section.

8. Tax exemption. The reinsurance mechanism is exempt from payment of all fees and all taxes levied by the State or any of its subdivisions, except for taxes levied on real property.

APPENDIX E:

**MOUNT DESERT ISLAND
COMMUNITY HEALTH PLAN MODEL**

APPENDIX F:
SMALL GROUP
PURCHASING ALLIANCE MODEL