MAINE ASSOCIATION
OF
HEALTH PLANS

Testimony of Katherine Pelletreau
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

Neither For nor Against

Proposed Amendment to L.D. 1 An Act to Protect Health Care Coverage for Maine Families (1/24/19 Amendment)

January 29, 2019

Good Afternoon Senator Sanborn, Representative Tepler, Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:

My name is Katherine Pelletreau and I am the Executive Director of the Maine Association of Health Plans (MeAHP). MeAHP has five members including Aetna, Anthem Blue Cross and Blue Shield, Cigna, Community Health Options and Harvard Pilgrim Health Care. Collectively, MeAHP's members provide or administer health insurance coverage to over 600,000 Maine people.

MeAHP is commenting on the proposed amendment to L.D. 1 distributed last Thursday, January 24th, 2019, acknowledging that the extent of the amendments requires more time to fully understand the sponsor's intended goals with the amendment as well as whether the proposed language aligns, conflicts or complicates unnecessarily existing federal insurance statute and rules related to the Affordable Care Act. If the sponsor's goal is to embed ACA provisions and protections within Maine statute, then MeAHP believes that can be accomplished with tighter drafting.

If the sponsors wish to use the current federal ACA statutory and regulatory framework as a platform from which to create a "Maine specific ACA", which several provisions of this bill appear to do, then MeAHP asks that legislators clarify areas for which they are seeking expanded coverage in state law, allowing MeAHP to provide more comment on those objectives.

This amendment to L.D. 1 incorporates into Maine state law ***selected*** provisions of the Affordable Care Act, some of which were in Maine law prior to the ACA. However, the amendment while incorporating patient protections, is silent on how Mainers will afford the system they are creating in state law. As drafted, the amendment creates a parallel system, not a system that "kicks in" should the ACA be repealed. The bill creates no mechanism to support affordability such as funding for subsidies and/or an individual mandate for the coverage it is seeking to provide.

The Affordable Care Act provided a national framework with a goal of providing affordable and accessible health coverage through the establishment of minimum plan design standards (EHBs), a means to access coverage (the Exchange, and Medicaid Expansion) and a means-tested way to help finance coverage for individuals and small groups. The "system" was intended to be the sum of its parts: subsidies and cost sharing reductions for individual purchasers, small business tax credits to help offset the increased cost for expanded coverage for the smallest of small businesses, penalties for individuals opting out of coverage; penalties for employers which opted not to provide health coverage to their employees; and taxes on insurers to fund reinsurance pools to stabilize the individual and small group markets.

MeAHP members have operated fully within the framework of the ACA since its adoption in 2010, and as various elements were phased in for full implementation by 2014. It remains the law of the land, and as currently drafted, the proposed L.D. 1 amendment would supplement, not supplant, the ACA provisions, should federal law be repealed. This creates a question on whether the bill sponsors' intent is to create parallel systems of program design and regulation (both federal and state, and within the state).

Examples of inconsistencies between the ACA and the L.D. 1 amendment language include:

- Use of the term "substantially similar" within several sections of the amendment; keep in mind that the ACA-defined EHBs were intended as a 'floor' not a 'ceiling';

- Application of the Essential Health Benefits to large group plans in Maine.[1] (The citation for EHB being limited to individual and small group plans is 45 CFR 147.150 - Coverage of essential health benefits). The direct application of standardized EHB's to large group plans could be disruptive for many Maine employers as it could limit their ability to have a more flexible plan design that meetings their needs while remaining consistent with broad ACA consumer protections.

- Establishing a new category of plans, as the bill appears to, creates a category of "Keep What You Have" ACA-compliant plans in both the individual and group market, and "new" Maine ACA plans that meet the newly added Maine-specific requirements.

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[1] The citation for EHB being limited to individual and small group plans is 45 CFR 147.150 - Coverage of essential health benefits.
"(a)*Requirement to cover the essential health benefits package.* A health insurance issuer offering health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package as defined in section 1302(a) of the Affordable Care Act effective for plan or policy years beginning on or after January 1, 2014."
An FAQ document from CMS further clarifies that large group plans are not required to cover EHB, but they are prohibited from imposing annual/lifetime limits.
"Under the Affordable Care Act, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHB. However, the prohibition in PHS Act section 2711 on imposing annual and lifetime dollar limits on EHB does apply to self-insured group health plans, large group market health plans, and grandfathered group market health plans." (page 4 of FAQ)

- Conflicts between federal guidance on how dependent children are defined for the purpose of family rating[2]. The new section limiting family rating to no more than three dependents deviates from the ACA by prohibiting the ability to rate a family plans with adult children differently from those with non-adult dependent children.

Maine has a long history of providing strong patient protections. Several of the provisions outlined in the bill as presented already exist, at least to some degree, in state law. For example, Maine law already largely prohibits the use of pre-existing conditions to limit or deny coverage (Title 24-A §2850-A), permits children up to age 25 to remain on their parents' health plan (Title 24-A MRSA §2742-B), and has eliminated annual and lifetime limits on most health insurance benefits (Title 24-A MRSA §4320).

It is important that this bill *mirror* the language in the ACA if that is indeed the intention. Without changes, this amendment appears to create expanded, state-specific provisions which will increase volatility in the Maine market, likely increasing costs for employers and individuals. We would request that the sponsors consider revisions to ensure consistency with the ACA including for those issues we have raised.

These comments are offered based on the Plans' preliminary review. It will take more time to fully analyze the language against the complex web of guidance (rules, laws, and letters) that is the ACA.

Thank you.

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[2] The 2013 Final Rule for Health Insurance Market Reforms, under the section for Fair Health Insurance Premiums (Section147.102) provides for the following: "that issuers may vary rates based on whether a plan covers an individual or a family. PHS Act section 2701(a)(4) provides that, with respect to family coverage, the rating variation permitted for age and tobacco use must be applied based on the portion of the premium attributable to each family member covered under a plan. Section147.102(c)(2) of the final rule provides that if a state does not permit any rating variation for age and tobacco use, then the state may elect to require that premiums for family coverage be determined by using uniform family tiers and corresponding multipliers established by the state. For 2014, a state must submit its election of family tiers and corresponding multipliers to CMS no later than March 29, 2013. If a state does not establish uniform family tiers and corresponding multipliers, then the per-member rating methodology under § 147.102(c)(1) will apply. Per-member rating requires that the age and tobacco use factors be apportioned to each family member. The final rule imposes a cap of no more than three covered children under the age of 21 whose per-member rates are taken into account in determining the family premium." (See page 3 of the CMS technical summary: https://www.cms.gov/CCIIO/Resources/Files/Downloads/market-rules-technical-summary-2-27-2013.pdf)