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TESTIMONY OF ERIC A. CIOPPA
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In support of L.D. 2007
"An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine"
Presented by Speaker of the House Sara Gideon
Before the Joint Standing Committee on Health Coverage, Insurance & Financial Services
February 5, 2020 at 10:00 a.m.

Senator Sanborn, Representative Tepler, and members of the Committee, I am Superintendent of Insurance Eric Cioppa. I am here today to testify in support of L.D. 2007.

My testimony addresses Parts B and C of the bill, which amend the Insurance Code. As you have already heard, the overriding purpose of the bill is to make health insurance in Maine more affordable for individuals, families, and small business, and better designed to meet their needs.

The insurance provisions of the bill will implement the following five initiatives:

- Clear choice designs for cost sharing, which will simplify deductibles, coinsurance, and copayments and allow consumers and small employers to make apples-to-apples comparisons between health plans;
- More affordable access to primary care and behavioral health care for consumers covered by individual and small group plans;
- Pooling the individual and small group health insurance markets;
- Simplifying the coverage provided by the Maine Guaranteed Access Reinsurance Association (MGARA), and extending its protection to small employers in the pooled market;
- Adding cost-control incentives to the MGARA program design.

The first of these initiatives, the clear choice design framework, will encourage carriers in the individual and small group markets to compete on the basis of price and quality by requiring more transparency in the deductibles, copayments, coinsurance, and out-of-pocket limits that consumers must pay. Similar plans will be required to use the same cost-sharing framework for some of the most commonly used covered benefits, so that consumers will have the information they need to make a straightforward cost comparison without the need to calculate the effect of minor variations in cost sharing. Setting the specific cost-sharing design will be a cooperative effort, giving patients, carriers, and providers the opportunity to provide input on the rules that will establish the number of different designs in each metal level and the structure of these designs. This will

also be subject to annual revision, and to the right of carriers to offer additional plans if they can demonstrate that the ability to offer nonstandard plans is in the interest of consumers.

The other cost-sharing initiative in the bill builds on the preventive care benefit established under the Affordable Care Act (ACA) and incorporated into Maine law last year. This initiative recognizes that affordability is not measured by premium alone, but also by out-of-pocket costs at the time of service. These are a real and growing concern for consumers. This bill helps to relieve those costs by making some of the most common medical visits less expensive. All health insurance plans for individuals and small businesses in Maine will cover the first primary care visit and behavioral health visit for free – with no cost sharing – just as they now do for specified preventive care services. Additionally, the second and third primary care and behavioral health visits would not be subject to the deductible, although they could have copayments. Unlike the other provisions of the bill, which require a longer planning phase and will not take effect until the 2022 plan year, this benefit will be available in 2021. It is important to note, however, that the new benefit will not be available for consumers who are contributing to health savings accounts (HSAs) unless and until it is authorized by the Internal Revenue Service. This is because, without such authorization, first-dollar coverage of primary and behavioral health care would disqualify an insurance plan from HSA-compatible status.

Next, the bill will merge Maine's small group and individual health insurance markets into a single statewide risk pool. This means insurance companies would pool all individual and small business enrollees when

determining premiums and would offer the same plans to both individuals and small businesses. This would increase the size and stability of the risk pool. However, because making coverage affordable for small business is one of the overriding goals of the bill, the bill provides that the pooled market will not be implemented unless and until the Superintendent determines that it will not raise average premium rates for small employers.

The key to lowering premiums for small employers is the provision extending MGARA to the entire pooled market. This means that small group health plans will receive the same protection against catastrophic claims that the existing program has provided for individual plans. The bill will also restructure MGARA to provide a simplified "retrospective" program design, similar to the federal program that operated in the initial years of the ACA, reimbursing carriers for all eligible claims in excess of the attachment point. This is in contrast to the existing prospective structure under which policies must be either predesignated as high-risk policies by the carrier or identified as providing coverage for patients with specified high-cost medical conditions on a list issued by MGARA, and carriers must pay a substantial premium to MGARA for each policy ceded. The current prospective program design has been made even more difficult to implement by federal regulations that prohibit carriers from gathering health data from applicants. Carriers had previously used this data to decide which enrollees presented a risk of large claims that was high enough to be worth the cost of paying the reinsurance premium to MGARA.

As noted earlier, however, the changes to MGARA are contingent on federal approval of an amendment to Maine's Section 1332 waiver, and on approval by the

Superintendent based on a demonstration that the revised MGARA program will be able to provide savings in average premiums for both small businesses and individuals. Importantly, the bill requires MGARA to continue operating within its available resources, and does not change the assessments that are currently paid to fund the program.

The final initiative takes a step towards addressing the most intractable problem health reform must deal with in the United States – the high cost of care. The bill will revise MGARA's payment structure by limiting the amount MGARA would reimburse carriers, through assessments and federal Section 1332 funding, for designated high-priced services to no more than twice what Medicare would pay. The bill would also require MGARA to compile and publish a list of providers whose charges exceed the reimbursement limit.

In addition, the bill also includes provisions improving Maine's ability to leverage federal programs for the benefit of Maine residents and Maine businesses. Many of you are familiar with the federal Innovation Waiver, under Section 1332 of the Affordable Care Act (ACA). The waiver provides crucial federal funding to ensure that MGARA can carry out its mission of reducing costs in the individual market by providing protection against catastrophic claims. The improvements to MGARA contemplated by this bill can only be implemented if the Centers for Medicare and Medicaid Services (CMS) approves an amendment to our Section 1332 waiver, and one of the conditions required by Section 1332 is language in state law authorizing the State to submit an application. Our current enabling language, found in the MGARA chapter, is limited to one specific application for a particular federal program – an application for a Section 1332 waiver for the

purpose of reactivating MGARA in 2019. The state-federal health coverage partnership provision of the bill generalizes this process, rather than specifically authorizing an application to amend the existing waiver and nothing else. This gives Maine the flexibility to take advantage of any new options or resources that might come from the federal government, including ACA Section 1332 but not limited to that single program.

Finally, the bill includes a number of technical updates that make conforming revisions to existing law, including clarifying that MGARA does not cover association health plans that opt out of the statewide rating pool for individual and small group coverage.[1]

Thank you, I would be glad to answer any questions now or at the work session.

[1] Although Section B-3 of the bill appears to enact more than a page of new language, most of that is simply a restatement of the existing language, as most recently amended last year.