



STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BUREAU OF INSURANCE  
34 STATE HOUSE ST A TION  
AUGUSTA, MAINE  
04333-0034

Paul R. LePage  
GOVERNOR

Eric A. Cioppa  
Superintendent

May 9, 2018

Alex M. Azar II  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington DC 20201

Dear Secretary Azar:

Stabilizing Maine's health insurance market is one of the highest priorities for the Maine Bureau of Insurance. The Maine Guaranteed Access Reinsurance Association (MGARA), which has become popularly known as Maine's "invisible high risk pool," was one of the centerpieces of Maine's 2011 health reform legislation. It had a proven track record of success, lowering individual health premiums by approximately 20 percent.

We are pleased to submit this State Innovation Waiver application under PPACA Section 1332. The waiver we are requesting will enable the reactivation of MGARA without losing the federal funding that would otherwise be available under the Obamacare premium subsidy program. It will allow us to provide much-needed premium relief to Mainers who do not qualify for subsidies, without increasing the cost of subsidized coverage or changing the benefits provided in any way.

As explained in the enclosed application, MGARA will be financed through a combination of reinsurance charges paid by participating insurers, a modest assessment on all health coverage sold in Maine, and the federal pass-through funding provided under Section 1332.

We appreciate your consideration of our waiver request. If there are any questions or concerns, please do not hesitate to contact myself or Superintendent of Insurance Eric Cioppa directly.

Respectfully submitted on behalf of the Maine Bureau of Insurance,

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance



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**STATE OF MAINE  
EXECUTIVE SUMMARY AND  
APPLICATION FOR WAIVER  
UNDER SECTION 1332 OF THE  
PATIENT PROTECTION AND AFFORDABLE CARE ACT**

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- B. Maine Guaranteed Access Reinsurance Association Plan of Operation**
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- D. Maine Bureau of Insurance Cost Report of Public Law Chapter 488, “An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program,” January 2018**
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**State of Maine**  
**Executive Summary and**  
**Application for Waiver under Section 1332**  
**of the Patient Protection and Affordable Care Act**

**I. Executive Summary**

A. Request. The State of Maine, through its Bureau of Insurance, Department of Professional and Financial Regulation (“State”) submits this Section 1332 State Innovation Waiver request to the United States Department of the Treasury and to the Centers for Medicare and Medicaid Services (“CMS”), a division of the United States Department of Health and Human Services (“HHS”). This request seeks waiver of Section 1312(c)(1) under Section 1332 of the Patient Protection and Affordable Care Act (“ACA”) for a period of five years beginning in the 2019 plan year to permit the reinstatement of Maine Guaranteed Access Reinsurance Association (“MGARA”), the State’s existing reinsurance program (described in the following section). This waiver will not affect any other provision of the ACA, but will result in lowering premiums and reducing federal payment of premium tax credits (“PTC”)

B. Background. Prior to the implementation of the ACA, Maine was a leader in state-level innovation designed to reduce Mainers’ healthcare costs and increase their access to affordable health coverage. The State’s flagship innovation was MGARA, a legislatively established private nonprofit organization operating a reinsurance program for the higher-risk segment of the State’s individual health insurance market. In 2013, MGARA’s presence limited what otherwise would have been a 22 percent rate increase to only a 2 percent increase. That highly successful program was placed in suspension with the advent of the ACA, to avoid the imposition of redundant costs on the Maine market through parallel federal and state reinsurance programs. The State now seeks a State Innovation Waiver under Section 1332 of the ACA (a “1332 Waiver”) to permit the reinstatement of this program and to build upon the State’s past health reform successes.

Under the proposed 1332 Waiver, Maine would restart the MGARA reinsurance program (the “State Program”) and receive federal pass-through funding in the amount of the savings that would be generated from the resulting reduction in PTC subsidies. The proposed 1332 Waiver would be effective January 1, 2019 for an initial period of five years, with an option to renew for an additional five years.

C. Basis for Request and Goal of Reinsurance Program. During the past few years, Maine’s individual health insurance market has undergone significant change. Community Health Options (“CHO”), the State’s Consumer Operated and Oriented Plan (CO-OP), has emerged as the State’s largest carrier serving the individual market. Anthem, formerly the State’s largest carrier serving the individual market, announced on September 27, 2017, that it would not be writing ACA plans in Maine for 2018. Premiums have increased significantly throughout the market, and we have seen the implementation of narrower provider networks by health carriers.

The restart of the State Program through the 1332 Waiver will bring increased certainty and stability to Maine’s individual health insurance market through a positive effect on premium

levels. By reinsuring high-cost claims, the State Program will spread risk across the broader Maine health insurance market, thereby lowering premiums. The program also spreads the most volatile component of the risk within the individual market, thereby providing stability. The program is also expected to encourage participation (or continued participation) by insurers in that market.

D. Impact of the State Program. Title 24-A M.R.S. §3953(1)(C) authorizes the Superintendent of Insurance (“Superintendent”) to develop a proposal for a 1332 Waiver to facilitate resumption of the State Program, and, upon approval by the Governor, to apply for the waiver and implement it upon federal approval. The Legislation conditions resumption of the State Program on the granting of a 1332 Waiver. Total funding for the State Program for 2019 is estimated to be approximately \$93 million (see funding model described in Section III below). The State estimates that the State Program will result in a net premium decrease of nine percent (9%) in 2019. Through this waiver request, Maine seeks federal pass-through funds – provided from the proceeds of net premium tax credit savings, estimated to be in excess of \$33 million per year through 2027 – to partially recoup expenditures made from assessments collected under state law.

E. Compliance with Section 1332. Granting the 1332 Waiver will not impact the comprehensiveness of coverage in the Maine insurance markets. As noted above, the waiver will reduce premiums and increase affordability. As a result, the State estimates enrollment in the individual market will increase by approximately 1.1 percent in 2019, 0.9 percent in 2020, and 0.3-0.8 percent in the eight years remaining in the ten-year budget cycle over what enrollment would be without MGARA<sup>1</sup> (see Exhibit A, Figure 1). Due to the resulting reduction in individual health insurance premiums, including premiums for the second-lowest-cost silver plan, the federal government will see a net reduction in spending of more than \$33 million for each year the five-year waiver and the State Program are in place.

## **II. Assurances of Compliance with Section 1332 Guardrails**

The State anticipates that its proposal will meet the parameters set forth in Section 1332 of the ACA and provides the following assurances:

A. Comprehensive Coverage – 1332(b)(1)(A). The proposed waiver makes no alterations to the required scope of benefits offered in the insurance market in Maine and will not result in a decrease in the number of individuals with coverage that meets the ACA’s Essential Health Benefits requirements.

B. Affordability – 1332(b)(1)(B). The proposed waiver will not decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending. The waiver will not result in any decrease in affordability for individuals; on the contrary, the purpose of the waiver is to revive the State Program’s favorable effect on insurance rates in Maine’s individual market.

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<sup>1</sup> Exhibit A, pp. 11-17.

C. Scope of Coverage – 1332(b)(1)(C). The proposed waiver will facilitate the provision of coverage to at least a comparable number of Maine residents as would be provided absent the waiver. The total estimated non-group enrollment increase resulting from the waiver is 1.1% in 2019 and ranges from 0.3% to 0.9% each year through 2028. Percentage enrollment increases are greatest for those persons not eligible for premium tax credits.

D. Federal Deficit Neutrality – 1332(b)(1)(D). The proposed waiver will not result in increased spending, administrative, or other expenses to the federal government. It requests pass-through payments that mirror the State Program’s reduction in federal PTC subsidies for which the federal government would otherwise be responsible, net of reductions in premium-based Exchange user fees.

E. Pass-Through Funding. Under the proposed waiver, the federal government would pass through to the State, as contemplated by Section 1332(a)(3) of the ACA, its cost savings resulting from the State Program’s positive effect on premium rates and corresponding reduction in the amount of PTC that would otherwise be claimed by many individual market participants in Maine in a given calendar year.

F. Effect on Federal Operational Considerations. The proposed waiver requests no changes to Maine’s federally-facilitated exchange (the “Exchange”) or treatment by the Internal Revenue Service.

G. Public Notice. The proposed waiver has been publicly posted, public information and comment hearings were held, and public comments were solicited in compliance with 31 CFR 33.112 and 45 CFR 155.1312. Postings on-line met national standards to assure access to individuals with disabilities.

### **III. Background and Description of Maine’s Health Insurance Market**

A. Background: Maine’s Individual Market Reinsurance Program. MGARA is a key component of the reforms originally instituted in May 2011, when the Maine State Legislature passed 2011 Public Law Chapter 90, “An Act To Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services” (“PL90”). During its period of active operation (prior to suspension of operations due to the transitional reinsurance provided under the ACA), MGARA reduced insurance costs in Maine’s individual health insurance market by providing reinsurance for a significant portion of the coverage provided through individual health insurance policies. If the 1332 Waiver request is granted, MGARA’s re-activation is intended to again reduce insurance costs in Maine’s individual health insurance market through operation of its reinsurance program.

Over MGARA’s period of active operation (2012 and 2013), MGARA paid approximately \$66 million in claims and generated a positive fund balance of approximately \$5 million. Based on rate filings submitted by insurance carriers operating in Maine’s individual market, the State Program generated an approximate **20% reduction in requested rates**. By way of example, Anthem Health Plans of Maine, Inc.’s (“Anthem”) 2013 rate filing sought a rate increase of 1.7%. Anthem projected that without the State Program, its 2013 rate increase would have been 21.6%.

Despite this success, the State Program was rendered redundant during the pendency of the federal transitional reinsurance program (the “Federal Program”) established by HHS under the ACA. Both programs offered reinsurance for the individual health insurance market in Maine, subsidized by broad-based assessments on the entire health benefit market. Although there were differences between the structures of the two programs, the Federal Program served essentially the same functions as MGARA and there was substantial overlap in the benefits that would have been paid to ceding insurers. Accordingly, MGARA suspended all but limited administrative operations effective January 1, 2014, to avoid imposing redundant costs on the Maine market through parallel federal and state individual market reinsurance programs.

The Federal Program ended as scheduled on December 31, 2016. Cognizant of the success of its pre-ACA health reform efforts and the unfavorable rate effects associated with the absence of any individual market reinsurance program in the State, Maine seeks to reinstate the State Program. By this Application, Maine seeks a 1332 Waiver pursuant to the provisions of Section 1332 of the Act, as discussed below.

PL90 established a four-part funding mechanism to spread the costs associated with the MGARA reinsurance program across the individual, group, and self-insurance markets. Under the proposed waiver, pass-through funds received by the State would be contributed to MGARA as a fifth revenue source, further enhancing its ability to make insurance more affordable for Maine residents and increase market stability for insurers. The funding sources are described in the following table.

**Table 1**

<b><u>Funding Mechanism</u></b>	<b><u>Description</u></b>
Organizational Assessment	One-time nominal \$500 fee for each insurer licensed in 2012 for medical insurance, whether or not active in that market (not applicable prospectively)
Base Market Assessment	Assessment to health insurers and third-party administrators based on the number of insured lives covered by each in the Individual, Small Group, Large Group, and Self-insured Markets (excluding State and Federal employees), at a rate of up to \$4 per covered person per month (“PMPM”)
Reinsurance Premium	Insurers ceding covered persons to MGARA pay a ceding premium, currently set at 90% of the premium received from the enrollee
Deficit Assessment	Optional Assessments to cover any Net Losses — up to a maximum of \$2 PMPM

	assessed to health insurers based on the number of insured lives covered by each
Pass-Through Funding	Under the proposed waiver, all pass-through funds will be contributed to MGARA to enhance its capabilities.

The definition of “insurer” includes any insurance company, nonprofit hospital and medical service organization, fraternal benefit society, health maintenance organization, non-ERISA self-insured employer, third-party administrator, multiple employer welfare arrangement, health reinsurer, health insurance captive, and any other State-sponsored health benefit program, whether fully insured or self-funded.

The MGARA Board of Directors retained Milliman, Inc. (“Milliman”) to perform the economic and actuarial modeling contained in this Application. Milliman’s Report to the Board is Exhibit A to this Application.

The current MGARA Plan of Operation is attached hereto as Exhibit B. A revised Plan of Operation will be finalized by the Board following approval of the 1332 Waiver. The revised Plan will incorporate updated payment parameters and coverage ceding processes as described below, and will be consistent with the existing Plan of Operation in most other material respects.

The State Program provides reinsurance for policies covering high-risk individuals, as identified by medical diagnosis or by the insurance carrier’s underwriting judgment. When the carrier cedes a policy to MGARA, it operates like a traditional reinsurance program: the ceding carrier pays MGARA a premium, and in return, MGARA pays a portion of the carrier’s claims if they exceed the specified attachment point. When reactivated in 2019, MGARA will collect a reinsurance premium for each ceded policy that is equal to 90% of the underlying insurance premium, and reimburse the ceding carrier for eligible claims incurred during the year under the policy, at the following levels:

- 90 percent of claims paid between \$47,000 and \$77,000; and
- 100 percent of claims paid in excess of \$77,000, net of amounts recoverable from a federal high cost risk pool (60% of claims over \$1 million in 2019).

The Board determines the reinsurance premium, the attachment points, and the list of medical conditions for which ceding is mandatory.<sup>2</sup> The ceding carrier has the responsibility, under both the statute and the Plan of Operation, to manage reinsured claims in the same manner as it manages claims that are paid from the carrier’s own funds.

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<sup>2</sup> 24-A Me. Rev. Stat. §§ 3958 & 3959(2). MGARA’s enabling legislation specifies the attachment points to be used in 2012, but grants the Board the power to adjust the attachment points annually to reflect increases in costs and utilization.

Eligible claims are only those amounts that are actually paid by a ceding carrier for benefits provided to the individual. Eligible claims do not include such things as administrative expenses, attorneys' fees, or non-medical benefits. The ceding carrier's maximum exposure for any reinsured individual in a single calendar year is \$50,000 (100% of the first \$47,000 plus 10% of the next \$30,000).

MGARA has unlimited exposure to \$1 million per calendar year for all eligible claims on ceded policies in excess of the exposure retained by the ceding carrier. In its 2018 Notice of Benefit and Payment Parameters, CMS made changes to the ACA risk adjustment program to include a high-cost risk pooling mechanism, under which carriers are reimbursed 60% of claim costs above \$1,000,000 for members whose claims exceed that threshold. The current claim threshold of \$1,000,000, set for the 2019 benefit year via recently finalized regulations, is subject to adjustment through rulemaking. Although the MGARA Board of Directors has not yet formally adopted a change in response to this development, based on conversations with MGARA's General Counsel, the Bureau of Insurance anticipates the MGARA program will coordinate with the federal risk adjustment program; for example, with respect to claims that exceed the federal pooling threshold (currently \$1,000,000), the federal risk adjustment program could pay 60% and the MGARA program could pay 40%.

Under the MGARA program, there are currently eight designated medical conditions which require ceding of coverage. A list of the eight conditions is attached as Exhibit C. Carriers may voluntarily cede other coverage to MGARA. The 90% ceding premium was actuarially determined to be sufficient to support anticipated levels of mandatory and voluntary ceding. Together with the ceding carrier's retained risk, it has operated as a sufficient deterrent to excessive voluntary ceding.

During MGARA's operations in 2012–13, it had reinsured 90% of claims paid on ceded policies from \$7,500 to \$32,500 and 100% of claims in excess of \$32,500. When setting the revised payment parameters for 2019, Milliman and the Board considered the significant differences in the Maine insurance market between 2013 and present, including lower deductibles, mandatory prescription drug benefits, increases in medical trend, changes in benefit design, and a significantly larger individual market. They modeled potential adjustments in attachment points, ceding premiums, and mandatory ceding conditions to determine the optimal way to provide premium relief and market stability while assuring the solvency of the program. Other factors, in particular the maximum assessment of \$4 per member per month, are fixed by MGARA's enabling legislation. Based on the Milliman modeling and Board's consideration of alternatives, it was determined that the original eight ceding conditions remained optimal, that increasing ceding premiums above 90% was not necessary, and that the proposed increases in the attachment points will be sufficient to address MGARA's financial needs.

During MGARA's 2012-13 operations, carriers were able to evaluate coverage eligible or suitable for ceding to MGARA on the basis of a health statement collected at the time of application for insurance. Because the large majority of Maine's individual insurance market is now enrolled through the federally-facilitated Exchange (also known as "the Marketplace") and no health information is collected there, MGARA's reliance on health statements is no longer feasible. MGARA will be replacing reliance on the health statement with mandatory ceding

based on carriers identifying policies with ICD 10 codes associated with the mandatory ceding conditions. Mandatory ceding will be able to occur at any point in the year with reinsurance retroactive to the beginning of the policy year with respect to both coverage and premium. Discretionary ceding will remain subject to procedures set forth in MGARA's Plan of Operation. Discretionary ceding will be allowed only during the first 60 days following the effective date of the underlying primary coverage, thereby minimizing the opportunity for carriers to cede mid-term policies on which adverse claims experience has developed.

The changes in ceding procedures described above will require changes in MGARA's Plan of Operation prior to its January 1, 2019 reactivation. Proposed changes in the Plan of Operation must be filed with and approved by the Superintendent of Insurance.

#### B. Characteristics of Maine's Health Insurance Market.

Maine's individual market has grown significantly in the last several years, from approximately 28,500 individuals in 2013 to over 85,000 in 2017 and 78,000 as of February, 2018. Approximately 90% of the individual market is insured through the Exchange. A very high percentage of the individual market (estimated at 78%) qualifies for federal Premium Tax Credit (PTC) subsidy, with 51% of the individual market at less than 250% of the federal poverty level (FPL) and 27% between 250% FPL and 400% FPL. Approximately 73% of the Exchange individual market is enrolled in Silver Plans. Maine's individual coverage rates were increased by approximately 23% in 2017 (the first year following the cessation of the Federal Program), and again by approximately 32% in 2018. This reflects, among other things, the continued absence of an individual market reinsurance program in Maine following the cessation of the Federal Program. Granting of the 1332 Waiver is required in order to re-start the State Program.<sup>3</sup>

Maine's small employer health insurance market has declined over the years from approximately 94,000 insured lives in 2013 just before implementation of the Affordable Care Act to approximately 60,000 in 2018. This is partly due to self-employed individuals becoming ineligible for small group coverage, but most of the market attrition is due to other structural factors, including large premium increases in the small group market, the availability of subsidized alternatives in the individual market, and changes in the age rating methodology. Both small and large employers expressed concern during the public comment period about the cost of reinstating MGARA's \$4 per member per month assessment. However, Milliman's modeling estimates this cost to be less than 1% of the total cost of employer-sponsored insurance in Maine.<sup>4</sup>

Maine has been active in seeking to control health care costs. The Maine Health Data Organization maintains "Compare Maine" ([www.comparemaine.org](http://www.comparemaine.org)), a website which provides the public with comparative health care cost and quality information for a wide variety of medical procedures. Recent legislation addressing costs includes 2017 Public Law

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<sup>3</sup> 24-A Me. Rev. Stat. § 3953(1)(A)(1).

<sup>4</sup> Exhibit A, p. 19

Ch. 232, “An Act To Encourage Maine Consumers to Comparison-shop for Certain Health Care Procedures and to Lower Health Care Costs,”<sup>5</sup> which when fully implemented in 2019 will encourage group insurance enrollees to use lower-cost health care providers by requiring carriers to return a portion of the savings to consumers when the actual cost of the service is less than the average cost. Another recent law, 2015 Public Law Ch. 488, “An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Monitoring Program,”<sup>6</sup> enacted stringent limitations on the ability of health care practitioners to write opioid prescriptions. Although this law was enacted as an opioid abuse measure rather than a cost control measure, a January 2018 Maine Bureau of Insurance study of initial results found that insurance carriers spent \$2.4 million (46.7%) less on opioid and opioid derivative claims in the first half of 2017 than in the first half of 2016. Health plan members spent nearly \$580,000 (36.9%) less in out-of-pocket costs during the same time periods. A copy of the study is attached as Exhibit D.

#### **IV. Description of Proposed 1332 Waiver**

As described above, during its period of operation, the State Program brought a rapid and dramatic improvement in individual market premiums in the State. A 1332 Waiver will permit the resumption of the State Program and apply its ameliorative effect to the high rates that have characterized the ACA market.

A. Overview. As contemplated by Section 1332, the State proposes to apply the federal funding that would have been paid to Maine Exchange participants absent the State Program, as pass-through payments under Section 1332(a)(3) of the ACA (“Pass-Through Payments”). This funding would be combined with MGARA’s existing funding mechanism to support and enhance the State Program’s continued ameliorative impacts on Maine’s individual market insurance rates. Without a reinsurance program, individual health insurance premiums will continue to rise at an unsustainable rate. Consequently, more Mainers will choose or be forced to go without health insurance, further driving up rates due to adverse selection and provider cost shifting. By re-implementing the State Program, Maine will reduce the potential for further market disruption, lower the cost of individual premiums, and decrease federal government PTC obligations.

Exhibit A, Figure I-5D(ii) shows that, after factoring in the 1332 Waiver and the re-implementation of the State Program, average 2019 federal PTC payments are estimated to be \$500 per member per month. Exhibit A, Figure I-5D(iii) also shows that without the 1332 Waiver and the State Program, 2019 federal PTC payments will be an estimated \$65 per member per month higher.

In order to reestablish the State Program, Maine seeks federal pass-through funds in the amount the federal government would have otherwise paid in PTC absent consideration of the reinsurance payments in the premiums paid by insureds in the individual market. By mitigating high-cost individual health insurance claims, the State Program will help to stabilize Maine’s

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<sup>5</sup> 2017 Public Law of Maine Chapter 232.

<sup>6</sup> 2015 Public Law of Maine Chapter 488 (enacted in 2016).

individual market and make premiums more affordable. With the 1332 Waiver in place and State Program in operation, Maine anticipates that individual premiums, including premiums for the second-lowest-cost silver plan, will be lower, net of the premium assessment, by 9% in 2019, 9.4% in 2020, and in the 8–9% range for 2021 through 2028 than they would have been without the 1332 Waiver and re-implementation of the State Program.

The following snapshot illustrates the projected benefits of resumption of the State Program under the proposed 1332 Waiver:

**Table 2**

Source	Baseline	Waiver/State Program
2019 Premium	\$683 PMPM	\$618 PMPM
2019 Enrollment	61,000	62,100

**B. Need for the Waiver**

The proposed 1332 Waiver would resolve an unintended consequence of the interface between the ACA and the State Program. The State Program, by reducing premiums in the individual market, will decrease the PTC amount that Maine’s Exchange participants have the right to receive. Section 1332 of the ACA was enacted to recognize the federal government’s continuing obligation to provide equivalent funding in such situations. The reduced PTC amount represents a measurable loss of federal support to Maine’s insurance market, compared to the amount that would otherwise be received by Exchange participants in Maine in a given calendar year absent the State Program.

**C. Impact if Waiver is Not Granted**

Absent a Section 1332 Waiver, even if the law had permitted the resumption of the State Program, it would almost certainly remain in suspension. This is because, if operated without a 1332 Waiver, the State Program would impose costs on the Maine insurance market without the materialization of a corresponding market benefit, as outlined above. Maine has already experienced average annual individual market rate increases of 23% in 2017 and 32% in 2018 since the suspension of MGARA and the cessation of the federal transitional reinsurance. These increases are expected to continue and, indeed, intensify. If a 1332 Waiver is granted and the State Program resumes, it is anticipated that approximately 300 to 1,100 additional individuals will have access to affordable coverage due to the lower cost of health insurance through MGARA’s ameliorative effect on rates.

**D. Legislation**

2017 Public Law Chapter 124, “An Act To Amend the Maine Guaranteed Access Reinsurance Act,” authorizes the State Superintendent of Insurance to develop a proposal for a 1332 Waiver to facilitate resumption of the State Program, to apply for the proposed waiver upon approval by the Governor, and to implement the waiver if it receives federal approval. Consistent with

the rationale articulated above, the Legislation conditions resumption of the State Program on the granting of a 1332 Waiver. A copy of the Legislation is attached as Exhibit E hereto.

E. Pass-Through Funding and Tax Credit Proposal; Section Impacted by Waiver

Consistent with Section 1332(a)(3) of the ACA, the State requests that the aggregate amount of credits and reductions that would have been paid on behalf of Maine Exchange participants absent the resumption of the State Program, be paid to the State for the purposes of implementing the State Program under the 1332 Waiver. Table II-1 of the actuarial analysis (Exhibit A) projects a net reduction in federal expenditures of approximately \$33 million in 2019 under a resumption of the State Program, and accordingly this amount is requested in the form of federal Pass-Through Payments. These funds will be leveraged by the State Program to further augment its beneficial effects on Maine's individual health insurance rates. The implementation of the State Program directly affects the cost of the baseline plan as defined in Section 36B(b)(3)(B) of the Internal Revenue Code, and it alters the rating calculations mandated under the regulations implementing Section 1312(c)(1) of the ACA, which requires "all enrollees in all health plans ... offered by [an] issuer in the individual market ... to be members of a single risk pool." In order to allow the benefits of MGARA to be fully realized through the rate-setting process, Maine seeks a waiver of Section 1312(c)(1) to the extent that it would otherwise require excluding expected reinsurance payments, ceding premiums, or assessments when establishing the marketwide index rate. Consideration of these payments will lower the marketwide index rate. A lower index rate will lower premiums for Maine's second lowest-cost silver plan, which will reduce the overall PTC that the federal government is obligated to pay to subsidy-eligible consumers.

F. Effect on ACA Sections that are Not Proposed to be Waived

No other section of the ACA would be affected by the proposed 1332 Waiver.

**V. Actuarial Analyses and Certifications**

A. Coverage Comparability

Actuarial analysis modeling included in this Application estimates that MGARA will result in a lower number of uninsured Mainers each year than in the baseline scenario in which MGARA is not reactivated. The analysis estimates that MGARA will not have any material impacts on the number of Mainers covered under employer-sponsored plans, traditional Medicaid, Medicare, or other public programs. For the duration of the projection period, the analysis estimates approximately 300 to 1,100 additional annual enrollees in the non-group market relative to the non-MGARA scenario.

B. Affordability of Coverage

MGARA is not estimated to impact premium rates materially for employer-sponsored insurance. A state-based assessment of \$4 per member per month on commercial insurers and

group health plans administered by third party administrators will be reimplemented as partial funding for MGARA. The modeling estimates this assessment will be less than 1% of an average employer's premium rate. There will be no impact on public programs such as Medicare and Medicaid. For the non-group market, there is an estimated 9% aggregate premium reduction relative to what rates would be without the waiver. Similar premium reductions are projected for each year through 2028. Net impact on any individual insured will vary greatly depending on his or her household income and interaction with the ACA's premium assistance program.

### C. Scope and Comprehensiveness of Coverage

Because MGARA makes no change to insurer benefit requirements for plans offered in Maine's health insurance markets, MGARA meets the comprehensiveness requirements required for a Section 1332 waiver.

## **VI. Implementation Plan and Timeline**

The State Program will be re-implemented by MGARA under the supervision of the Superintendent and the Maine Bureau of Insurance ("MBOI") in accordance with an amended Plan of Operation to be filed with the Superintendent for approval at the time the waiver is granted.<sup>7</sup>

06/02/17:	Legislation enacted.
4/2/18:	The public comment period begins.
4/13/18:	Second public comment hearing is held.
5/2/18:	The public comment period ends.
5/4/18	Tribal consultation period ends
5/9/18:	The 1332 waiver application is submitted to the federal government.
6/24/18:	The federal government determines that the waiver application is complete.
8/1/18:	CMS approves 1332 Waiver for State Program.
8/5/18:	Amended MGARA Plan of Operation approved by Superintendent of Insurance.
8/22/18	Deadline for final determination of 2019 rates.
9/1/18:	MGARA assessment notice to insurers for 2019 operations, to be paid quarterly.
12/31/18:	Insurers pay first quarterly assessment to fund the State Program.
1/1/19:	MGARA commences operation, including reporting to CMS or other federal agency or authority.
4/1/19:	The federal government funds the pass-through payments to the State Program for 2019.

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<sup>7</sup> MGARA's current Plan of Operation is attached as Exhibit B. Proposed amendments to the Plan are described in this Application.

## VII. Additional Information

A. Administrative Burden. The 1332 Waiver will cause minimal administrative burden and expense for Maine and for the federal government. The waiver will cause no additional administrative burden to employers and individual consumers because the State Program does not relate to the administrative functions or requirements typically undertaken by employers or individuals. Individual health insurers will see no additional administrative burden associated directly with the 1332 Waiver. Individual health insurers will experience additional administrative burden and associated expense as a result of the operation of the State Program resulting from ceding of policies and submission of reinsurance claims; however, the 1332 Waiver itself will not result in any additional administrative burden or cost, and the monetary benefit from the State Program's reinsurance will far exceed any resulting administrative expense.

MGARA and the MBOI, collectively, have the resources and staff necessary to absorb the following administrative tasks that the 1332 Waiver will require the state to perform:

- Administer the State Program
- Collect and apply federal pass-through funds
- Monitor compliance with federal law
- Collect and analyze data related to the 1332 Waiver
- Perform reviews of the implementation of the 1332 Waiver
- Submit annual reports (and quarterly reports, if ultimately required) to the federal government

The 1332 Waiver will require the federal government to perform the following administrative tasks:

- Review documented complaints, if any, related to the 1332 Waiver.
- Review state reports.
- Periodically evaluate the state's 1332 Waiver program.
- Calculate and facilitate the transfer of pass-through funds to the State.

Maine believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government, so that their effect should be insignificant. The 1332 Waiver does not necessitate any changes to the Federally-Facilitated Marketplace and will not affect how PTC or cost-sharing reduction payments are calculated or paid.

B. Impact on Residents Who Need to Obtain Health Care Services Out-of-State. The vast majority of Maine residents receive healthcare services from Maine-based providers. Maine does share a border with New Hampshire, and is not far from Boston, which is a center for advanced health care facilities; however, insurer service areas and networks that cover border areas generally are serviced through Maine-based providers and insurers' networks make adequate provision for any service required in New Hampshire or Massachusetts. Granting the 1332 Waiver request will not

affect insurer networks or service areas that provide coverage for services performed by out-of-state providers.

C. Ensuring Compliance; Preventing Waste, Fraud, and Abuse. MGARA is required under its enabling legislation to annually prepare comprehensive financial accounting statements audited by an independent certified public accountant and file the audited statements with the Superintendent and the Joint Standing Committee on Insurance and Financial Services of the Maine Legislature. The independent certified public accountant is required to make an annual review of MGARA's solvency, and submit that review to the Superintendent. The Superintendent has authority to order MGARA to charge additional assessments, as necessary to maintain solvency. MGARA is also required to report annually to the Joint Standing Committee on Insurance and Financial Services of the Maine Legislature regarding its operations and financial condition. MGARA and the Maine Bureau of Insurance will administer the State Program in accordance with its existing accounting, auditing, and reporting procedures. Auditing and reporting obligations of participating insurers are governed by MGARA's Plan of Operation and State rules and regulations.

The Maine Bureau of Insurance is responsible for regulating and ensuring regulatory compliance and monitoring the solvency of MGARA and all insurers; performing market conduct analysis, examinations, and investigations; and providing consumer outreach and protection. The Maine Bureau of Insurance investigates all complaints that fall within its regulatory authority.

The federal government is responsible for calculating the savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

D. State Reporting Requirements and Targets. The Maine Bureau of Insurance will submit the required quarterly, annual, and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive requirement, and the federal deficit requirement, in accordance with 45 CFR 155.1308(f)(4).

As required, the State will hold public meetings six months after the proposed 1332 Waiver is granted and annually thereafter. The date, time and location of each forum will be posted on the MGARA website and the Bureau of Insurance website. The division will also notify consumer and business advocacy organizations. Each meeting will be conducted at a site that allows both in-person and telephonic attendance to accommodate residents across the State.

The Maine Bureau of Insurance will assume responsibility for the reporting requirements of 45 CFR 155.1324, including the following:

- Quarterly reports [45 CFR 155.1324(a)]: To the extent required, the Maine Bureau of Insurance will submit quarterly reports, including reports of ongoing operational challenges, if any, and plans for, and results of, associated corrective actions.

- Annual reports [45 CFR 155.1324(b)]: MBOI will submit annual reports documenting the following:

- (1) The progress of the waiver.
- (2) Data on compliance with Section 1332(b)(1)(B) through (D) of the ACA.
- (3) Modifications, if any, to the essential health benefits for compliance with Section 1332(b)(1)(A) of the ACA.
- (4) The premium for the second lowest-cost silver plan under the waiver and an estimate of the premium as it would have been without the waiver for a representative consumer in each rating area.
- (5) A summary of the annual post-award public forum required by 45 CFR 155.1320(c) together with a summary of action taken in response to public input.
- (6) Any additional information required by the terms of the Section 1332 Waiver.

MBOI will submit and publish annual reports by the deadlines established in 45 CFR 155.1324(c) or the deadlines established by the terms of the 1332 Waiver.

### **VIII. Public Comment and Tribal Consultation**

A. Public Comment. On March 30, 2018, MBOI opened public comment on this 1332 Waiver request and posted notice of the opportunity to comment on the MBOI website and the MGARA website. On the same day, MBOI sent notice via govdelivery to its list of interested parties and stakeholders. The Notice issued is attached as Exhibit F. The list comprises more than 1500 individuals and organizations with an expressed interest in insurance-related matters.

On April 12 and 13, 2018 MBOI held public comment and information sessions in Bangor and Portland, Maine. These sessions were lightly attended and nearly all attendees were representatives of various stakeholders. Attendees included a representative of the Maine Chamber of Commerce, a representative of the Eastern Maine Health Care system, several representatives of health plans, a representative of a consumer group, an insurance producer, a legislator, and one unaffiliated member of the general public. Two members of the MGARA Board of Directors and its General Counsel attended the Portland meeting. The Superintendent of Insurance utilized a PowerPoint presentation to present the proposal and facilitate discussion during each meeting. The PowerPoint is attached as Exhibit G to this Application. Two major points were raised by attendees during the sessions: (1) reinsurance programs such as the one proposed, like any other insurance affordability initiative, redistribute the funding resources within the health care cost payment system but do not address underlying high health care costs; and (2) reinstatement of the \$4 per member per month assessment is of concern to the employer representatives who spoke, though they acknowledged that similar assessments were levied by

MGARA in 2012–13 and by the federal transitional reinsurance program from 2014–16.

A thirty-day public comment period was held from April 2, 2018 through May 2, 2018. Written comments were received from the following nine interests:

- American Lung Association;
- American Cancer Society Cancer Action Network
- American Heart Association & American Stroke Association
- Anthem Blue Cross/Blue Shield
- Epilepsy Foundation & Epilepsy Foundation New England
- Maine Association of Health Plans
- Maine Hospital Association
- Maine State Chamber of Commerce, and
- National Multiple Sclerosis Society

These comments are set forth as Exhibits H-1 to H-9 to this Application.

#### B. Tribal Consultation

Maine has four federally-recognized tribes, the Aroostook Band of Micmacs, the Houlton Band of Maliseets, the Passamaquoddy Tribe and the Penobscot Nation. Representatives of each of these tribes were contacted, information about the proposal was provided and consultation with or comments from the tribes were solicited. No comments were received from any of the tribes. Communications with each tribe are set forth as Exhibit I-1 to I-4 of this Application.



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# Section 1332 State Innovation Waiver Actuarial Analyses and Certification and Economic Analyses

## Maine Guaranteed Access Reinsurance Association

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## EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) has been retained by the Maine Guaranteed Access Reinsurance Association (MGARA) to provide actuarial and consulting services related to the State of Maine's proposed Section 1332 State Innovation Waiver Application (Section 1332 Waiver). This Section 1332 Waiver seeks federal pass-through funding to support the re-start of MGARA beginning in calendar year 2019. This report provides the required actuarial analysis and certification, and economic analyses supporting the State's demonstration to CMS that MGARA meets the requirements for Federal pass-through funding.

Legislation authorizing the re-start of MGARA was signed on June 2, 2017 by Governor Paul LePage.<sup>1</sup> MGARA is a key component of the insurance market reforms originally instituted in May 2011, when the Maine State Legislature passed Public Law Chapter 90, "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services" (PL90). During its period of active operation (prior to suspension of operations due to the transitional reinsurance provided under the Affordable Care Act (ACA)), MGARA reduced insurance costs in Maine's individual health insurance market by providing reinsurance coverage for individual health insurance policies (subsidizing insurer paid claims for high cost members). For Maine's Section 1332 Waiver application, the State seeks to re-implement a state-based prospective reinsurance program for the individual market (also known as "non-group" coverage) beginning on January 1, 2019.

Under the re-activated MGARA, insurers offering comprehensive ACA-compliant individual market coverage will be eligible for reimbursement by submitting claims to MGARA through two mechanisms:

- 1) Automatic Ceding, whereby carriers are required to cede 90% of a non-group policy's contract premium<sup>2</sup> for any covered member having at least one of eight conditions specified by the MGARA Board of Directors.
- 2) Voluntary Ceding, whereby carriers may cede 90% of a non-group policy's contract premium to MGARA at the carrier's discretion.

In both cases, ceding occurs as members are identified with the qualifying conditions. MGARA then reimburses a portion of paid claims above the attachment point thresholds set by the MGARA Board of Directors. MGARA intends to fund its claim payments using assessments collected from group and non-group markets and through available Federal pass-through funding. Reimbursement for qualifying policyholders as defined by MGARA will be available regardless of whether the coverage is sold inside or outside the federally-facilitated insurance marketplace (FFM).

For MGARA to meet the Federal requirements for Section 1332 Waivers, it must be deficit neutral to the Federal government and meet the following standards:

- *Coverage*: The Section 1332 Waiver must provide health insurance to *at least* as many people as would be projected under the status-quo ACA (without waiver).
- *Affordability*: The Section 1332 Waiver must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as would be projected without the waiver.
- *Comprehensiveness*: The Section 1332 Waiver must provide coverage at least as comprehensive (as defined by the ACA's essential health benefits) as would be projected without the waiver.

It should be stressed that these requirements are in relation to coverage, affordability, and comprehensiveness without the waiver. For example, a Section 1332 Waiver is not required to result in more insured individuals relative to a period before its implementation. Rather, it must be estimated to insure at least as many during the projection period relative to if the Section 1332 Waiver was not implemented.

Our analysis indicates that all Federal requirements cited above are met by MGARA.

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<sup>1</sup> <http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280063452>

<sup>2</sup> Contract premium is the sum of all member premiums paid under a single non-group medical contract

## Coverage

During the course of the five-year initial waiver period and the ten-year projection period, we estimate MGARA will result in a lower number of uninsured Mainers each year than in the without MGARA scenario (also referred to as the baseline scenario). We estimate the reductions in the uninsured population attributable to MGARA will occur primarily in the population with income above 400% of the federal poverty level (FPL), as non-group (individual market) premium rates will be more affordable under MGARA.<sup>3</sup>

For the population with income between 100% and 400% FPL, who are eligible for Federal premium assistance, out-of-pocket premium rate changes have been limited since the ACA-reformed rating rules were implemented in January 2014. While premium rates for plans offered through the FFM have increased significantly from 2014, these increases have largely been borne by additional Federal premium assistance for the population with income between 100% and 400% FPL qualifying for premium assistance. Effective January 1, 2019, eligibility for Federal premium assistance will shrink to income ranges between 139% and 400% FPL due to the approval of Medicaid expansion by Maine residents on November 7, 2017.<sup>4</sup>

We estimate MGARA will not have any material impacts to the number of Mainers covered under employer-sponsored plans, traditional Medicaid, Medicare, or other public programs. We also assume the effective repeal<sup>5</sup> of the individual mandate and the approval of Medicaid expansion in Maine in 2019 will have impacts on the market independent of MGARA's operations. These anticipated changes are estimated to have large, one-time effects on the size of the non-group market and uninsured pool in 2019. Figure 1 illustrates changes in the number of Mainers uninsured and purchasing coverage in the non-group market under MGARA relative to the without MGARA scenario.

Calendar Year	Uninsured			Individuals Insured in Non-Group Market		
	Without MGARA	With MGARA	Change	Without MGARA	With MGARA	Change
2018	92.2	92.2	0.0	78.1	78.1	0.0
2019	63.0	62.0	-1.1	61.0	62.1	1.1
2020	62.5	61.6	-0.9	60.5	61.3	0.9
2021	62.0	61.2	-0.8	59.9	60.7	0.8
2022	61.5	60.8	-0.7	59.4	60.1	0.7
2023	61.0	60.4	-0.6	58.9	59.6	0.6
2024	60.6	60.0	-0.5	58.4	59.0	0.5
2025	60.2	59.7	-0.5	57.8	58.3	0.5
2026	59.8	59.4	-0.4	57.3	57.7	0.4
2027	59.4	59.0	-0.4	56.7	57.1	0.4
2028	59.0	58.7	-0.3	56.2	56.5	0.3

Note: Values are shown in thousands. Numbers may not add due to rounding.

For the duration of the projection period, we estimate that approximately 300 to 1,100 additional annual non-group enrollees will enroll in the non-group market relative to the without MGARA scenario. This additional membership is assumed to come from previously uninsured members entering the market, as well as from reducing the annual lapse rate in the non-group market.

Modelling changes in individual enrollment involves a variety of competing influences including socio-economic status, social factors, political beliefs, health status, affordability, and other factors. The enrollment assumptions in this report are

<sup>3</sup> In 2018, the FPL is \$12,140 for a single household and \$25,100 for a family of four. 400% FPL would reflect income levels of \$48,560 and \$100,400, respectively. Please see <https://aspe.hhs.gov/poverty-guidelines> for more information.

<sup>4</sup> <http://maine.gov/sos/cec/elec/results/2017/results1117.xlsx>. [Legal non-citizens with income up to 400% FPL will remain eligible for premium assistance.](#)

<sup>5</sup> Legislators have eliminated the impact of the individual mandate by amending the penalty to \$0. While not technically a repeal, this has the same effect.

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point estimates within a range of reasonable values whose impacts were tested using economic and actuarial modeling; all tested enrollment scenarios were assumed to decrease Maine's uninsured pool and produced results satisfying the 1332 waiver guardrails. Based on this projected reduction in uninsured on an annual basis, we believe that MGARA meets the coverage requirement for approval of the Section 1332 Waiver.

With or without MGARA, we estimate a decline in non-group coverage over the course of the ten-year projection period. Most notably, in 2019 we expect a significant one-time reduction in non-group membership due to Medicaid expansion, which we estimate will result in a 19% contraction of the non-group market. We estimate Medicaid expansion will result in a modest reduction to individual market premium rates based on expected improvements to the morbidity of the non-group insurance pool; however, improvements in risk pool acuity are estimated to be offset by impacts of the effective repeal of the individual mandate penalty as signed into law on December 22, 2017 (effective January 1, 2019). The individual mandate repeal is estimated to further shrink the non-group market in 2019 and throughout the remainder of the ten year projection period. These estimates are assumptions based on professional judgment. It is certain that actual enrollment will vary from the estimates provided in this report by an unknown degree.

It is worth noting that while MGARA is estimated to reduce premiums in 2019, premiums are still estimated to increase over the course of the projection period at a rate greater than general inflation, resulting in higher costs for the population not qualifying for premium assistance. The MGARA-based premium reductions are expected to foster a non-group insurance market where existing enrollees are more likely to remain enrolled and where previously uninsured individuals are more likely to purchase insurance; as such, the with-waiver scenario complies with the 1332 Waiver coverage guardrail.

## Affordability

MGARA is not estimated to materially impact premium rates for employer-sponsored insurance, nor change costs, eligibility parameters, or enrollment levels for public programs such as Medicaid and Medicare. A state-based assessment of \$4 per member per month (PMPM) on commercial insurers and self-funded employers will be implemented to provide partial funding for MGARA. It is possible that this additional cost will be passed-through to employees in the form of slightly higher plan contributions or additional cost sharing requirements. However, we estimate the assessment for MGARA will be less than 1% of an average employer's premium costs.

For the non-group market, MGARA is estimated to reduce premium rates by 9.0% in 2019 (relative to without the waiver). This is achieved through a reinsurance mechanism that reduces insurers' paid claims expenses for certain high cost individuals insured in the ACA-compliant individual market. The program is funded through the \$4 PMPM market-wide assessment and Federal pass-through funding.

During each year, the impact to consumers will vary significantly within the non-group market based on the consumer's household income and its interaction with the ACA's premium assistance program. Under the ACA's premium assistance program, qualifying households with income between 100% and 400% FPL (139% to 400% FPL after Medicaid expansion<sup>6</sup>) have out-of-pocket premium expenses capped to a specified percent of income. In 2018, we estimate approximately 78% of Mainers purchasing coverage in the ACA-compliant individual market will receive Federal premium assistance. We project that the vast majority of individuals receiving premium assistance without the waiver will also receive premium assistance under MGARA. For these individuals, the premium savings will accrue to the Federal government, as it reduces the amount of premium assistance necessary to ensure the out-of-pocket cost of coverage does not exceed the maximum specified by the ACA. It is possible that some young adults and other persons with income approaching 400% FPL receiving premium assistance without the waiver will see out-of-pocket premiums fall below the maximum specified by the ACA under MGARA. In these cases, only partial premium savings accrue to the Federal government, while the consumer also directly benefits from part of the premium reduction.

For households not eligible for premium assistance, the full amount of premium rate reduction will be realized under MGARA, with the Federal government not accruing any savings. As premium rates are estimated to be more affordable under MGARA, this should provide financial incentive for some of the uninsured individuals in the absence of the waiver to purchase health insurance. Figure 2 illustrates premium rate reductions for a 21-year old and a 64-year old for the second lowest cost silver plan (the benchmark plan that is used to determine available premium assistance).

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<sup>6</sup> Legal aliens have and will continue to qualify for premium assistance in qualifying households with income up to 400% FPL.

Figure 2 MGARA Changes in Second Lowest Cost Silver Plan Monthly Premium from MGARA Implementation						
Calendar Year	21-Year Old Monthly Premium			64-Year Old Monthly Premium		
	Without MGARA	With MGARA	Change	Without MGARA	With MGARA	Change
2018	\$456	\$456	\$0	\$1,367	\$1,367	\$0
2019	\$463	\$421	(\$42)	\$1,388	\$1,263	(\$125)
2020	\$497	\$451	(\$47)	\$1,492	\$1,352	(\$140)
2021	\$525	\$476	(\$49)	\$1,574	\$1,427	(\$147)
2022	\$554	\$503	(\$50)	\$1,661	\$1,510	(\$151)
2023	\$581	\$531	(\$50)	\$1,744	\$1,594	(\$150)
2024	\$610	\$560	(\$51)	\$1,831	\$1,679	(\$152)
2025	\$641	\$589	(\$52)	\$1,923	\$1,768	(\$155)
2026	\$673	\$623	(\$50)	\$2,019	\$1,869	(\$150)
2027	\$703	\$652	(\$51)	\$2,110	\$1,957	(\$153)
2028	\$735	\$686	(\$49)	\$2,205	\$2,058	(\$147)

Notes:

1. Values are rounded.
2. Values do not reflect available premium assistance for qualifying individuals.
3. Premiums are for non-tobacco user and assume Federal default 3:1 age rating.
4. The change in premium between 2018 and 2019 is primarily impacted by the lower risk patients being removed from the pool due to Medicaid Expansion, among other influences.

Based on the above summary of our analysis, we believe MGARA meets the affordability requirement for approval of a Section 1332 Waiver.

## Comprehensiveness

As MGARA makes no change to insurer benefit requirements for plans offered in Maine's health insurance markets, MGARA meets the comprehensiveness requirements required for a Section 1332 Waiver. MGARA makes no changes to essential health benefit (EHB) or state-mandated benefit requirements in the individual market. Therefore, the focus of the actuarial analysis was related to coverage and affordability requirements for this Section 1332 Waiver, as presented above and discussed in greater detail later in this report.

## Economic Analyses

A Section 1332 waiver application must demonstrate that it will not increase the Federal deficit. By reducing non-group premiums, MGARA is estimated to result in Federal savings on premium assistance provided through the FFM. We also evaluated changes in Federal revenue related to FFM user fees and the health insurance providers fee (HIF). Note, we do not estimate changes to Federal cost-sharing reduction (CSR) payments, because CSR payments from the Federal government were halted in late 2017.

- *FFM user fees*: As a result of reducing premiums in the individual market, we estimate the Federal government will collect a decreased amount of revenue related to the FFM user fee (assumed to be 3.5% of FFM premium).
- *HIF*: National collected revenue amounts for the HIF are prescribed in 2018 (premium volume changes that year do not impact the collected amount). In 2019, the HIF has a one year suspension signed into law on January 22, 2018 as part of a continuing appropriations act.<sup>7</sup> Thereafter, the national HIF collection amount is estimated to be indexed by changes in per capita employer-sponsored insurance premiums. As MGARA does not materially impact employer-sponsored insurance, we do not estimate any impacts to the national HIF amounts during the ten-year projection period from 2019 through 2028.

It is possible that MGARA may impact other Federal revenue items, such as Federal income taxes paid by insurers. However, quantifying these items is beyond the scope of our analysis. The combination of Federal premium assistance savings plus the sum of revenue changes from the other described Federal revenue sources comprise the estimated Federal pass-through funding available to Maine under Section 1332 Waiver regulations. Figure 3 illustrates the division of state and Federal funding for the ten-year projection period and the state-based assessment amount.

Figure 3 MGARA Estimated Available Pass-Through Funding and State-Based Assessment							
Calendar Year	State-Based Assessment (\$ Millions)	Federal Pass-through Funding (\$ Millions)	Ceded Premiums (\$ Millions)	Total Revenue (\$ Millions)	Estimated Assessment Enrollment Base (Thousands)	State-Based Assessment PMPM	Ceded Lives
2019	\$22.6	\$33.4	\$37.0	\$93.0	471	\$4.00	5,500
2020	22.4	37.5	39.7	99.6	467	4.00	5,600
2021	22.2	38.9	41.2	102.3	462	4.00	5,500
2022	22.0	39.8	42.6	104.4	457	4.00	5,400
2023	21.7	38.9	43.6	104.2	453	4.00	5,200
2019-2023	\$110.9	\$188.6	\$204.1	\$503.6	2,310		27,200
2024	21.5	39.2	44.6	105.3	449	\$4.00	5,100
2025	21.3	39.1	46.1	106.5	444	4.00	5,000
2026	21.1	37.5	47.5	106.1	440	4.00	4,900
2027	20.9	37.5	48.9	107.3	436	4.00	4,800
2028	20.7	35.7	49.9	106.3	432	4.00	4,700

Notes:

1. State-based assessment PMPM does not include cost of administering MGARA. The \$4.00 PMPM assessment generates an estimated \$20 to \$22 million in state-based revenue per year.
2. Federal Pass-through Funding is shown net of FFM Exchange Fees
3. Actual Federal pass-through funding will be determined based on premium rates filed for each year and is shown net of exchange fees.

<sup>7</sup> <https://www.congress.gov/bill/115th-congress/house-bill/195/text>

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4. Estimated values are rounded.
  5. The 2019 assessment base may be lower than the values illustrated to the extent employer-sponsored plans do not begin paying the assessment until the beginning of their plan year in 2019 (which may be on a non-calendar year basis).

For the state-based assessment amount, the State of Maine will assess a \$4 PMPM fee on health insurance coverage for all insured persons in the Individual, Small Group, Large Group and Self-insured Markets (excluding State and Federal employees). Premiums ceded by insurers will be (and are modeled as being) netted out of the premium reductions applied to non-group rates under MGARA.

## Sensitivity of Results

It should be noted there is significant uncertainty surrounding future enrollment and premiums in health insurance programs, particularly within the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. *As final Federal pass-through funding will be based on actual premiums filed by insurers offering coverage in Maine's non-group market, final funding amounts may differ significantly from the estimates provided in this report. It is our assumption that insurers will file rates to reflect the estimated impact of MGARA in 2019.*

The actuarial and economic analyses presented in this report solely reflect the estimated incremental impact of MGARA. Other state or Federal policy changes may impact actual amounts presented in this report.

We specifically note that our projections of enrollment and premium rates in the individual market assume direct Federal funding of CSR subsidies is not re-instated, Medicaid expansion occurs in Maine starting in 2019, and insurer pricing assumptions and resulting enrollment behaviors do not materially deviate from 2018 assumptions and behaviors. The changes occurring in 2019 relative to Medicaid expansion and the effective repeal of the individual mandate are expected to be highly impactful to Maine's insurance markets and as such create significant uncertainties in projecting future market enrollment and premium rates. Additionally, to the extent judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted to a significant degree.

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## SECTION I. ACTUARIAL ANALYSIS

This section provides the required actuarial analysis for Maine's Section 1332 Waiver application. Appendix 1 contains the actuarial certification for the Section 1332 Waiver.

A description of the actuarial analysis meeting the requirements under 45 CFR 155.1308(f)(4)(i) and other applicable information as requested in the Checklist for Section 1332 Innovation Waiver Applications has been provided in this section. For purposes of this analysis, calendar year 2018 serves as the baseline year for the ten-year required projections.

As discussed in the Assumptions and Methodology section of this report, we utilized a combination of U.S. Census Bureau data, population growth projections from Maine's Office of Policy and Management, publicly available health insurance enrollment and premium data, modeling of the ACA's premium assistance structure, a survey developed by Milliman and administered to Maine carriers through MGARA requesting multiple years of claims, premiums, and enrollment data, and proprietary insurer data provided by the Maine Bureau of Insurance (BOI), to model the estimated impact of MGARA during the ten-year projection period. Our analysis reflects Maine's estimated demographics during the projection period and models insurance purchasing behavior based on changes in premium rates and Federal premium subsidies. Our modeling allows for the summarization of projected enrollment and premium information by age, gender, health status, household income, and insurance market.

Prior to performing any projections, we calibrated our projection model's census, premium, claims expense, and other assumptions to reflect Maine's insurance markets. As MGARA is estimated to primarily impact Maine's individual health insurance market and uninsured population, the focus of our modeling efforts was on the interaction between these populations under both the status-quo ACA and the Section 1332 Waiver.

### 1. REINSURANCE PARAMETERS

MGARA was established in 2011 under Maine Law<sup>8</sup> as a private, nonprofit association and shares the goal of the Federal transitional reinsurance program operated under the ACA of providing premium relief to the individual health insurance market. MGARA actively operated between July 1, 2012 and December 31, 2013. The Maine individual market consisted of approximately 34,000 in-force lives during this period, after which the ACA facilitated the creation of a three-year transitional reinsurance program, which led to the eventual suspension of MGARA operations. The State of Maine intends to reinstate MGARA beginning January 1, 2019.<sup>9</sup>

Similar to the federal transitional reinsurance plan, MGARA is intended to subsidize insurers' claim expenses for high cost claimants, while maintaining an insurer's incentive to manage the costs associated with these claimants. The basic prospective model, scheduled to be reinstated January 1, 2019, is anticipated to be configured as follows:

- MGARA Funding
  - A \$4.00 PMPM market assessment on nearly 500,000 lives. A supplemental assessment of \$2.00 may be made under conditions of adverse experience.
  - 90% of contract (subscriber and dependents) premium for ceded members and their dependents.
  - Federal pass-through funding granted from the 1332 Waiver application.
- MGARA Parameters and Reinsurance Payments
  - Medical and Pharmacy plan paid claims expenses for ceded members. Ceded members are identified as having any of eight conditions MGARA defines as mandatory for ceding to the reinsurance pool. The eight mandatory ceded conditions are: Uterine Cancer; Metastatic Cancer; Prostate Cancer; Chronic Obstructive Pulmonary Disease (COPD); Congestive heart Failure; HIV Infection; Renal Failure; and Rheumatoid Arthritis. Claims for the entire contract (subscriber and dependents) are ceded to the reinsurance pool. MGARA is responsible for claims according to the threshold formula described below.

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<sup>8</sup> 24-A M.R.S. § 3858(1).

<sup>9</sup> Note that the parameters proposed for the 2019 and future MGARA operations are not identical to the parameters used in MGARA's 2012 operations.

- Carriers also have the option of voluntarily ceding members along with their dependents. MGARA is responsible for claims according to the threshold formulas described below.
- Reinsurance Thresholds: MGARA makes payments to an insurer when an eligible claimant's accumulated claims incurred during the calendar year exceed the initial attachment point. The initial attachment point during early operations (i.e., in 2012-13) was set at \$7,500. The proposed initial attachment point for operations starting in 2019 is \$47,000. For claimants with annual paid claim expenses not exceeding \$47,000, insurers will not receive any payments from the reinsurance fund. To the extent a claimant's paid medical<sup>10</sup> expenses exceed \$47,000, the insurer will receive a payment from the reinsurance fund based on the parameters outlined in Figure I-1A.
- MGARA expenses include \$8.00 per ceded person per month for administrative costs and an additional \$150,000 per year cost in overhead. These expenses are funded by the MGARA funding items.
- MGARA set the final ceding premium rate at 90% of the policy premium.

Figure I-1A illustrates the assumed reinsurance parameters for the program.

Figure I-1A MGARA Calendar Year 2019 Reinsurance Parameters	
Parameter	Parameter Value
Initial Attachment Point	\$47,000
Reinsurance Threshold 2	\$77,000
Coinsurance Percentage 1 (between Initial Attachment Point and Reinsurance Threshold 2)	90%
Coinsurance Percentage 2 (above Reinsurance Threshold 2)	100%

*Reinsurance Payment*

$$= \text{Maximum}[0, [ \text{Minimum} (\text{Annual Paid Claim Expense} - \text{Initial Attachment Point}, \text{Reinsurance Threshold 2} - \text{Initial Attachment Point}) ] \times \text{Coinsurance Percentage 1} + \text{Maximum}(0, \text{Annual Paid Claims Expense} - \text{Reinsurance Threshold 2}) \times \text{Coinsurance Percentage 2}]$$

The reinsurance attachment point parameters displayed above were selected to keep MGARA solvent and to preserve a target level of surplus over the course of the projection period based on the modeled outcomes. In practice, the MGARA board will set the reinsurance parameters. The Initial Attachment Point and Reinsurance Threshold 2 parameter values shown in Figure I-1A are appropriate for the non-group enrollment, premium, and claims assumptions underlying a singular set of with-MGARA and without-MGARA scenarios; these parameters may need to be revised if the underlying assumptions are changed.

Figure I-1B provides several examples of reinsurance payments in 2019 for claimants with varying annual medical expenses, based on the parameter values in Figure I-1A.

<sup>10</sup> Includes amounts for all services and materials covered under the health care plans, including medical services, prescription drugs, and medical equipment and supplies.

Figure I-1B MGARA Individual Health Insurance Market Calendar Year 2019 Reinsurance Payment Examples <sup>11</sup>				
Person	Annual Medical Expense	Reinsurance Eligible Medical Expense	Coinsurance Percentage	Reinsurance Payment
A	\$20,000	\$0	90%	\$0
B	\$48,500	\$1,500	90%	\$1,350
C	\$250,000	\$203,000	90% between 47k and 77k, then 100%	\$27,000 + \$173,000 = \$200,000

We believe insurers continue to have a financial incentive to manage health care costs and utilization for insured individuals meeting the payment criteria for the reinsurance program because the carrier must cover the claim amounts up to the attachment point while ceding 90% of the total premium to MGARA. After the member is ceded to MGARA, the insurers recognize that efficient claims management translates into lower individual market rates albeit indirectly. Annual MGARA funds are fixed pools of money and are not retrospectively adjusted to cover the total claim costs incurred by ceded members. If MGARA's subsidization of carrier liability leads to ineffective management of ceded member costs, the program may require adjustments to MGARA's plan design parameters. From the consumer and provider perspective, the reinsurance program is not expected to have a material impact on incentives to manage health care costs and utilization relative to the ACA's current structure.

## 2. PROJECTED REINSURANCE FUNDING LEVELS

For calendar year 2019, in addition to receiving Federal pass-through payments granted by the 1332 Waiver application, the State intends to collect a \$4 PMPM assessment across Maine's commercial insurance markets (excluding state and Federal employees). The \$4 PMPM assessment is constant for each year of operation and, with the other sources of MGARA funding, covers costs associated with administering and operationalizing MGARA. The parameters displayed in the "Reinsurance Parameters" section are estimated to ensure high probabilities of program solvency based on the projected payments into and out of MGARA over the 10-year projection period.

Our modeling has assumed that the full annual value of the \$4 PMPM assessment (i.e., \$48 per member per year [PMPY]) charged to the assessed markets is paid by all assessable lives. In practice, depending on the timing associated with the re-instatement of MGARA, the actual assessment collections may be affected by durational effects including policy lapses and mid-year renewals; for 2019 in particular, the \$48 annual assessment may only be partially paid by policies priced prior to the reinstatement of MGARA and/or renewed after January 1, 2019. Depending on timing of assessments relative to approval data from the BOI, the modelling may need to reflect a partial year assessment for MGARA's first year of operation, or an alternative delay for the first year of operation.

Please note that all modeling results displayed henceforth in this report assume the \$48 PMPY MGARA assessment is collected across all assessable lives.

Using 2015 incurred claims data from the Maine All Payer Database, which includes de-identified individuals in the individual market and their associated medical costs, we summarized costs associated with individuals who would be subject to mandatory ceding as well as high cost individuals that carriers would likely cede to the reinsurance pool voluntarily. The costs were adjusted to 2019 dollars using historical trends for the Maine non-group market between 2015 and 2017, and a projected trend from 2017 to 2019.

The aggregate dollar amount of the reinsurance fund will be distributed to qualifying insurers offering coverage in the non-group market. To the extent the initial reinsurance parameters for the year result in a shortage of payments to insurers relative to the aggregate fund amount, the reinsurance threshold parameters will be adjusted to increase insurer payments

<sup>11</sup> Initial Attachment Point = 47,000; Reinsurance Threshold #2 = 77,000. Coinsurance Percentage #1 = 90%; Coinsurance Percentage #2 = 100%

to the aggregate fund amount on a retrospective basis. Conversely, MGARA's Board will monitor payments and adjust the reinsurance parameters as necessary to avoid a funding deficit.

Figure I-2A illustrates the estimated aggregate reinsurance funding, insurer paid claim expenses (prior to reinsurance), and reinsurance funding as a percent of ceded member paid claim expenses during the ten-year projection period. On an annual basis, MGARA will evaluate the reinsurance parameters and estimated impact to Maine's individual health insurance market. As illustrated in Figure I-2A, due to health care inflation greater than the modeled inflation of MGARA attachment points and the flat MGARA assessments that reduce in value over time, the reinsurance recoveries decrease as a percentage of the total ceded member paid claims over time, going from an estimated 24% of insurer paid claims expense in 2019 to an estimated 18% in 2028.

Figure I-2A MGARA Section 1332 Waiver Application Estimated Reinsurance Payments and Aggregate Insurer Paid Claims Expenses			
Calendar Year	Reinsurance Payments (\$ Millions)	Insurer Paid Claims Expenses for Ceded Members Prior to Reinsurance (\$ Millions)	Ratio: Reinsurance Payments to Paid Claims Expense
2019	89.7	399.4	22%
2020	97.7	417.8	23%
2021	100.9	438.1	23%
2022	103.3	459.3	22%
2023	102.9	478.6	22%
2024	104.2	498.8	21%
2025	105.7	518.1	20%
2026	104.6	538.4	19%
2027	106.0	556.5	19%
2028	104.2	575.3	18%

Note: Reinsurance payments funded through a combination of Federal and state dollars and ceded premiums. Insurer paid claims reflect estimated enrollment changes. Values are rounded.

### 3. ESTIMATED PREMIUM IMPACT FROM REINSURANCE PROGRAM

In modeling the impact of MGARA, we have assumed MGARA reinsurance payments (net of costs to insurers from the \$4 PMPM assessments and ceded premiums) will produce dollar-for-dollar reductions in individual market insurer paid claims expense. Additionally, our analysis is based on the scenario whereby carriers take full credit for the modeled MGARA reinsurance claims recoveries; in other words, we assume that carriers reduce their projected claim amounts (and, in result, premium rates) by the total projected reinsurance recoveries per member per month (PMPM) estimated by our actuarial modeling, less ceded premiums. Should carriers apply less than full credit for MGARA reinsurance recoveries in reducing paid claim costs, a smaller premium impact for the reinsurance program would result.

Under the ACA, qualifying households not eligible for Medicaid with incomes between 100%<sup>12</sup> and 400% of the FPL (between 139% and 400% FPL with Medicaid expansion) are eligible for an Advance Premium Tax Credit (APTC) that may be used to lessen the cost of health insurance coverage in the ACA marketplaces. APTC amounts are funded as subsidies issued by the Federal Government. These subsidies are determined based on the second lowest cost silver plan in a rating region (i.e., the subsidy benchmark plan); all else being equal, a reduction in the cost of the subsidy benchmark plan produces a reduction in Federal expenditures associated with APTCs. Our modeling assumes that MGARA reinsurance recoveries are applied to all on- and off-FFM non-group plans as a constant percent of premium.

<sup>12</sup> Legal aliens with income below 100% FPL may also receive a premium tax credit.

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## 4. COVERAGE REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(C), the State's proposed waiver must provide coverage to at least a comparable number of its residents as the provisions of Title I of the ACA. Under MGARA, we expect that an additional number of individuals will have health insurance. This is a result of MGARA reducing premiums in the individual market, which we estimate will incentivize additional individuals to purchase health insurance relative to without the waiver.

By making premium rates more affordable, we estimate the average member persistency (number of months during the year coverage is maintained/in force) under the Section 1332 Waiver may improve, reducing the potential for gaps in insurance coverage. As discussed throughout this report, we estimate individuals not qualifying for the Advanced Premium Tax Credit (APTC) in absence of the waiver will see the greatest reduction in out-of-pocket premiums, and therefore may have more significant changes in coverage relative to the population qualifying for APTCs.

Funding for MGARA will be through a combination of federal pass-through funding (as a result of reducing the federal government's expenditures on premium tax credits) and a state-based assessment on comprehensive commercial health plan coverage. Insurers, third-party administrators, and other self-funded employer plans will be assessed a PMPM amount to generate the targeted state-based revenue needed for the reinsurance fund. We estimate that the cost of the assessment will be less than 1% of an average employer's total health insurance costs (including employee contributions). While a new assessment for MGARA may marginally increase the cost of offering employer-sponsored insurance, we do not estimate the assessment amounts are large enough to result in a material change in the likelihood of employers offering health insurance coverage relative to current law. As observed in the Agency for Health Care Quality & Research's Medical Expenditure Panel Survey (MEPS), the percentage of private sector establishments with fifty or more employees offering coverage has remained at approximately 96% since the late 1990's, despite significant cost increases for employer-sponsored insurance during that timeframe.<sup>13</sup> While more significant changes have occurred for establishments with fewer than fifty employees, we do not estimate the assessment, by itself, will result in a material change in the likelihood of such an employer offering health insurance to its employees; this is supported by experience with MGARA during its operations in 2012 through 2013.

The following paragraphs detail 2018 (baseline year) health insurance coverage in the non-group market, as well as estimated coverage changes during the ten-year projection period, 2019 through 2028.

### A. NON-GROUP MARKET ENROLLEES BY HOUSEHOLD INCOME

Figure I-4A(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2018), and from 2019 through 2028 by household income, as measured as a percentage of the federal poverty level (FPL). Enrollment figures include comprehensive non-group coverage; we note that based on a survey provided to Maine's individual market carriers (see Market Calibration segment of Section III – Assumptions and Methodology), Maine was reported to have no transitional or grandfathered plans in 2017.

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<sup>13</sup> Agency for Healthcare Research and Quality. *Percent of private-sector establishments that offer health insurance by firm size and selected characteristics* (Table I.A.2), year 1996-2015. Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. (July 11, 2017)

**Figure I-4A(i)**  
**MGARA**  
**Individual Health Insurance Market**  
**Estimated Non-Group Market Enrollees by Household Income: 2018 through 2028 (Thousands)**  
**Without Waiver**

Income Level % of FPL	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
0% - 99%	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>=100% to <=150%	18.1	4.2	4.1	4.1	4.1	4.1	4.0	4.0	4.0	3.9	3.9
>150% to <=200%	15.2	15.2	15.1	15.0	14.8	14.7	14.6	14.5	14.4	14.3	14.1
>200% to <=250%	11.8	11.7	11.7	11.6	11.5	11.4	11.3	11.2	11.1	11.1	11.0
>250% to <=300%	7.5	7.4	7.4	7.3	7.3	7.2	7.2	7.1	7.0	7.0	6.9
>300% to <=400%	8.4	8.3	8.3	8.2	8.2	8.1	8.1	8.0	7.9	7.8	7.8
>400%	16.0	14.2	13.9	13.7	13.5	13.4	13.2	13.0	12.8	12.6	12.5
<b>Total</b>	<b>78.1</b>	<b>61.0</b>	<b>60.5</b>	<b>59.9</b>	<b>59.4</b>	<b>58.9</b>	<b>58.4</b>	<b>57.8</b>	<b>57.3</b>	<b>56.7</b>	<b>56.2</b>

Note: Values are shown in thousands. Total values are rounded separately.

As shown in Figure I-4A(i), the greatest concentration of non-group market enrollment in the 2018 baseline year and ten-year projection period has household income ranging from 100% to 250% FPL, representing nearly 51% of market enrollment in each year of the projection period (after Medicaid expansion is assumed to occur). It is assumed that the vast majority of these households are receiving federal premium assistance to purchase health insurance coverage in the FFM. The structure of the ACA's premium subsidy is expected to result in minimal out-of-pocket premium rate increases for households purchasing coverage with federal premium assistance in the FFM.

The population with household income above 400% FPL or below 100% FPL is not eligible for premium assistance under the ACA.<sup>14</sup> As a result of additional premium rate increases, we estimate the number of individuals purchasing coverage in the non-group market declines during the ten-year projection period. From 2020 through the end of the projection period, we estimate a slow erosion of enrollment from the population not qualifying for premium assistance. Note that this long-term erosion differs from the short-term, one-time enrollment reduction between 2018 and 2019, where we assume that all non-group market enrollees with income below 139% FPL exit the individual marketplace and instead received coverage from Maine's Medicaid Expansion program; this corresponds with the projected reduction of the >=100% to <=150% FPL cohort by approximately 77% between 2018 and 2019. An additional one-time reduction in members >400% FPL (i.e., non-subsidized individual market members) is assumed to occur in 2019 coinciding with the effective date of the elimination of the individual mandate penalty. We assume no material change in membership from enrollees with income <400% FPL in response to the effective individual mandate repeal – such enrollees have been more likely to qualify for individual mandate affordability exemptions<sup>15</sup> and have been subject to lesser individual mandate penalties than members with incomes >400% FPL. We therefore expect an insignificant amount of low-income, non-group enrollment to have been driven by the force of the individual mandate penalty.

Figure I-4A(ii) illustrates estimated non-group market enrollment in thousands under MGARA (with waiver) during the baseline year (2018), and from 2019 through 2028.

<sup>14</sup> With the exception of legal aliens within income below 100% FPL.

<sup>15</sup> <http://www.milliman.com/insight/2018/The-individual-mandate-repeal-Will-it-matter/>

Figure I-4A(ii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Household Income: 2018 through 2028 (Thousands) With Waiver											
Income Level % of FPL	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
0% - 99%	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>=100% to <=150%	18.1	4.2	4.1	4.1	4.1	4.1	4.0	4.0	4.0	3.9	3.9
>150% to <=200%	15.2	15.2	15.1	15.0	14.8	14.7	14.6	14.5	14.4	14.3	14.1
>200% to <=250%	11.8	11.7	11.7	11.6	11.5	11.4	11.3	11.2	11.1	11.1	11.0
>250% to <=300%	7.5	7.4	7.4	7.3	7.3	7.2	7.2	7.1	7.0	7.0	6.9
>300% to <=400%	8.4	8.6	8.5	8.4	8.3	8.2	8.2	8.1	8.0	7.9	7.9
>400%	16.0	15.0	14.6	14.4	14.1	13.9	13.6	13.3	13.1	12.9	12.7
<b>Total</b>	<b>78.1</b>	<b>62.1</b>	<b>61.3</b>	<b>60.7</b>	<b>60.1</b>	<b>59.6</b>	<b>59.0</b>	<b>58.3</b>	<b>57.7</b>	<b>57.1</b>	<b>56.5</b>

Note: Values are shown in thousands. Total values are rounded separately.

Figure I-4A(iii) illustrates the estimated net non-group market enrollment change resulting from the implementation of MGARA from 2019 through 2028 (note that values in this table are not rounded to thousands). For 2018, the baseline year, no change occurs since MGARA begins in 2019. Enrollment figures reflect comprehensive non-group coverage (Maine is estimated to have a trivial number of transitional and grandfathered coverage in 2018 and none thereafter).

Figure I-4A(iii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Household Income: 2018 through 2028 (Thousands) Net Enrollment Change Resulting from Waiver											
Income Level % of FPL	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
0% - 99%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>=100% to <=150%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>150% to <=200%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>200% to <=250%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>250% to <=300%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
>300% to <=400%	0.0	0.3	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
>400%	0.0	0.8	0.7	0.6	0.6	0.5	0.4	0.4	0.3	0.3	0.2
<b>Total</b>	<b>0.0</b>	<b>1.1</b>	<b>0.9</b>	<b>0.8</b>	<b>0.7</b>	<b>0.6</b>	<b>0.5</b>	<b>0.5</b>	<b>0.4</b>	<b>0.4</b>	<b>0.3</b>

Note: Values are shown in thousands. Total values are rounded separately.

As observed in Figure I-4A(iii), enrollment increases resulting from MGARA are estimated to come primarily from the population not eligible for premium assistance and not eligible for the ACA's Medicaid expansion (i.e., those with household income greater than 400% FPL). As this population is not eligible for premium assistance under the ACA, these households realize the full impact of MGARA's premium reduction (rather than all or a portion of the savings accruing to the Federal government). Out-of-pocket premium costs for the vast majority of the population eligible for premium assistance are not estimated to be reduced by MGARA. For young adults with income approaching 400% FPL, we estimate the premium savings achieved through MGARA may result in persons no longer being eligible for premium assistance (as the cost of the second lowest cost silver plan decreases below the maximum permitted under the ACA), while still decreasing out-of-pocket premiums. Therefore, we estimate individual market enrollment increases may also occur for persons with household income between 300% and 400% FPL under the waiver.

The net enrollment changes above represent point estimates from a range of reasonable enrollment responses. Due to the high uncertainty in non-group market enrollment behavior, we tested the impact of assuming that enrollment by previously uninsured members in the non-group market more than doubled in 2019 from 1,100 to 2,300. This enrollment increase resulted in the following outcomes:

- **Reduced Pass-Through Funding:** We assume that a percentage of the previously uninsured members enrolling in the 2019 non-group market are eligible for modest premium subsidies (i.e., members with incomes between 300% and 400% FPL). The increased volume of these members decreases the level of pass-through funding available to fund MGARA.
- **Lower Average Non-Group Market Premium Rate:** We assume that members transitioning from being uninsured to having non-group market insurance have income above 300% FPL; on average, it is estimated that these members have a lower health risk than the average continuously-enrolled non-group market member. Increasing the enrollment from these lower morbidity, previously uninsured members reduces the average non-group market premium rate.
- **Increased Reinsurance Attachment Points:** Because of the reduction to the Federal pass-through funding and to the average non-group market premium rate, both of which are used to fund MGARA, the reinsurance attachment points must increase to meet MGARA’s solvency and target surplus requirements. When the previously uninsured member migration increased from 1,100 to 2,300, all else equal, the MGARA attachment points rose by \$5,000 from \$47,000 and 77,000 to \$52,000 and \$82,000
- **Smaller Non-Group Premium Reduction:** Based on the increased reinsurance attachment points and because of the larger non-group market membership, MGARA produces a small change in non-group market premium rates when the previously uninsured member migration into the non-group market is increased.

## B. NON-GROUP MARKET ENROLLMENT BY PREMIUM TAX CREDIT ELIGIBILITY

The next series of figures illustrates the impact to non-group market enrollment resulting from MGARA based on enrollee advance premium tax credit (APTC) eligibility status. Under the ACA, qualifying households with income between 100%<sup>16</sup> and 400% of the FPL are eligible for an APTC that may be used to purchase health insurance coverage in the FFM. Figure I-4B(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2018), and from 2019 through 2028, while Figure I-4B(ii) illustrates the same information under MGARA (with waiver). Figure I-4B(iii) illustrates the net change in enrollment by APTC status resulting from MGARA (note that values in this table are not rounded to thousands). Enrollment figures include comprehensive non-group coverage (Maine is estimated to have trivial transitional or grandfathered coverage in 2018 and thereafter).

Figure I-4B(i) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2018 through 2028 (Thousands) Without Waiver											
APTC Status	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Eligible	61.0	46.9	46.5	46.2	45.9	45.6	45.2	44.8	44.5	44.1	43.7
Not Eligible	17.1	14.2	13.9	13.7	13.5	13.4	13.2	13.0	12.8	12.6	12.5
Composite	78.1	61.0	60.5	59.9	59.4	58.9	58.4	57.8	57.3	56.7	56.2

Note: Values are shown in thousands. Composite values are rounded separately.

As shown in Figure I-4B(i), approximately 78% of individual market enrollees are estimated to receive an APTC to purchase health insurance coverage during the 2018 baseline year. During the ten-year projection period, the percentage of market enrollees estimated to receive an APTC is relatively flat, remaining at about 78% in 2028. Note that from 2018 to 2019, the APTC eligible population is projected to decrease by approximately 23% in both scenarios due to the availability of expanded Medicaid coverage. The non-APTC eligible cohort is projected to decrease by around 17% between 2018 and 2019 due to a combination of persons with income below 100% FPL now being eligible for Medicaid and the individual mandate repeal. Under MGARA, this enrollment reduction is mitigated by members assumed to enter the market to take advantage of lower premiums.

<sup>16</sup> Legal aliens with income below 100% FPL may also receive a premium tax credit.

Figure I-4B(ii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2018 through 2028 (Thousands) With Waiver											
APTC Status	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Eligible	61.0	47.1	46.7	46.4	46.0	45.7	45.4	45.0	44.6	44.2	43.8
Not Eligible	17.1	15.0	14.6	14.4	14.1	13.9	13.6	13.3	13.1	12.9	12.7
Composite	78.1	62.1	61.3	60.7	60.1	59.6	59.0	58.3	57.7	57.1	56.5

Note: Values are shown in thousands. Composite values are rounded separately.

Figure I-4B(iii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Premium Tax Credit Status: 2018 through 2028 (Thousands) Net Enrollment Change Resulting from Waiver											
APTC Status	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Eligible	0.0	0.3	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
Not Eligible	0.0	0.8	0.7	0.6	0.6	0.5	0.4	0.4	0.3	0.3	0.2
Composite	0.0	1.1	0.9	0.8	0.7	0.6	0.5	0.5	0.4	0.4	0.3

Note: Values are shown in thousands. Composite values are rounded separately.

As MGARA is estimated to have the greatest consumer premium impact to the population not eligible for Federal premium assistance (APTC), the majority of coverage gains in the individual market are estimated to occur from persons not eligible for APTC. Under the waiver, it is possible that a small number of APTC-enrollees without the waiver may no longer qualify for APTC upon MGARA implementation. As MGARA is estimated to reduce the cost of the second lowest cost silver plan, young adults with income near 400% FPL may have the value of available premium assistance reach \$0. However, to the extent that healthcare inflation assumptions outstrip income growth, over time, some of these persons are modeled to regain APTC-eligibility during the course of the projection period.

## C. NON-GROUP MARKET ENROLLMENT BY PLAN

This section provides the estimated impact to non-group market enrollment by plan level resulting from MGARA. Under the ACA, households may purchase a non-group plan in one of four metallic tiers: bronze, silver, gold, or platinum.<sup>17</sup> However, insurers participating in Maine's non-group market do not currently offer platinum level coverage. For individuals under age 30 or persons qualifying for an unaffordability or hardship exemption, a catastrophic plan may also be purchased.

Figure I-4C(i) illustrates estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2018), and from 2019 through 2028, while Figure I-4C(ii) illustrates the same information under MGARA (with waiver). Figure I-4C(iii) illustrates the net change in enrollment by plan level resulting from MGARA.

<sup>17</sup>Please see <https://www.healthcare.gov/choose-a-plan/plans-categories/> for more information.

Figure I-4C(i) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Plan Level: 2018 through 2028 (Thousands) Without Waiver											
Plan Level	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Catastrophic	1.0	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8	0.8	0.8
Bronze	34.6	31.1	30.8	30.5	30.2	29.9	29.7	29.4	29.1	28.8	28.5
Silver	39.5	26.3	26.1	25.9	25.7	25.6	25.4	25.1	24.9	24.7	24.5
Gold	3.0	2.7	2.7	2.6	2.6	2.6	2.6	2.5	2.5	2.5	2.4
Platinum	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Composite	78.1	61.0	60.5	59.9	59.4	58.9	58.4	57.8	57.3	56.7	56.2

Note: Values are shown in thousands. Composite values are rounded separately.

Figure I-4C(ii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Plan Level: 2018 through 2028 (Thousands) With Waiver											
Plan Level	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Catastrophic	1.0	1.0	0.9	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8
Bronze	34.6	31.8	31.3	31.0	30.7	30.3	30.0	29.7	29.3	29.0	28.7
Silver	39.5	26.5	26.3	26.1	25.9	25.7	25.5	25.2	25.0	24.7	24.5
Gold	3.0	2.8	2.8	2.7	2.7	2.7	2.6	2.6	2.5	2.5	2.5
Platinum	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Composite	78.1	62.1	61.3	60.7	60.1	59.6	59.0	58.3	57.7	57.1	56.5

Note: Values are shown in thousands. Composite values are rounded separately.

Figure I-4C(iii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Plan Level: 2018 through 2028 (Thousands) Net Enrollment Change Resulting from Waiver											
Plan Level	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Catastrophic	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Bronze	0.0	0.7	0.6	0.5	0.5	0.4	0.3	0.3	0.3	0.2	0.2
Silver	0.0	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Gold	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0
Platinum	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Composite	0.0	1.1	0.9	0.8	0.7	0.6	0.5	0.5	0.4	0.4	0.3

Note: Values are shown in thousands. Composite values are rounded separately.

As shown in Figure I-4C(iii), the majority of enrollment increases resulting from MGARA are estimated to occur in the Bronze metallic tier.. As MGARA has the greatest premium effect on consumers not eligible for premium assistance, we estimate Bronze coverage will experience the greatest enrollment increase as a result of the waiver. We note that for both scenarios in 2019, the silver plan enrollment is projected to decrease by one-third due to the availability of expanded Medicaid coverage, which impacts individuals with incomes of 100%-138% FPL who enroll largely in on-exchange silver cost-sharing reduction plans.

## D. NON-GROUP MARKET ENROLLMENT BY AGE

This section provides the estimated impact to non-group market enrollment by age group from MGARA. Figure I-4D(i) illustrates the estimated non-group market enrollment in thousands under the status-quo ACA (without waiver) during the baseline year (2018), and from 2019 through 2028, while Figure I-4D(ii) illustrates the same information under MGARA (with waiver). Figure I-4D(iii) illustrates the net change in enrollment by plan level resulting from MGARA (note that values in this table are not rounded to thousands).

Figure I-4D(i) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Age Group: 2018 through 2028 (Thousands) Without Waiver											
Age Group	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
17 and Under	9.8	7.6	7.5	7.4	7.3	7.3	7.2	7.2	7.1	7.1	7.0
18 to 25	10.7	8.3	8.3	8.3	8.3	8.3	8.2	8.2	8.1	8.0	7.9
26 to 34	10.7	8.4	8.3	8.2	8.1	8.0	7.9	7.9	7.9	8.0	8.0
35 to 44	12.7	9.8	9.9	10.0	10.1	10.1	10.2	10.2	10.2	10.1	10.1
45 to 54	9.8	7.5	7.3	7.1	6.9	6.8	6.6	6.6	6.5	6.5	6.4
55 to 64	21.5	17.1	16.7	16.4	16.1	15.8	15.5	15.0	14.6	14.2	13.8
65 and Over	2.9	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.8	2.9	2.9
Total	78.1	61.0	60.5	59.9	59.4	58.9	58.4	57.8	57.3	56.7	56.2

Note: Values are shown in thousands. Total values are rounded separately.

As shown in Figure I-4D(i), approximately 44% of individual market enrollees are estimated to be 45 years or older during the 2018 baseline year.

Figure I-4D(ii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Age Group: 2018 through 2028 (Thousands) With Waiver											
Age Group	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
17 and Under	9.8	7.8	7.7	7.6	7.5	7.4	7.3	7.3	7.2	7.2	7.1
18 to 25	10.7	8.5	8.4	8.4	8.4	8.4	8.3	8.2	8.2	8.1	8.0
26 to 34	10.7	8.5	8.4	8.3	8.2	8.1	8.0	8.0	8.0	8.0	8.0
35 to 44	12.7	10.0	10.0	10.1	10.2	10.2	10.3	10.3	10.2	10.2	10.2
45 to 54	9.8	7.7	7.5	7.3	7.1	6.9	6.7	6.6	6.6	6.5	6.5
55 to 64	21.5	17.2	16.8	16.5	16.2	15.8	15.5	15.1	14.6	14.2	13.8
65 and Over	2.9	2.4	2.5	2.5	2.6	2.7	2.7	2.8	2.8	2.9	2.9
Total	78.1	62.1	61.3	60.7	60.1	59.6	59.0	58.3	57.7	57.1	56.5

Note: Values are shown in thousands. Total values are rounded separately.

Figure I-4D(iii) MGARA Individual Health Insurance Market Estimated Non-Group Market Enrollees by Age Group: 2018 through 2028 (Thousands) Net Enrollment Change Resulting from Waiver											
Age Group	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
17 and Under	0.0	0.3	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
18 to 25	0.0	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
26 to 34	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
35 to 44	0.0	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
45 to 54	0.0	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1
55 to 64	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0
65 and Over	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	1.1	0.9	0.8	0.7	0.6	0.5	0.5	0.4	0.4	0.3

Note: Values are shown in thousands. Total values are rounded separately.

As shown in Figure I-4D(iii), additional incremental non-group enrollment is estimated to occur across each age group due to MGARA.

## 5. AFFORDABILITY REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(B), a State’s proposed waiver must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable under Title I of the ACA. As described in CMS-9936-N, increasing the number of state residents with large health care spending burdens relative to their incomes would result in a waiver proposal failing to meet the affordability requirement of the 1332 waiver application.<sup>18</sup> Additionally, regulations state an evaluation of the affordability requirement will take into account the impact of the waiver proposal to “vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues”.

Under MGARA, we estimate premium rates in the non-group market will be reduced. For the majority of the APTC-eligible population, this will not impact out-of-pocket premium costs for the second-lowest cost Silver plan (subsidy benchmark plan). These households will continue to pay up to a maximum percentage of their household income for the subsidy benchmark plan. A portion of consumers receiving an APTC in the absence of MGARA will no longer be eligible for the subsidy after the reinsurance program is implemented due to the premium expense not exceeding the maximum percentage of household income as defined under the ACA. These consumers will realize out-of-pocket premium savings as a result of MGARA. Finally, for consumers purchasing coverage in the FFM without an APTC or outside the FFM, premium savings will be realized from MGARA. Consumers not receiving an APTC under current law will realize the greatest savings from MGARA, as they accrue 100% of premium savings, whereas for APTC consumers, a large portion of savings are retained by the Federal government (which will be re-distributed in the form of pass-through funding).

For persons qualifying for APTC that are purchasing Bronze level coverage, it is possible that out-of-pocket premiums may increase as a result of MGARA. As MGARA is estimated to reduce the dollar amount of the APTC for qualifying individuals, the available financial assistance that can be applied to the purchase of Bronze level coverage is reduced. However, we estimate the impact to low income persons is limited for the following reasons:

- Because members with household income under 250% of FPL and purchasing bronze level coverage qualify for cost sharing reductions if a Silver plan is purchased<sup>19</sup>, there is a strong financial incentive to purchase Silver coverage.

<sup>18</sup> <https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf>

<sup>19</sup> Native Americans qualify for a zero cost sharing plan if income is between 100% and 300% FPL, regardless of metal level purchased.

- For certain low income individuals, the ACA's subsidy structure has created the availability of a \$0 out-of-pocket premium for Bronze coverage.<sup>20</sup>
  - As MGARA is estimated to reduce premiums, it is likely the number of marketplace enrollees qualifying for a \$0 Bronze plan will decrease to some degree.
  - We do not anticipate that the magnitude of the premium reductions produced by MGARA will have a large impact on the cost of subsidized premiums for members eligible for a \$0 Bronze plan in the without waiver scenario.
  - Rating loads applied to silver plans in 2018 to account for the termination of CSR subsidies have further reduced the likelihood of enrollees losing \$0 Bronze plan eligibility due to MGARA.

Premium savings from MGARA will vary by allowable rating factors under the ACA and the APTC structure: age, tobacco usage, geographic location, plan metallic level, and household income. Vulnerable residents will realize out-of-pocket premium savings consistent with their demographics as they relate to these factors. MGARA does not make any changes to required insurer plan design, cost sharing limitations, or cost sharing assistance in the non-group market. For persons not eligible for APTC, it may be possible that MGARA allows the consumer to purchase a richer benefit plan (e.g., a Silver instead of a Bronze plan), which may result in lower out-of-pocket cost sharing expenses. As discussed previously, funding for MGARA will be through a combination of federal pass-through funding (as a result of reducing the federal government's expenditures on premium tax credits) and a state-based assessment on comprehensive commercial health insurance coverage. Individual, Small Group, Large Group, and Self-Funded plans will be assessed a PMPM amount to generate the state-based revenue for the reinsurance fund.

As the cost of the MGARA assessment is estimated to be less than 1% of the total cost of employer-sponsored insurance in Maine, we do not estimate a material change in employee contributions or cost sharing requirements resulting from MGARA.

Sections A through D below provide estimates of changes in market premiums and APTC amounts resulting from MGARA.

## A. NON-GROUP MARKET PER MEMBER PER MONTH PREMIUM

The following tables illustrate estimated non-group PMPM premium for 2018 and the ten-year projection period without the waiver, under the waiver, and the net change in per member per month premium. We have illustrated premiums for ACA-compliant coverage (ACA), which reflects premiums attributable to coverage purchased in the FFM, as well as coverage outside the FFM that is compliant with ACA rating rules. Note, drivers of premium rate changes resulting from the waiver include the reinsurance program, as well as age and plan mix changes.

Figure I-5A(i) MGARA Individual Health Insurance Market Estimated Non-Group Premium PMPM by Plan Type: 2018 through 2028 Without Waiver											
Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	\$681	\$683	\$732	\$771	\$812	\$852	\$893	\$935	\$979	\$1,020	\$1,063

Note: Values are rounded to the nearest whole dollar.

2018 premium rate changes are based on the current rate filings submitted by the carriers actively selling ACA products in Maine. Premium rates for ACA-compliant coverage are estimated to increase from 2019 through 2028 due to assumed marketplace premium trend ranging from at 4.5% to 5.5% per year. In 2019, we model Medicaid expansion as producing a modest reduction to individual market rates based on expected morbidity improvements to the non-group insurance pool; additionally, we assume a 2% reduction in 2019 premiums due to the one-year suspension of the Health Insurer Fee using our best estimate produced in a Milliman analysis.<sup>21</sup> We assume these rate reductions are partially offset by impacts of the effective repeal of the individual mandate penalty. We do not apply an explicit rate adjustment to reflect the effective

<sup>20</sup> <https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/>

<sup>21</sup> <http://www.milliman.com/uploadedFiles/insight/healthreform/pdfs/ACA-health-insurer-fee.pdf>

individual mandate penalty repeal in 2019, as Maine carriers made consideration for a weakly enforced individual mandate in pricing 2018 policies.<sup>22</sup>

Figure I-5A(ii) MGARA Individual Health Insurance Market Estimated Non-Group Premium PMPM by Plan Type: 2018 through 2028 With Waiver											
Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	\$681	\$618	\$661	\$697	\$736	\$777	\$817	\$858	\$904	\$944	\$990

Note: Values are rounded to the nearest whole dollar.

Figure I-5A(iii) MGARA Individual Health Insurance Market Estimated Non-Group Premium PMPM by Plan Type: 2018 through 2028 Net PMPM Dollar Change											
Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	\$0	(\$64)	(\$71)	(\$74)	(\$76)	(\$75)	(\$76)	(\$77)	(\$74)	(\$75)	(\$72)

Note: Values are rounded to the nearest whole dollar.

As observed in the above figures, MGARA is estimated to result in a PMPM premium decrease for ACA compliant coverage that ranges from about \$65 to almost \$80 PMPM during the ten year projection period relative to estimated premium levels without the waiver. MGARA is estimated to result in a premium decrease in 2019 relative to the prior year rates; however, premium rates are estimated to increase thereafter under both scenarios due primarily to healthcare expense inflation, while still being lower than if the waiver was not implemented.

Under MGARA, premium rates are estimated to trend higher during 2021 through 2028 relative to the status-quo scenario. As MGARA funding is assumed to be held constant at a flat \$4 PMPM assessment, there is a leveraging impact on premium rates, resulting in average annual premium increases ranging from 4.5% to 5.6% during that portion of the projection period relative to 4.2% to 5.3% without the waiver (including impact of plan selections).

## B. NON-GROUP MARKET AGGREGATE PREMIUM

The following tables illustrate estimated non-group aggregate annual premiums during the ten-year projection period without the waiver, under the waiver, and the net change in aggregate annual premiums. We have illustrated premiums for ACA-compliant coverage (ACA). ACA coverage reflects premiums attributable to coverage purchased in the FFM, as well as coverage outside the FFM that is compliant with ACA rating rules.

Figure I-5B(i) MGARA Individual Health Insurance Market Estimated Non-Group Aggregate Annual Premiums by Plan Type: 2018 through 2028 (\$ Millions) Without Waiver											
Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	\$ 638	\$ 500	\$ 531	\$ 555	\$ 579	\$ 602	\$ 626	\$ 649	\$ 672	\$ 694	\$ 716

Note: Dollar amounts are rounded to the nearest million.

<sup>22</sup> <https://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/>

As illustrated in Figure I-5B(i), aggregate ACA-compliant annual premiums in 2018 are estimated to be approximately \$638 million. During the projection period, individual market annual premium volume is estimated to increase to approximately \$716 million.

<b>Figure I-5B(ii)</b> <b>MGARA</b> <b>Individual Health Insurance Market</b> <b>Estimated Non-Group Aggregate Annual Premiums by Plan Type: 2018 through 2028 (\$ Millions)</b> <b>With Waiver</b>											
Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	\$ 638	\$ 461	\$ 487	\$ 508	\$ 531	\$ 555	\$ 578	\$ 600	\$ 626	\$ 647	\$ 671

Note: Dollar amounts are rounded to the nearest million.

<b>Figure I-5B(iii)</b> <b>MGARA</b> <b>Individual Health Insurance Market</b> <b>Estimated Non-Group Aggregate Annual Premiums by Plan Type: 2018 through 2028 (\$ Millions)</b> <b>Net Change</b>											
Plan Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
ACA	\$ 0	\$ (39)	\$ (45)	\$ (47)	\$ (48)	\$ (47)	\$ (48)	\$ (48)	\$ (47)	\$ (47)	\$ (45)

Note: Dollar amounts are rounded to the nearest million.

The above figures illustrate a significant decrease to aggregate annual ACA premiums resulting from the implementation of MGARA in 2019, even with the migration of some uninsured people to the non-group market under MGARA.

## C. SECOND-LOWEST-COST SILVER PLAN PREMIUM – 40 YEAR OLD

The following tables illustrate the estimated second-lowest-cost silver plan PMPM premium (also referred to as the “subsidy benchmark plan”) for a single, 40 year old, non-tobacco user by Maine’s four rating areas.<sup>23</sup> The majority of enrollment is estimated to be in Rating Areas 1 and 3, together representing 65% of statewide individual marketplace enrollment. We have assumed the member distribution by rating area during the projection period is consistent with the observed member distribution in the baseline year. As shown in Figure-5C(i), Rating Areas 2, 3, and 4 have premium rates that are approximately 2%, 7% to 49% higher than the statewide average, while Rating Area 1 has premium rates approximately 5.5% lower than the statewide average.

Figure I-5C(i) MGARA Individual Health Insurance Market Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old: 2018 through 2028 Without Waiver											
Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
1	\$513	\$523	\$561	\$591	\$622	\$652	\$684	\$715	\$749	\$780	\$813
2	\$554	\$565	\$606	\$638	\$672	\$704	\$738	\$772	\$808	\$842	\$878
3	\$581	\$592	\$635	\$669	\$705	\$738	\$774	\$810	\$848	\$884	\$921
4	\$810	\$825	\$885	\$932	\$981	\$1,028	\$1,078	\$1,128	\$1,181	\$1,230	\$1,282
Composite	\$582	\$591	\$636	\$671	\$708	\$743	\$780	\$819	\$860	\$899	\$939

Notes:

1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

Figure I-5C(ii) MGARA Individual Health Insurance Market Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old: 2018 through 2028 With Waiver											
Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
1	\$513	\$476	\$508	\$536	\$566	\$596	\$627	\$658	\$693	\$724	\$759
2	\$554	\$514	\$549	\$578	\$610	\$644	\$676	\$710	\$748	\$781	\$819
3	\$581	\$539	\$576	\$607	\$640	\$675	\$710	\$745	\$785	\$820	\$859
4	\$810	\$750	\$802	\$845	\$892	\$940	\$988	\$1,037	\$1,093	\$1,141	\$1,196
Composite	\$582	\$538	\$576	\$608	\$643	\$679	\$715	\$753	\$796	\$834	\$877

Notes:

1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

<sup>23</sup> <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/me-gra.html>

Figure I-5C(iii) MGARA Individual Health Insurance Market Estimated Second Lowest Cost Silver Plan PMPM Premium, Single 40 Year Old: 2018 through 2028 Net Change											
Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
1	\$0	-\$47	-\$53	-\$55	-\$56	-\$56	-\$57	-\$57	-\$56	-\$56	-\$54
2	\$0	-\$51	-\$57	-\$60	-\$62	-\$60	-\$62	-\$62	-\$60	-\$61	-\$59
3	\$0	-\$53	-\$59	-\$62	-\$65	-\$63	-\$64	-\$65	-\$63	-\$64	-\$62
4	\$0	-\$75	-\$83	-\$87	-\$89	-\$88	-\$90	-\$91	-\$88	-\$89	-\$86
Composite	\$0	-\$53	-\$60	-\$63	-\$65	-\$64	-\$65	-\$66	-\$64	-\$65	-\$62

Notes:

1. Values have been rounded to the nearest whole dollar.
2. Premiums reflect non-tobacco user.

As shown in Figure I-5C(iii), each rating area is estimated to experience a reduction in the premium amount for the subsidy benchmark plan under the “with waiver” scenario. We have assumed the baseline premium rates accurately reflect the underlying insured population in each rating region. Therefore, on a PMPM basis, rating areas with higher baseline premiums are estimated to have a greater PMPM reduction relative to rating areas with lower premiums.

We note that while we expect fewer silver 94% CSR plan enrollees to be in the market in 2019 and future years due to Medicaid expansion, we do not explicitly reduce the second lowest cost silver plan (2LCSP) premiums for this scenario. The rate reduction to the 2LCSP (and all other) non-group market premiums in Maine due to the shift of these 94% CSR plan members is partly dependent on how the excess cost of CSR plans is allocated to plans on and off the exchange. Because we do not have clear guidance at this time on what allocation strategies the Maine BOI will allow in 2019 for covering excess costs associated with CSR plans, which would impact the rate level of the 2LCSP in 2019, we do not make an adjustment to premiums for this component of the membership change. The ultimate CSR allocation methodologies permitted by the Maine BOI would impact both the with- and without-waiver scenario premium rates; therefore, the impact of the allowed rating methodologies would have minimal impact on the projected Federal pass-through funding.

## D. ADVANCED PREMIUM TAX CREDIT

The following tables illustrate the estimated number of average enrollees per month receiving an APTC through the FFM, the average APTC PMPM amount, and aggregate annual APTC expenditures for 2018 and the ten-year projection period without the waiver, under the waiver, and the net change for these values resulting from waiver implementation. Without the waiver, aggregate annual APTC expenditures are estimated to increase to over \$475 million by 2028.

Figure I-5D(i) MGARA Individual Health Insurance Market Estimated Premium Tax Credit Enrollment and Expenditures: 2018 through 2028 Without Waiver											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
APTC Enrollees <sup>1</sup>	61	47	47	46	46	46	45	45	44	44	44
APTC PMPM <sup>2</sup>	\$584	\$565	\$608	\$644	\$682	\$718	\$755	\$793	\$832	\$868	\$906
Aggregate APTC <sup>3</sup>	\$427	\$318	\$340	\$357	\$376	\$393	\$410	\$426	\$444	\$459	\$475

Notes:

1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC represent annual values and have been rounded to the nearest million.

Figure I-5D(ii) MGARA Individual Health Insurance Market Estimated Premium Tax Credit Enrollment and Expenditures: 2018 through 2028 With Waiver											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
APTC Enrollees <sup>1</sup>	61	47	47	46	46	46	45	45	45	44	44
APTC PMPM <sup>2</sup>	\$584	\$500	\$536	\$568	\$605	\$642	\$678	\$715	\$757	\$792	\$834
Aggregate APTC <sup>3</sup>	\$427	\$283	\$301	\$316	\$334	\$352	\$369	\$386	\$405	\$420	\$438

Notes:

1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC represent annual values and have been rounded to the nearest million.

Figure I-5D(iii) MGARA Individual Health Insurance Market Estimated Premium Tax Credit Enrollment and Expenditures: 2018 through 2028 Net Change											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
APTC Enrollees <sup>1</sup>	0.0	0.3	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1
APTC PMPM <sup>2</sup>	\$0	-\$65	-\$72	-\$76	-\$78	-\$76	-\$77	-\$78	-\$75	-\$76	-\$73
Aggregate APTC <sup>3</sup>	\$0	-\$35	-\$39	-\$41	-\$42	-\$41	-\$41	-\$41	-\$39	-\$39	-\$37

Notes:

1. Values for APTC enrollees are rounded to the nearest thousand and reflect average monthly effectuated enrollment.
2. Values for APTC PMPM have been rounded to the nearest whole dollar.
3. Values for Aggregate APTC represent annual values and have been rounded to the nearest million.

As shown in Figure I-5D(iii), MGARA is estimated to cause a slight increase in the number of APTC enrollees by inducing enrollees with incomes between 300% FPL to 400% FPL (i.e., lightly subsidized members) to enter the market. MGARA is also estimated to have an effect on the per capita APTC amount, decreasing it by nearly 11% in 2019 relative to the baseline scenario. The per capita APTC savings translate to significant aggregate savings on APTC expenditures. These savings, net of other applicable Federal revenue changes, are estimated to become available pass-through funding for MGARA.

## 6. COMPREHENSIVENESS REQUIREMENTS

As required under 45 CFR 155.1308(f)(3)(iv)(A), a State's proposed waiver must provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) of the ACA. As described in CMS-9936-N, comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs). MGARA makes no changes to EHB requirements in the individual market, nor is it estimated to have any effect on other health insurance programs and populations within the State of Maine. Additionally, MGARA makes no changes to state-mandated benefits. As MGARA is estimated to increase enrollment in the non-group market relative to projections absent the waiver, it increases the number of Mainers with insurance coverage that meets the EHB requirements, fulfilling the comprehensiveness requirements of 45 CFR 155.1308(f)(4)(iv)(A).

## SECTION II. ECONOMIC ANALYSIS

45 CFR 155.1308(f)(4)(ii) requires the Section 1332 waiver application to provide economic analyses to support the State's estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement and the Federal deficit requirement. Analyses related to the estimated impact of MGARA to health insurance coverage in Maine have been provided within the actuarial certification. This section addresses the deficit neutrality requirements of the waiver application, providing a ten-year budget plan that includes all costs under the waiver, including administrative and other costs to the Federal government.

As shown in the actuarial analysis, Figure I-4D(iii), MGARA is estimated to have a material impact on the Federal government APTC expenditures for Mainers purchasing health insurance coverage through the FFM. As permissible under Section 1332 of the ACA, Maine seeks to apply the Federal savings on APTC expenditures to support MGARA. To fulfill the Section 1332 Waiver budget neutrality requirements, Maine seeks Federal pass-through funding equal to Federal APTC savings, less other changes to Federal government expenses. Figure II-1 provides a summary of estimated Federal expenditure changes during the ten-year projection period.

Figure II-1 MGARA Individual Health Insurance Market Estimated Federal Government Expenditures Changes: 2019 through 2028 (in Millions)										
Revenue / (Expense) Item	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Federal APTC Expenditures	\$35	\$39	\$41	\$42	\$41	\$41	\$41	\$39	\$39	\$37
Aggregate Shared Responsibility Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Exchange User Fee	(\$1)	(\$2)	(\$2)	(\$2)	(\$2)	(\$2)	(\$2)	(\$2)	(\$2)	(\$2)
Health Insurer Fee	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Net Reduction in Federal Expenditures	\$33	\$37	\$39	\$40	\$39	\$39	\$39	\$38	\$38	\$36

Note: Values are on an annual basis.

*Federal APTC Expenditures:* As MGARA is estimated to reduce the cost of the second lowest cost silver plan (subsidy benchmark plan) during the projection period, the federal government's expenditures on APTC for Mainers is estimated to be reduced. Further detail on APTC savings is provided in Section I-5D of the actuarial certification.

*Aggregate Shared Responsibility Payments:* On December 22, 2017, President Trump signed into law "H.R.1 - An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018." Section 11081 of that Act repeals the Shared Responsibility Payments for individuals established by the Affordable Care Act. The repeal becomes effective January 1, 2019; therefore, we project no change to Federal Expenditures based on changes to Aggregate Shared Responsibility Payments in the 2019 to 2028 projection period.

*Exchange User Fee:* For states electing to use the FFM, the federal government requires a 3.5% assessment on insurance marketplace coverage to support the operation of the FFM. As MGARA is estimated to reduce premium rates for non-group coverage purchased both on and off the marketplace, it is also estimated to reduce the revenue generated by the 3.5% premium assessment on insurance purchased through the FFM.

*Health Insurer Fee:* Section 9010 of the ACA mandates a national assessment on health insurers of \$14.3 billion in 2018; that assessment has been suspended for 2019. Thereafter, the national assessment amount is indexed based on the "premium growth rate" as defined under the ACA. As the premium growth rate is calculated based on changes per capita costs for employer-sponsored insurance, we do not believe MGARA materially impacts the premium growth rate calculation. Therefore, MGARA is not estimated to result in any changes to Federal revenue from the HIF.

The remainder of this section provides more detailed discussion on the components of Federal revenue changes, excluding APTC expenditures, which are discussed in detail within the actuarial certification.

# 1. EXCHANGE USER FEE

Section 1311(d)(5)(A) of the ACA allows an Exchange (also referred to as a marketplace) to charge assessments or user fees to participating health insurers to generate funding to support the operation of the Exchange. In the proposed 2019 Notice of Benefit and Payments parameters, the Federal government set the 2019 user fee for insurers offering coverage in the FFM at 3.5% of charged premium.<sup>24</sup> For purposes of our ten-year projection, we have assumed that Maine will continue to utilize the FFM and the 3.5% user fee will continue through the course of the projection period.

FFM user fee revenue may change as a result of the following impacts under MGARA:

- MGARA is estimated to result in a decrease in per capita premiums charged by insurers in the ACA-compliant non-group market, both within the FFM and in the outside market.
- To the extent persons receive an APTC without MGARA, but no longer receive an APTC under the waiver (as a result of premium rate decreases rendering the APTC worth \$0), the financial incentive to purchase coverage through the FFM is removed. FFM data through 2017 indicate that about 86% of Mainers purchasing coverage in FFM qualify for an APTC.<sup>25</sup> Therefore, it is possible that a small portion of the APTC population in the absence of the waiver will shift to purchasing coverage outside of the FFM as a result of MGARA. These households are most likely to consist of young adults, with income above 300% FPL, as these persons receive a lower amount of APTC relative to older and/or lower income households.
- Additional persons entering the non-group market as a result of MGARA are more likely to not qualify for an APTC, as MGARA's premium reduction will primarily accrue to consumers with income above 400% FPL who do not qualify for APTC.

Figure II-2A illustrates the estimated change in premium revenue during the projection period, as well as the corresponding change in the collected FFM user fee, based on 3.5% of premium revenue. The On-Exchange premiums for 2019 and beyond were estimated based on the split of non-group market premiums by on-exchange and off-exchange markets from a survey administered to Maine Carriers by Milliman through MGARA.

<b>Figure II-2 MGARA Individual Health Insurance Market Estimated Change in Insurer Assessment Revenue 2019 through 2028 3.5% Premium Assessment Assumed (in Millions)</b>		
<b>Calendar Year</b>	<b>Change in On-Exchange Premium Revenue</b>	<b>Change in Federal Assessment from Exchange Fee</b>
2019	\$42.2	\$1.5
2020	\$46.2	\$1.6
2021	\$47.7	\$1.7
2022	\$48.5	\$1.7
2023	\$47.3	\$1.7
2024	\$47.4	\$1.7
2025	\$47.4	\$1.7
2026	\$45.4	\$1.6
2027	\$45.5	\$1.6
2028	\$43.2	\$1.5

Note: Values are rounded to the nearest hundred thousand and are on an annual basis.

<sup>24</sup> <https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf>, page 51054.

<sup>25</sup> [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2017\\_OEP\\_State-Level\\_Public\\_Use\\_File.zip](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2017_OEP_State-Level_Public_Use_File.zip), worksheet (5) by Premium and FA

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## 2. HEALTH INSURANCE PROVIDERS FEE

The Health Insurer Providers Fee (HIF), mandated by Section 9010 of the ACA is applicable to qualifying health insurance premiums earned by for-profit and a portion of non-profit insurers. The annual fee amount required for an insurer is based on its premium volume in proportion to the premium volume of other health insurers subject to the HIF during the prior year. Nonprofit insurers who receive more than 80% of their premium revenue from Medicare, Medicaid, CHIP, and dual eligible plans are exempted from the fee. Other nonprofit insurers will be able to exclude 50% of their premium revenue from the health insurer fee calculation. In 2018, the national HIF charge is \$14.3 billion. In 2019, there is a moratorium on the collection of the HIF; thereafter, the HIF charge is increased by the rate of premium growth relative to the preceding year (as defined in Section 36B(b)(3)(A)(ii) by the IRS).<sup>26</sup>

As MGARA is not estimated to materially change employer-sponsored insurance premiums in Maine, we do not estimate MGARA will impact CMS' projection of per enrollee employer-sponsored insurance premiums. In the absence of other information and based on current regulations, we assume that CMS will continue to calculate the premium growth rate based on projected changes in employer-sponsored insurance premiums.

Since the ACA's implementation, the Centers for Medicare & Medicaid Services (CMS) has used a methodology based on the most recent National Health Expenditures Accounts projection of per capita employer-sponsored insurance premiums to develop the above referenced premium growth percentage.<sup>27</sup> It is uncertain to what degree (if any) changes would be made to this calculation in the future.

Based on this set of assumptions, we do not estimate MGARA will have any material impact on HIF charges during the ten-year projection period. To the extent the state-based assessments supporting MGARA result in higher per capita employer-sponsored insurance premiums in Maine, MGARA would actually result in greater HIF revenue for the Federal government based on the current indexing methodology.

It is possible that the share of HIF payments made attributable to Maine health insurance premiums may vary as a result of MGARA. As MGARA is estimated to reduce insurer premium volume, it may result in a slight increase in required payments from insurers not participating in Maine's individual health insurance market (as well as APTC expenditures in other states). This may change the amount of HIF revenue collected from Maine insurers, but will not change the national assessment amount.

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<sup>26</sup> Please see <https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010> for more information related to the HIF.

<sup>27</sup> <https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-12-16.html>, see paragraph entitled "Premium Adjustment Percentage".

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## SECTION III. ASSUMPTIONS AND METHODOLOGY

### 1. MARKET CALIBRATION

A key aspect of modeling healthcare reform proposals is establishing a status quo set of assumptions for the population being modeled. For the State of Maine insurance markets, we developed estimates for the number of individuals insured in Maine through the non-group insurance market (or uninsured) in the baseline year (2018) by age, gender, household income, health status, metallic level and premium rates (if applicable), and other factors to establish baseline assumptions for Maine's population. We did not perform these estimates for Maine's transitional policies as, based on proprietary data provided in a survey to Maine's individual market carriers, no transitional policy enrollment was reported for 2017. We calibrated the total 2018 individual market enrollment to actual on- and off-exchange open enrollment figures known as of mid-January 2018; this calibration was based on proprietary data that we received from Maine insurers and Maine's Bureau of Insurance (BOI). We developed our starting census and premium rate assumptions for the non-group insurance market from a number of publicly available data sources. The assumptions in the model related to insurance take-up rates and market migration specific to Maine have been informed by studies on the impact of key changes to the regulations and composition of the non-group market (e.g., individual mandate repeal, Medicaid expansion, etc.) and by actuarial judgment. Data from insurers included estimated 2017 enrollment by income level. Proprietary data received from Maine's BOI included aggregate open enrollment figures by metal level and by on-exchange/off-exchange. Additional detail on data sources used in our census and assumption calibration process is provided below:

- **2018 Open Enrollment data** – The Maine BOI provided proprietary data by carriers operating in Maine's non-group insurance markets, which was used along with 2017 Marketplace Enrollment Reports to determine the 2018 on-exchange and off-exchange enrollment by plan metal level and income level.
- **2017 Marketplace Enrollment Reports** – We utilized publicly available data provided by Centers for Medicare and Medicaid Services (CMS) to estimate the split of 2018 Individual Health Insurance Marketplace enrollment by income level.
- **U.S. Census Bureau data** – The U.S. Census Bureau contains state-by-state counts which identify population cohorts by gender, age, income level, and insurance type. This information was used to estimate the size of Maine's uninsured population, as well as to calibrate income levels for non-group market enrollees who were not already tagged with income indicators.
- **Maine Carriers 2015 to 2017 Survey Data** – This survey was developed by Milliman and administered to Maine carriers through MGARA requesting claims, premiums, and enrollment data from 2015 through 2017. This source was used to evaluate the need to model transitional and grandfathered policies, as well as to estimate the split of On-Exchange and Off-Exchange premiums as a percentage of total non-group market premiums for 2019 and beyond.
- **2018 Filed Premium Rates** – The 2018 rates used were those filed by the two major carriers active in the Maine individual market in 2018 (i.e., Community Health Options and Harvard Pilgrim). We applied adjustments to age-specific and area-specific rates to normalize them to a state-wide basis before applying to the model; Federal age curve factors were applied to the rates to restate premiums on the appropriate age basis for each projection cohort.
- **CPI** – We used CPI-U projections from the Congressional Budget Office (CBO) June 2017 report, "An Update to the Budget and Economic Outlook: 2017 to 2027" to project changes in the Federal Poverty Level through 2028. Our modeling assumes that the rate of wage inflation in Maine does not differ materially from the inflation rate indicated by the CPI-U.
- **Long-Term Marketplace Premium Trends** – We referred to the CBO report, "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2017 to 2027," as a source for our long-term marketplace trend estimates, which range from 5.5% to 4.5% over the course of the projection period (averaging to a 5% overall trend during the projection period).<sup>28</sup>

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<sup>28</sup> <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf>

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- **Enrollment Changes due to Individual Mandate Repeal** – To estimate the impact of the repeal of the individual mandate penalty on Maine’s non-group market enrollment, we reviewed studies published by the CBO and by S&P Global to determine a range of estimated Individual insurance market contraction; we then selected within that range using actuarial judgment. We applied adjustments based on the 2017 Marketplace Enrollment Reports to reflect the size of Maine’s insurance market as a proportion of the national market, Maine’s prevalence of unsubsidized non-group insurance market enrollees compared to the national average prevalence (subsidies – and the lack thereof – impact willingness to remain insured), and the expected duration of members who exit the individual insurance market due to the individual mandate penalty repeal.
  - **Medicaid Expansion** – Our modeling assumes that Medicaid expansion is effective in 2019 and that eligible individuals enroll in Medicaid-sponsored insurance rather than through the Marketplace. Beginning in 2019, we therefore reduce the estimated non-group enrollment to exclude individuals with income levels <138% of the FPL. We apply an adjustment to the 2019 rates to reflect changes to the market-wide morbidity level following the Medicaid expansion population shift; that adjustment was determined using a 2016 issue brief published by ASPE with judgment-based modifications to produce results consistent with Maine’s population characteristics.

Based on actual insurance enrollment from insurer eligibility reports and public programs, we estimated 2018 counts for the non-group insurance market. The demographic distributions were used to allocate enrollment by age, gender, and income level.

## 2. POPULATION MODELING

Based on the Maine census projections, we estimated enrollment in each insurance market from 2019 through 2028 by assuming the distribution of insurance market enrollment by age, gender, and income level would remain constant relative to 2017. Changes in insurance market enrollment during the projection period are a result of changes in Maine’s estimated population by age and gender in the census projections. For example, the census projections estimate the Maine population age 65 and over will increase from approximately 286,000 in 2019 to 358,000 by 2029. This results in a corresponding increase in the number of estimated Medicare enrollees during the same time period.

For the uninsured and non-group market, further adjustments were made to enrollment projections based on the census projections. We have observed a significant increase in the individual market enrollment in Maine from 2013 through 2015, and some volatility from 2015 through 2017. Maine enrolled approximately 34,000 individual members in individual coverage in 2012, while the individual market reached more than 90,000 by 2017.

In our projections, we have estimated immaterial changes in non-group coverage for the population eligible for APTC over the 10 year projections. As the structure of the APTC calculation caps a consumer’s out-of-pocket premium, we have assumed little enrollment changes (other than those driven by census projections), for the population eligible for APTC. This assumption is supported by the stability in APTC enrollment between 2016 and 2017, despite significant premium rate increases occurring in the market. As discussed in this report, MGARA is not estimated to have a material impact on out-of-pocket premiums for the population eligible for the APTC. Therefore, under both the without waiver and waiver scenarios, we projected similar APTC enrollment.

For the uninsured and non-group markets, we divided enrollment into risk quintiles. Individuals in high risk quintiles were assumed to have a greater likelihood of maintaining insurance (current non-group) or entering the market (current uninsured) relative to enrollees in lower risk quintiles.

For the population not eligible for APTC, mostly Maine individuals with income above 400% FPL, we have assumed further attrition in market enrollment will occur if premium rate growth exceeds income growth. As a result of MGARA, we estimate enrollment attrition is halted for several years for Mainers currently purchasing coverage in the non-group market. Additionally, the decrease in premiums is estimated to incent a small number of currently uninsured individuals to purchase coverage in the projection period.

## 3. PREMIUM PROJECTIONS

Premiums estimated in the non-group market for 2019 are based on estimated healthcare inflation (assuming no change in benefit levels or insured demographics), the estimated premium reduction due to the one-year suspension of the Health Insurer Fee, and on changes in market-wide morbidity due to Medicaid expansion.

Federal premium assistance was estimated based on premium rate changes for the second-lowest cost Silver plan available in the FFM, projected household income by FPL, and the indexing of the premium tax credit expenditures. For each enrollee

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cohort, a rating factor corresponding to the default Federal age curve was assigned.<sup>29</sup> We confirmed that our model produced an estimated, aggregate, Federal premium assistance amount that closely corresponds to the average APTC per month for qualifying enrollees published by CMS (\$413) using results from the June 2017 Enrollment Snapshot Report to calibrate the pre-baseline year of our economic model.<sup>30</sup>

## 4. REINSURANCE PAYMENT MODELING

For our reinsurance modeling we used medical and prescription drug claim and eligibility data from the Maine All Payer Database as the source of the model's experience data. Members in the individual market who were not covered by Medicare Part C or by supplemental plans and who had sufficient months of eligibility were included along with their incurred allowed claims. Allowed claims were trended to the projection period using trend consistent with the long-term premium trends in the economic model. Paid claims were determined by multiplying allowed claims by the average paid-to-allowed ratio from carriers' 2018 URRT.

Eligibility for MGARA is determined either by auto-ceding conditions defined by MGARA or by voluntary ceding by non-group insurers. The following conditions for auto-ceding members into MGARA are used: Chronic Obstructive Pulmonary Disease (COPD); Cancer – Corpus Uterus (Endometrial Carcinoma); Cancer – Metastatic; Rheumatoid Arthritis; Cancer – Prostate Gland; Congestive Heart Failure; Renal Failure; HIV Infection.

The financial projection model assigns expected claims to each insured person based on their assumed medical conditions and, for in-force business, their historical claims experience. Rounded output from the actuarial modeling of MGARA operations is displayed in Appendix II: Actuarial Modeling Summary.

## 5. ALTERNATE SCENARIOS

In addition to modeling with- and without-MGARA scenarios under the assumption that Maine Medicaid expansion is implemented in 2019, we modeled with- and without-MGARA scenarios under conditions having no Maine Medicaid expansion in 2019 or future years. Figure II-4 summarizes enrollment assumptions based on the no Medicaid expansion scenario.

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<sup>29</sup> <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf>, page 4.

<sup>30</sup> <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>, Average Advanced Premium Tax Credit by State, February 2017, page 6

Figure II-4 MGARA No Medicaid Expansion Changes in Uninsured and Non-Group Market Resulting from MGARA Implementation (in Thousands)						
Calendar Year	Uninsured			Individuals Insured in Non-Group Market		
	Without MGARA	With MGARA	Change	Without MGARA	With MGARA	Change
2018	92.2	92.2	0.0	78.1	78.1	0.0
2019	93.2	92.4	-0.8	75.9	76.7	0.8
2020	92.4	91.7	-0.7	75.2	75.9	0.7
2021	91.6	91.0	-0.6	74.6	75.3	0.6
2022	90.9	90.3	-0.6	74.0	74.6	0.6
2023	90.2	89.7	-0.5	73.4	73.9	0.5
2024	89.5	89.1	-0.4	72.8	73.2	0.4
2025	88.9	88.5	-0.4	72.1	72.4	0.4
2026	88.3	88.0	-0.3	71.4	71.7	0.3
2027	87.7	87.5	-0.3	70.7	70.9	0.3
2028	87.2	87.0	-0.2	70.0	70.2	0.2

Medicaid expansion is estimated to reduce the non-group market by about 19% - without Maine's Medicaid expansion the projected size of the non-group market in 2019 shifts from 61.0K to 75.9K under the without MGARA scenario and from 62.1K to 76.7K under the with MGARA conditions. The 0.8K difference in membership between the with- and without-MGARA scenarios under no Medicaid expansion is less than the 1.1K difference for the Medicaid expansion scenarios, meaning MGARA is estimated to have a smaller impact on enrollment if Medicaid expansion does not take place. This is due primarily to the following factors:

- Under the no Medicaid expansion scenario, while the nearly 500,000 member assessable pool (and therefore the collected MGARA assessments) increases slightly by retaining the would-be Medicaid expansion enrollees in the non-group market, the 70,000 member non-group market increases at a rate much greater than the assessable market. This dynamic means that each dollar of MGARA assessment funding must be spread over an increased number of non-group market claimants in the no Medicaid expansion scenario, reducing the impact of the MGARA recoveries on premiums. The reduced impact on premiums leads to a reduction in the estimated enrollment changes.
- The average non-group market premiums are higher in the no Medicaid expansion scenario because members with income ranges <138% FPL, a group having average morbidity, remain in the non-group risk pool; this relative premium increase reduces expected enrollment into the non-group market.

As discussed above, the MGARA assessments must cover an increased claimant population in the no Medicaid expansion scenario, and in result the MGARA attachment points are raised to ensure program solvency.

Figures II-5 through II-7 illustrate the average premiums, reinsurance attachment points, and MGARA cash flow assumptions under the no Medicaid expansion scenario.

Figure II-5 MGARA No Medicaid Expansion Changes in Second Lowest Cost Silver Plan Monthly Premium from MGARA Implementation						
	21-Year Old Monthly Premium			64-Year Old Monthly Premium		
Calendar Year	Without MGARA	With MGARA	Change	Without MGARA	With MGARA	Change
2018	\$456	\$456	\$0	\$1,367	\$1,367	\$0
2019	\$472	\$439	(\$33)	\$1,415	\$1,317	(\$98)
2020	\$507	\$470	(\$37)	\$1,521	\$1,410	(\$112)
2021	\$535	\$492	(\$43)	\$1,605	\$1,476	(\$128)
2022	\$564	\$520	(\$44)	\$1,693	\$1,560	(\$133)
2023	\$593	\$549	(\$44)	\$1,778	\$1,646	(\$131)
2024	\$622	\$578	(\$44)	\$1,867	\$1,734	(\$133)
2025	\$653	\$609	(\$44)	\$1,960	\$1,827	(\$133)
2026	\$686	\$643	(\$43)	\$2,058	\$1,928	(\$130)
2027	\$717	\$673	(\$43)	\$2,151	\$2,020	(\$130)
2028	\$749	\$705	(\$45)	\$2,247	\$2,114	(\$134)

Figure II-6 MGARA No Medicaid Expansion Calendar Year 2019 Reinsurance Parameters	
Parameter	Parameter Value
Initial Attachment Point	\$55,000
Reinsurance Threshold 2	\$85,000
Coinsurance Percentage 1 (between Initial Attachment Point and Reinsurance Threshold 2)	90%
Coinsurance Percentage 2 (above Reinsurance Threshold 2)	100%

**Figure II-7  
MGARA  
No Medicaid Expansion  
Estimated Available Pass-Through Funding and State-Based Assessment**

<b>Calendar Year</b>	<b>State-Based Assessment (\$ Millions)</b>	<b>Federal Pass-through Funding (\$ Millions)</b>	<b>Ceded Premiums (\$ Millions)</b>	<b>Total Revenue (\$ Millions)</b>	<b>Estimated Assessment Enrollment Base (Thousands)</b>	<b>State-Based Assessment PMPM</b>	<b>Ceded Lives</b>
2019	\$23.3	\$34.7	\$46.7	\$104.7	486	\$4.00	6,500
2020	23.1	39.2	49.9	112.2	481	\$4.00	6,500
2021	22.9	44.6	52.6	120.1	476	\$4.00	6,600
2022	22.6	45.6	54.6	122.8	472	\$4.00	6,500
2023	22.4	44.6	56.0	123.0	467	\$4.00	6,300
2019-2023	\$114.3	\$208.7	\$259.8	\$582.8	2,382		32,400
2024	22.2	44.7	58.0	124.9	462	\$4.00	6,200
2025	22.0	44.1	59.7	125.8	458	\$4.00	6,100
2026	21.8	42.4	61.3	125.5	453	\$4.00	6,000
2027	21.6	42.0	62.9	126.5	449	\$4.00	5,900
2028	21.3	42.6	64.6	128.5	445	\$4.00	5,800

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## LIMITATIONS

The services provided for this project were performed under the contract between Milliman and MGARA dated July 31, 2017.

The information contained in this report has been prepared for MGARA to provide actuarial certification and economic analyses related to the State of Maine's Section 1332 Waiver application that seeks Federal funding for MGARA. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for MGARA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the premium rates, insurance market population estimates, trend rates, and other assumptions.

Milliman has relied upon the accuracy and completeness of data and information provided by MGARA, the Maine Bureau of Insurance (BOI), and Maine insurance carriers; data sources underlying the analysis include Federal government reports related to insurance marketplace enrollment and premiums, proprietary insurer financial data, and Federal economic and healthcare expenditure forecasts. Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data provided are not accurate, the estimates provided in this report would need to be modified to reflect revised information.

It should be noted there is significant uncertainty surrounding future enrollment, premiums, and claims in health insurance programs, particularly within the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

We specifically note our projections of enrollment and premium rates in the individual market assume no direct Federal funding of CSR subsidies, Medicaid expansion effective January 1, 2019, insurer pricing assumptions do not materially deviate from 2018 assumptions, and there are no material changes to the ACA and its associated regulations following the completion date of the supporting analyses. It is certain that values presented in this report will deviate from actual amounts. However, to the extent judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted by a significant degree. Actual insurer premiums in 2019 and beyond may contain additional margin related to these contingencies to provide financial protection for these occurrences.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Several of the authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

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## **APPENDIX I: ACTUARIAL CERTIFICATION**

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**Maine Bureau of Insurance  
Section 1332 Waiver Application  
Maine Guaranteed Access Reinsurance Association  
Actuarial Certification**

I, Kathleen E. Ely, am a Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been engaged by the Maine Guaranteed Access Reinsurance Association (MGARA) to perform an actuarial analysis and certification regarding the State's Section 1332 Innovation Waiver proposal that seeks Federal funding for implementation of MGARA. I am generally familiar with the federal requirements for Section 1332 waiver proposals, commercial health insurance rating rules, insurance exchanges, the Affordable Care Act's premium assistance structure, rules surrounding individual shared responsibility payments, and other components of the Affordable Care Act relevant to this Section 1332 State Innovation Waiver proposal.

As required under 45 CFR 155.1308 (f)(4)(i), this certification provides documentation that the actuarial analyses support the State of Maine's finding that MGARA complies with the following requirements for Section 1332 waivers as defined under 45 CFR 155.1308 (f)(3)(iv)(a)-(c):

- The proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver;
- the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; and,
- the proposal will provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver

The assumptions and methodology used in the development of the actuarial certification has been documented in my report provided to the State of Maine. The actuarial certification provided with this report is for the period from January 1, 2019 through December 31, 2023. To the extent state or federal regulations are modified through the end of the waiver period, it may be necessary for this actuarial certification and corresponding analyses to be amended.

The actuarial analyses presented with this certification is based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the analyses.

In developing the actuarial certification, I have relied upon data and information provided by the State of Maine, publicly available Federal government data sets and reports, and insurer enrollment and financial data. I have relied upon these third parties for audit of the data. However, I did review the data for reasonableness and consistency.



Kathleen E. Ely, FSA  
Member, American Academy of Actuaries  
2018

## APPENDIX II: ACTUARIAL MODELING SUMMARY

### MGARA Operation Financial Projections

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Commercial Market for Assessment	471,000	467,000	462,000	457,000	453,000	449,000	444,000	440,000	436,000	432,000
Assessment PMPM	\$4.00	\$4.00	\$4.00	\$4.00	\$4.00	\$4.00	\$4.00	\$4.00	\$4.00	\$4.00
Market Premium	\$683	\$732	\$771	\$812	\$852	\$893	\$935	\$979	\$1,020	\$1,063
Premium with Waiver	\$618	\$661	\$697	\$736	\$777	\$817	\$858	\$904	\$944	\$990
Premium Change Percentage	-9.4%	-9.7%	-9.6%	-9.4%	-8.8%	-8.5%	-8.2%	-7.6%	-7.4%	-6.8%
Individual Enrollment	62,100	61,300	60,700	60,100	59,600	59,000	58,300	57,700	57,100	56,500
Number of Auto Cedes	4,300	4,300	4,200	4,200	4,200	4,100	4,100	4,000	4,000	3,900
Number of Voluntary Cedes	1,200	1,300	1,200	1,200	1,000	1,000	900	800	800	700
Initial Attachment Point	\$47,000	\$47,000	\$51,000	\$56,000	\$63,000	\$69,000	\$75,000	\$84,000	\$90,000	\$100,000
Reinsurance Threshold 2	\$77,000	\$77,000	\$81,000	\$86,000	\$93,000	\$99,000	\$105,000	\$114,000	\$120,000	\$130,000
<b>Revenue (millions)</b>										
Estimated Passthrough Dollars from Waiver	\$33.4	\$37.5	\$38.9	\$39.8	\$38.9	\$39.2	\$39.1	\$37.5	\$37.5	\$35.7
Market Assessment at \$4.00 PMPM	\$22.6	\$22.4	\$22.2	\$22.0	\$21.7	\$21.5	\$21.3	\$21.1	\$20.9	\$20.7
Autocede Premium	\$28.9	\$30.5	\$31.9	\$33.3	\$34.8	\$36.2	\$37.6	\$39.2	\$40.6	\$42.1
Voluntary Cedes Premium	\$8.1	\$9.2	\$9.3	\$9.3	\$8.8	\$8.4	\$8.5	\$8.3	\$8.3	\$7.8
<b>Total Revenue</b>	<b>\$93.0</b>	<b>\$99.6</b>	<b>\$102.3</b>	<b>\$104.4</b>	<b>\$104.2</b>	<b>\$105.3</b>	<b>\$106.5</b>	<b>\$106.1</b>	<b>\$107.3</b>	<b>\$106.3</b>
<b>Expenses (millions)</b>										
Autocede Claims	\$60.2	\$64.8	\$67.2	\$69.3	\$70.0	\$71.4	\$72.9	\$73.1	\$74.5	\$74.2
Voluntary Cede Claims	\$29.5	\$32.9	\$33.6	\$33.9	\$32.9	\$32.8	\$32.8	\$31.5	\$31.6	\$30.1
MGARA Admin	\$0.7	\$0.7	\$0.7	\$0.7	\$0.6	\$0.6	\$0.6	\$0.6	\$0.6	\$0.6
<b>Total Expenses</b>	<b>\$90.4</b>	<b>\$98.4</b>	<b>\$101.5</b>	<b>\$103.9</b>	<b>\$103.5</b>	<b>\$104.8</b>	<b>\$106.3</b>	<b>\$105.2</b>	<b>\$106.7</b>	<b>\$104.9</b>
<b>Net Gain/Loss</b>	<b>\$2.6</b>	<b>\$1.2</b>	<b>\$0.8</b>	<b>\$0.5</b>	<b>\$0.7</b>	<b>\$0.5</b>	<b>\$0.2</b>	<b>\$0.9</b>	<b>\$0.6</b>	<b>\$1.4</b>
<b>Ending Surplus (1)</b>	<b>\$8.0</b>	<b>\$9.1</b>	<b>\$9.7</b>	<b>\$9.9</b>	<b>\$10.3</b>	<b>\$10.6</b>	<b>\$10.7</b>	<b>\$11.6</b>	<b>\$12.0</b>	<b>\$13.3</b>

Notes

(1) MGARA Operational Surplus is currently \$5.4m



**MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION**

**PLAN OF OPERATION**

**Effective June 12, 2012**

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ARTICLE I NAME

- 1.1 The Maine Guaranteed Access Reinsurance Association, hereinafter referred to as the "Association," is a Maine mutual benefit nonprofit corporation created pursuant to Titles 13-B and 24-A, Chapter 54-A of the Maine Revised Statutes.

ARTICLE II ASSOCIATION MEMBERS

- 2.1 The members of the Association (each, a "Member Insurer") are Insurers (as defined herein) that offer individual health plans and are actively marketing individual health plans in the State of Maine.

ARTICLE III PURPOSE

- 3.1 The Association was established pursuant to Maine Public Law Chapter 90, "An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-based Purchasing of Health Care Services", exclusively for the purpose of providing a reinsurance program for the higher risk segment of Maine's individual health insurance market in order to reduce insurance costs in that market and assure availability of affordable health insurance to residents of the State of Maine by providing reinsurance of a significant portion of the coverage provided through individual health insurance policies offered by its Member Insurers.

ARTICLE IV DEFINITIONS

- 4.1 For purposes of this Plan, the following terms shall have the definition hereinafter set forth:

"Administrator" means the organization selected by the Board for the fair, equitable and reasonable administration of the Association pursuant to the applicable provisions of the Enabling Act.

"Association" is defined in Section 1.1.

"Board" is defined in Section 7.2.

"Board Petition" is defined in Section 14.7(d).

"Bureau" means the Maine Department of Professional and Financial Regulation, Bureau of Insurance.

"Business Day" means any day other than Saturday, Sunday or any other day on which banks in the State of Maine are permitted or required to be closed.

“Ceding Notice” is defined in Sections 9.4(a)(i) and (ii).

“Ceding Records” is defined in Section 9.4(f).

“Ceding Term” is defined in Section 9.4(h).

“Claims Reports” is defined in Section 9.8.

“Covered Person” means an individual covered as a policyholder, participant or Dependent under a plan, policy or contract of medical insurance.

“Deficit Assessment” is defined in Section 11.3.

“Dependent” means a spouse, a domestic partner as defined in 24-A M.R.S. § 2832-A(1) or a child under 26 years of age.

“Discretionary Cede” or “Discretionary Ceding” is defined in Section 10.1.

“Dispute Notice” is defined in Section 14.7(b).

“Eligible Claims” is defined in Section 9.7.

“Eligible Health Plan” is defined in Section 9.2.

“Enabling Act” means the Maine Guaranteed Access Reinsurance Association Act, 24-A M.R.S. §§ 3951 *et seq.*

“Enrollment Report” is defined in Section 9.5(d)(ii).

“Executive Dispute Process” is defined in Section 14.7(b).

“Freeze Out Period” is defined in Section 9.4(h)(iii).

“Health maintenance organization” means an organization authorized under 24-A M.R.S. Chapter 56 to operate a health maintenance organization in this State.

“Health Statement” is defined in Section 10.1(a)(i).

“IBNR” means losses that have been incurred but not reported.

“In-Force Book” means all medical insurance policies, as defined by 24-A M.R.S. 3952(7), that a Member Insurer has in force covering residents (as

defined by 24-A M.R.S. 2736-C(1)(C-2)) of the State of Maine, as of June 30, 2012.

“Initial Designation” refers to the initial designation process described in Section 9.4(a).

“Insurance Code” means the Maine Insurance Code, M.R.S. Title 24-A.

“Insurer” means an entity that is authorized to write medical insurance or that provides medical insurance in the State of Maine, including an insurance company, a nonprofit hospital and medical service organization, a fraternal benefit society, a health maintenance organization, a self-insured employer subject to state regulation as described in 24-A M.R.S. §2848-A, a Third-Party Administrator, a multiple-employer welfare arrangement, a reinsurer that reinsures health insurance in the State of Maine, a captive insurance company established pursuant to Chapter 83 of the Insurance Code that insures the health coverage risks of its members, the Dirigo Health Program established in Chapter 87 of the Insurance Code, or any other state-sponsored health benefit program whether fully insured or self-funded.

“Investment Policy” is defined in Section 12.5.

“Joint Standing Committee” means the joint standing committee of the Maine State Legislature having jurisdiction over health insurance matters.

“Legal Committee Hearing” is defined in Section 14.7(c).

“Mandatory Ceding” and “Mandatory Cede” is defined in Section 10.2.

“Medical Insurance” means a hospital and medical expense-incurred policy, nonprofit hospital and medical service plan, health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. “Medical insurance” does not include accidental injury, specified disease, hospital indemnity, dental, vision, disability income, Medicare supplement, long-term care or other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

“Medicare” means coverage under both Parts A and B of Title XVIII of the federal Social Security Act, 42 United States Code, Section 1395 *et seq.*, as amended.

“Member Insurer” is defined in Section 2.1.

“New Business Book” means all medical insurance policies, as defined by 24-A M.R.S. 3952(7), a Member Insurer sells to any Covered Person with an initial effective date on or after July 1, 2012.

“Nonprofit Act” means M.R.S. Title 13-B.

“Organizational Assessment” is defined in Section 11.1.

“Petition” is defined in Section 14.7(c).

“Quarterly Assessment Report” is defined in Section 11.6(b).

“Rating Methodology” is defined in Section 9.5(c).

“Regular Assessment” is defined in Section 11.2.

“Reinsurance Effective Date” is defined in Section 9.6(a).

“Reinsurance Program” is defined in Section 9.1.

“Reinsurance Reimbursement” is defined in Section 9.6(b) and refers to the reinsurance proceeds the Member Insurers are entitled to under the Enabling Act upon compliance with the terms and conditions thereof and the terms and conditions of this Plan.

“Reinsurer” means an insurer from whom a person providing health insurance for a resident procures insurance for itself with the insurer with respect to all or part of the medical insurance risk of the person.

“Reinsurer” includes an insurer that provides employee benefits excess insurance.

“Renewal/Cancellation Notice” is defined in Section 9.4(h)(ii).

“Resident” has the same meaning as in 24-A M.R.S § 2736-C(1)(C-2).

“Specified Condition” is defined in Section 10.2.

“Superintendent” means the Superintendent of Insurance of the State of Maine.

“Third Party Administrator” means an entity that is paying or processing medical insurance claims for a resident.

“Transition Period” means the period beginning July 1, 2012 and ending December 31, 2012.

#### 4.2 Construction.

- (a) Headings and the rendering of text in bold and/or italics are for convenience and reference purposes only and do not affect the meaning or interpretation of this Plan.
- (b) A reference to an Exhibit, Schedule, Article, Section or other provision shall be, unless otherwise specified, to exhibits, schedules, articles, sections or other provisions of this Plan, which exhibits and schedules are incorporated herein by reference.
- (c) Any reference in this Plan to another document shall be construed as a reference to that other document as the same may have been, or may from time to time be, varied, amended, supplemented, substituted, novated, assigned or otherwise revised.
- (d) Any reference to “this Plan,” “herein,” “hereof” or “hereunder” shall be deemed to be a reference to this Plan as a whole and not limited to the particular Article, Section, Exhibit, Schedule or provision in which the relevant reference appears and to this Plan as varied, amended, supplemented, substituted, novated, assigned or otherwise transferred from time to time.
- (e) References to the term “includes” or “including” shall mean “includes, without limitation” or “including, without limitation.”
- (f) Words importing the singular include the plural and vice versa and the masculine, feminine and neuter genders include all genders.
- (g) If the time for performing an obligation under this Plan occurs or expires on a day that is not a Business Day, the time for performance of such obligation shall be extended until the next succeeding Business Day.
- (h) References to any statute, code or statutory provision are to be construed as a reference to the same as it may have been, or may from time to time be, amended, modified or reenacted, and include references to all bylaws, instruments, orders and regulations for the time being made thereunder or deriving validity therefrom unless the context otherwise requires.

- (i) References to “assessment” shall refer to Organizational Assessments, Regular Assessments and Deficit Assessments, as the context requires.
- (j) References to “primary coverage” shall mean the coverage provided by Member Insurer to a Covered Person under an Eligible Health Plan.
- (k) Generally, a Covered Person is “designated” for reinsurance, while a policy is “ceded,” although the terms are occasionally used interchangeably in this Plan. A Covered Person designated pursuant to the provisions of Section 9.4 and those other individuals covered under the same policy may collectively be referred to as “reinsured by the Association.”

ARTICLE V POWERS OF THE ASSOCIATION

- 5.1 The Association shall have the powers and authority granted by the Nonprofit Act and the Enabling Act.

ARTICLE VI PLAN OF OPERATION

- 6.1 The Association shall perform its functions pursuant to and in accordance with this Plan of Operation and the Enabling Act. This Plan is intended to assure the fair, reasonable and equitable administration of the Association’s Reinsurance Program. This Plan shall be effective upon the adoption by the Board and approval of the Superintendent.

ARTICLE VII GOVERNANCE

- 7.1 Governing Documents. The activities of the Association shall be governed pursuant to and in accordance with the Nonprofit Act and the Enabling Act, the Articles of Incorporation and Bylaws of the Association, and this Plan. In the event of a conflict between this Plan and any of the Enabling Act, the Nonprofit Act, the Bylaws, or the Articles, then the Enabling Act, the Nonprofit Act, the Articles, or the Bylaws, as applicable, shall control. The Association’s Articles of Incorporation are attached hereto as Exhibit A, and its Bylaws are attached hereto as Exhibit B.
- 7.2 Board of Directors. The Association is governed by a Board of Directors (the “Board”) appointed by the Superintendent and Member Insurers as provided in the Association’s Articles of Incorporation and Section 3953(2) of the Enabling Act.
- 7.3 Committees. The Board may establish and appoint its members (or other persons) to any of the committees described in Article IV, Section 2 of the

Association's Bylaws, or otherwise established by the Board. A written record of the proceedings of each committee shall be maintained by a secretary appointed from the membership of the committee. The Board shall, at a minimum, establish the following Committees, which shall have the responsibilities and scope of authority and operation set forth under its name below.

- (a) Actuarial Committee – The duties of the Actuarial Committee are to:
  - i. Recommend to the Board appropriate Rating Methodology and reinsurance premium rates;
  - ii. Review the Reinsurance Reimbursement, reimbursement rates, retention levels and attachment points for the Reinsurance Program and make appropriate recommendations to the Board; and
  - iii. Review, determine and report to the Board the incurred claim losses of the Association, including amounts for IBNR.
  
- (b) Operations Committee – The duties of the Operations Committee are to:
  - i. Provide oversight of the Administrator's performance of its functions and responsibilities;
  - ii. Periodically review this Plan and the operation and implementation of the Association's Reinsurance Program and make recommendations to the Board regarding amendments or changes to this Plan and/or the Reinsurance Program;
  - iii. Provide administrative interpretation as to the intent of the Plan and provide administrative direction of issues referred to the Board by the Administrator or the Member Insurers; and
  - iv. Identify items for which operating rules are needed and propose such rules for adoption by the Board.
  
- (c) Audit Committee – The duties of the Audit Committee are to:
  - i. Develop a uniform audit program to be utilized to conduct a review of agreed upon procedures between the Member Insurers and the Association that assures compliance with the provisions of this Plan;

- ii. Establish standards of acceptability for the selection of independent auditors or consultants;
  - iii. Assist the Board in the selection of an independent auditor for the annual audit of the Association's financial statements; and
  - iv. Assist the Board in the review of the reports prepared by the independent auditors in conjunction with subsections (i) and (iii) above, and any other audit-related matters the Board deems necessary.
- (d) Legal Committee – The duties of the Legal Committee are to:
- i. Coordinate with legal counsel, as needed, on routine legal matters relating to the Association's operations, including proposed contracts and operational practices;
  - ii. Be familiar with, and provide assistance to the Board concerning, litigation and other disputes involving the Association and its operations;
  - iii. Participate in the dispute resolution procedures set forth in Section 14.7 hereof; and
  - iv. Assist the Board in other legal-related matters as appropriate.

7.4 Policies. The Board shall adopt and implement policies governing the conduct of members of the Board. These shall include the following policies, in addition to any others that may be adopted from time to time at the Board's discretion.

- (a) Conflict of Interest Policy. The Conflict of Interest Policy shall be designed to avoid improper conflicts of interest in the actions of and decisions by directors, officers and employees of the Association.
- (b) Confidentiality Policy. The Confidentiality Policy shall be designed to protect the Association's confidential information from improper disclosure.
- (c) Whistleblower Policy. The Whistleblower Policy shall be designed to protect directors, officers, and employees of the Association from retaliation or victimization for raising, in good faith, concerns or complaints that activities of the Association, or the action or inaction of its directors, officers, employees or contracted agents, are improper or unlawful.
- (d) Reimbursement Policy. The Reimbursement Policy shall be designed to reimburse members of the Board for expenses they

incur while fulfilling their duties as directors of the Association while limiting costs to the Association and its Member Insurers.

7.5 Annual Meeting. An annual meeting of the Board shall be held on the second Tuesday in April of each year unless the Board designates some other date and time. At the annual meeting, the Board shall:

- (a) Review this Plan of Operation and submit proposed amendments, if any, to the Superintendent for approval.
- (b) Review the annual audited financial statements for the Association and such other annual reports as the Board may require from the Administrator regarding the financial position of the Association, the operation of the Reinsurance Program and all other material matters, as determined by the Board.
- (c) Review reports of the committees established by the Board.
- (d) Determine whether any technical corrections and amendments to the Enabling Act should be proposed by the Association.
- (e) Review and duly consider the performance of the Association in support of its purpose.
- (f) Review the rates for the Association's Reinsurance Program.
- (g) Review the Association's administration expenses, incurred losses and IBNR and related reserves.
- (h) Determine if any Regular Assessment or Deficit Assessment is necessary and establish the rate for such assessments.
- (i) Review, consider and act on any matters deemed by the Board to be necessary and proper for the administration of the Association.

## ARTICLE VIII ADMINISTRATOR

- 8.1 Role. The Administrator performs administrative functions associated with the operations of the Association as delegated by the Board to the Administrator. The Administrator is responsible, together with the Board, for the fair, equitable and reasonable administration of the Reinsurance Program.
- 8.2 Selection. The Administrator shall be selected by the Board through a competitive bidding process and shall serve pursuant to the terms of a contract with the Association that complies with the requirements of §3956(2) of the Enabling Act and Section 8.5 hereof.
- 8.3 Statutory Duties. The Administrator shall perform the following functions under the supervision of, and as directed by, the Board.

- (a) Perform all administrative functions relating to the Association, as required or directed by the Board, including the functions more particularly described in Section 8.4 below;
- (b) Submit regular reports to the Board regarding the operation of the Association, with the frequency, content and form of such reports to be as determined by the Board;
- (c) Following the close of each calendar year, determine reinsurance premiums less any administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the Association and the incurred losses of the year, and report this information to the Superintendent; and
- (d) Pay reinsurance amounts as provided for in this Plan.

8.4 Board-Determined Functions. The Board shall, from time to time, in its discretion, assign to the Administrator such functions as the Board determines necessary or appropriate in connection with the proper administration of the business of the Association which may include, but shall not be limited to, the following:

- (a) Organizational Assistance. The Administrator shall assist the Board and its professional service providers in organizing and establishing the initial operations of the Association in order to achieve full operational capacity on or before July 1, 2012. The Administrator shall be charged with working with the Board and other professional service providers to expedite the process of establishing the Association and the Reinsurance Program, including:
  - (i) Assisting the Board in developing financial modeling and determination of appropriate levels of assessments and premiums;
  - (ii) Assisting the Board in developing appropriate categories of Specified Conditions and development of the Health Statement;
  - (iii) Assisting the Board in selection and development of a work plan for actuarial support;
  - (iv) Assisting the Board in developing rules, protocols and other requirements associated with designation of Covered

Persons for ceding to the Reinsurance Program and payment of claims; and

- (v) Analysis of potential reinsurance of the Association's claims exposure and assisting the Board with the structuring of any such reinsurance.

(b) Management Services. The Administrator shall be responsible for managing all aspects of the Association's Reinsurance Program, under the direction of the Board, and working in conjunction with the other professional service providers retained by the Association, and shall ensure the efficient and effective operation of the Association, respond to the needs of Member Insurers, coordinate service providers and assure compliance with all applicable laws, rules and regulations. The scope of management services shall be determined by the Board from time to time in its discretion, and may include, but shall not be limited to, the following:

- (i) Administration of the day-to-day operations of the Association;
- (ii) Implementation and oversight of the Reinsurance Program;
- (iii) Implementation and oversight of the assessment process, including assessment calculation, billing, processing and collection;
- (iv) Work with Member Insurers in the implementation and administration of the Reinsurance Program, including ceding risks and managing the enrollment process, collection of premium, and submission and processing of claims for reimbursement, as more specifically described below;
- (v) Assisting the Board and the Association's actuarial consultants in the determination of assessment levels, premiums and all financial modeling associated therewith, including the provision of all data necessary for actuarial analysis of the Reinsurance Program and determination of appropriate assessments and premiums;
- (vi) Establish procedures and install and maintain the systems needed to properly administer the operations of the Association in accordance with the Enabling Act, any rules

or regulations issued by the Bureau, this Plan and the directives of the Board;

- (vii) Assemble and file all reports required under applicable laws, rules and regulations, together with any other required filings and reports which are not within the expertise or contracted services of any service provider (e.g., any rate and policy form filings with the Bureau);
  - (viii) Prepare and file for approval all insurance policy forms and endorsements needed from time to time for the operation of the Reinsurance Program, if any (reviewed annually for necessary modifications based on experience, change in operations or change in laws and regulations);
  - (ix) Monitor and propose to the Board, for its consideration, any needed revisions to this Plan;
  - (x) Act as a communications resource for Member Insurers regarding the Reinsurance Program; and
  - (xi) Maintain all records pertaining to the Association and the operation of its business in accordance with record retention policies adopted by the Board.
- (c) Financial Services. The Administrator shall be responsible for managing the financial affairs of the Association. The scope of financial services shall be determined by the Board, from time to time, in its discretion, and may include, but shall not be limited to, the following:
- (i) Provision of all finance and accounting services necessary for the operation of the Reinsurance Program, as described herein;
  - (ii) Preparation and maintenance of all financial information and reports of the Association, including timely preparation and presentation to the Board of accurate, easy-to-understand monthly financial reports, and such interim reporting as the Board may direct;
  - (iii) Maintain general ledger systems and administer all accounts payable and accounts receivable;
  - (iv) Budget preparation, implementation and monitoring;

- (v) Maintenance of and accounting for Association funds;
  - (vi) Management of billing, payment, and collection process for assessments and premiums;
  - (vii) Working with the Association's independent accountants in the preparation of its annual audited financial statements, and managing the certification and filing with any necessary state and federal authorities;
  - (viii) Establish on behalf of the Association one or more bank accounts for the transaction of Association business, as approved by the Board. Recommend to the Board and implement, from time to time, appropriate procedures for cash management and short-term investment with the financial institutions(s) designated by the Board. Deposit all cash collected on behalf of the Association in the established bank account(s) on a timely basis;
  - (ix) Recommend to the Board and apply for, from time to time, appropriate grants or other sources of funding or credits;
  - (x) Perform Reinsurance Reimbursement for claims paid on Covered Persons pursuant to policies ceded to the Reinsurance Program, consistent with the timelines established by the Board;
  - (xi) Issue checks or drafts on and/or approve charges against bank accounts of the Association;
  - (xii) Collect and provide all information required in order to calculate assessments in accordance with this Plan;
  - (xiii) Invest available cash in accordance with investment guidelines approved by the Board and report to the Board all cash management and investment activities results;
  - (xiv) Assist the Association in establishing and maintaining any necessary lines of credit or other credit facilities necessary for the operation of the Association's business, as determined by the Board; and
  - (xv) Perform other necessary functions as directed by the Board.
- (d) Technology and Systems. The Administrator shall be responsible for installing, managing and operating all information technology

and related systems necessary for the effective and efficient operation of the Association's Reinsurance Program. The scope of technology and systems services shall be determined by the Board, from time to time, in its discretion, and may include, but shall not be limited to, the following:

- (i) Provide all necessary technology, systems, software and related support required in connection with the Association's operations;
  - (ii) Create, host, maintain and update the Association's website, with basic public information and public relations data on the Association; and
  - (iii) Maintain a complete database of all information related to the business of the Association and the Reinsurance Program, including Insurers, Member Insurers, assessments, designated lives, ceded policies, premium calculation, billing and collection and such other information as is relevant to the Association's operations.
- (e) Planning and Compliance. The Administrator shall be responsible for assisting the Board with planning and working with the Board and its professional service providers regarding compliance with all applicable laws, rules and regulations, as well as the requirements of this Plan. The scope of planning and compliance services shall be determined by the Board, from time to time, in its discretion, and may include, but shall not be limited to, the following:
- (i) Serve the Board in an advisory capacity, developing recommendations and submitting reports as needed or requested; and
  - (ii) Work with the Association's legal counsel to maintain compliance by the Association with all laws and regulations applicable to the Association and the operation of the Reinsurance Program, including without limitation all filing and reporting requirements, and with the provisions of the Enabling Act, its Bylaws and this Plan.
- (f) Government and Public Relations. The Administrator shall be responsible for assisting the Board with government and public relations. The scope of government and public relations services shall be determined by the Board, from time to time, in its discretion, and may include, but shall not be limited to, assisting

the Board with regulatory, governmental and public relations matters, as directed by the Board.

8. 5 Administrator Contract. Subject to the provisions of the Enabling Act, the Board shall have responsibility for determining the terms and conditions of the contract with the Administrator, including without limitation the compensation paid to the Administrator for its services. The contract shall provide, at a minimum, for reimbursement to the Administrator for its direct and indirect expenses incurred in the performance of its services, as provided in §3956(4) of the Enabling Act.
8. 6 Subcontracted Services. The Administrator shall not subcontract for any services except to the extent expressly permitted pursuant to the terms of its contract with the Association.
8. 7 Confidentiality. The Administrator shall maintain the confidentiality of all information pertaining to Insurers and/or Covered Persons in accordance with Section 10.1(a)(iii) herein and all applicable federal and state statutes, regulations and principles of common law pertaining to confidentiality and trade secrets. Such information shall be used only for the purposes necessary for the operation of the Association and shall be strictly segregated from other records, data or operations of the Administrator. Unless specifically required by this Plan or by the Enabling Act, no information shall be retained or used by the Administrator or disclosed to any third party which information identifies a specific Covered Person.

## ARTICLE IX REINSURANCE PROGRAM

- 9.1 Reinsurance Program. The Association shall provide reinsurance in accordance with the requirements of the Enabling Act. Member Insurers shall designate Covered Persons for reinsurance, cede to the Association each insurance policy covering a designated Covered Person, and pay premiums for reinsurance of each Covered Person covered under each ceded policy, and the Association shall provide reinsurance coverage to Member Insurers for such persons, in accordance with the provisions set forth herein (the "Reinsurance Program"). The Reinsurance Program will commence operation as of July 1, 2012.
- 9.2 Member Insurer Benefit Plans. Each Member Insurer shall provide to the Association a summary of each plan of Medical Insurance offered by the Member Insurer in the State of Maine (each, an "Eligible Health Plan"). A copy of each new Eligible Health Plan, and each amendment, change or revision to any existing plan, shall be provided at least ninety (90) days prior to the implementation of such plan, amendment, change or revision.
- 9.3 Basis for Ceding.

- (a) Mandatory or Discretionary. Covered Persons shall be designated for reinsurance either (i) at the discretion of the applicable Member Insurer, as more fully described in Section 10.1; or (ii) automatically and mandatorily on the basis of a Specified Condition (as defined herein), as more fully described in Section 10.2.
- (b) Policy Basis. Member Insurers shall cede coverage of Covered Persons to the Association on a policy basis, and not individually. This means that, in the event any person covered by an Eligible Health Plan, whether as the policyholder or a Dependent of the policyholder or other person or participant entitled to coverage under an Eligible Health Plan issued by a Member Insurer, is designated for reinsurance by a Member Insurer, then all Covered Persons entitled to coverage under the policy covering such Covered Person are automatically, and without further action on the part of the Member Insurer (whether as a Discretionary Cede or a Mandatory Cede), included for reinsurance by the Association.
- (c) Association Coverage. To the extent that any policy available to members of an association or a professional or trade group, or offered on any similar master policy basis, is eligible for reinsurance by the Association, Member Insurers shall cede such coverage on a family basis, and each covered family shall be treated as a separate policy for purposes of this Plan.

9.4 Designation for Ceding.

- (a) Initial Designation.
  - (i) *New Business Book.* For each Covered Person insured through an Eligible Health Plan in a Member Insurer's New Business Book who is initially designated for reinsurance by a Member Insurer (whether a Mandatory Cede or a Discretionary Cede), the Member Insurer shall give notice to the Administrator of such designation within sixty (60) days from the date primary coverage for such Covered Person becomes effective (a "Ceding Notice"). Such notice shall be in the form required by the Association, containing such information as the Association may, from time to time, specify, and shall be accompanied by (A) a completed Health Statement, to the extent available, and (B) for Mandatory Ceding, a statement from the Member Insurer that such Covered Person demonstrates the existence or history of a Specified Condition together with

identification of the Specified Condition and the basis for such determination.

(ii) *In-Force Book.*

(1) Ceding Notice for In-Force Book. For each Covered Person insured through an In-Force Book who is initially designated for reinsurance by a Member Insurer (whether pursuant to Mandatory or Discretionary Ceding), the Member Insurer shall give notice to the Administrator of such designation by October 1, 2012 (also a "Ceding Notice"). Such notice shall be in the form required by the Association, containing such information as the Association may specify from time to time, and describing in such detail as the Association may require the basis for the Member Insurer's ceding decision.

(2) Mandatory Ceding. On or before October 1, 2012, each Member Insurer shall identify and designate for Mandatory Ceding each Covered Person insured through its In-Force Book who demonstrates the existence or history of a Specified Condition. In order to obtain uniformity among Member Insurers' respective procedures for identifying Covered Persons insured through an In-Force Book for Mandatory Ceding, each Member Insurer shall review each policy within its In-Force Book for, and base its Mandatory Ceding determinations on, the diagnosis code(s) associated with each Specified Condition, as provided by the Administrator. Where multiple diagnosis codes are used, this review shall include all diagnosis code fields (and not, for example, only the first one or two fields populated for a given Covered Person).

(iii) Each Ceding Notice shall list, and include any other information as the Association may request regarding, each other individual covered under the ceded policy.

(b) Adding a Covered Person to an Existing Policy; Change Between Member Insurer's Plans.

- (i) If a Covered Person is added to an Eligible Health Plan, including as the result of such Covered Person's change from one plan offered by a Member Insurer to another plan offered by the same Member Insurer, a Member Insurer shall have the ability to designate (or redesignate, in the case of a plan change) such Covered Person for Discretionary Ceding by giving notice to the Administrator of such designation within sixty (60) days from the date primary coverage for such Covered Person becomes effective. Such notice shall be in the form described above applicable to initial designations of Covered Persons. The effective date of reinsurance of such Covered Person is governed by Section 9.6(a)(6) of this Plan.
- (ii) A Covered Person's change from one plan offered by the Member Insurer to another plan offered by such Member Insurer constitutes a termination of primary coverage under clause (ii) of Section 9.6(d). As such, the Member Insurer must give notice of the redesignation of such Covered Person within sixty (60) days of the effective date of primary coverage under the new plan in order to effectively designate such Covered Person for Discretionary Ceding under the new plan.
- (c) Transfer from In-Force Book to New Business Book. Notwithstanding the application of the Freeze Out Period, if a Covered Person enrolls for primary coverage in an Eligible Health Plan that results in transfer of a Covered Person from a Member Insured's In-Force Book to the Member Insurer's New Business Book, a Member Insurer shall have the ability to designate such Covered Person for reinsurance by giving notice to the Administrator of such designation within sixty (60) days from the date primary coverage for such Covered Person becomes effective. Such notice shall be in the form described above applicable to initial designations of Covered Persons. Mandatory Ceding under Section 10.2 shall apply to transfer of a Covered Person who demonstrates the existence or history of a Specified Condition.
- (d) Covered Person Information Omission or Misrepresentation. If a Covered Person fails to complete the Health Statement, omits material information from the Health Statement or materially misrepresents his or her health status to a Member Insurer, a Member Insurer may designate that person for reinsurance within sixty (60) days after the date on which the Member Insurer becomes, or reasonably should have become, aware that the person should have been designated.

- (e) Mandatory Cede Corrections. If at any time within 24 months following the effective date of a Covered Person's primary coverage the Association or the applicable Member Insurer determines that such Covered Person should previously have been designated for Mandatory Ceding pursuant to Section 10.2 hereof but was either (i) not designated for ceding or (ii) erroneously classified as a Discretionary Cede, then the Association may require that the Member Insurer designate such Covered Person as a Mandatory Cede and such designation shall be effective as of the effective date of the primary coverage. In such event, (x) premium for reinsurance shall accrue as of the effective date of the designation (and any accrued and unpaid premium shall be due promptly upon the corrected designation), and (y) the renewal and cancellation provisions applicable to Discretionary Cedes pursuant to Section 9.4(h) will not apply.
- (f) Designation Records. Member Insurers shall establish, and maintain for seven (7) years following the date of termination of reinsurance of a Covered Person, the records governing such Covered Person's eligibility for reinsurance and the Member Insurer's determination to designate the Covered Person for reinsurance, including the Health Statements or similar questionnaires utilized by the Member Insurer, claims history, risk scores, diagnosis code analysis or any other information utilized or relied upon in making its ceding decisions (collectively, "Ceding Records"). The Member Insurer shall provide the Association, the Administrator and its agents and employees, access to all such records upon reasonable advance notice. In addition to the foregoing, the Member Insurer shall electronically transmit to the Association, in the format required by the Association, any Ceding Record as may be requested from time to time by the Association. The Association shall not be required to request or maintain Ceding Records and may rely on each Member Insurer to maintain and provide access to the Ceding Records in connection with any audit or review of such transactions as may be conducted by the Association from time to time, in its discretion.
- (g) Term of Designation: Mandatory Ceding. Each Covered Person who is designated pursuant to Mandatory Ceding, and each individual covered under the same policy as such Covered Person, shall be reinsured by the Association for a period commencing on the effective date of the designation (determined pursuant to Section 9.6(a)) through the date of termination of such Covered Person's primary coverage provided by the Member Insurer, unless

such reinsurance is earlier terminated in accordance with clause (iii) of Section 9.6(d) hereof.

(h) Term of Designation; Renewal and Cancellation; Discretionary Ceding.

(i) *Term of Designation.* Each Covered Person designated for reinsurance pursuant to Discretionary Ceding shall be reinsured by the Association for a “Ceding Term,” as follows:

(1) the initial Ceding Term shall consist of (x) the time from the effective date of the initial designation (determined pursuant to Section 9.6(a)) through the end of the calendar year in which the Covered Person is initially designated (*i.e.*, through December 31<sup>st</sup> of the year in which such designation is made), plus (y) one calendar year thereafter, unless such reinsurance is earlier terminated in accordance with Section 9.6(d) hereof; and

(2) each subsequent Ceding Term shall consist of one calendar year, unless such reinsurance is earlier terminated in accordance with Section 9.6(d) hereof.

(ii) *Renewal and Cancellation.* For each Covered Person designated for Discretionary Ceding, a Member Insurer shall, at the conclusion of each Ceding Term, give notice to the Administrator of such Member Insurer’s intention to either (x) renew the designation of such Covered Person for reinsurance, or (y) cancel such designation (“Renewal/Cancellation Notice”). The Renewal/Cancellation Notice shall be provided to the Association for all Covered Persons renewed or cancelled for each year in a single consolidated notice aggregating all Covered Persons whose Ceding Term is expiring as of the December 31 preceding such year. The Renewal/Cancellation Notice shall be provided to the Association not later than December 31<sup>st</sup> of the preceding year. Such notice shall be in the form required by the Association, containing such information as the Association may specify from time to time. The Member Insurer’s renewal of a designation decision shall be binding for one calendar year (also referred to as the “Ceding Term”). For the avoidance of doubt, the provisions of this Section 9.4(h), including the renewal and cancellation

provisions of this subsection (ii), apply only to Discretionary Ceding and not to Mandatory Ceding. In the event that a Member Insurer fails to provide the required Renewal/Cancellation Notice, or omits one or more of its currently designated Covered Persons from the Notice, then the applicable designation or designations shall be deemed renewed for the ensuing calendar year.

- (iii) *Re-designation; Freeze Out.* A Member Insurer shall be prohibited from designating (or re-designating, as the case may be) a Covered Person for reinsurance pursuant to Discretionary Ceding for a period of three calendar years after (x) such Member Insurer's initial determination not to designate such Covered Person for reinsurance, measured from December 31<sup>st</sup> of the year in which such determination is made; or (y) the cancellation of designation of a previously designated Covered Person pursuant to subsection (ii) above, measured from the date of the Renewal/Cancellation Notice deadline applicable to such Covered Person (in either such case, the "Freeze Out Period").

By way of illustration:

- if a Covered Person becomes covered by a Member Insurer effective September 1, 2012, and no Ceding Notice is delivered to the Association within 60 days of such date, then the last day of the Freeze Out Period applicable to such Covered Person would be December 31, 2015 (i.e., the end of the third calendar year following December 31<sup>st</sup> of 2012, the year in which the Member Insurer made the non-designation determination); and
- if a Member Insurer cancels the designation of a previously designated Covered Person in December 2013, effective January 1, 2014, then the last day of the Freeze Out Period applicable to such Covered Person would be December 31, 2016 (i.e., the end of the third calendar year following the Renewal/Cancellation Notice deadline applicable to the Member Insurer's cancellation of such Covered Person's designation).

The Freeze Out Period shall apply to the following specific circumstances as set forth below:

- (1) *Non-designation determination.* Covered Person X is insured through a Member Insurer A's In-Force Book and is not required to be designated pursuant to Mandatory Ceding. Member Insurer A has until October 1, 2012 to give notice to the Administrator of a Discretionary Ceding designation of X. Member Insurer A determines not to designate X for Discretionary Ceding and, accordingly, submits no Ceding Notice with respect to X on or before the Ceding Notice deadline of October 1, 2012. Member Insurer A will be precluded from subsequently designating X pursuant to Discretionary Ceding for the duration of the Freeze Out Period, which will remain in place through December 31, 2015 (i.e., the end of the third calendar year following A's determination not to designate X, measured from December 31 of the year of non-designation). If X were insured through a New Business Book, the same analysis would apply.
- (2) *Enrollment in new plan.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. X enrolls in a new plan offered by Member Insurer A, effective January 1, 2015. The Freeze Out Period continues to apply to preclude A's Discretionary Ceding designation of X through December 31, 2016, after which A is free to redesignate X for Discretionary Ceding on a going-forward basis.
- (3) *Change in carrier.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. One year into the Freeze Out Period, Covered Person X changes insurance carriers to Member Insurer

B, effective January 1, 2015. No Freeze Out Period applies with respect to B's ability to designate X upon X's enrollment in B's plan.

- (4) *Return following change in carrier.* In the scenario described in (3) above, X subsequently cancels X's enrollment in B's plan and re-enrolls for insurance coverage with Member Insurer A, effective January 1, 2016. No Freeze Out Period applies with respect to A's ability to designate X upon X's re-enrollment in A's plan (notwithstanding that the original Freeze Out Period applicable to A's ability to designate X would otherwise have continued through December 31, 2016).
- (5) *Addition as Dependent under non-Freeze Out policy.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. X then marries Covered Person Y, who is insured under a policy offered by Member Insurer A that has been Discretionarily Ceded. X is added as a Dependent under that policy, effective January 1, 2015. The Freeze Out Period does not affect A's ability to reinsure X upon X's addition as a Dependent under the ceded policy covering Y.
- (6) *Addition of qualifying Dependent.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. X then experiences a life event that adds as a Dependent on X's policy, effective January 1, 2015, Covered Person Z. The Freeze Out Period does not prohibit A from re-ceding X's policy (and thus reinsuring X) based on Z's profile, whether Z is a Mandatory Cede or a Discretionary Cede.

(7) *Development of Specified Condition.* Member Insurer A cancels the Discretionary Ceding designation of Covered Person X on December 1, 2013, effective January 1, 2014. The applicable Freeze Out Period is scheduled to remain in place through December 31, 2016. During the Freeze Out Period, X develops a health condition that is a Specified Condition for which Mandatory Ceding is required. The Freeze Out Period does not apply to the Mandatory Ceding designation of X.

(iv) *Carrier Ceding Responsibilities.* Each carrier designating a Covered Person for reinsurance by the Association is responsible for ascertaining and certifying to the Association that:

- (1) The Covered Person is eligible for reinsurance; and
- (2) The reinsurance premium has been correctly determined.

Each carrier must also document these determinations in its Ceding Notice and subsequent Enrollment Reports.

## 9.5 Premium Calculation and Payment.

- (a) Determination of Premium. Reinsurance rates, determined by the Board pursuant to Subsection 9.5(c) below, shall be made available to the Member Insurers. Each Member Insurer shall determine the applicable reinsurance premium for each Covered Person reinsured by the Association based on the reinsurance premium rates in effect on the applicable reinsurance effective date for each Covered Person.
- (b) Rate Changes. The initial reinsurance rates for the Transition Period shall be provided as soon as reasonably possible in advance of the July 1, 2012 effective date of the Reinsurance Program. Thereafter, the Association shall provide at least a ninety (90) day advance notice in the event of a change in its reinsurance rates. Unless a different effective date is established by the Association (with the approval of the Superintendent) rate changes shall become effective on the January 1<sup>st</sup> following notice of the change to Member Insurers.

- (c) Methodology for Determining Rates. This section describes the methodology for determining reinsurance premium rates (the "Rating Methodology"). Reinsurance premium rates shall be determined as a fixed percentage of the gross premiums charged for individual health plans offered by Member Insurers, to be set at levels that, together with other funds available to the Association, will be sufficient to meet the Association's anticipated costs. As an alternative to a single applicable percentage of underlying premiums, the Association may, in its discretion, (1) develop differential rates for policies within In-Force Books versus New Business Books and/or (2) develop a variable range of applicable percentage rates to be applied based on the structure and benefit levels of the primary Eligible Health Plans. The applicable percentage or range of percentages shall be subject to approval of the Superintendent.

The Association shall periodically review the Rating Methodology and may make changes to the Rating Methodology as needed with the approval of the Superintendent. The Actuarial Committee shall periodically (and not less often than annually on or before August 31 of each year) make recommendations to the Board regarding the Rating Methodology. The Board shall be required to approve any changes in the Rating Methodology. The Board may, from time to time, as it deems necessary or appropriate, provide for adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by a Member Insurer. The Association's Rating Methodology will be subject to amendment as required to conform to applicable changes in state and federal rating laws, subject to approval of the Superintendent. In addition to the foregoing, the Rating Methodology may include provisions for trend which shall adjust ceding premium rates for reinsurance periods with varying effective dates.

- (d) Billing and Payment.
- (i) Payment of Premiums. Member Insurers shall pay all reinsurance premiums due in accordance with this Section 9.5(d). All premium for reinsurance begins to accrue as of the effective date of the designation of the Covered Person for reinsurance, whether such designation is a Mandatory Cede, a Discretionary Cede, or a result of the correction of errors or omissions pursuant to Sections 9.4(d) or (e) hereof.
- (ii) Self-Billing. The payment of reinsurance premiums will be handled on a "self-billed" basis. On or before the 20<sup>th</sup> day

of each month, each Member Insurer shall provide the Administrator with (1) an enrollment report listing all of the Member Insurer's Covered Persons reinsured by the Association during all or any portion of the preceding month; (2) the amount of the applicable reinsurance premium for each Covered Person; (3) such other information as may be required by the Association; and (4) payment of the applicable premium as provided therein (collectively, an "Enrollment Report"). Because Member Insurers have 60 days after the effective date of coverage to designate a Covered Person for reinsurance, there shall be an exception to the payment deadline set forth above for the initial reinsurance premium payment, which shall be considered timely if made together with the notice of the Member Insurer's ceding decision.

- (iii) Premium Determination Date. Premium is due and payable on or before the 20<sup>th</sup> day of each month with respect to each Covered Person reinsured by the Association during any portion of the preceding calendar month. Reinsurance premium amounts are to be paid based on whole month increments only. (Thus, for each Covered Person with respect to whom reinsurance coverage by the Association is effective at any time between the first and the last day of a given calendar month, premium for that entire month is earned and due in full on or before the 20<sup>th</sup> day of the following month.) Premium for the entire month is earned notwithstanding termination of coverage at any time during the month.
- (iv) Late Premiums. Premium not received by the applicable due date shall accrue interest at the rate of eighteen percent (18%) per annum.
- (v) Termination for Non-Payment. The Association shall have the right, but not the obligation, to terminate reinsurance of any Covered Person in its sole discretion in the event premium is not paid on or before thirty (30) days following the applicable due date. This right shall be in addition to, and not in limitation of, any other rights or remedies available to the Association with respect to collection of premium due from any Member Insurer.
- (vi) Termination for Non-Payment and Reinstatement of Primary Coverage. Member Insurers shall follow requirements of Maine law related to termination for non-

payment and reinstatement of a Covered Person. Any reinsurance premium adjustment that is necessary due to termination for non-payment or reinstatement of a Covered Person shall be reconciled at the time of the next monthly payment by the Member Insurer. Unless reinsurance is otherwise terminated, a Covered Person who was designated for reinsurance shall be automatically designated again without a lapse in reinsurance in the event of reinstatement. If a Covered Person terminates coverage with a Member Insurer by active lapse, the Member Insurer will notify the Administrator within sixty (60) days of the cancellation. For Covered Persons that fail to pay premiums, the Member Insurer will notify the Administrator within ninety (90) days of the non-payment of premium. Such notice shall be in the form required by the Association, containing such information as the Association may specify from time to time.

9.6 Reinsurance Coverage.

- (a) Reinsurance Effective Date. Reinsurance for a Covered Person designated for reinsurance, and for each individual covered under the same policy as such Covered Person, shall be effective on the following dates (“Reinsurance Effective Date”):
- (i) For a Covered Person in a New Business Book designated for reinsurance during the Transition Period, the effective date shall be the effective date of such person’s coverage under the primary coverage provided by the Member Insurer for such Covered Person, but in no event earlier than July 1, 2012.
  - (ii) For a Covered Person in a New Business Book with a primary coverage effective date on or after January 1, 2013, the effective date shall be the same as the effective date of the primary coverage provided by the Member Insurer for such Covered Person.
  - (iii) For a Covered Person in an In-Force Book designated for reinsurance according to the Initial Designation process under Section 9.4(a)(ii), the effective date shall be July 1, 2012.
  - (iv) Beginning January 1, 2013 and continuing thereafter for a Covered Person in either an In-Force Book or a New Business Book redesignated in the Renewal/Cancellation

Notice described in Section 9.4(h)(ii), the effective date shall be January 1 of each year.

- (v) For a Covered Person in either an In-Force Book or a New Business Book designated for reinsurance after being added to an Eligible Health Plan providing primary coverage as described in Section 9.4(b), the effective date shall be the effective date of such Covered Person's coverage under such Eligible Health Plan.
  - (vi) For a Covered Person designated for reinsurance after being added to an Eligible Health Plan, which addition results in the transfer of such Covered Person from an In-Force Book to the New Business Book as described in Section 9.4(c), the effective date shall be the same date as the primary coverage in a New Business Book provided by the Member Insurer for such Covered Person.
  - (vii) For a Covered Person designated for reinsurance pursuant to Sections 9.4(d) or (e), the effective date shall be the effective date that would have applied had the Covered Person been designated on a timely basis.
- (b) Level of Coverage. The Association shall reimburse a Member Insurer for Eligible Claims paid under an Eligible Health Plan with respect to a Covered Person reinsured by the Association after the Member Insurer has incurred Eligible Claims for that Covered Person under the Eligible Health Plan during the applicable calendar year in excess of \$7,500, at the following rates of reimbursement (the "Reinsurance Reimbursement"):
- (i) 90% of claims paid in excess of \$7,500 to and including \$32,500; and
  - (ii) 100% of claims paid in excess of \$32,500.

The Association may annually adjust the initial level of Reinsurance Reimbursement and the maximum limit to be retained by the Member Insurer to reflect increases in costs and utilization within the standard market for individual health plans within the State of Maine. Such annual adjustments may not be less than the annual percentage change in the Consumer Price Index for medical care services from the later of July 1, 2012 or the effective date of the last adjustment through the date of calculation, unless the Superintendent approves a lower adjustment factor as requested by the Association. Any such adjustments shall be effective as of

January 1 of each year, and notice of such adjustments shall be provided to Member Insurers not less than 90 days prior to the effective date of such adjustment.

For the Transition Period, reimbursement shall be available only for Eligible Claims incurred by a Member Insurer on or after July 1, 2012, and only Eligible Claims incurred by a Member Insurer on or after July 1, 2012 shall be considered in calculating the claims incurred in calendar year 2012 for purposes of the retention levels set forth in Section 9.6(b).

- (c) Member Insurer Payment Obligation. No Reinsurance Reimbursement shall be provided on any Eligible Claim until the Member Insurer has made actual payments on Eligible Claims in an aggregate amount equal to the retention level specified in Section 9.6(b), as adjusted from time to time pursuant thereto.
- (d) Termination of Reinsurance. The Association's liability for Reinsurance Reimbursement for a ceded policy ceases upon the earliest of (i) the first day of the next Ceding Term following the Member Insurer's non-renewal of a Discretionary Ceding designation pursuant to Section 9.4(h)(ii); (ii) the termination of such policy by the Member Insurer; and (iii) termination of reinsurance by the Association in accordance with the terms of this Plan. Termination of reinsurance does not terminate Reinsurance Reimbursement for losses incurred during the term of the reinsurance in excess of the retention levels established pursuant to Section 9.6(b), provided, however, that reimbursement is subject to the claims submission deadlines set forth in Section 9.9.

9.7 Eligible Claims. "Eligible Claims" include only such amounts as are actually paid by a Member Insurer for benefits provided to Covered Persons reinsured by the Association with respect to claims incurred after the Reinsurance Effective Date. Eligible Claims do not include:

- (a) Claim expenses or salaries paid to employees of the Member Insurer who are not providers of health care services;
- (b) Court costs, attorney's fees or other legal expenses;
- (c) Claim expenses incurred as a result of the investigation of any submitted claims prior to payment;
- (d) Any amount paid by the Member Insurer for (i) punitive or exemplary damages; (ii) compensatory or other damages awarded to any Covered Person, arising out of the conduct of the Member

Insurer in the investigation, trial, or settlement of any claim or failure to pay or delay in payment of any benefits under any policy; or (iii) the operation of any managed care, cost containment, or related programs;

- (e) Any statutory penalty imposed upon a Member Insurer, whether on account of any unfair trade practice, any unfair insurance practice, or otherwise; or
- (f) Non-medical benefits, such as dental, vision, disability, or other non-medical benefits or services.

9.8 Claims Reporting. Within thirty (30) days after the close of each month, each Member Insurer shall furnish to the Association, in a form approved by the Board, the following information with respect to (i) Eligible Claims incurred, and (ii) Eligible Claims paid, by such Member Insurer during such month ("Claims Reports"):

- (a) the Covered Person's name;
- (b) the Covered Person's identification number;
- (c) the claimant's name and date of birth;
- (d) the claim incurred date and paid date;
- (e) any claim payment and the reinsurance claim amount;
- (f) the claim coding (e.g., CPT and ICD9) as required by the Board; and
- (g) such other information as may be required by the Board.

9.9 Claim Submission Deadlines. Except as otherwise approved by the Board in writing, reimbursement will be provided only for Reinsurance Reimbursement related to Eligible Claims incurred during the period of reinsurance coverage which are submitted (i) within ninety (90) days from the date the claim was paid, and (ii) no more than twelve (12) months from the date the expenses were incurred, in each case unless the Member Insurer demonstrates that the claimant was not legally capable of submitting the claims within such timeframe. In the event of prolonged subrogation proceedings or other extraordinary circumstances which make compliance with the 12-month deadline infeasible, Member Insurers shall have the right to apply to the Association for an extension of the 12-month deadline, and the Association shall have the right, but not the obligation, to extend such deadline for such period and under such terms and

conditions as the Association may deem appropriate under the circumstances. The claims payment submission deadline will be extended to accommodate claims reporting covering the period from July 1, 2012 through October 1, 2012 with respect to Covered Persons from an In-Force Book designated for ceding according to the Initial Designation process under Section 9.4(a)(ii).

9.10 Conduct of Member Insurers.

- (a) Member Insurers shall promptly investigate, settle, defend and take other appropriate action on all claims arising under the risks reinsured in a manner consistent with the Member Insurer's non-reinsured business. Upon the request of the Association, Member Insurers shall promptly forward to the Association copies of such reports of investigation.
- (b) Member Insurers shall adjudicate all claims on reinsured risks in a manner consistent with the Member Insurer's non-reinsured business.
- (c) Each Member Insurer shall use its cost containment programs to control costs on reinsured business to the same extent it would use such programs on its non-reinsured business, including but not limited to utilization review, individual case management, preferred provider arrangements, claims processing and other methods of operation on the same basis as the Member Insurer's non-reinsured business, without regard to whether claims are reinsured with the Association.
- (d) Failure to satisfy the requirements of Sections 9.10(a), (b) and (c) may result in the denial or reduction of reinsurance claim payments, as determined by the Administrator. Disagreements regarding denial of claims for Reinsurance Reimbursement may be appealed to the Board for a final and binding determination pursuant to the provisions of Section 14.7 hereof.
- (e) The Association shall have the right, at its own expense, to participate jointly with a Member Insurer in the investigation, adjustment or defense of any claim. Notwithstanding any such participation, the investigation, adjustment and defense of claims shall remain the responsibility of the Member Insurer, and any such participation shall in no way prejudice the Association's rights to deny or reduce claims payments pursuant to Section 9.10(d) above.

- (f) The Association shall have the right (1) to inspect the records of the Member Insurer in connection with the risks reinsured by the Association and (2) to request Member Insurers to provide to the Association records, data, or other information relevant to the operation of the Association. Member Insurers shall submit to the Association any additional information within their possession or control that the Association may request in connection with claims submitted to the Association for reimbursement or otherwise in connection with the operation of the Association. Member Insurers shall be responsible to secure necessary authorization from Covered Person(s) for this purpose.
- (g) All information disclosed to the Association by the Member Insurer or to the Member Insurer by the Association in connection with operations pursuant to this Plan shall be considered by both the Member Insurer and the Association to be confidential information.
- (h) In the event that the Member Insurer is reimbursed by another party for expenses previously reimbursed by the Association, the Member Insurer shall reimburse the Association for the amount of any duplicate reimbursement. The Member Insurer shall execute and deliver any instruments and otherwise undertake any actions necessary in order to preserve and secure its right to reimbursement from third parties, including any actions that may be required by the Association.
- (i) Member Insurers shall pay claims that are subject to Reinsurance Reimbursement on the same basis as the Member Insurer's non-reinsured claims, and shall not delay payment of otherwise valid claims due to such claims' being reinsured with the Association.

9.11 Audit and Inspection Rights. As a condition of each Member Insurer's membership in the Association and as a condition of the Member Insurer's ability to obtain reinsurance of Covered Persons by the Association, the Association shall have the following audit and inspection rights:

- (a) At any time and from time to time upon reasonable advance notice to any Member Insurer, audit and inspect all the Member Insurer's books and records relating in any way to the identification of Covered Persons eligible for reinsurance, the designation of Covered Persons and ceding of policies, the issuance and administration of primary coverage underlying the Association's reinsurance, the calculation of reinsurance premium, and the Member Insurer's systems for managing each of the foregoing.

(b) At any time and from time to time upon reasonable advance notice to any Member Insurer, audit and inspect all the Member Insurer's books and records relating to the investigation, adjustment and defense of any claims, including, without limiting the generality of the foregoing, all books and records relating to the Member Insurer's claims administration process and systems and the compliance or non-compliance by the Member Insurer with the requirements of Sections 9.10(a), (b) and (c) hereof.

(c) All references to books and records shall include all data and information storage regardless of the technology or media used to produce, capture and retain such data and information. Member Insurers shall provide access to qualified personnel sufficient in all respects to assist the Association's audit personnel with access to and review and analysis of all books, records, data and other information required in connection with performing complete audits and inspections, in accordance with the foregoing.

9.12 Computation of Time Period. In computing a period of time allowed by this Article IX, the date of the event after which the period of time begins to run is not to be included. The last day of the period so computed is to be included, unless it is a day that is not a Business Day, in which event the period runs until the end of the next day which is a Business Day.

9.13 Notices. All notices and other communications required or permitted by this Article IX shall be deemed given when (a) delivered to the appropriate address by hand or by nationally recognized overnight courier service (costs prepaid); (b) sent by facsimile or internet e-mail with confirmation of transmission by the transmitting equipment to a fax number or email address provided by the recipient; or (c) deposited in the U.S. mail properly addressed and with sufficient postage.

## ARTICLE X HEALTH STATEMENT; LIST OF SPECIFIED CONDITIONS

10.1 Discretionary Ceding: Health Statement; Other Basis. Designation of a Covered Person pursuant to this Section 10.1 is referred to herein as a "Discretionary Cede" or "Discretionary Ceding," as applicable. Discretionary Ceding determinations may be made by Member Insurers on the basis of any reasonable means of determination, including, but not limited to, information contained in a Health Statement submitted by a Covered Person, the Covered Person's claims history or any risk scoring methodology.

10.2 Mandatory Ceding: Specified Conditions List.

- (a) Mandatory Ceding. The Board shall develop, and may amend from time to time, a list of medical or health conditions for which a person shall be automatically and mandatorily designated for reinsurance by the Association (“Specified Condition(s)”). Member Insurers shall exercise a reasonable level of care and make diligent inquiry in identifying Specified Conditions, and shall designate any Covered Person who demonstrates the existence or history of any Specified Condition, whether discovered by the Member Insurer through the completion of the Health Statement, through claims history or risk scores or through review of diagnosis codes associated with each Covered Person to identify any diagnosis codes associated with Specified Conditions, as provided by the Administrator. The designation of Covered Persons pursuant to this Section is referred to herein as “Mandatory Cede” or “Mandatory Ceding,” as applicable.
- (b) Development of Specified Conditions. In the event that a Covered Person, who is either (i) not designated or (ii) classified as a Discretionary Cede, demonstrates the existence or history of a Specified Condition that was not previously in evidence, such Covered Person shall be designated for Mandatory Ceding effective upon the commencement of the next Ceding Term following the appearance of such Specified Condition. Any such Mandatory Ceding designation of a Covered Person due to a newly-developed (or newly-demonstrated) Specified Condition shall be communicated to the Association not later than the applicable deadline for receipt of a Renewal/Cancellation Notice for the next Ceding Term.

10.3 Health Statement. A Member Insurer is permitted, but not required, to use a Health Statement (as described herein) for guidance in making Discretionary Ceding determinations. The Health Statement will also serve as a means, but not the exclusive means, of identifying Specified Conditions for purposes of Mandatory Ceding.

- (a) Development and Use. The Board shall develop, and may at its discretion update from time to time, a Health Statement to be used by each Member Insurer to collect information from individuals for purposes of making reinsurance determinations (“Health Statement”). A Member Insurer shall require a completed Health Statement in order for an application for coverage to be considered complete. Member Insurers may require an updated Health Statement from Covered Persons on an annual basis to assist in making the determination whether to renew or cancel the designation of the Covered Person for reinsurance pursuant to Section 9.4(h)(ii) hereunder. Notwithstanding anything contained herein to the contrary, a Member Insurer is not required to use a Health Statement as the basis, or as the sole basis, for Discretionary Ceding determinations.

- (b) Prohibition on Denial of Coverage. A Member Insurer may not deny coverage or refuse to renew or cancel an Eligible Health Plan on the basis of a Covered Person's complete or incomplete Health Statement, claims history or risk scores or on the basis of any omission of material information from a Health Statement or misrepresentation of such Covered Person's health status. The rejection of an application for coverage as incomplete because a Covered Person has not submitted a completed Health Statement is not a denial of coverage for purposes of this prohibition.
  
- (c) Confidentiality of Information. Protected health information included in a Health Statement submitted to the Association that is covered by the federal Health Insurance Portability and Accountability Act of 1996 or covered by Chapter 24 of the Insurance Code, remains confidential and is not open to public inspection. In addition to the foregoing, all information (whether protected health information or otherwise, and whether or not included in a Health Statement) that is required to be maintained as confidential, protected, or otherwise subject to statutory safeguards pursuant to Chapter 24 of the Insurance Code shall be so maintained.

## ARTICLE XI ASSESSMENTS

- 11.1 Organizational Assessment. The Board shall assess each Insurer a one-time initial organizational assessment in an amount of \$500 per Insurer. This assessment shall be due within 30 days following receipt of a bill therefor from the Association ("Organizational Assessment").
  
- 11.2 Regular Assessments. On an annual basis, the Board shall assess each Insurer an amount not to exceed four dollars (\$4) per month per Covered Person resident in the State of Maine enrolled in Medical Insurance insured, reinsured or administered by the Insurer ("Regular Assessment"). Except for the Transition Period, beginning calendar year 2013, the Board shall determine the rate of the Regular Assessment on or before March 31 of each year. Notification of Regular Assessments due from Insurers shall be provided on or before March 31 of each year, and Regular Assessments shall be payable on a quarterly basis, due within 30 days after the end of each calendar quarter. The Board shall determine the rate of Regular Assessments for the Transition Period as soon as reasonably possible following the effective date of this Plan. The Regular Assessment for the Transition Period shall be assessed beginning with the second calendar quarter of 2012 and shall be due and payable on or before July 31, 2012. Thereafter, Regular Assessments shall be made on the quarterly schedule described herein.

- 11.3 Assessments to Cover Net Losses. In addition to the Organizational and Regular Assessments described in Sections 11.1 and 11.2, the Board may, in accordance with this Section 11.3, assess Insurers at such a time and for such amounts as the Board finds necessary in its discretion to cover any net loss in an amount not to exceed two dollars (\$2) per month per Covered Person enrolled in Medical Insurance insured, reinsured or administered by each Insurer (“Deficit Assessment”).
- 11.4 Self-Reporting. Both Regular Assessments and Deficit Assessments shall initially be calculated and paid by each Insurer on a self-reported basis. When such an assessment payment is due, each Insurer shall submit to the Association (i) the calculation of the assessment applicable to such Insurer, together with (ii) the payment required under Sections 11.2 or 11.3 above, as applicable, and (iii) a certification by an authorized officer of the Insurer that all self-reported enrollment data, if any, has been prepared consistent with the basis, reporting methodology, and sources used by such Insurer to calculate enrollment data for purposes of reporting to the Superintendent pursuant to the provisions of the Insurance Code. The Insurer’s determinations shall be subject to verification by the Association, either through audit or through any other independent means available to the Association for verification of Insurer enrollment. Notwithstanding the self-reporting process described herein, the Association reserves the right to undertake such billing and collection measures or activities as the Board may deem appropriate and nothing set forth herein shall be construed as limiting that authority.
- 11.5 Federal or State Employees. An Insurer shall not be subject to assessments pursuant to Sections 11.2 or 11.3 on policies or contracts insuring federal or state employees, except with respect to coverage of Maine state legislators and their dependents.
- 11.6 Determination and Payment of Assessments.
- (a) Basis. The Regular Assessment payable by each Insurer pursuant to Section 11.2, and the Deficit Assessment payable by each Insurer pursuant to Section 11.3, will each be calculated based upon the rate of assessment determined by the Board and each Insurer’s Covered Person enrollment.
- (b) Calculation of Assessments. For purposes of calculating their Regular Assessments, Insurers shall report to the Association their Covered Person enrollment (determined on a basis consistent with Section 11.6(f) below) within thirty (30) days after the close of each calendar quarter (“Quarterly Assessment Report”) and shall remit payment of the Regular Assessment due, calculated in accordance with the enrollment reported therein. The most current

enrollment information shall also be used for calculation of Deficit Assessments payable by Insurers if, as and when Deficit Assessments are declared by the Association.

- (c) Third Party Administrator Enrollment and Assessment Determination. In the event a Third Party Administrator demonstrates to the Administrator's satisfaction that it is unable to determine the actual number of Covered Persons enrolled in a self-insurance program or plan administered by the Third Party Administrator with reasonable effort, then the Administrator may, in its discretion, calculate, and allow the Third Party Administrator to calculate, its enrollment and the resulting assessment based on an estimated average number of covered persons per employee enrolled in the plan or program, based on such actuarial analysis as the Administrator deems necessary or appropriate to make such determination.
  
- (d) Assessment Payments. Regular and Deficit Assessment payments shall be made on a provisional basis, and the Association shall have a right to adjust enrollment reported by Insurers to reflect any additional information obtained or provided to the Association regarding an Insurer's enrollment and make appropriate adjustments in the amount of Regular Assessments and/or Deficit Assessments.
  
- (e) Verifying Enrollment. The Board may verify the amount of each Insurer's assessment based on annual statements and other reports determined to be necessary by the Board. The Board may use any reasonable method of estimating the number of Covered Persons enrolled with an Insurer if a specific number is not reported, including, without limitation, the Insurer's enrollment as reported to the Bureau of Insurance pursuant to Rule 945. With respect to self-insured health plans subject to assessment, the Association shall develop and apply a consistent reasonably appropriate methodology to determine the enrollment in those plans based on such information as may from time to time be or become available to the Association. In the event a self-insured health plan subject to assessment does not provide a Quarterly Assessment Report or other adequate information to allow for determination of its enrollment, then the Association may extrapolate its enrollment based on such other data as the Board may deem appropriate.
  
- (f) Determining Enrollment: Special Provisions. In preparing its count of Covered Persons for assessment purposes:

- (i) The Board shall make reasonable efforts to ensure that each Covered Person is counted only once with respect to a given assessment;
  - (ii) Each Insurer that obtains excess or stop loss insurance shall include in its count of Covered Persons all persons whose coverage is insured, in whole or in part, through excess or stop loss coverage; and
  - (iii) A Reinsurer shall be permitted to exclude from its number of Covered Persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment.
- (g) Responsibility for Paying Assessments. As between an insurance carrier that insures a Covered Person and a Third Party Administrator that administers such insurance (or provides any related service) with respect to such Covered Person on behalf of such insurance carrier, the payment of Regular Assessments and Deficit Assessments based on the coverage of such Covered Person shall be the responsibility of the insurance carrier, unless the insurance carrier and the Third Party Administrator agree otherwise (and provided that the assessment is paid on a timely basis). The carrier and the Third Party Administrator shall be responsible to coordinate their respective responsibilities with respect to payment and self-reporting to assure timely reporting and payment in accordance with this Plan.
- 11.7 Late Payment of Assessments. Assessment payments paid after the applicable due date shall be subject to a late payment charge equal to 5% of the amount due, plus interest at the rate of 18% per annum, to be charged on and after the applicable due date.
- 11.8 Deferral of Assessments. An Insurer may apply to the Superintendent for a deferral of all or part of an assessment imposed by the Association. The Superintendent may defer all or part of the assessment if the Superintendent determines that the payment of the assessment would place the Insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred shall be assessed against other Insurers in a proportionate manner consistent with this Article XI. The Insurer that receives a deferral remains liable to the Association for the amount deferred and is prohibited from reinsuring any person through the Association until such time as the Insurer pays the assessments.
- 11.9 Failure to Pay Assessment.

- (a) The Association shall report all unpaid assessments to the Superintendent requesting that appropriate action be taken to facilitate collection of such amounts.
- (b) The Superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in Maine of any Insurer that fails to pay an assessment.
- (c) As an alternative, the Superintendent may levy a penalty on any Insurer that fails to pay an assessment when due.
- (d) In addition, the Superintendent may use any power granted to the Superintendent under the Insurance Code to collect any unpaid assessment.

11.10 Excess Funds. If assessments and other receipts by the Association, Board or Administrator exceed the actual losses and administrative expenses of the Association, the Board shall hold the excess in an interest bearing account or otherwise invested in accordance with the Association's Investment Policy and shall use those excess funds to offset future losses or to reduce reinsurance premiums, as determined by the Board in its discretion. As used in this Section 11.10, "future losses" includes reserves for IBNR.

11.11 Federal Funds to Reduce Assessment. The Board shall comply with § 3957(9) of the Enabling Act with respect to unused funds from the federal pre-existing condition insurance plan.

11.12 Disputes Regarding Assessments. The Administrator will act on behalf of the Board in connection with billing, payment and collection of assessments. In the event of any dispute between an Insurer and the Association, the Administrator will act on behalf of the Association in attempting to resolve any dispute; provided, however, in the event such dispute cannot be resolved within thirty (30) days following written notice of the dispute, the Insurer shall be entitled to petition the Board for an appearance before the Board in connection with such dispute, as more particularly described in Section 14.7 hereof.

## ARTICLE XII FINANCIAL ADMINISTRATION

12.1 Books and Records. The Association shall maintain books and records to satisfy any applicable requirements of law and/or of the Board, the Superintendent, and outside auditors, and may contract with the Administrator or such other third party as the Board shall in its discretion select to carry out one or more of the following functions:

- (a) The receipt and disbursement of cash by the Association and financial statements shall be prepared on the accrual basis of accounting.
- (b) Non-cash transactions shall be recorded when the asset or the liability should be realized by the Association in accordance with generally accepted accounting principles.
- (c) Assets and liabilities of the Association, other than cash, shall be accounted for and described in itemized records.
- (d) For each Insurer, the net balance due to/from the Association shall be calculated and confirmed with Insurers as deemed appropriate by the Board or when requested by the respective Insurer. Such net balance shall be supported by a record of such Insurer's financial transactions with the Association. For each Insurer, this record shall include:
  - (i) Assessments, including any late, deferred, or unpaid assessments.
  - (ii) Any adjustments to the amount due to/from the Insurer resulting from corrections to information submitted by the Insurer.
  - (iii) Interest charges due from the Insurer for late payments.
  - (iv) If the Insurer is a Member Insurer, the amount of reinsurance premium due from the Member Insurer to the Association.
  - (v) If the Insurer is a Member Insurer, the amount of reimbursement due from the Association to the Member Insurer.
  - (vi) Such other records as may be required by the Board.
- (e) The Association shall maintain a general ledger whose balances are used to produce the Association's financial statements in accordance with generally accepted accounting principles.
- (f) The Association shall maintain all records as to premium, reimbursement, and administrative expenses with respect to a given calendar year for a period of seven (7) years following the end of such calendar year.

12.2 Handling and Accounting of Assets and Money. Money and marketable securities shall be kept in bank accounts and investment accounts as approved by the Board. The Administrator, or other party selected by the Board, shall deposit receipts into and make disbursements from these accounts.

- 12.3 Bank Accounts. All bank accounts/checking accounts shall be established in the name of the Maine Guaranteed Access Reinsurance Association, and shall be approved by the Board. Authorized check signers shall be approved by the Board.
- 12.4 Lines of Credit. All lines of credit shall be established in the name of the Maine Guaranteed Access Reinsurance Association, and shall be approved by the Board. Lines of credit may be used for any operating expense, including to meet cash shortfalls.
- 12.5 Investment Policy. There shall be an "Investment Policy" established by the Board with the assistance of professional investment advisors selected by the Board, which shall identify the appropriate types of investments to be held by the Association, together with any applicable limitations on such investments. All cash shall be invested in accordance with the Investment Policy.

#### ARTICLE XIII AUDIT FUNCTION

- 13.1 Statutory Reporting. On an annual basis, the Association shall provide the following audits and reports to the parties indicated:
- (a) Annual Audit. The Board shall cause an audit of the Association to be conducted annually and shall provide the certified audit report to the Superintendent and the Joint Standing Committee.
  - (b) Annual Report to the Legislature. The Association shall report to the Joint Standing Committee not later than March 15th of each year, commencing in 2013. The report shall include information on the financial solvency of the Association and the administrative expenses of the Association.
  - (c) Annual Review for Solvency. The Board shall cause a review of the Association for solvency to be conducted annually and shall submit the results of such review to the Superintendent. Before April 1st of each year, commencing in 2013, the Association shall determine and report to the Superintendent (i) the Association's expected net losses for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses, and (ii) an estimate of the assessments needed to cover the losses incurred by the Association in the previous calendar year, including IBNR reserves.

- 13.2 Audit Scope. The audit shall review both the Association and the relevant operations of the Administrator. The audit report shall include the auditor's opinion as to whether the financial statements of the Association fairly present in all material respects the financial position of the Association. Auditors of the Association shall also provide the Audit Committee and the Board a report of any reportable conditions or material weaknesses in the internal controls and processes of the Association. Each of the Board or Audit Committee may at its discretion request copies of audit programs and details of audit testing from the auditor.
- 13.3 Auditor. The Association's annual audit shall be conducted by a firm of Certified Public Accountants selected by the Board. The audit firm shall be independent and have no conflicting interests with any Member Insurer, the Association, or the Administrator. The Association's annual audit examinations shall be made in accordance with the Generally Accepted Auditing Standards of the American Institute of Certified Public Accountants, and all annual solvency reviews shall be made using generally accepted accounting principles.
- 13.4 Additional Testing, Audits and Investigation. The Board may, at its discretion, cause such additional audit procedures to be conducted as it deems appropriate. Such additional audits may include detailed testing of representative samples of items required in order to inform the Audit Committee regarding the accuracy, completeness and timeliness of the Administrator's performance of all duties and responsibilities specified hereunder and under the Administrator's contract; the compliance by the Administrator and the Association with all applicable laws, rules, regulations and industry standards; and the adequacy of internal financial and operating controls and procedures.

#### ARTICLE XIV PENALTIES AND DISPUTE RESOLUTION

- 14.1 Good Faith and Due Diligence Of Insurers. Given the numerous factual determinations and tasks to be performed by Insurers in connection with their participation in the Association, it is expected that all Insurers will exercise the highest degree of good faith and due diligence in all aspects of their relationship with the Association.
- 14.2 Common Administrative Errors. There are certain common administrative errors that, notwithstanding the exercise of good faith and due diligence can be expected to occur. The following provisions govern the corrective actions to be taken in connection with certain anticipated administrative errors. The following provisions do not, and are not intended to, limit the Association's right to exercise any rights or remedies to which it may be entitled under this Plan, the Enabling Act or to request the Superintendent

exercise enforcement or supervisory authority in connection with any of the following circumstances.

- (a) *Reinsuring an ineligible individual (initial placement or failure to remove an individual becoming ineligible):* Coverage for the individual shall be terminated as of the first date of ineligibility, unless the Member Insurer was not notified of the ineligibility in a timely manner and/or the termination occurs on a prospective basis. Reimbursements paid by the Association in excess of premiums received are to be promptly returned to the Association. Premiums paid in excess of reimbursements paid by the Association will be promptly refunded by the Association, subject to the limitation on premium refunds.
- (b) *Reinsuring an eligible individual at the incorrect premium rate (failure to use correct rates or to apply correct rates to persons reinsured):* Reinsurance premiums for the persons involved shall be recalculated and any additional premiums shall be promptly paid. Excess premium payments will be promptly refunded, subject to the limitation on premium refunds.
- (c) *Incorrect claim payments or submissions:* The claim will be recalculated and any amount due to the Association will be repaid immediately.

14.3 Errors Related to Assessments. All Insurer errors related to assessments shall require the immediate payment of any additional amounts due plus interest calculated from the date such sum should have been paid and an administrative charge. Nothing set forth in this Section shall limit the Association's right to take any action or exercise any remedies provided in this Plan, the Enabling Act or other applicable law.

14.4 Other Errors. All additional sums due to the Association as a result of errors made by Insurers (including Member Insurers) other than those listed above shall be paid immediately. Nothing set forth in this Section shall limit the Association's right to take any action or exercise any remedies provided in this Plan, the Enabling Act or other applicable law.

14.5 Interest and Administrative Charges. Usual and ordinary errors and corrections shall not result in interest or administrative charges. In the event the Association determines that errors are the result of intentional, negligent or habitual behavior, then interest and administrative charges may be imposed in the Association's discretion. Any such charges shall require Board approval. All interest payments required under this Article XIV shall be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment, and shall bear interest at eighteen percent (18%) per annum. Any applicable administrative charge shall be established by the Board, in its discretion.

- 14.6 Limitation on Premium Refunds. All premium refunds due under this Article XIV shall be limited to a period of twelve (12) months from the date the error was corrected, except as otherwise agreed by the Board. This determination is subject to the dispute resolution provisions set forth in Section 14.7 below.
- 14.7 Dispute Resolution. In the event of any dispute between the Association and a Member Insurer, the following provisions shall govern resolution of the dispute. In the event of a dispute with an Insurer (other than a Member Insurer), the Association shall make dispute resolution available based on the following provisions, to the extent the Insurer agrees to follow such provisions.
- (a) In the event of a dispute between the Administrator and any Member Insurer regarding the implementation of this Plan or the operation of the Reinsurance Program, the Administrator and the Member Insurer shall exercise good faith efforts to resolve such dispute in the normal course of business.
  - (b) In the event a dispute is not resolved in the ordinary course of business, then a Member Insurer may give the Association written notice of such dispute (a "Dispute Notice"). The executive of the Administrator and counsel for the Association shall meet with authorized representatives of the Member Insurer within thirty (30) days following the receipt of a Dispute Notice in an attempt in good faith to resolve any such dispute through informal communication accompanied by such documentation, presentation or other materials as the parties may mutually find helpful in facilitating an informal, amicable resolution ("Executive Dispute Process").
  - (c) In the event the dispute has not been resolved within thirty (30) days after the Executive Dispute Process, the Member Insurer shall have the right to submit a petition to the Legal Committee of the Board for an appearance before the Legal Committee in connection with the dispute ("Petition"). The Petition shall include with reasonable particularity (i) the name and title of the executive who will represent that party and of any other person who will accompany the executive, (ii) a statement of each party's position and a summary of arguments supporting that position, (iii) any supporting documentation the Member Insurer deems relevant or appropriate. At the next regularly scheduled meeting of the Legal Committee following receipt of a Petition, the Legal Committee shall provide the Member Insurer an opportunity to meet with the Legal Committee and make a presentation regarding the dispute

("Legal Committee Hearing"). The Legal Committee shall provide the Member Insurer with notice of the time and place of the meeting. The Legal Committee shall provide notice of its determination regarding the dispute within fifteen (15) days after the Legal Committee Hearing.

- (d) In the event the dispute has not been resolved within thirty (30) days after the Legal Committee Hearing, the Member Insurer shall have the right to submit a petition to the full Board for an appearance before the Board in connection with the dispute ("Board Petition"). The Board Petition shall include with reasonable particularity (i) the name and title of the executive who will represent that party and of any other person who will accompany the executive, (ii) a statement of each party's position and a summary of arguments supporting that position, (iii) any supporting documentation the Member Insurer deems relevant or appropriate and for the clear and concise statement of the Member Insurer's objection to the determination by the Legal Committee. Within forty-five (45) days following receipt of a Board Petition, the Board shall schedule a special meeting at which the Member Insurer shall have the opportunity to make a presentation regarding the dispute. The Board shall provide the Member Insurer with notice of the time and place of the meeting. The Member Insurer shall provide such further information, documentation and other data as the Board may reasonably request, in advance of the hearing. The Board shall provide notice of its determination regarding the dispute within thirty (30) days after the hearing, which determination shall be final and binding.
- (e) All offers, promises, conduct and statements, whether oral or written, made in the course of the negotiation by any of the parties, their agents, employees, experts and attorneys are confidential, privileged and inadmissible for any purpose, including impeachment, in arbitration or other proceeding involving the parties, provided that evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or non-discoverable as a result of its use in the negotiation. All applicable statutes of limitation and defenses based upon the passage of time shall be tolled while the procedures specified in subsections (a)-(d) of this Section 14.7 are pending and for fifteen (15) calendar days thereafter. The parties will take such action, if any, required to effectuate such tolling.

## ARTICLE XV INDEMNIFICATION AND LIABILITY

15.1 Indemnification. The Association shall indemnify directors and officers of the Association, and may indemnify employees and agents of the Association, pursuant to and as provided in the Bylaws of the Association.

15.2 Liability. Liability of directors and employees of the Association and others is limited as set forth in the Enabling Act.

#### ARTICLE XVI AMENDMENT

16.1 Amendments to this Plan of Operation may be adopted by the Board at any time, subject to the approval of the Superintendent.

#### ARTICLE XVII REPORTING REQUIREMENTS

17.1 General. This Plan sets forth certain reports and reporting requirements for Insurers summarized in Section 17.2 below. The Association reserves the right to adopt additional reporting requirements and require submission of additional reports, or require additional information in the existing reports, as the Board, in its discretion, deem appropriate. The identification of reports and the information contained therein in this Plan shall not limit the Association's ability to establish additional reporting requirements, as determined necessary to effectively implement this Plan.

17.2 Summary of Reporting Requirements. The following summarizes the reports required by this Plan. This section is included for reference and organizational purposes, and does not alter the reports or reporting requirements set forth in other sections of the Plan.

- (a) Ceding Notice. Described in Sections 9.4(a)(i) and (ii) is the notice provided by Member Insurers upon initial ceding of a Covered Person to the Reinsurance Program.
- (b) Enrollment Report. Described in Section 9.5(d)(ii) is the monthly report provided by Member Insurers listing all Covered Persons reinsured with the Association by the Member Insurer.
- (c) Renewal/Cancellation Notice. Described in Section 9.4(h)(ii) is the annual notification by a Member Insurer of the Covered Persons designated for ceding for the applicable year, and termination of reinsurance for any formerly designated Covered Persons withdrawn from the Reinsurance Program for that year, pursuant to Discretionary Ceding.
- (d) Claims Report. Described in Section 9.8 is the monthly report by each Member Insurer describing reinsurance-eligible losses incurred by the Member Insurer for the preceding month.

- (e) Quarterly Assessment Report. Described in Section 11.6(b) is the quarterly report of each Insurer's Covered Person enrollment utilized to calculate the Insurer's Regular Assessment payment, and any Deficit Assessment.

## ARTICLE XVIII TERMINATION

- 18.1 The Association shall continue in existence perpetually, subject to termination in accordance with the requirements of any law or laws enacted by the State of Maine or the United States of America. In case of enactment of a law or laws which, in the determination of the Board and the Superintendent, shall result in, or require, the termination of the Association, the Association shall terminate and conclude its affairs in a manner to be determined by the Board and set forth in a Plan of Termination, which shall be subject to approval by the Superintendent. Any funds or assets of any nature held by the Association at the time of adoption of the Plan of Termination shall be applied and distributed in the following order of priority:
- (a) To the payment of the expenses of liquidation and the debts and liabilities of the Association, including all claims for reimbursement by the Member Insurers;
  - (b) To the setting up of any reserves which the Board may deem necessary or desirable for any contingent or unforeseen liabilities or obligations of the Association, which reserves shall be held for such period as the Plan of Termination may specify for the purpose of payment of the aforesaid liabilities and obligations, at the expiration of which period the balance of such reserves shall be distributed in accordance with the following subparagraph; and
  - (c) After satisfaction of all liabilities and obligations for which reserves have been established pursuant to subparagraph (b) above, all remaining property and assets of the Association shall be transferred to a trust, non-profit corporation or other fund established pursuant to the Plan Termination to be used and applied for the general purposes for which the Association was originally organized, and provided that no part of the remaining assets or net earnings of the Association shall inure to the benefit of any private entity or individual.

**EXHIBIT A**  
**ARTICLES OF INCORPORATION**

DOMESTIC  
NONPROFIT CORPORATION

STATE OF MAINE

ARTICLES OF INCORPORATION

File No. 20120270ND Pages 7  
Fee Paid \$ 40  
DCN 2120231800012 ARTI  
FILED  
01/23/2012

*Julie L Flynn*  
Deputy Secretary of State

A True Copy When Attested By Signature

*Julie L Flynn*  
Deputy Secretary of State

Pursuant to 13-B MRSA §403, the undersigned incorporator(s) execute(s) and deliver(s) the following Articles of Incorporation

FIRST: The name of the corporation is Maine Guaranteed Access Reinsurance Association

SECOND: ("X" one box only. Attach additional page(s) if necessary.)

The corporation is organized as a public benefit corporation for the following purpose or purposes

The corporation is organized as a mutual benefit corporation for all purposes permitted under Title 13-B or, if not for all such purposes, then for the following purpose or purposes  
SEE EXHIBIT A ATTACHED

THIRD: The Registered Agent is a (select either a Commercial or Noncommercial Registered Agent)

Commercial Registered Agent CRA Public Number: P10026  
Christopher E. Howard  
(name of commercial registered agent)

Noncommercial Registered Agent  
\_\_\_\_\_  
(name of noncommercial registered agent)

\_\_\_\_\_  
(physical location, not P O Box – street, city, state and zip code)

\_\_\_\_\_  
(mailing address if different from above)

FOURTH: Pursuant to 5 MRSA §108.3, the registered agent as listed above has consented to serve as the registered agent for this nonprofit corporation.

**FIFTH:** The number of directors (not less than 3) constituting the initial board of directors of the corporation, if the number has been designated or if the initial directors have been chosen, is 11.

The minimum number of directors (not less than 3) shall be 11 and the maximum number of directors shall be 11.

**SIXTH:** Members ("X" one box only)

- There shall be no members  
 There shall be one or more classes of members and the information required by 13-B M.R.S.A. §402 is attached.

**SEVENTH:** (Optional)  (Check if this article is to apply)

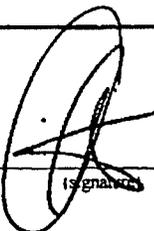
No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of any candidate for public office

**EIGHTH:** (Optional)  (Check if this article is to apply)

Other provisions of these articles including provisions for the regulation of the internal affairs of the corporation, distribution of assets on dissolution or final liquidation and the requirements of the Internal Revenue Code section 501(c) are set out in Exhibit A attached hereto and made a part hereof

Incorporators\*

Dated January 20, 2012



Street 89 Whites Point Road  
(residence address)

Christopher E. Howard  
(type or print name)

Standish, ME 04084  
(city, state and zip code)

(signature)

Street \_\_\_\_\_  
(residence address)

(type or print name)

(city, state and zip code)

(signature)

Street \_\_\_\_\_  
(residence address)

(type or print name)

(city, state and zip code)

**For Corporate Incorporators\***

Name of Corporate Incorporator \_\_\_\_\_

By \_\_\_\_\_  
(signature of officer)

Street \_\_\_\_\_  
(principal business location)

\_\_\_\_\_  
(type or print name and capacity)

\_\_\_\_\_  
(city, state and zip code)

Name of Corporate Incorporator \_\_\_\_\_

By \_\_\_\_\_  
(signature of officer)

Street \_\_\_\_\_  
(principal business location)

\_\_\_\_\_  
(type or print name and capacity)

\_\_\_\_\_  
(city, state and zip code)

---

**\*Articles are to be executed as follows:**

If a corporation is an incorporator (13-B MRSA §401), the name of the corporation should be typed or printed and signed on its behalf by an officer of the corporation. The articles of incorporation must be accompanied by a certificate of an appropriate officer of the corporation, not the person signing the articles, certifying that the person executing the articles on behalf of the corporation was duly authorized to do so.

Please remit your payment made payable to the Maine Secretary of State

Submit completed form to:

**Secretary of State  
Division of Corporations, UCC and Commissions  
101 State House Station  
Augusta, ME 04333-0101  
Telephone Inquiries (207) 624-7752**

Email Inquiries: [SEC.Corporations@Maine.gov](mailto:SEC.Corporations@Maine.gov)

**EXHIBIT A**  
**TO**  
**ARTICLES OF INCORPORATION**  
**OF**  
**MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION**

Capitalized terms used in this Exhibit A and not otherwise defined herein shall have the meanings assigned to them in Section 3952 of the Maine Guaranteed Access Reinsurance Association Act, Chapter 54-A of Title 24-A of the Maine Revised Statutes (the "Act")

**EIGHTH:**

**Purposes**

Section 1. The Corporation is organized and operated exclusively for the provision of reinsurance coverage for medical care on a not-for-profit basis to individuals, subject to and pursuant to the provisions of the Act and the provisions of Section 501(c) (26) of the Internal Revenue Code of 1986, as amended (the "Code").

Section 2. All activities and functions of the Corporation shall be conducted in a manner which is consistent with the requirements of Section 501(c)(26) of the Code, and solely in furtherance of its purposes, the Corporation is authorized to do everything necessary, suitable, or proper for the accomplishment, attainment, or furtherance of, to do every other act or thing incidental to, appurtenant to, growing out of, or connected with, the purposes, objects, or powers set forth in these Articles of Agreement, whether alone or in association with others: to possess all the rights, powers, and privileges now, or hereafter conferred by the laws of the State of Maine upon a nonprofit corporation organized as a mutual benefit corporation under Title 13-B of the Maine Revised Statutes, as amended, and, in general, to carry on any of the activities and to do any of the things herein set forth to the same extent and as fully as a natural person might or could do; provided that nothing herein set forth shall be construed as authorizing the Corporation to possess any purpose, object, or power, or to do any act or thing forbidden of any organization exempt from federal income tax pursuant to Section 501(c)(26) of the Code, or any successor provision, which would threaten the Corporation's tax exempt status.

**NINTH: Membership**

Section 1. Membership. Each Member Insurer of the Corporation, as defined in Section 3953(9) of the Act, is a member of the Corporation with all rights and obligations of such membership provided by these Articles of Incorporation, the Bylaws of the Corporation, and by law.

Section 2. Authority of the Board of Directors. The Board of Directors shall have the authority to determine whether any insurer is a duly qualified Member Insurer, in accordance with applicable provisions of law.

Section 3. Voting Rights. Members shall have no right to vote except as provided in Article TENTH with respect to the election of Member Directors, for which each member shall have one vote.

**TENTH: Board of Directors**

Section 1. Composition of Board.

- (a) General. The Board of Directors shall consist of 11 members, comprised of 5 Member Directors and 6 Public Interest Directors.
- (b) Member Directors. "Member Directors" mean natural persons who are designated by Member Insurers, at least one of whom shall be an officer, employee, director, manager, shareholder, partner, member or designee of a domestic insurer (as defined in the Act) and at least one of whom shall be an officer, employee, director, manager, shareholder, partner, member or designee of a third party administrator (as defined in the Act). Member Directors shall be elected by the Member Insurers at the Annual Meeting of the Corporation
- (c) Public Interest Directors. "Public Interest Directors" mean natural persons serving as members of the Board of Directors appointed by the Superintendent of Insurance ("Superintendent"). The Public Interest Directors shall consist of:
  - (i) 2 individuals chosen from the general public who are not associated with the medical profession, a hospital or an insurer;
  - (ii) 2 individuals who represent medical providers;
  - (iii) 1 individual who represents a statewide organization that represents small businesses; and

- (iv) 1 individual who represents producers, as defined in Section 3952(10) of the Act.

Section 2. Elections; Appointments.

Subject to any requirements contained in the Bylaws, Member Directors shall be elected by the Member Insurers. The Public Interest Directors shall be appointed by the Superintendent as provided in Section 3953(2)(A) of the Act.

Section 3. Terms.

The Directors shall be divided into three classes, as nearly equal in number as practicable. The terms of office of each class shall expire at staggered annual intervals over three years. A full term on the Board of Directors is three years. An individual may not serve more than three consecutive full terms as a director. At each Annual Meeting of the Corporation, the Member Directors elected to succeed those Member Directors whose terms expire shall be elected for a term of office to expire at the third succeeding Annual Meeting of the Corporation after their election. All Directors shall serve for the terms provided and until their successors are duly appointed or elected and qualified.

Section 4. Vacancies; Action by Board of Directors when Vacancies Exist. Any vacancy in the Member Directors may be filled by a majority of the remaining Directors. Any Director so elected to fill any vacancy shall be elected for the unexpired term of his predecessor. Except as provided in the following sentence, a majority of the total number of Directors then in office shall constitute a quorum for the transaction of business. If at any time there are fewer Directors in office than one-half of the total number of Directors fixed in these Articles of Incorporation, *i.e.*, fewer in office than six, the Directors then in office may transact no other business than the filling of vacancies on the Board of Directors, until sufficient vacancies have been filled so that there are in office at least one-half of the number of Directors fixed in these Articles of Incorporation.

Section 5. Initial Directors. The names, addresses and initial term of the initial members of the Board of Directors, are as follows:

<u>Name</u>	<u>Initial Term</u> (in years)	<u>Address</u>
Jennifer Juke	1	585 Winthrop Road, Deep River, CT 06417
Edward J. Kane	2	1 Market Street, 3 <sup>rd</sup> Floor Portland, ME 04101
Katherine Pelletreau	1	250 Greely Road, Cumberland, ME, 04021
Christopher T. Roach	3	254 Commercial Street

		Portland, ME 04101
William M. Whitmore	3	2 Gannett Drive Portland, ME 04106
Jolan F. Ippolito	3	442 Ellis River Road Rumford Point, ME 04276
Dr. David Howes, M D	1	331 Veranda Street Portland, ME 04104
Dana C. Kempton	3	98 Malbons Mills Road Skowhegan, ME 04976
Scott Davis	1	155 Highland Avenue Winthrop, ME 04364
Joel Allumbaugh	2	30 Deane Street Gardiner, ME 04345
Charles Gaunce	2	420 Kennedy Memorial Dr. Waterville, ME 04901

**ELEVENTH: Assessments**

For the purpose of providing funds necessary to carry out the powers and duties of the Corporation under applicable law, including without limitation Section 3955 of the Act, the Board of Directors shall assess insurers, as defined in Section 3952(6) of the Act ("Insurers"), at such time or times and for such amounts as the Board finds necessary, as more fully provided in Section 3957 of the Act. Any assessment levied against Insurers is for the benefit of the Corporation and shall be utilized to carry out the powers and duties of the Corporation under Section 3955 of the Act. Assessments shall be on such other terms and conditions, not inconsistent with the Act, as the Board shall determine in its discretion.

**TWELFTH: Amendments**

The Board of Directors shall have the exclusive power to alter, amend or repeal these Articles of Incorporation, subject to approval of the Superintendent, provided that the notice of any regular or special meeting at which such action is to be taken shall either set out the text of the proposed new provision or amendment, or any provision to be repealed, or shall summarize the changes to be effected by such adoption, amendment or repeal.

**EXHIBIT B**

**BYLAWS**

## BYLAWS

OF

### MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

These Bylaws have been adopted this 6th day of January, 2012, by the persons constituting all of the members of the first Board of Directors of the Maine Guaranteed Access Reinsurance Association, a Maine nonprofit corporation formed under Title 13-B, Maine Revised Statutes (the "Corporation").

#### ARTICLE I

##### GENERAL

Section 1. Definitions. Capitalized terms used herein without definition shall have the same definitions as such terms have in the Corporation's Articles of Incorporation and in Chapter 54-A of the Maine Revised Statutes, the Maine Guaranteed Access Reinsurance Association Act (the "Enabling Act").

Section 2. Compliance. Every Member Insurer and every Insurer shall comply with these Bylaws.

Section 3. Office. The office of the Corporation and the Board of Directors shall be located at such place as may be designated from time to time by the Board of Directors.

Section 4. Prohibited Activities. No part of the net earnings of the Corporation shall insure to the benefit of, or be distributable to the Members, the Board, its officers, its employees, or other private person, except (i) reasonable compensation for services rendered and payments and distributions in furtherance of the purposes set forth herein, and (ii) as provided for in the Articles in the event of dissolution of the Corporation. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these Bylaws, for so long as the Corporation is or seeks to remain exempt from federal income tax under Section 501(c)(26) of the Internal Revenue Code of 1986, as now in force or hereafter amended and in effect from time to time (the "Code"), the Corporation shall not carry on any other activities not permitted to be carried on by a corporation exempt from federal income tax under Section 501(c)(26) of the Code, or the corresponding section of any future federal tax code.

## ARTICLE II

### THE CORPORATION

Section 1. Membership. The Corporation is a Maine mutual benefit nonprofit corporation, all the members of which are Insured Members, as defined in the Enabling Act. A person shall automatically become a Member of the Corporation at the time it becomes an Insured Member within the meaning of the Enabling Act, and shall continue to be a Member so long as it continues to be an Insured Member within the meaning of the Enabling Act.

Section 2. Meetings. Meetings of Members of the Corporation shall be conducted in accordance with the following:

(a) Annual Meetings.

(1) Members shall hold an Annual Meeting of Members for the purposes stated in Section 2(a)(2) hereof (the "Annual Meeting"). The Annual Meeting shall be held on the second Tuesday of April of each year unless such date shall be a legal or religious holiday, in which event the meeting shall be held on the next following Tuesday.

(2) The purpose of the Annual Meeting shall be to elect the Member Directors of the Board of Directors, and to conduct such other business as may properly come before the meeting. The Treasurer shall present at each Annual Meeting a financial report, which shall include audited financial statements of the Corporation as contemplated by Section 3955(6) of the Enabling Act.

(b) Special Meetings.

(1) The President shall call a special meeting of the Corporation, if so directed by resolution of the Board of Directors or upon petition signed and presented to the Secretary by Member Insurers entitled to cast at least twenty-five percent (25%) of the votes in elections Corporation, for any lawful. The notice of any special meeting shall state the time, place and purpose thereof. Such meetings shall be held within forty-five (45) days after receipt by the President of said resolution or petition. No business shall be transacted at a special meeting except business that is lawfully brought before the meeting and is stated in the notice.

(c) Notice. Notices to Member Insurers of meetings of the Corporation shall be delivered either by hand or by prepaid mail to the mailing address of each Member Insurer or to another mailing address designated in writing by the Member Insurer to the Board of Directors. All such notices shall be delivered to all Member Insurers not less than ten (10) nor more than fifty (50) days in advance of the date of the meeting to which the notice relates and shall state the date, time and place of the meeting and the items on the agenda. The Secretary shall cause all such notices to be delivered as aforesaid. Notice sent by mail shall be deemed to have been delivered on the second day after the date of mailing, in the case of mailed notices or the date of deposit in the Member Insurer's mailbox in the case of hand delivery. No subject may be dealt with at any Annual Meeting or Special Meeting of the Corporation unless the notice for such meeting stated that such subject would be discussed at such meeting.

(d) Quorum. Except as set forth below, the presence in person or by proxy of 2 or more of the Member Insurers at the commencement of a meeting shall constitute a quorum at all meetings of the Corporation. If a quorum is not present, Member Insurers entitled to cast a majority of the votes represented at such meeting may adjourn the meeting to a time not less than forty-eight (48) hours after the time for which the original meeting was called. If a meeting is adjourned, a quorum at the reconvened meeting, and throughout such reconvened meeting, shall be deemed present if 2 or more of the Member Insurers are present in person or by proxy at the beginning of the meeting.

(e) Voting. Voting by Members at all meetings of Members of the Corporation shall be only as provided in Articles Ninth and Tenth of the Articles of Incorporation of the Corporation.

(f) Proxies. A vote may be cast in person or by proxy. Such proxy may be granted by any Member Insurer only in favor of another Member Insurer or an officer or director of the Corporation. Proxies shall be duly executed in writing, shall be valid only for the particular meeting designated therein and must be filed with the Secretary of the Corporation at least twenty (20) days before the appointed time of the meeting. Such proxy shall be deemed revoked only by actual receipt by the person presiding over the meeting of written notice of revocation from the grantor of the proxy. No proxy shall be valid for a period in excess of one year after the execution thereof.

A Proxy Committee of the Board may be designated by the Board of Directors. The Proxy Committee may utilize the facilities of the Corporation for the purpose of soliciting proxies. The expense of the Committee incurred in the solicitation of proxies shall be defrayed from the funds of the Corporation. No person, other than the Proxy Committee, shall be authorized to employ Corporation facilities or funds for the purposes of soliciting proxies from Members.

(g) Actions of Corporation without a Meeting. Any action required or permitted to be taken by a vote of the Corporation may be taken without a meeting if all Member Insurers shall individually or collectively consent in writing to such action. Any such written consent shall be filed with the proceedings of the Corporation.

(h) Conduct of Meetings. The Chair of the Board shall preside over all meetings of Members of the Corporation, and the Secretary shall keep the minutes of all such meeting, and record in a Minute Book all resolutions adopted at any such meeting as well as keep a record of all transactions occurring at any such meeting.

(i) Proper Business at Meetings. At any annual or special meeting of Members of the Corporation, only such business shall be conducted as shall have been properly brought before such meeting. To be properly brought before a special meeting, business must be specified in the notice of meeting given by or at the direction of the Board of Directors. To be properly brought before an annual meeting, business must be specified in the notice of meeting given by or at the direction of the Board of Directors, or otherwise properly brought before the

meeting by or at the direction of the Board of Directors or otherwise properly brought before the meeting by a Member.

For business to be properly brought before an annual meeting by a Member, the Member must have given timely notice thereof in writing to the Secretary of the Corporation. To be timely, a Member's notice must be delivered to, or mailed and received at, the principal executive offices of the Corporation not less than 120 days nor more than 180 days prior to the annual meeting; provided, however, that in the event that written notice is given, and such written notice is less than 135 days' prior to the date of such meeting, notice by the member to be timely must be so received not later than the close of business on the 15th day following the day on which such notice of the date of the meeting was mailed. In no event shall an adjournment of an annual or special meeting commence a new time period for the giving of a Member's notice as described above. A Member's notice to the Secretary shall set forth as to each matter the Member proposes to bring before the meeting (i) a brief description of the business desired to be brought before the meeting and the basis on which it is a proper action to be taken by Members at such meeting, (ii) the name and record address of the Member proposing such business, and (iii) any material interest of such Member in such business. The Chair of the meeting shall, if the facts warrant, determine and declare to the meeting that such business is not properly brought before the meeting in accordance with these provisions, and if he or she should so determine, he or she shall so declare to the meeting and any such business not properly brought before the meeting shall not be transacted.

(j) Nominations to Board by the Governance and Nominating Committee. The Governance and Nominating Committee of the Board shall nominate persons who are or will become Member Directors (as defined in the Corporation's Articles of Incorporation) for election as directors to serve for terms commencing at the next succeeding Annual Meeting. Nominations shall be made by the Committee at least sixty days before the date of the Annual Meeting at which the persons nominated are to be voted upon, except that a vacancy in the list of nominees caused by the death, resignation or removal of a nominee may be filled at any time.

(k) Nominations to Board by Members. Other nominations for election to the Board for terms commencing at an Annual Meeting of the Corporation may be made by petition of any Member containing the signatures of not less than three Member Insurers entitled to vote at such election. Each such nominee shall be an individual qualified to serve as a Member Director under the Corporation's Articles of Incorporation. Such petition shall be filed with the Secretary of the Corporation at its principal office not later than one hundred twenty days before the date of the Annual Meeting at which the persons therein nominated are to be voted upon. Each petition shall be accompanied by a statement giving all information relating to each such proposed nominee that would be required to be disclosed in solicitations of proxies for election of directors in an election contest, or that otherwise would be required, if the Corporation were subject to the proxy rules promulgated under the Exchange Act, in each case pursuant to Regulation 14A under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and Rule 14a-11 thereunder (including such proposed nominee's written consent to serve as a Member Director if elected).

(l) Record Date. For the purpose of determining the Members entitled to notice of or to vote at any meeting of the Members or any adjournment thereof, or to make a determination of Members for any other proper purpose, the Board of Directors shall fix in advance a record date for any such determination. Such record date shall not in any case be more than sixty (60) days nor less than thirty (30) days prior to the date designated for the particular action. If a meeting of the Members is adjourned for less than thirty (30) days, a determination of the Members entitled to vote at the original meeting, made as provided in this section, shall apply to the adjourned meeting unless the Board of Directors shall fix a new record date for such adjourned meeting in accordance with this section and cause new notice of the adjourned meeting to be given as for an original meeting. If a meeting of the Corporation is adjourned for thirty (30) days or more, a new record date shall be fixed for the adjourned meeting in accordance with this section.

### ARTICLE III

#### BOARD OF DIRECTORS

Section 1. Management of the Corporation; Composition. The business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors, which may exercise all of the powers granted the Corporation in its Articles of Incorporation and by the Enabling Act, and do all lawful acts and things as are not by statute, the Articles of Incorporation or the Bylaws required to be exercised or done by the Members.

The Board of Directors shall consist of individuals elected or appointed by the Superintendent of Insurance of the State of Maine and by the Member Insurers, as provided in the Corporation's Articles of Incorporation.

Section 2. Election and Term of Office.

The Public Interest Directors shall be appointed by the Superintendent as provided in Section 3953(2)(A) of the Act.

The election of Member Directors shall be held at the Annual Meeting of Members of the Corporation, in accordance with the Articles of Incorporation and these Bylaws. The term of office of any member of the Board of Directors shall be three years. The members of the Board of Directors shall hold office until the earlier to occur of the election of their respective successors or their death, adjudication of incompetency, removal or resignation. A member of the Board of Directors may serve up to three (3) consecutive terms, and may succeed himself.

Vacancies on the Board may be filled as provided in the Articles of Incorporation.

Section 3. Meetings of the Board of Directors. Meetings of the Board of Directors shall be conducted in accordance with the following:

(a) Regular Meetings. Regular meetings of the Board of Directors may be held at such time and place, either within or without the State of Maine, as shall from time to time be fixed by the Board. Unless otherwise specified by the Board, once the schedule of regular meetings is established no additional notice of regular meetings shall be necessary.

(b) Special Meetings. Special meetings of the Board of Directors may be called by the Chairman of the Board of Directors (if any), the President, the Secretary, or a majority of the Directors. The person or persons calling the special meeting shall fix the time and place thereof.

(c) Notice; Generally. Notice of each special meeting of the Board of Directors shall be given to each Director who has not signed a waiver of notice before or after the meeting. Notices of meetings of the Board of Directors shall be given by the Registered Agent or the Secretary, or the person or persons calling the meeting. Neither the business to be transacted at nor the purpose of the meeting need be specified in the notice unless the Act shall otherwise require. The giving of notice of a special meeting of the Board of Directors by or at the direction of the person or persons authorized to call the same shall constitute the call thereof.

(d) Notice; When and How Given. Notice of meetings of the Board of Directors may be given by any of the following methods within the time period specified for that method:

(i) by depositing a copy of the notice in the United States mail, first class postage prepaid, addressed to the Director at his usual or last known business or residence address, at least 3 business days before the meeting;

(ii) by delivering a copy of the notice to a recognized overnight delivery or express service addressed to the Director at his usual or last known business or residence address, including street or the like in the address, at least 2 business days before the meeting;

(iii) by delivering a copy of the notice in hand to the Director at least 24 hours before the meeting;

(iv) by reading or causing to be read the notice over the telephone to the Director at least 24 hours before the meeting;

(v) by sending a telegram containing the contents of the notice addressed to the Director at his usual or last known business or residence address at least 2 business days before the meeting;

(vi) by electronic transmission, including email or fax, as provided in, and subject to, the provisions of this Section relating to electronic transmissions and set forth below; or

(vii) by sending a copy of the notice by any usual means of communication addressed to the Director at his usual or last known business or residence address, including street or the like in the address, at least 3 business days before the meeting.

Notice to any Director actually received by him at least 24 hours before the meeting shall be deemed sufficient, notwithstanding the method or means of communication selected or the time when sent. For the purposes of this Section, a "business day" is any day other than a Saturday, Sunday or legal holiday in Maine.

Written notice of an meeting of directors includes any notice delivered by electronic transmission, as defined below, provided that the Corporation shall have sent an electronic transmission to such Director at a specific e-mail address selected and confirmed by the Director, and that such electronic transmission shall contain the full text of the notice of the meeting. For purposes of these Bylaws, an "electronic transmission" means any form or process of communication, not directly involving the physical transfer of paper or another tangible medium, which (a) is suitable for the retention, retrieval, and reproduction of information by the recipient, and (b) is retrievable in paper form by the recipient through an automated process used in conventional commercial practice. Electronic transmission includes, without limitation, communications by e-mail and by fax. An electronic transmission is received by the recipient when (1) it enters an information processing system that the recipient has designated or uses for the purpose of receiving electronic transmissions or information of the type sent, and from which the recipient is able to retrieve the electronic transmission, and (2) it is in a form capable of being processed by that system. An electronic transmission is received even if no individual is aware of its receipt.

(e) Telephone Meetings. Members of the Board of Directors or of any committee designated thereby may hold a regular or special meeting by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. The provisions of this Article relating to notice shall apply to such meetings.

(f) Attendance as Waiver of Notice. Attendance of a Director at any meeting, including participation in any telephone meeting, shall constitute a waiver of notice of such meeting, except where a Director attends for the express purpose, stated at the commencement of the meeting, of objecting to the transaction of any business because the meeting is not lawfully called, noticed or convened. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need be specified in the notice or waiver of notice of such meeting.

(g) Quorum and Vote Required. At any meeting of the Directors, a majority of the Directors then in office shall constitute a quorum for the transaction of business. The Directors present at a duly called or held meeting at which a quorum was once present may continue to do business notwithstanding the withdrawal of enough Directors to leave less than a quorum; provided, however, that a quorum must be present in order for the Board to take action, and any action of the Board shall be subject to the voting requirements set forth below. Any meeting may be adjourned from time to time by a majority of the votes cast upon the question, whether or not a quorum is present, and the meeting may be held as adjourned without further notice if the time and place to which it is adjourned is fixed and announced at such meeting. The vote of a majority of the directors present at a meeting at which a quorum is present shall be the act of the

Board of Directors unless the vote of a greater number is required by these Bylaws, the Articles of Incorporation, or statute; provided, however, that all matters submitted for a vote of the Directors must receive at least six (6) affirmative votes in order to be approved.

(h) Action by Unanimous Consent. Any action required or permitted to be taken at a meeting of the Directors, or of a committee of the Directors, may be taken without a meeting if written consents setting forth the action so taken are signed by all the Directors or members of such committee and are filed with the minutes of Directors' meetings or committee meetings, as the case may be. Any such action shall have the same effect as if taken at a meeting duly called and held.

#### ARTICLE IV

##### COMMITTEES OF THE BOARD OF DIRECTORS

Section 1. Executive Committee. The Board of Directors by resolution adopted by a majority of the full Board of Directors then in office may create and appoint an Executive Committee consisting of three or more Directors and may delegate to it some or all of the Board's authority in the management of the corporation's business and affairs except as limited by Section 709 of the Maine Nonprofit Corporations Act, the resolution establishing such executive authority or any other resolutions thereafter adopted by the Board of Directors. The Executive Committee shall keep regular minutes of its proceedings and report the same to the Board of Directors. Members of the Executive Committee may be removed, with or without cause, and vacancies may be filled by resolution adopted by a majority of the full Board of Directors then in office.

Section 2. Other Committees. Other committees may be designated by a resolution adopted by a majority of the Directors present at a meeting at which a quorum is present. Members of each such committee shall be Directors of the Corporation, and shall include the following:

- (a) Executive Committee.
- (b) Governance and Nominating Committee.
- (c) Actuarial Committee.
- (d) Audit Committee.
- (e) Investment Committee.
- (f) Legal Committee.
- (g) Finance Committee.

Any member of a committee may be removed by a majority of the Directors whenever in their judgment the best interest of the Corporation shall be served by such removal.

Section 3. Term of Office. Each member of a committee shall continue as such until the next annual meeting of the Members of the Corporation and until his or her successor is appointed, unless the committee shall be sooner terminated, or unless such member shall be removed from such committee, or unless such member shall cease to qualify as a member of the Board of Directors as provided in Article Tenth of the Articles of Incorporation.

Section 4. Chairperson. One (1) member of each committee shall be appointed chairperson by the person or persons authorized to appoint the members thereof.

Section 5. Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of the original appointments.

Section 6. Quorum. Unless otherwise provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum, and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

## ARTICLE V

### OFFICERS

Section 1. Election. At the first meeting of the Board of Directors, and at every annual meeting of the Board of Directors thereafter, the members of the Board of Directors, if a quorum is present, shall elect officers of the Corporation for the following year, such officers to serve for a one year term and until their respective successors are elected. The officers to be elected are: Chair of the Board, President, Secretary, and Treasurer. Each officer may serve an unlimited number of terms so long as such member or officer continues to be re-elected to the Board of Directors. Any member may hold two offices simultaneously, except that the President shall not hold any other office.

Section 2. Duties. The duties of the officers shall be as follows:

(a) Chair. The Chair shall be the chairperson of the Board and shall preside over all meetings of the Board of Directors. If the Chair is absent from any meetings of Board of Directors, the President of the Corporation shall preside, and in his or her absence the senior officer of the Corporation present at such meeting shall preside, and in the absence of any officer, the Board shall elect a person to preside.

(b) President. The President shall be the chief executive officer of the Corporation. The President shall be responsible for implementing the decisions of the Board of Directors and in that capacity shall direct, supervise, coordinate and have general control over the affairs of the Corporation and the Board of Directors, subject to the limitations of the laws of the State of Maine, the Enabling Act, these Bylaws and the actions of the Board of Directors. The President shall have the power to sign checks and other documents on behalf of the Corporation with or without the signatures of any other officers, as may be determined by the Board of Directors.

The President shall be a member of all committees. If the Board of Directors so provides, the President also shall have any or all of the powers and duties ordinarily attributable to the chief executive officer of a corporation domiciled in Maine.

(c) Secretary. Unless otherwise determined by the Board of Directors, the Secretary shall keep or cause to be kept all records (or copies thereof if the original documents are not available to the Corporation) of the Corporation and the Board of Directors and shall have the authority to affix the seal of the Corporation to any documents requiring such seal. The Secretary shall give or cause to be given all notices as required by law, the Enabling Act or these Bylaws, shall take and keep or cause to be taken and kept minutes of all meetings of the Corporation, the Board of Directors and all committees, and shall take and keep or cause to be taken and kept at the Corporation's office a record of the names and addresses of all Member Insurers as well as copies of the Enabling Act, the Articles of Incorporation and these Bylaws, all of which shall be available at the office of the Corporation for inspection by Member Insurers during normal business hours of the Corporation and for distribution to them at such reasonable charges (if any) as may be set from time to time by the Board of Directors. The Secretary shall also perform all duties and have such other powers as are ordinarily attributable to the secretary of a corporation domiciled in Maine.

(d) Treasurer. Unless otherwise determined by the Board of Directors, the Treasurer shall have the charge and custody of, and be responsible for, all funds and securities of the Corporation, shall deposit or cause to be deposited all such funds in such depositories as the Board of Directors may direct, shall keep or cause to be kept correct and complete accounts and records of all financial transactions of the Corporation and the Board of Directors and shall submit or cause to be submitted to the Board of Directors and the Corporation such reports thereof as the Declaration, the Board of Directors or these Bylaws may from time to time require. The foregoing financial records shall be kept at the Corporation's office and shall be available there for inspection by Member Insurers during normal business hours of the Corporation. The Treasurer shall also perform such duties and have such powers as are ordinarily attributable to the treasurer of a corporation domiciled in Maine.

Section 3. Compensation. The officers of the Corporation shall serve without compensation for their services in such capacity unless such compensation is expressly authorized or approved by a vote of more than fifty percent (50%) of the votes of all Member Insurers, at any Annual or Special Meeting of the Corporation; provided that no such compensation shall be permitted in violation of the restrictions set forth in Article I, Section 4 hereof.

Section 4. Resignation and Removal. Any officer may resign at any time by written notice to the Board of Directors, such resignation to become effective at the next meeting of the Board of Directors. Any officer may be removed from his office at any time by vote of Board of Directors, with or without cause.

Section 5. Vacancies. Vacancies caused by resignation or removal of officers or the creation of new offices may be filled by a majority vote of the Board of Directors.

## ARTICLE VI

### Indemnification

#### Section 1. Mandatory Indemnification and Advances for Directors and Officers.

(a) Indemnification. The Corporation shall in all cases indemnify, to the fullest extent permitted by law, any individual who is a party or threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative, arbitrative, or investigative and whether formal or informal (a "proceeding") because that person (i) is or was a director or officer of the Corporation, or (ii) is or was serving at the request of the Corporation as a director, officer, trustee, partner, manager, member, fiduciary, employee or agent of another corporation, partnership, limited liability company, limited liability partnership, joint venture, trust, pension, or other employee benefit plan, or other enterprise, against liability incurred in the proceeding.

(b) Advances. The Corporation shall in all cases, before final disposition of a proceeding, advance funds to pay for or reimburse the reasonable expenses incurred by a director or officer who is a party or threatened to be made a party to a proceeding because that individual (i) is or was a director or officer of the Corporation, or (ii) is or was serving at the request of the Corporation as a director, officer, trustee, partner, manager, member, fiduciary, employee or agent of another corporation, partnership, limited liability company, limited liability partnership, joint venture, trust, pension, or other employee benefit plan, or other enterprise, against liability incurred in the proceeding, if the director or officer delivers to the Corporation:

(1) a written affirmation of the director's or officer's good faith belief that the director or officer acted in good faith in the reasonable belief that his action was in the best interests of the Corporation or, with respect to any criminal action or proceeding, had reasonable cause to believe that his conduct was lawful, or that the proceeding involves conduct for which liability has been eliminated under the Enabling Act; and

(2) the director's or officer's written undertaking to repay any funds advanced if the director or officer is not entitled to mandatory indemnification under Section 714 of the Act and it is ultimately determined that the director or officer has not met the relevant standard of conduct described in Section 714(1) of the Act.

The undertaking required by paragraph (2) shall be an unlimited general obligation of the director or officer seeking the advance, but need not be secured and may be accepted without reference to the financial ability of the director or officer to make repayment.

(c) Indemnification and Advances Regardless of Capacity. Indemnification and advances for directors and officers of the Corporation under this Section 1 shall be required in all cases, regardless of the capacity in which such director and officer is or was made a party or threatened to be made a party to the proceeding.

Section 2. Permissive Indemnification of Employees and Agents. The Corporation may, in its discretion, indemnify any individual who is not a director or officer of the Corporation, but who is a party or threatened to be made a party to a proceeding because that person is an employee or agent of the Corporation, against liability incurred in the proceeding, only as authorized for a specific proceeding upon a determination, based solely on the facts then known to those making the determination and authorization but without further investigation, that (a) the individual's conduct was in good faith, and (b) the individual reasonably believed:

(a) in the case of conduct in the individual's capacity as an employee or agent of the corporation, that the individual's conduct was in the best interests of the Corporation;

(b) in the case of any criminal proceeding, that the individual had no reasonable cause to believe that the individual's conduct was unlawful; and

(c) in the case of an employee benefit plan, that the individual's conduct was in the interests of the participants in, and the beneficiaries of, the plan.

The termination of a proceeding by judgment, order, settlement or conviction or upon a plea of *nolo contendere* or its equivalent is not of itself determinative of the employee or agent did not meet the relevant standard of conduct described in this Section.

A specific determination as provided above shall be made by the board of directors, based solely on the facts then known to those making the determination and authorization but without further investigation, by a majority vote of a quorum consisting of directors who were not parties to such action, suit or proceeding, or if such a quorum is not obtainable, or even if obtainable, if a quorum of disinterested directors so directs, by independent legal counsel in a written opinion.

Once such a determination has been made, a specific authorization of indemnification must also be made for any such indemnification of employees or agents, in the same manner as the foregoing determination except that if there are fewer than two disinterested directors or if the determination is made by special legal counsel, then authorization of indemnification must be made by those persons entitled above to select special legal counsel.

Such a determination and authorization, once made, may not be revoked and, upon the making of that determination and authorization, the employee or agent may enforce the indemnification against the Corporation by a separate action notwithstanding any attempted or actual subsequent action by the Corporation.

Section 3. Permissive Advances for Employees and Agents. The Corporation may, in its discretion, advance funds before final disposition of a proceeding to pay for or reimburse the reasonable expenses incurred by an employee or agent of the Corporation who is a party or threatened to be made a party to a proceeding because that individual is an employee or agent of the Corporation, upon (1) a determination and authorization made in accordance with the procedures established in Section 3 hereof, based solely on the facts then known to those making

the determination and authorization but without further investigation, and (2) the delivery by the employee or agent to the Corporation of:

(a) a written affirmation of the employee or agent (i) that such individual's conduct was in good faith, and (ii) that such individual reasonably believed:

(1) in the case of conduct in the individual's capacity as an employee or agent of the corporation, that the individual's conduct was in the best interests of the corporation;

(2) in the case of any criminal proceeding, that the individual had no reasonable cause to believe that the individual's conduct was unlawful; and

(3) in the case of an employee benefit plan, that the individual's conduct was in the interests of the participants in, and the beneficiaries of, the plan; and

(b) a written undertaking of the employee or agent to repay any funds advanced unless it shall ultimately be determined that the individual is entitled to be indemnified by the Corporation as authorized in this Article.

Section 4. Mandatory Indemnification on Successful Defense. Any provisions of this Article VII hereof to the contrary notwithstanding, the Corporation shall indemnify a director, officer, employee or agent of the Corporation, to the extent that individual has been successful, on the merits or otherwise, in the defense of any action, suit or proceeding to which the individual was a party or threatened to be made a party because the individual was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, trustee, partner, manager, member, fiduciary, employee or agent of another corporation, partnership, limited liability company, limited liability partnership, joint venture, trust, pension, or other employee benefit plan, or other enterprise, against reasonable expenses incurred by the individual in connection with the proceeding.

Section 6. Enforceable by Separate Action. A right to indemnification or to advances of expenses required by, or established pursuant the provisions of, this Article may be enforced by a separate action against the Corporation pursuant to Section 714 of the Maine Nonprofit Corporations Act.

Section 7. Miscellaneous. The Corporation shall be deemed to have requested a person to serve an employee benefit plan whenever the performance by him or her of his or her duties to the Corporation also imposes duties on, or otherwise involves services by, him or her to the plan or participants or beneficiaries of the plan.

Section 8. Indemnification Not Exclusive; Limits. The indemnification and entitlement to advances of expenses provided by this Article shall not be deemed exclusive of any other rights to which an individual may be entitled under any agreement, vote of Members or disinterested directors or otherwise, both as to action in the individual's official capacity and as to action in another capacity while a director, officer, employee or agent of this Corporation, and shall continue as to an individual who has ceased to be a director, officer, employee, agent,

trustee, partner, or fiduciary, and shall inure to the benefit of the heirs, personal representatives, executors and administrators of such a person; provided, however, that no indemnification or advances of expenses under this Article VI shall be permitted in violation of the restrictions set forth in Article I, Section 4 hereof.

Section 9. Insurance. The Corporation may purchase and maintain insurance on behalf of an individual who is a director or officer of the Corporation or who, while a director or officer of the Corporation, serves at the Corporation's request as a director, officer, partner, trustee, employee or agent of another domestic or foreign corporation, partnership, joint venture, trust, employee benefit plan or other entity against liability asserted against or incurred by that individual in that capacity or arising from the individual's status as a director or officer, whether or not the Corporation would have power to indemnify or advance expenses to the individual against the same liability under Section 714 of the Maine Nonprofit Corporations Act.

Section 10. Amendment. No amendment, modification or repeal of this Article, in whole or in part, shall deny, diminish or otherwise limit the rights of any individual to indemnification or advances hereunder with respect to any action, suit or proceeding arising out of any conduct, act or omission occurring or allegedly occurring at any time prior to the date of such amendment, modification or repeal.

## ARTICLE VII

### GENERAL PROVISIONS

Section 1. Severability. The provisions of these Bylaws shall be deemed independent and severable and the invalidity, partial invalidity or unenforceability of any provision or portion hereof shall not affect the validity or enforceability of any other provision or portion thereof.

Section 2. Conflicts. The Enabling Act shall control in the event of any conflict between the provisions thereof and the provisions of these Bylaws. The Articles of Incorporation shall control in the event of any conflict between the provisions thereof and the provisions of these Bylaws.

Section 3. Amendments. The Board of Directors shall have the exclusive power to alter, amend or repeal these Bylaws, and to adopt new Bylaws provided that the notice, unless notice shall be duly waived, of any regular or special meeting at which such action is to be taken shall either set out the text of the proposed new Bylaw, amendment or Bylaw to be repealed, or shall summarize the changes to be effected by such adoption, amendment or repeal.

**ATTACHMENT B: ICD-9 CODES****MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION**

List of Conditions requiring Automatic Ceding

See Plan of Operations for Ceding Rules

3 Digit ICD-9	ICD 9 Codes	Description	Condition
182	182	Malignant neoplasm of body of uterus	Cancer - Corpus Uterus (Endometrial Carcinoma)
182	1820	Malig Neo Corpus Uteri	Cancer - Corpus Uterus (Endometrial Carcinoma)
182	1821	Mal Neo Uterine Isthmus	Cancer - Corpus Uterus (Endometrial Carcinoma)
182	1828	Mal Neo Body Uterus Nec	Cancer - Corpus Uterus (Endometrial Carcinoma)
209	20970	Sec Neuroendo Tumor Nos	Cancer - Metastatic
209	20971	Sec Neuroend Tu Dist Lym	Cancer - Metastatic
209	20972	Sec Neuroend Tumor-Liver	Cancer - Metastatic
209	20973	Sec Neuroendo Tumor-Bone	Cancer - Metastatic
209	20974	Sec Neuroendo Tu-Periton	Cancer - Metastatic
209	20975	Secondary Merkel Cell Ca	Cancer - Metastatic
209	20979	Sec Neuroend Tu Oth Site	Cancer - Metastatic
196	196	Secondary and unspecified malignant neoplasm of lymph nodes	Cancer - Metastatic
196	1960	Mal Neo Lymph-Head/Neck	Cancer - Metastatic
196	1961	Mal Neo Lymph-Intrathor	Cancer - Metastatic
196	1962	Mal Neo Lymph Intra-Abd	Cancer - Metastatic
196	1963	Mal Neo Lymph-Axilla/Arm	Cancer - Metastatic
196	1965	Mal Neo Lymph-Inguin/Leg	Cancer - Metastatic
196	1966	Mal Neo Lymph-Intrapelv	Cancer - Metastatic
196	1968	Mal Neo Lymph Node-Mult	Cancer - Metastatic
196	1969	Mal Neo Lymph Node Nos	Cancer - Metastatic
197	197	Secondary malignant neoplasm of respiratory and digestive systems	Cancer - Metastatic
197	1970	Secondary Malig Neo Lung	Cancer - Metastatic
197	1971	Sec Mal Neo Mediastinum	Cancer - Metastatic
197	1972	Second Malig Neo Pleura	Cancer - Metastatic
197	1973	Sec Malig Neo Resp Nec	Cancer - Metastatic
197	1974	Sec Malig Neo Sm Bowel	Cancer - Metastatic
197	1975	Sec Malig Neo Lg Bowel	Cancer - Metastatic
197	1976	Sec Mal Neo Peritoneum	Cancer - Metastatic
197	1977	Second Malig Neo Liver	Cancer - Metastatic
197	1978	Sec Mal Neo Gi Nec	Cancer - Metastatic
198	198	Secondary malignant neoplasm of other specified sites	Cancer - Metastatic
198	1980	Second Malig Neo Kidney	Cancer - Metastatic
198	1981	Sec Malig Neo Urin Nec	Cancer - Metastatic
198	1982	Secondary Malig Neo Skin	Cancer - Metastatic

3 Digit ICD-9	ICD 9 Codes	Description	Condition
198	1983	Sec Mal Neo Brain/Spine	Cancer - Metastatic
198	1984	Sec Malig Neo Nerve Nec	Cancer - Metastatic
198	1985	Secondary Malig Neo Bone	Cancer - Metastatic
198	1986	Second Malig Neo Ovary	Cancer - Metastatic
198	1987	Second Malig Neo Adrenal	Cancer - Metastatic
198	1988	Secondary malignant neoplasm of other specified sites	Cancer - Metastatic
198	19881	Second Malig Neo Breast	Cancer - Metastatic
198	19882	Second Malig Neo Genital	Cancer - Metastatic
198	19889	Secondary Malig Neo Nec	Cancer - Metastatic
199	199	Malignant neoplasm without specification of site	Cancer - Metastatic
199	1990	Malig Neo Disseminated	Cancer - Metastatic
199	1991	Malignant Neoplasm Nos	Cancer - Metastatic
199	1992	Malignant neoplasm associated with transplant organ	Cancer - Metastatic
233	2334	Ca In Situ Prostate	Cancer - Prostate Gland
185	185	Malignant neoplasm of prostate	Cancer - Prostate Gland
V10	V1046	Hx-Prostatic Malignancy	Cancer - Prostate Gland
491	491	Chronic bronchitis	Chronic Obstructive Pulmonary Disease
491	4910	Simple Chr Bronchitis	Chronic Obstructive Pulmonary Disease
491	4911	Mucopurul Chr Bronchitis	Chronic Obstructive Pulmonary Disease
491	4912	Obstructive chronic bronchitis	Chronic Obstructive Pulmonary Disease
491	49120	Obst Chr Bronc W/O Exac	Chronic Obstructive Pulmonary Disease
491	49121	Obs Chr Bronc W(Ac) Exac	Chronic Obstructive Pulmonary Disease
491	4918	Chronic Bronchitis Nec	Chronic Obstructive Pulmonary Disease
491	4919	Chronic Bronchitis Nos	Chronic Obstructive Pulmonary Disease
492	492	Emphysema	Chronic Obstructive Pulmonary Disease
492	4920	Emphysematous Bleb	Chronic Obstructive Pulmonary Disease
492	4928	Emphysema Nec	Chronic Obstructive Pulmonary Disease
493	4932	Chronic obstructive asthma	Chronic Obstructive Pulmonary Disease
493	49320	Chronic Obst Asthma Nos	Chronic Obstructive Pulmonary Disease
493	49321	Ch Ob Asthma W Stat Asth	Chronic Obstructive Pulmonary Disease
493	49322	Ch Obst Asth W (Ac) Exac	Chronic Obstructive Pulmonary Disease
496	496	Chronic airways obstruction, not elsewhere classified	Chronic Obstructive Pulmonary Disease
518	5181	Interstitial Emphysema	Chronic Obstructive Pulmonary Disease
402	40201	Mal Hypert Hrt Dis W Hf	Congestive Heart Failure
402	40211	Benign Hyp Ht Dis W Hf	Congestive Heart Failure
402	40291	Hyp Ht Dis Nos W Ht Fail	Congestive Heart Failure
428	428	Heart failure	Congestive Heart Failure
428	4280	Chf Nos	Congestive Heart Failure
428	4281	Left Heart Failure	Congestive Heart Failure
428	4282	Systolic heart failure	Congestive Heart Failure

3 Digit ICD-9	ICD 9 Codes	Description	Condition
428	42820	Systolic Hrt Failure Nos	Congestive Heart Failure
428	42821	Ac Systolic Hrt Failure	Congestive Heart Failure
428	42822	Chr Systolic Hrt Failure	Congestive Heart Failure
428	42823	Ac On Chr Syst Hrt Fail	Congestive Heart Failure
428	4283	Diastolic heart failure	Congestive Heart Failure
428	42830	Diastolc Hrt Failure Nos	Congestive Heart Failure
428	42831	Ac Diastolic Hrt Failure	Congestive Heart Failure
428	42832	Chr Diastolic Hrt Fail	Congestive Heart Failure
428	42833	Ac On Chr Diast Hrt Fail	Congestive Heart Failure
428	4284	Combined systolic and diastolic heart failure	Congestive Heart Failure
428	42840	Syst/Diast Hrt Fail Nos	Congestive Heart Failure
428	42841	Ac Syst/Diastol Hrt Fail	Congestive Heart Failure
428	42842	Chr Syst/Diastl Hrt Fail	Congestive Heart Failure
428	42843	Ac/Chr Syst/Dia Hrt Fail	Congestive Heart Failure
428	4289	Heart Failure Nos	Congestive Heart Failure
V08	V08	Asymptomatic human immunodeficiency virus [HIV] infection status	HIV / AIDS
795	79571	Nonspcf Serlgc Evdnc Hiv Retrovirus in conditions classified elsewhere and of unspecified site	HIV / AIDS
79	795	Hiv-2 Infection Oth Dis	HIV / AIDS
79	7953	Hiv-2 Infection Oth Dis	HIV / AIDS
572	5724	Hepatorenal Syndrome	Renal Failure
585	585	Chronic renal failure	Renal Failure
585	5851	Chro Kidney Dis Stage I	Renal Failure
585	5852	Chro Kidney Dis Stage Ii	Renal Failure
585	5853	Chr Kidney Dis Stage Iii	Renal Failure
585	5854	Chr Kidney Dis Stage Iv	Renal Failure
585	5855	Chron Kidney Dis Stage V	Renal Failure
585	5856	End Stage Renal Disease	Renal Failure
585	5859	Chronic Kidney Dis Nos	Renal Failure
V56	V56	Encounter for dialysis and dialysis catheter care	Renal Failure
V56	V560	Renal Dialysis Encounter	Renal Failure
V56	V561	Ft/Adj Xtrcorp Dial Cath	Renal Failure
V56	V562	Fit/Adj Perit Dial Cath	Renal Failure
V56	V5631	Hemodialysis Testing	Renal Failure
V56	V5632	Peritoneal Dialysis Test	Renal Failure
V56	V568	Dialysis Encounter, Nec	Renal Failure
792	7925	Cloudy Dialysis Effluent	Renal Failure
714	714	Rheumatoid arthritis and other inflammatory polyarthropathies	Rheumatoid Arthritis
714	7140	Rheumatoid Arthritis	Rheumatoid Arthritis
714	7141	Felty'S Syndrome	Rheumatoid Arthritis
714	7142	Syst Rheum Arthritis Nec	Rheumatoid Arthritis

3 Digit ICD-9	ICD 9 Codes	Description	Condition
714	7143	Juvenile chronic polyarthritis	Rheumatoid Arthritis
714	71430	Juv Rheum Arthritis Nos	Rheumatoid Arthritis
714	71431	Polyart Juv Rheum Arthr	Rheumatoid Arthritis
714	71432	Pauciar Juv Rheum Arthr	Rheumatoid Arthritis
714	71433	Monoart Juv Rheum Arthr	Rheumatoid Arthritis
714	7144	Chr Postrheum Arthritis	Rheumatoid Arthritis
714	7148	Other specified inflammatory polyarthropathies	Rheumatoid Arthritis
714	71481	Rheumatoid Lung	Rheumatoid Arthritis
714	71489	Inflamm Polyarthrop Nec	Rheumatoid Arthritis
714	7149	Inflamm Polyarthrop Nos	Rheumatoid Arthritis



DEPARTMENT OF

**Professional &  
Financial Regulation**

STATE OF MAINE

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

**COST REPORT OF PUBLIC LAW 2015, CHAPTER 488**  
*AN ACT TO PREVENT OPIATE ABUSE*  
*BY STRENGTHENING THE CONTROLLED SUBSTANCES*  
*PRESCRIPTION MONITORING PROGRAM*

PREPARED BY THE MAINE BUREAU OF INSURANCE  
JANUARY 2018

PAUL R. LEPAGE

GOVERNOR

ANNE L. HEAD

COMMISSIONER

ERIC A. CIOPPA

SUPERINTENDENT

## BACKGROUND

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In 2016, the Legislature enacted Public Law 2015, Chapter 488, “An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program.” This statute established limits on both the duration and dosage of prescriptions which health care providers may write for opioid medications. Section 38 tasks the Bureau of Insurance with studying the effects of this legislation on claims paid by health carriers and the out-of-pocket costs (coinsurance, copayments and deductibles) paid by policy holders and certificate holders:

***Sec. 38. Effect on out-of-pocket costs.*** *The Bureau of Insurance within the Department of Professional and Financial Regulation shall evaluate the effect of the limits on prescriptions for opioid medication established by this Act on the claims paid by health insurance carriers and the out-of-pocket costs, including copayments, coinsurance and deductibles, paid by individual and group health insurance policyholders. On or before January 1, 2018, the bureau shall submit a report on the evaluation, along with any recommended policy and regulatory options that will ensure costs for patients are not increased as a result of new prescribing limitations on the amounts of opioid medications, to the joint standing committees of the Legislature having jurisdiction over health and human services matters and over insurance and financial services matters. The joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out legislation related to the evaluation to the Second Regular Session of the 128th Legislature.*

Public Law Chapter 488 is attached as Appendix 1 of this report.

## PROCESS

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The Bureau held a stakeholder meeting on October 31, 2016 to determine the types of data to be reviewed to meet the requirements in the statute.

Prior to this meeting, the Bureau requested a copy of each insurance company’s policy on opioids and their derivatives for prescription allowances, including their formularies, and any formulary requirements, such as prescription limits and prior authorizations. This information was requested for individual, small group and large group fully-funded plans in Maine, and was utilized to determine which medications needed to be reported. Through this process, the Bureau determined that all carriers enforced quantity limits on chronic pain medications and required prior authorization for certain medications, and their formularies included abuse deterrent forms of the medications.

The stakeholder meeting included representatives from

- Aetna
- American Cancer Society/Maine Cancer Action Network
- Anthem
- CIGNA
- Community Health Options
- Consumers for Affordable Health Care

- Harvard Pilgrim Health Care
- Maine Health Data Organization
- Maine Medical Association
- Maine Quality Counts
- United Healthcare.

## MAINE HEALTH DATA ORGANIZATION DATA

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The Bureau and the stakeholders agreed that the Maine Health Data Organization's (MHDO) all-payer, all-claims database could provide a summary of total carrier members with opioid prescriptions, opioid claims, total carrier payments and total member payments. It was determined that the data for the full year of 2017 would not be available in time to analyze data for the purposes of this report. Information regarding the first two quarters of 2017 was not expected to be available until October 2017. Therefore, to provide a comparative analysis, only the first two quarters of 2016 were reviewed and used in this report. This data is available in Appendix 2.

The Federal Center for Disease Control (CDC) maintains a National Drug Code (NDC) file for Morphine Milliequivalents (MME's) with Opioids. Data from that file was also utilized in this report.<sup>1</sup>

Twenty-four companies submitted data for the first and second quarters of 2016 and 2017 for this report. Company information derived from pharmacy benefit managers, payers and third party administrators was utilized. A list of the companies is provided in Appendix 3.

Pursuant to Public Law 2015 Chapter 488, data analyzed in this report excludes data from Medicare and Medicaid. It further excludes the exceptions listed in Public Law 2015 Ch. 488, specifically:

*A. When prescribing opioid medication to a patient for:*

- (1) Pain associated with active and aftercare cancer treatment;*
- (2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;*
- (3) End-of-life and hospice care;*
- (4) Medication-assisted treatment for substance use disorder; or*
- (5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and*

*B. When directly ordering, or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility.*

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<sup>1</sup> Changes in the reporting to CDC or in the NDC's file could affect the data, as certain classes of opioids may have been missed in the gathering of the data.

The data is an aggregate of all carriers and all claims as provided by the Maine Health Data Organization (MHDO). However, the time for prescription claims to be submitted to carriers (run-off period) and subsequently reported to MHDO by carriers could differ due to differences in pharmacy settings; this could possibly affect the validity of the data. Quarter one of 2016 reflects a nine-month run-off. Quarter two of 2016 data had a six-month run-off. By contrast, because MHDO 2017 data is reported only through June 30, 2017, quarter one of 2017 data reflects only a three-month run-off and quarter two data has no run-off. Although 2017 data used in this report does not reflect late-submitted claims on the same basis as 2016 data, the Bureau’s judgment is that the effect of this variance on results is minimal because it is the Bureau’s experience that most pharmacies submit claims promptly.

## FINDINGS

Table 1 outlines the number of unduplicated members whose plans include pharmacy benefits, with prescription claims for each quarter (column 1), and with claims specifically for opioids and opioid derivatives (column 2). Overall, there were 1.5% fewer members with opioid prescription claims in the first half of 2017 compared to 2016.

<b>Table 1 – Pharmacy Members with Claims</b>			
	Pharmacy Members with All Types of Prescription Claims	Pharmacy members with Opioid Prescription Claims	Percentage of prescriptions for opioid medications
Quarter 1 2016	333,767	34,056	10.2%
Quarter 2 2016	302,495	29,727	9.8%
<b>Overall Q1 &amp; Q2 2016</b>	<b>393,434</b>	<b>51,253</b>	<b>13%</b>
Quarter 1 2017	300,359	26,512	8.8%
Quarter 2 2017	293,394	24,091	8.2%
<b>Overall Q1 &amp; Q2 2017</b>	<b>354,232</b>	<b>40,591</b>	<b>11.5%</b>

Table 2 compares opioid prescription claims by quarter. It shows an overall decrease in opioid prescription claims of 19.8%. This number could reflect many factors which would require prescriber clarification, but could include: providers weaning patients' dosages; adherence to prescription limits; or uses of alternative pain treatments, such as physical therapy, massage or other alternative treatments. Information about these potential factors is not available and would be difficult to measure.

<b>Table 2 - Counts of Opioid Claims</b>				
	2016	2017	Difference	Percentage
Q1	75,466	58,631	- 16,835	-22.4%
Q 2	64,300	53,389	-10,911	-17%
<b>Overall</b>	<b>139,754</b>	<b>112,015</b>	<b>-27,739</b>	<b>-19.8%</b>

Table 3 shows the amounts paid by the carriers and consumers for all opioid claims in the first two quarters of 2016 and 2017.

<b>Table 3 – Dollars Paid for Opioid Claims</b>			
	Total Carriers Paid	Total Members paid	Overall total
Q1 2016	\$2,811,997.42	\$923,758.74	\$3,735,756.16
Q2 2016	\$2,444,551.02	\$644,609.79	\$3,089,170.81
<b>Overall Q1 &amp; Q2 2016</b>	<b>\$5,256,548.44</b>	<b>\$1,568,368.53</b>	<b>\$6,824,916.97</b>
Q1 2017	\$1,452,072.35	\$555,736.52	\$2,007,808.87
Q2 2017	\$1,351,184.42	\$433,248.11	\$1,784,432.53
<b>Overall Q1 &amp; Q2 2017</b>	<b>\$2,803,256.77</b>	<b>\$988,984.63</b>	<b>\$3,792,241.40</b>

Table 4 compares the cost per year (based on the first two quarters of each year) of the cost paid out by insurance plans for opioid related claims. Carriers had an average cost of \$37.61 per opioid claim in the first two quarters of 2016 and \$25.03 per claim in the first two quarters of 2017. The variance in the cost may be a result of the prescription limits from 90 days to 30 days, but this cannot be determined based on the data used in this report.

<b>Table 4 – Dollars Spent by Payers for Opioid Claims</b>				
	2016	2017	Difference	Percentage
Q1 & Q2	\$5,256,548.44	\$2,803,256.77	\$2,453,291.67	-46.7%

Table 5 outlines the decrease in consumer cost-sharing of opioid related prescription costs (deductibles, copayments and coinsurance). As is the case with all the tables in this report, this data is an aggregate of all carriers and all claims as provided by the Maine Health Data Organization (MHDO). On average, consumers paid \$11.22 per claim in the first two quarters of 2016 and \$8.83 per claim in the first two quarters of 2017. Again, the variance in the cost may be a result of adherence to prescription limits from 90 days to 30 days, but that cannot be determined from data used for this report.

<b>Table 5 – Cost-sharing Dollars Spent by Members</b>				
	2016	2017	Difference	Percentage
Q1 & Q2	\$1,568,368.53	\$988,984.63	\$579,383.90	-36.9%

## CONCLUSIONS

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In summary, the Bureau’s analysis of the Maine Health Data Organization’s data for the first two quarters of 2016 and 2017 indicates the following:

- The number of members with prescriptions for opioids and opioid derivatives decreased from 51,253 in the first half of 2016 to 40,591 in the first half of 2017, a drop of over 10,000 members with these prescriptions.
- The number of prescription claims for opioids and opioid derivatives decreased 19.8%, with 27,739 fewer claims between the first half 2016 and the first half of 2017.
- Insurance carriers spent more than \$2.4 million less (46.7%) on opioid and opioid derivative claims in the first half of 2017 than in the first half of 2016.
- Plan members spent nearly \$580,000 less (36.9%) in cost-sharing for opioid and opioid derivative claims in the first half of 2017 than in the first half of 2016.

Because these findings indicate decreases in the number of claims, the dollars spent by carriers, and the cost-sharing paid by members, the Bureau does not have any recommendations regarding policy and regulatory options that will ensure that costs for patients are not increased as a result of new prescribing limitations on the amounts of opioid medications.

# APPENDICES

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## STATE OF MAINE

—  
IN THE YEAR OF OUR LORD  
TWO THOUSAND AND SIXTEEN

—  
S.P. 671 - L.D. 1646

**An Act To Prevent Opiate Abuse by Strengthening the Controlled  
Substances Prescription Monitoring Program**

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

**Sec. 1. 22 MRSA §7246, sub-§§1-A, 1-B and 1-C** are enacted to read:

**1-A. Acute pain.** "Acute pain" means pain that is the normal, predicted physiological response to a noxious chemical or thermal or mechanical stimulus. "Acute pain" typically is associated with invasive procedures, trauma and disease and is usually time-limited.

**1-B. Administer.** "Administer" means an action to apply a prescription drug directly to a person by any means by a licensed or certified health care professional acting within that professional's scope of practice. "Administer" does not include the delivery, dispensing or distribution of a prescription drug for later use.

**1-C. Chronic pain.** "Chronic pain" means pain that persists beyond the usual course of an acute disease or healing of an injury. "Chronic pain" may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

**Sec. 2. 22 MRSA §7246, sub-§5,** as enacted by PL 2003, c. 483, §1, is amended to read:

**5. Prescriber.** "Prescriber" means a licensed health care professional with authority to prescribe controlled substances and a veterinarian licensed under Title 32, chapter 71-A with authority to prescribe controlled substances.

**Sec. 3. 22 MRSA §7249, sub-§4,** as enacted by PL 2003, c. 483, §1, is amended to read:

**4. Immunity from liability.** A dispenser or prescriber is immune from liability for disclosure of information if the disclosure was made pursuant to and in accordance with this chapter.

**Sec. 4. 22 MRSA §7250, sub-§4, ¶G**, as amended by PL 2011, c. 657, Pt. O, §3, is further amended to read:

G. The office that administers the MaineCare program pursuant to chapter 855 for the purposes of managing the care of its members, monitoring the purchase of controlled substances by its members, avoiding duplicate dispensing of controlled substances and providing treatment pattern data under subsection 6; ~~and~~

**Sec. 5. 22 MRSA §7250, sub-§4, ¶H**, as enacted by PL 2011, c. 218, §3, is amended to read:

H. Another state or a Canadian province pursuant to subsection 4-A;

**Sec. 6. 22 MRSA §7250, sub-§4, ¶¶I and J** are enacted to read:

I. Staff members of a licensed hospital who are authorized by the chief medical officer of the hospital, insofar as the information relates to a patient receiving care in the hospital's emergency department or receiving inpatient services from the hospital;  
and

J. Staff members of a pharmacist who are authorized by the pharmacist on duty, insofar as the information relates to a customer seeking to have a prescription filled.

**Sec. 7. 22 MRSA §7250, sub-§4-A**, as amended by PL 2011, c. 657, Pt. AA, §69, is further amended to read:

**4-A. Information sharing with other states and Canadian provinces.** The department may provide prescription monitoring information to and receive prescription monitoring information from another state or a Canadian province that has prescription monitoring information provisions consistent with this chapter and has entered into a prescription monitoring information sharing agreement with the department. The department may enter into a prescription monitoring information sharing agreement with another state or a Canadian province to establish the terms and conditions of prescription monitoring information sharing and interoperability of information systems and to carry out the purposes of this subsection. For purposes of this subsection, "another state" means any state other than Maine and any territory or possession of the United States, but does not include a foreign country.

**Sec. 8. 22 MRSA §7251, sub-§1**, as amended by PL 2011, c. 657, Pt. AA, §70, is further amended to read:

**1. Failure to submit information.** A dispenser who knowingly fails to submit prescription monitoring information to the department as required by this chapter commits a civil violation for which a fine of \$250 per incident, not to exceed \$5,000 per calendar year, may be adjudged and is subject to discipline by the Maine Board of Pharmacy pursuant to Title 32, chapter 117, subchapter 4 or by the applicable professional licensing entity.

**Sec. 9. 22 MRSA §§7253 and 7254** are enacted to read:

**§7253. Prescribers and dispensers required to check prescription monitoring information**

**1. Prescribers.** On or after January 1, 2017, upon initial prescription of a benzodiazepine or an opioid medication to a person and every 90 days for as long as that prescription is renewed, a prescriber shall check prescription monitoring information for records related to that person.

**2. Dispensers.** On or after January 1, 2017, a dispenser shall check prescription monitoring information prior to dispensing a benzodiazepine or an opioid medication to a person under any of the following circumstances:

- A. The person is not a resident of this State;
- B. The prescription is from a prescriber with an address outside of this State;
- C. The person is paying cash when the person has prescription insurance on file; or
- D. According to the pharmacy prescription record, the person has not had a prescription for a benzodiazepine or an opioid medication in the previous 12-month period.

A dispenser shall notify the program and withhold a prescription until the dispenser is able to contact the prescriber of that prescription if the dispenser has reason to believe that the prescription is fraudulent or duplicative.

**3. Exception; hospital setting and facilities.** When a licensed or certified health care professional directly orders or administers a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility, the requirements to check prescription monitoring information established in this section do not apply.

**4. Violation.** A person who violates this section commits a civil violation for which a fine of \$250 per incident, not to exceed \$5,000 per calendar year, may be adjudged.

**5. Rulemaking.** Notwithstanding section 7252, the department may adopt routine technical rules as defined in Title 5, chapter 375, subchapter 2-A to implement this section.

**§7254. Exemption from opioid medication limits until January 2017; rulemaking**

**1. Exemption until January 2017.** In addition to the exceptions established in Title 32, section 2210, subsection 2; section 2600-C, subsection 2; section 3300-F, subsection 2; section 3657, subsection 2; and section 18308, subsection 2, a licensed health care professional may prescribe opioid medication in an amount greater than the morphine milligram equivalents limited by Title 32, sections 2210, 2600-C, 3300-F, 3657 and 18308 as long as it is medically necessary and the need is documented in the patient's chart.

This subsection is repealed January 1, 2017 or on the effective date of the rules establishing exceptions to prescriber limits as provided in subsection 2, whichever is later. The Commissioner of Health and Human Services shall notify the Secretary of

State, Secretary of the Senate, Clerk of the House of Representatives and Revisor of Statutes of this effective date when this effective date is determined.

**2. Rulemaking.** Notwithstanding section 7252, no later than January 1, 2017, the department shall adopt routine technical rules as defined in Title 5, chapter 375, subchapter 2-A to establish reasonable exceptions to prescriber limits in Title 32, sections 2210, 2600-C, 3300-F, 3657 and 18308, including for chronic pain and acute pain. The rules must take into account clinically appropriate exceptions and include prescribers in the rule-making process including the drafting of draft rules and changes after the public hearing process to the extent permitted by Title 5, chapter 375.

**Sec. 10. 32 MRSA §2105-A, sub-§2, ¶H,** as amended by PL 1993, c. 600, Pt. A, §116, is further amended to read:

H. A violation of this chapter or a rule adopted by the board; ~~or~~

**Sec. 11. 32 MRSA §2105-A, sub-§2, ¶I,** as enacted by PL 1983, c. 378, §21, is amended to read:

I. Engaging in false, misleading or deceptive advertising; ~~or~~

**Sec. 12. 32 MRSA §2105-A, sub-§2, ¶J** is enacted to read:

J. Failure to comply with the requirements of Title 22, section 7253.

**Sec. 13. 32 MRSA §2210** is enacted to read:

**§2210. Requirements regarding prescription of opioid medication**

**1. Limits on opioid medication prescribing.** Except as provided in subsection 2, an individual licensed under this chapter whose scope of practice includes prescribing opioid medication may not prescribe:

A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day;

B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day;

C. On or after January 1, 2017, within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. "Chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or

D. On or after January 1, 2017, within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain. "Acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A.

**2. Exceptions.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:

(1) Pain associated with active and aftercare cancer treatment;

(2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;

(3) End-of-life and hospice care;

(4) Medication-assisted treatment for substance use disorder; or

(5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B.

**3. Electronic prescribing.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication and who has the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver for circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

**4. Continuing education.** By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication as a condition of prescribing opioid medication. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**5. Penalties.** An individual who violates this section commits a civil violation for which a fine of \$250 per violation, not to exceed \$5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

**Sec. 14. 32 MRSA §2591-A, sub-§2, ¶M,** as amended by PL 1997, c. 680, Pt. B, §6, is further amended to read:

M. Failure to comply with the requirements of Title 24, section 2905-A; ¶

**Sec. 15. 32 MRSA §2591-A, sub-§2, ¶N**, as enacted by PL 1997, c. 680, Pt. B, §7, is amended to read:

N. Revocation, suspension or restriction of a license to practice medicine or other disciplinary action; denial of an application for a license; or surrender of a license to practice medicine following the institution of disciplinary action by another state or a territory of the United States or a foreign country if the conduct resulting in the disciplinary or other action involving the license would, if committed in this State, constitute grounds for discipline under the laws or rules of this State; or

**Sec. 16. 32 MRSA §2591-A, sub-§2, ¶O** is enacted to read:

O. Failure to comply with the requirements of Title 22, section 7253.

**Sec. 17. 32 MRSA §2600-C** is enacted to read:

**§2600-C. Requirements regarding prescription of opioid medication**

**1. Limits on opioid medication prescribing.** Except as provided in subsection 2, an individual licensed under this chapter whose scope of practice includes prescribing opioid medication may not prescribe:

A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day;

B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day;

C. On or after January 1, 2017, within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. For purposes of this paragraph, "chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or

D. On or after January 1, 2017, within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain. For purposes of this paragraph, "acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A.

**2. Exceptions.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:

(1) Pain associated with active and aftercare cancer treatment;

(2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;

(3) End-of-life and hospice care;

(4) Medication-assisted treatment for substance use disorder; or

(5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B.

**3. Electronic prescribing.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication and who has the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver for circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

**4. Continuing education.** By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication as a condition of prescribing opioid medication. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**5. Penalties.** An individual who violates this section commits a civil violation for which a fine of \$250 per violation, not to exceed \$5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

**Sec. 18. 32 MRSA §3282-A, sub-§2, ¶¶Q and R,** as enacted by PL 2013, c. 355, §12, are amended to read:

Q. Failure to produce upon request of the board any documents in the licensee's possession or under the licensee's control concerning a pending complaint or proceeding or any matter under investigation by the board, unless otherwise prohibited by state or federal law; ~~or~~

R. Failure to timely respond to a complaint notification sent by the board; ~~or~~

**Sec. 19. 32 MRSA §3282-A, sub-§2, ¶S** is enacted to read:

S. Failure to comply with the requirements of Title 22, section 7253.

Sec. 20. 32 MRSA §3300-F is enacted to read:

**§3300-F. Requirements regarding prescription of opioid medication**

**1. Limits on opioid medication prescribing.** Except as provided in subsection 2, an individual licensed under this chapter and whose scope of practice includes prescribing opioid medication may not prescribe:

A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day;

B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day;

C. On or after January 1, 2017, within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. "Chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or

D. On or after January 1, 2017, within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain. "Acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A.

**2. Exceptions.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:

(1) Pain associated with active and aftercare cancer treatment;

(2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;

(3) End-of-life and hospice care;

(4) Medication-assisted treatment for substance use disorder; or

(5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B.

**3. Electronic prescribing.** An individual licensed under this chapter and whose scope of practice includes prescribing opioid medication with the capability to

electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure, and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver including circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

**4. Continuing education.** By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication as a condition of prescribing opioid medication. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**5. Penalties.** An individual who violates this section commits a civil violation for which a fine of \$250 per violation, not to exceed \$5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

**Sec. 21. 32 MRSA §3656, sub-§§3 and 4,** as enacted by PL 2007, c. 402, Pt. P, §14, are amended to read:

**3. False advertising.** Engaging in false, misleading or deceptive advertising; ~~or~~

**4. Unlawful prescription of controlled substance.** Prescribing narcotic or hypnotic or other drugs listed as controlled substances by the federal Drug Enforcement Administration for other than accepted therapeutic purposes; ~~or~~

**Sec. 22. 32 MRSA §3656, sub-§5** is enacted to read:

**5. Controlled Substances Prescription Monitoring Program.** Failure to comply with the requirements of Title 22, section 7253.

**Sec. 23. 32 MRSA §3657** is enacted to read:

**§3657. Requirements regarding prescription of opioid medication**

**1. Limits on opioid medication prescribing.** Except as provided in subsection 2, an individual licensed under this chapter and whose scope of practice includes prescribing opioid medication may not prescribe:

A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day;

B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount

of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day;

C. On or after January 1, 2017, within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. "Chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or

D. On or after January 1, 2017, within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain. "Acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A.

**2. Exceptions.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:

(1) Pain associated with active and aftercare cancer treatment;

(2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;

(3) End-of-life and hospice care;

(4) Medication-assisted treatment for substance use disorder; or

(5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B.

**3. Electronic prescribing.** An individual licensed under this chapter and whose scope of practice includes prescribing opioid medication with the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure, and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver including circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

**4. Continuing education.** By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication as a condition of prescribing opioid medication. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

5. Penalties. An individual who violates this section commits a civil violation for which a fine of \$250 per violation, not to exceed \$5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

**Sec. 24. 32 MRSA §4864, sub-§12, ¶D,** as amended by PL 2007, c. 402, Pt. R, §8, is further amended to read:

D. The continuance of a veterinarian directly or indirectly in the employ of or in association with any veterinarian after knowledge that such veterinarian is engaged in the violation of the provisions of this chapter; ~~or~~

**Sec. 25. 32 MRSA §4864, sub-§13,** as amended by PL 2007, c. 402, Pt. R, §8, is further amended to read:

**13. Lack of sanitation.** Failure to maintain veterinary premises and equipment in a clean and sanitary condition as defined by the board in accordance with the sanitation provisions included in Title 7, section 3936; or

**Sec. 26. 32 MRSA §4864, sub-§15** is enacted to read:

**15. Controlled Substances Prescription Monitoring Program.** Failure to comply with the requirements of Title 22, section 7253.

**Sec. 27. 32 MRSA §4878** is enacted to read:

**§4878. Requirements regarding prescription of opioid medication**

**1. Limits on opioid medication prescribing.** A veterinarian licensed under this chapter whose scope of practice includes prescribing opioid medication to an animal is subject to the requirements of the Controlled Substances Prescription Monitoring Program established under Title 22, chapter 1603, except that Title 22, section 7254 does not apply.

**2. Electronic prescribing.** A veterinarian licensed under this chapter whose scope of practice includes prescribing opioid medication and who has the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. A veterinarian who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver for circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

**3. Continuing education.** By December 31, 2017, a veterinarian who prescribes opioid medication must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication as a condition of prescribing opioid medication. The board shall adopt rules to implement this subsection. Rules adopted

pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

4. Penalties. A veterinarian who violates this section commits a civil violation for which a fine of \$250 per violation, not to exceed \$5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

**Sec. 28. 32 MRSA §13702-A, sub-§20-A** is enacted to read:

20-A. Opioid medication. "Opioid medication" means a controlled substance containing an opioid included in schedule II of 21 United States Code, Section 812 or 21 Code of Federal Regulations, Part 1308.

**Sec. 29. 32 MRSA §13756** is enacted to read:

**§13756. Electronic prescribing of opioid medication**

By July 1, 2017, a pharmacy must have the capability to process electronic prescriptions from prescribers for an opioid medication or request a waiver from the Commissioner of Health and Human Services stating the reasons for the waiver including but not limited to a lack of capability, the availability of broadband infrastructure and a plan for developing the ability to receive electronically prescribed opioid medication. The commissioner may grant a waiver for circumstances in which exceptions are appropriate, including technological failures.

**Sec. 30. 32 MRSA §13786-B** is enacted to read:

**§13786-B. Partial dispensing of prescription for opioid medication**

1. Partial dispensing authorized. Notwithstanding any law or rule to the contrary, a pharmacist may partially dispense a prescription for an opioid medication in a lesser quantity than the recommended full quantity indicated on the prescription if requested by the patient for whom the prescription is written. The remaining quantity of the prescription in excess of the recommended full quantity is void and may not be dispensed without a new prescription.

2. Notice to practitioner. If a pharmacist partially dispenses a prescription for an opioid medication as permitted under this section, the pharmacist or the pharmacist's designee shall, within a reasonable time following the partial dispensing but not more than 7 days, notify the practitioner of the quantity of the opioid medication actually dispensed. The notice may be conveyed by a notation on the patient's electronic health record or by electronic transmission, by facsimile or by telephone to the practitioner.

**Sec. 31. 32 MRSA §13786-C** is enacted to read:

**§13786-C. Dispensing of prescription of opioid medication; immunity**

A pharmacist who dispenses opioid medication in good faith is immune from any civil liability that might otherwise result from dispensing medication in excess of the

limit established in section 2210, subsection 1, paragraphs A and B; section 2600-C, subsection 1, paragraphs A and B; section 3300-F, subsection 1, paragraphs A and B; section 3657, subsection 1, paragraphs A and B; or section 18308, subsection 1, paragraphs A and B, if the medication was dispensed in accordance with a prescription issued by a practitioner. In a proceeding regarding immunity from liability, there is a rebuttable presumption of good faith.

**Sec. 32. 32 MRSA §18308** is enacted to read:

**§18308. Requirements regarding prescription of opioid medication**

**1. Limits on opioid medication prescribing.** Except as provided in subsection 2, an individual licensed under this chapter whose scope of practice includes prescribing opioid medication may not prescribe:

A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day;

B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day;

C. On or after January 1, 2017, within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. For purposes of this paragraph, "chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or

D. On or after January 1, 2017, within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain. For purposes of this paragraph, "acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A.

**2. Exceptions.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:

(1) Pain associated with active and aftercare cancer treatment;

(2) Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;

(3) End-of-life and hospice care;

(4) Medication-assisted treatment for substance use disorder; or

(5) Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B.

**3. Electronic prescribing.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication and who has the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver for circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.

**4. Continuing education.** By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication as a condition of prescribing opioid medication. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**5. Penalties.** An individual who violates this section commits a civil violation for which a fine of \$250 per violation, not to exceed \$5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.

**Sec. 33. 32 MRSA §18325, sub-§1, ¶¶N and O**, as enacted by PL 2015, c. 429, §21, are amended to read:

N. Any violation of a requirement imposed pursuant to section 18352; ~~and~~

O. A violation of this chapter or a rule adopted by the board; ~~and~~

**Sec. 34. 32 MRSA §18325, sub-§1, ¶P** is enacted to read:

P. Failure to comply with the requirements of Title 22, section 7253.

**Sec. 35. Department of Health and Human Services to amend rules to require registration of pharmacists; automatic enrollment.** The Department of Health and Human Services shall amend its rules governing the Controlled Substances Prescription Monitoring Program under the Maine Revised Statutes, Title 22, chapter 1603 no later than January 1, 2017 to require pharmacists to register as data requesters. The enrollment mechanism for pharmacists who are registering with the program or renewing registration must be automatic when applying for or renewing a professional

license in the same manner as it is for prescribers who are health care professionals with authority to prescribe controlled substances.

**Sec. 36. Department of Health and Human Services to amend rules to require registration of veterinarians; automatic enrollment.** The Department of Health and Human Services shall amend its rules governing the Controlled Substances Prescription Monitoring Program under the Maine Revised Statutes, Title 22, chapter 1603 no later than January 1, 2017 to require veterinarians to register as data requesters. The enrollment mechanism for veterinarians who are registering with the program or renewing registration must be automatic when applying for or renewing a professional license in the same manner as it is for prescribers who are health care professionals with authority to prescribe controlled substances.

**Sec. 37. Enhancements to the Controlled Substances Prescription Monitoring Program.** The Department of Health and Human Services shall include in its request for proposals process under the Maine Revised Statutes, Title 22, section 7248, subsection 2 the following enhancements to the Controlled Substances Prescription Monitoring Program under Title 22, chapter 1603:

1. A mechanism or calculator for converting dosages to and from morphine milligram equivalents;
2. A mechanism to automatically transmit de-identified peer data on an annual basis to prescribers of opioid medication;
3. Allowance for a broader authorization for staff members of prescribers to access the program including a single annual authorization for staff members at a licensed hospital and a pharmacy;
4. Improvements in communication regarding the ability of a prescriber to authorize staff members to access the program on behalf of the prescriber;
5. Improvements in communication regarding the ability of a pharmacist to authorize staff members to access the program on behalf of the pharmacist;
6. Improvements in the speed of the program for prescribers and pharmacists required to submit information and check the program, and the ability for prescribers and pharmacists to tailor the functions of the program to fit into the workflow of the prescribers and pharmacists required to access the program; and
7. The establishment of a data modifier for information from a veterinarian prescribing opioid medication to an animal that differentiates the recipient of the opioid prescription from people.

Notwithstanding the Title 32, section 2210, subsection 5; section 2600-C, subsection 5; section 3300-F, subsection 5; section 3657, subsection 5; and section 18308, subsection 5, a penalty may not be imposed for a violation of the limits on opioid prescribing in Title 32, section 2210, subsection 1; section 2600-C, subsection 1; section 3300-F, subsection 1; section 3657, subsection 1; or section 18308, subsection 1 until the

enhancement to the Controlled Substances Prescription Monitoring Program described in subsection 1 is implemented.

**Sec. 38. Effect on out-of-pocket costs.** The Bureau of Insurance within the Department of Professional and Financial Regulation shall evaluate the effect of the limits on prescriptions for opioid medication established by this Act on the claims paid by health insurance carriers and the out-of-pocket costs, including copayments, coinsurance and deductibles, paid by individual and group health insurance policyholders. On or before January 1, 2018, the bureau shall submit a report on the evaluation, along with any recommended policy and regulatory options that will ensure costs for patients are not increased as a result of new prescribing limitations on the amounts of opioid medications, to the joint standing committees of the Legislature having jurisdiction over health and human services matters and over insurance and financial services matters. The joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out legislation related to the evaluation to the Second Regular Session of the 128th Legislature.

**Sec. 39. Department of Health and Human Services implementation report.** The Department of Health and Human Services shall report to the joint standing committees of the Legislature having jurisdiction over health and human services matters and over occupational and professional regulation matters, no later than January 31, 2018, with progress on implementing the provisions of this Act. The report must contain information on the following:

1. Registration of prescribers and dispensers in the Controlled Substances Prescription Monitoring Program under the Maine Revised Statutes, Title 22, chapter 1603;
2. Data regarding the checking and using of the Controlled Substances Prescription Monitoring Program by data requesters;
3. Data from professional boards regarding the implementation of continuing education requirements for prescribers of opioid medication;
4. Effects on the prescriber workforce;
5. Changes in the numbers of patients taking more than 100 morphine milligram equivalents of opioid medication per day;
6. Data regarding the total number of opioid medication pills prescribed;
7. Progress on electronic prescribing of opioid medication; and
8. Improvements to the Controlled Substances Prescription Monitoring Program through the request for proposals process including feedback from prescribers and dispensers on those improvements.

	A	B	C	D	E	F	G
1	<b>APPENDIX 2</b>						
2							
3	MHDO Data Request #811165 - Maine Bureau of Insurance						
4	Instance Number 2017041401						
5	Opioid Rx Summary Ad Hoc						
6							
7							
8	<b>Table 1 Opioid Prescription Summary</b>						
9							
10		<b>Unduplicated Count of Pharmacy Members with Rx Claims</b>	<b>Unduplicated Count of Pharmacy Members w/ Opioid Rx</b>	<b>Unduplicated Count of Opioid Rx Claims</b>	<b>Unduplicated Count of Opioid Scripts</b>	<b>Total Plan Paid</b>	<b>Total Member Paid</b>
11	Q1 2016	337,767	34,056	75,466	75,545	\$2,811,997.42	\$923,758.74
12	Q2 2016	302,495	29,727	64,300	64,302	\$2,444,551.02	\$644,609.79
13	<b>Overall Q1 &amp; 2 2016</b>	<b>393,434</b>	<b>51,253</b>	<b>139,754</b>	<b>139,835</b>	<b>\$5,256,548.44</b>	<b>\$1,568,368.53</b>
14	Q1 2017	300,359	26,512	58,631	58,633	\$1,452,072.35	\$555,736.52
15	Q2 2017	293,394	24,091	53,389	53,389	\$1,351,184.42	\$433,248.11
16	<b>Overall Q1 &amp; 2 2017</b>	<b>354,232</b>	<b>40,591</b>	<b>112,015</b>	<b>112,018</b>	<b>\$2,803,256.77</b>	<b>\$988,984.63</b>
17	<b>Overall Total</b>	<b>494,524</b>	<b>78,856</b>	<b>252,130</b>	<b>252,214</b>	<b>\$8,059,805.21</b>	<b>\$2,557,353.16</b>
18							
19	Notes: Q1 2016 included 9 months runout. Q2 2016 included 6 months runout. Q1 2017 included 3 months runout. Q2 2017 included no runout. 2016 data were not updated from original report.						

## Appendix 3

### **Payer Names w/ Opioid Rx Claims**

Aetna Health Inc

Aetna Health Inc

Aetna Life Insurance Company

American Health Care Administrative Services Inc

Anthem Health Plans of Maine Inc

CaremarkPCS Health LLC

Cigna Health and Life Insurance Company

Cigna Health and Life Insurance Company

Comprehensive Benefits Administrator Inc

EBPA Benefits, LLC

Envision Pharmaceutical Services, LLC

Express Scripts Administrators, LLC

Geisinger Indemnity Insurance Company

Harvard Pilgrim Health Care

Harvard Pilgrim Insurance Company

Health Care Service Corporation

Health Care Service Corporation

Humana Insurance Company

Maine Community Health Options

OptumRx, Inc.

Prime Therapeutics LLC

UMR Inc

UnitedHealthcare Insurance Company

UnitedHealthcare Services Inc

## STATE OF MAINE

—  
 IN THE YEAR OF OUR LORD  
 TWO THOUSAND AND SEVENTEEN

—  
 S.P. 221 - L.D. 659

**An Act To Amend the Maine Guaranteed Access Reinsurance Association Act**

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

**Sec. 1. 24-A MRSA §3953, sub-§1**, as amended by PL 2015, c. 404, §1, is further amended to read:

**1. Guaranteed access reinsurance mechanism established.** The Maine Guaranteed Access Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business in the State, an insurer that has issued or administered medical insurance within the previous 12 months or is actively marketing a medical insurance policy or medical insurance administrative services in this State must participate in the association. The Dirigo Health Program established in chapter 87 and any other state-sponsored health benefit program shall also participate in the association. ~~Except as provided in section 3962~~ Unless an earlier resumption of operations is ordered by the superintendent in accordance with paragraph A, operations of the association are suspended until December 31, 2023 except to the extent provided in section 3962 and the association may not collect assessments as provided in section 3957, provide reinsurance for member insurers under section 3958 or provide reimbursement for member insurers under section 3961 as of the date on which a transitional reinsurance program established under the authority of Section 1341 of the federal Affordable Care Act commences operations in this State until December 31, 2017.

A. If the board proposes a revised plan of operation that calls for the resumption of operations earlier than December 31, 2023 and the superintendent determines that the revised plan is likely to provide significant benefit to the State's health insurance market, the superintendent may order the association to resume operations in accordance with the revised plan. This paragraph applies only if:

- (1) An innovation waiver under Section 1332 of the federal Affordable Care Act as contemplated by paragraphs B and C is granted; or
- (2) The federal Affordable Care Act is repealed or amended in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.

B. After consulting with the board and receiving public comment, the superintendent may develop a proposal for an innovation waiver under Section 1332 of the federal Affordable Care Act that facilitates the resumption of operations of the association in a manner that prevents or minimizes the loss of federal funding to support the affordability of health insurance in the State.

C. With the approval of the Governor, the superintendent may submit an application on behalf of the State in accordance with the proposal developed under paragraph B for the purposes of resuming operations of the association to the United States Department of Health and Human Services and to the United States Secretary of the Treasury to waive certain provisions of the federal Affordable Care Act as provided in Section 1332. The superintendent may implement any federally approved waiver.



## **Notice of Public Comment Period and Information Meetings**

### **Application for a State Innovation Waiver to Stabilize Maine's Individual Health Insurance Market and Reduce Premiums for Individual Consumers**

The Maine Bureau of Insurance will conduct public information meetings and accept public comments on a proposal for a Section 1332 State Innovation Waiver application to the U.S. Department of Health and Human Services to support the reactivation of the Maine Guaranteed Access Reinsurance Association (MGARA).

#### **Background Summary**

Section 1332 of the federal Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue innovative strategies to provide its residents with access to high-quality, affordable health insurance.

MGARA, pursuant to 2011 legislative authorization, had active operations in Maine in 2012-13. It provided reinsurance to the individual health insurance market which allowed premiums for that market to remain lower than they otherwise would have been. MGARA was funded by reinsurance premiums paid by health insurers as well as by a \$4 per member per month assessment across all segments of the health insurance market. Active operations were suspended in 2014 due to an analogous federal transitional reinsurance program which has since terminated.

In 2017, the Maine Legislature enacted a law that allows MGARA to resume operations, upon approval of the Superintendent of Insurance, however resumption is conditioned on the granting of a Section 1332 innovation waiver.

Under the proposed waiver application, savings to the federal government as a result of MGARA's operation would be returned to the State for the purpose of allowing MGARA to provide further premium relief to the individual market. The waiver application is required to be revenue neutral to the federal government.

More detailed information regarding the proposed waiver application may be viewed at the Maine Bureau of Insurance website. [www.maine.gov/pfr/insurance/mgara/index.html](http://www.maine.gov/pfr/insurance/mgara/index.html). Copies of this information will also be available at the public information meetings.

## **Public Information Meetings**

Public information meetings will include a presentation about the proposed waiver application, followed by a time for questions and comments. Comments at the meeting may be submitted orally or in writing. The meeting dates, times and locations are as follows:

April 12, 2018, 5:00 p.m. to 7:00 p.m.  
Board Room, Husson University, 1 College Circle, Bangor, Maine

April 13, 2018, 5:00 p.m. to 7:00 p.m.  
Room 213, Abromson Community Education Center, 88 Bedford St., Portland, Maine

Persons in need of auxiliary aid for effective participation in the meetings are invited to contact Karma Lombard at (207) 624-8540 or by email at [karma.y.lombard@maine.gov](mailto:karma.y.lombard@maine.gov) .

## **Public Comments**

Written comments will also be accepted by email to [karma.y.lombard@maine.gov](mailto:karma.y.lombard@maine.gov) or by mail to Maine Bureau of Insurance, 34 State House Station, Augusta, ME 04333-0034, ATTN: 1332 Proposed Waiver Application until 5:00 p.m. on May 2, 2018.



DEPARTMENT OF

# Professional & Financial Regulation

STATE OF MAINE

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

## ACA Section 1332 Waiver Innovation Application

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Maine Bureau of Insurance

APRIL 2018

ACA Section  
1332  
*What is It?*

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Allows states to apply to the US DHHS for “state innovation waivers” of ACA provisions.

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Encourages state-by-state strategies to improve patient access to care, increase affordability of coverage and choices offered, and improved market stability.

Key Section  
1332  
Requirements

Scope of Coverage –

- Will facilitate coverage for at least a comparable number of persons as without the waiver.

Affordability –

- Will not decrease existing coverage or cost-sharing protections and will not result in a decrease in coverage affordability.

Key Section  
1332  
Requirements  
(cont.)

Comprehensive Coverage –

- May not alter required scope of benefits offered in market and may not decrease the number of persons with coverage providing ACA Essential Health Benefits.

Federal Budget Neutrality –

- Must not increase the federal deficit.

## Preservation of Federal Support

Budget neutrality works both ways. Section 1332 provides that innovation waivers can't increase the cost to the federal government, but won't reduce it either.

States with approved Section 1332 innovation waivers receive "pass-through" funding to recover premium subsidies or other federal support they would otherwise lose by operating the state program.

Pass-through funding allows state and federal resources to be combined, rather than penalizing the state by reducing the federal contribution.

# Leveraging the Maine Guaranteed Access Reinsurance Association (MGARA) using a Section 1332 Waiver

Authorized by 2011 PL c. 90

Purpose –

- To stabilize and reduce premiums in individual health insurance market by providing reinsurance to insurers in that market.

Funding –

- Reinsurance premiums paid by carriers ceding coverage to MGARA and by \$4 per person per month assessment on all market segments.

No Effect on Insureds –

- Ceding of coverage does not affect individual insured's coverage in any way.

# MGARA Results

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During 18 months of operation in 2012-13 MGARA:

- Collected about \$26.3 million in premium and \$41.2 million in assessments
- Paid about \$66 million in reinsured health insurance claims
- Kept premium increases about 20% lower than they otherwise would have been

Federal  
Transitional  
Reinsurance  
Program

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ACA provided a national transitional reinsurance program which operated from 2014-16.

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Due to substantial overlap between the federal and state programs, MGARA's active operations were suspended effective January 1, 2014.

---

Authorizes MGARA's reactivation  
subject to a successful application  
to the federal government for a  
Section 1332 innovation waiver.

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A Section 1332 Innovation Waiver  
is necessary because ...

2017 Public  
Law c. 124

## Need for an Innovation Waiver

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Federal Premium Tax Credits (PTCs) currently subsidize persons in the individual market with income from 100% to 400% of the federal poverty level. Nearly 80% of Mainers insured in the individual market are in this demographic.

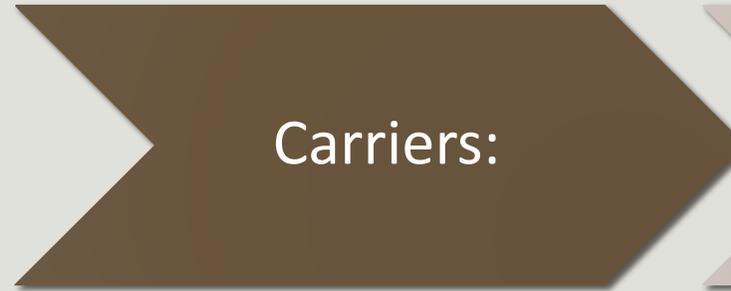
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The PTC program caps the net premiums paid by those persons on a sliding scale based on income. This means that when premiums decrease, federal support for Mainers receiving PTC assistance is reduced dollar-for-dollar.

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Therefore, absent a waiver, state efforts to utilize MGARA to stabilize the market and reduce premiums would primarily benefit the federal government, not Maine's insurance consumers.

# Maine's Individual Market - 2018



- Only 2 carriers currently selling on the Exchange
- 1 additional carrier has coverage available only off Exchange



- Approximately 80,000 enrollees in individual market
- Approximately 76,000 enrolled through the Exchange
- Approximately 65,000 eligible for premium tax credits

# Who Buys Insurance in the Individual Market

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Non-Medicare-eligible retirees

Individuals not eligible for group coverage

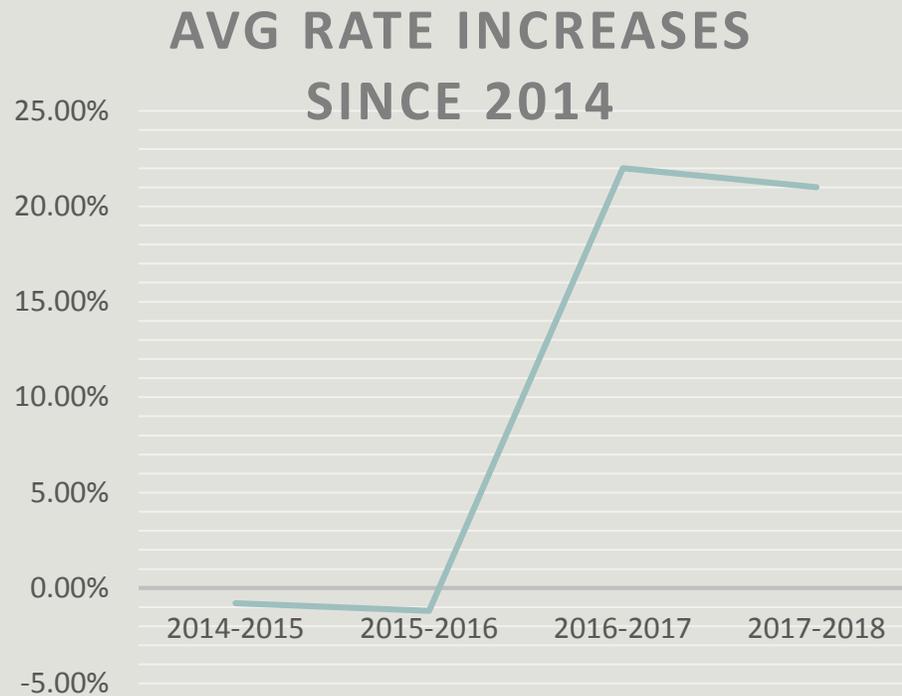
- Sole proprietors with no employees
- Part-time workers
- Contract employees
- No group coverage offered

# Rates are Increasing

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## Average rate increases since 2014:

- 2014-15 -0.8%
- 2015-16 -1.2%
- 2016-17 22%
- 2017-18 21%



# Rate Increase Impact on Consumers

Many individual  
market  
consumers are  
insulated from  
rate increases

- Federal tax credits are available to individuals with income up to 400%FPL
- 85% (2018) On-Exchange consumers eligible to access federal tax credits to offset their premium expenses
- For these people, rate increases result in higher federal tax credit amounts, not increased consumer costs

Other individual  
market  
consumers  
experience  
significant rate  
increases

- Incomes over 400% FPL
- Coverage purchased off-Exchange

# The Proposal

Maine to apply for a  
“Section 1332 State  
Innovation Waiver”

Waivers can be  
funded by “pass  
through dollars”

If the federal government will save money it otherwise would have spent in subsidies absent the waiver, the state can use those “pass-through dollars” to help fund MGARA, in turn helping those consumers who do not receive a subsidy.

# The Proposal (Continued)

MGARA to be reactivated effective January 1, 2019



MGARA funded by three, not two, sources:

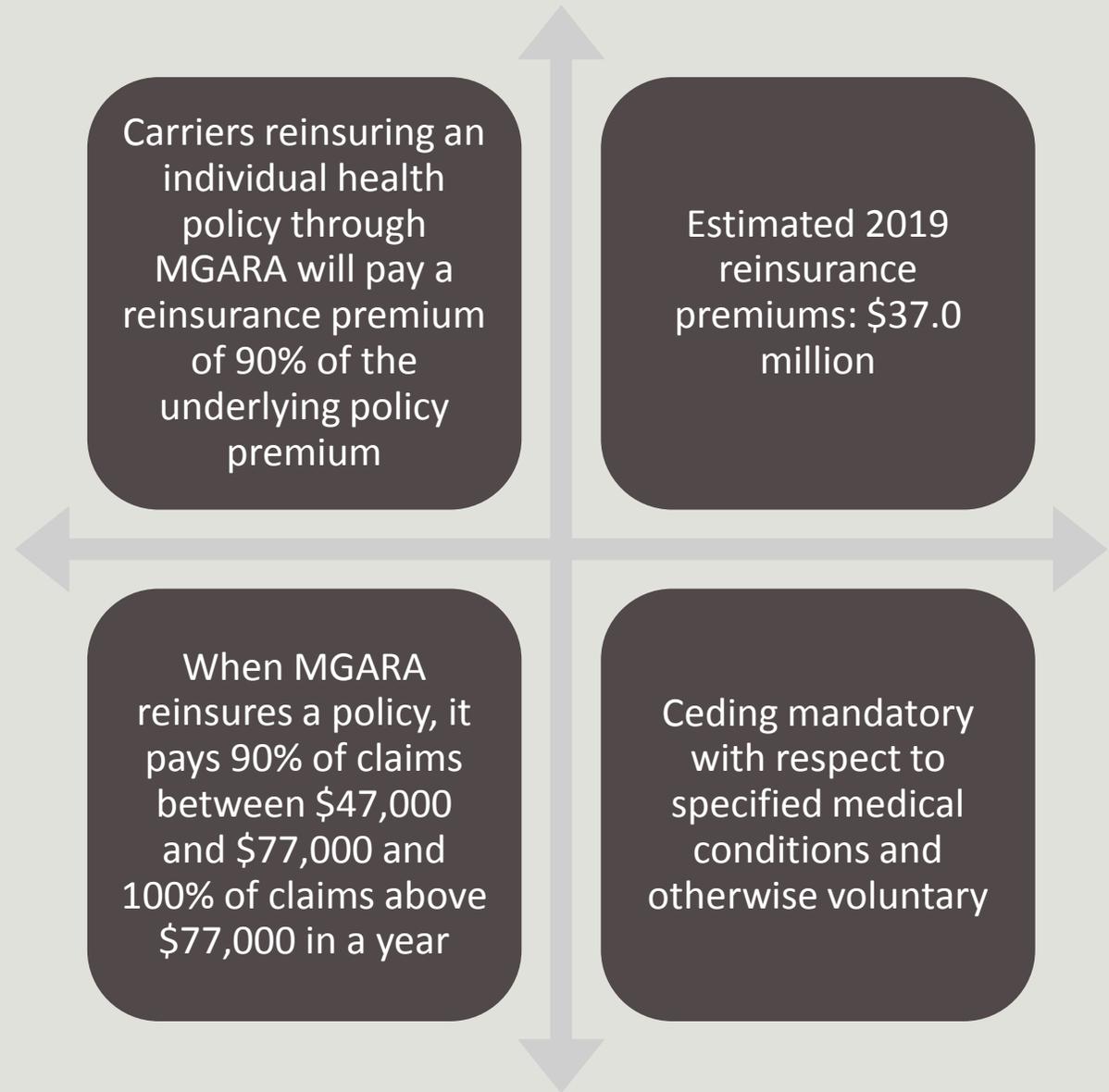
- Reinsurance premiums
  - \$4 per person per month assessment on all market segments
  - Federal “pass-through” payments
- 

Total 2019 estimated revenue: \$93 million



Total 2019-2023 estimated revenue: \$503.6 million

# Reinsurance Premiums and Coverage



# Assessments



- Includes individual and group markets and self-funded plans administered by third-party administrators

Reductions in federal premium tax credits as a result of MGARA's operation, net of minor adjustments, would be returned to the State for the purpose of further reducing premiums

Estimated 2019 pass-through payments: \$33.4 million

## Federal Pass-Through Payments

# Modeling

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Milliman, Inc. has performed economic and actuarial modeling of the program for 2019 through 2028.

## The modeling:

- Predicts program will meet all federal requirements
- Estimates individual market premium reduction of about 9% in 2019 relative to what they would otherwise be with similar results each year of the program.
- Estimates number of uninsured will be reduced by between 300 to 1,100 per year
- Program makes no change to required policy benefits for consumers

# How Will It Work?

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## Premium Savings

- In June 2018, insurers will be required to file 2019 rates that reflect their premiums with and without the program.
- If the 1332 Waiver is approved by CMS and the Board reactivates MGARA, insurers will use the rates reflecting the cost decrease in the program.

## Timeline

**April 2- May 2** Public comment period and tribal consultations

**May** Submission of 1332 waiver application to CMS

**June** Insurers file rates with Maine BOI

**Late Summer** Expected federal approval of waiver

**Late September** Insurer rates approved

**November** Open enrollment begins

**January 1, 2019** MGARA reactivated

# Maine Bureau of Insurance

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34 State House Station  
Augusta ME 04333

Phone: 800-300-5000 (TTY: Relay 711)

Fax: 207-624-8599

Email: [insurance.pfr@maine.gov](mailto:insurance.pfr@maine.gov)

Website: [maine.gov/pfr/insurance](http://maine.gov/pfr/insurance)

MGARA related information:

[maine.gov/pfr/insurance/mgara/index.html](http://maine.gov/pfr/insurance/mgara/index.html)

Harold P. Wimmer  
National President and  
CEO

May 2, 2018

Eric Cioppa  
Superintendent  
Maine Bureau of Insurance  
34 State House Station  
Augusta, ME 04333-0034

Re: 1332 Proposed Waiver Application

Dear Superintendent Cioppa:

The American Lung Association in Maine appreciates the opportunity to submit comments on Maine's Section 1332 State Innovation Waiver Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including over 198,000 Maine residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Lung Association believes everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with lung disease to access the coverage that they need. The Lung Association supports Maine's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.<sup>1</sup>

Maine Office:  
122 State Street  
Augusta, ME 04330  
Ph: 207-624-0325

Corporate Office:  
55 West Wacker Drive, Suite 1150 | Chicago, IL 60601  
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

Under Maine's proposal, the state would implement a reinsurance program starting for the 2019 plan year and continuing for five years. According to the state's analysis, this program is projected to reduce premiums by nine percent in 2019 and increase the number of individuals obtaining health insurance through the individual market by 1.1 percent. A reinsurance program would help patients with pre-existing conditions, including patients with asthma, COPD, lung cancer, and other lung diseases, obtain affordable, comprehensive coverage. We urge the state to operate this reinsurance program in a transparent manner with adequate opportunities for consumer input so that the program meets the needs of patients with pre-existing conditions.

The American Lung Association in Maine believes the proposed 1332 State Innovation Waiver will help stabilize the individual market in Maine and protect patients and consumers, and we urge its adoption. Thank you for the opportunity to provide comments.

Sincerely,



Lance Boucher  
Director, Public Policy  
American Lung Association in Maine

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<sup>1</sup> American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf).





via electronic submission

April 30, 2018

Eric A. Cioppa  
Superintendent  
Maine Bureau of Insurance  
#34 State House Station  
Augusta, ME 04333-0034

**Re: ACS CAN's Comments on Proposed 1332 Waiver**

Dear Superintendent Cioppa:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the request for comment on the Maine Bureau of Insurance's Section 1332 waiver proposal. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN supports a robust marketplace from which consumers can choose a health plan that best meets their needs. Access to health care is paramount for persons with cancer and survivors. In the United States, there are more than 1.7 million Americans who will be diagnosed with cancer this year.<sup>1</sup> An additional 15.5 million Americans are living with a history of cancer.<sup>2</sup> In Maine, an estimated 8,600 Mainers are expected to be diagnosed with cancer this year<sup>3</sup> and another 87,630 Mainers are cancer survivors.<sup>4</sup> For these Americans access to affordable health insurance is a matter of life or death. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.<sup>5</sup>

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<sup>1</sup> American Cancer Society. Cancer Facts & Figures: 2018. Atlanta: American Cancer Society, 2018.

<sup>2</sup> Id.

<sup>3</sup> Id.

<sup>4</sup> American Cancer Society. Cancer Treatment & Survivorship: Facts & Figures 2016-2017. Atlanta: American Cancer Society, 2016.

<sup>5</sup> E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), <http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care>.

A well-designed reinsurance program can help to lower premiums and mitigate plan risk associated with high-cost enrollees. We note that the Maine Bureau of Insurance estimates that the proposed reinsurance program will reduce premiums by 9 percent in 2019, and similar percent reductions in years 2020-2028.<sup>6</sup> These savings will not only benefit the federal government through reduced subsidy payments (an estimated \$33 million in 2019), but will also benefit consumers not eligible for subsidies who enroll in coverage through the exchange who will see lower premiums.

A reinsurance program may also encourage insurance carriers to continue offering plans through the exchange, or begin to offer plans, as applicable. The waiver application notes that one of the biggest insurers in the state stopped selling insurance through the marketplace in 2018, with rising premiums as a result. The expected maintenance or increase in plan competition due to the reinsurance program also may help to keep premiums from rising. These premium savings could help cancer patients and survivors afford health insurance coverage, and may allow some individuals to enroll who previously could not afford coverage (the Bureau estimates a 0.3 percent increase in enrollment in marketplace plans if the reinsurance program is reinstated<sup>7</sup>).

ACS CAN supports Maine's proposed 1332 waiver program because, as discussed in the 1332 waiver application and accompanying materials, the waiver would not affect adversely enrollees' scope of benefits. We are pleased that the PowerPoint presentation available on the Department's website recognizes the federal statutory requirement that states that 1332 waivers may not alter the scope of benefits and the proposal under consideration "does not affect individual insured's coverage in any way."<sup>8</sup> ACS CAN believes that patient protections in current law – like the prohibition on pre-existing condition exclusions, lifetime and annual limits, and Essential Health Benefits requirements – are crucial to making the healthcare system work for cancer patients and survivors. Our support for this proposal is conditioned on the waiver and the Department's implementation maintaining these protections and benefits.

We note that under the waiver, the reinsurance program would be run through the Maine Guaranteed Access Reinsurance Association (MGARA). The Department proposes to operate a prospective reinsurance program under which enrollees would be ceded to the reinsurance pool due to health condition or based on information collected from the enrollee via a detailed health questionnaire.<sup>9</sup> While we are pleased that from a consumer's perspective, this program would operate as an "invisible" high risk pool, we believe that public comment is warranted on

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<sup>6</sup> State of Maine. Executive Summary. Application for Waiver under Section 1332 of the Patient Protection and Affordable Care Act. Available at <http://www.maine.gov/pfr/insurance/mgara/State%20of%20Maine%20Executive%20Summary%20Application%20for%20Waiver%20Under%20Section%201332.pdf>

<sup>7</sup> *Id.*

<sup>8</sup> State of Maine. Power Point Presentation re Section 1332 Innovation Waiver Application. Available at [http://www.maine.gov/pfr/insurance/mgara/index.html?utm\\_content=&utm\\_medium=email&utm\\_name=&utm\\_source=govdelivery&utm\\_term=](http://www.maine.gov/pfr/insurance/mgara/index.html?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=)

<sup>9</sup> Maine Guaranteed Access Reinsurance Association. Health Assessment Form. Individual Insurance Plan. Available at <http://www.mgara.org/Health%20Assessment%20Form.pdf>.

the nature and scope of the health questionnaire, should MGARA continue the use of this practice. We urge the Department to require that MGARA's proposal to implement this reinsurance program be subject to a robust public comment process.

Finally, we strongly urge the Department to support additional transparency requirements on the MGARA so that consumers and consumer groups are able to actively participate in the Board's proceedings. We believe the Board will benefit from such consumer representation. We also urge the Department to consider additional requirements that the MGARA provide more frequent transparency. For example, while we are pleased that the Board's website provides minutes of Board meetings, such minutes are not updated in a timely manner (for example, no minutes have been posted for the January 2018 meeting<sup>10</sup>) nor are public comments available on the website.

### Conclusion

On behalf of the American Cancer Society Cancer Action Network, we thank you for the opportunity to comment on the proposed section 1332 waiver, which we believe will provide long-term viability of the individual market while not eroding important consumer protections. If you have any questions, please feel free to contact me at [hilary.schneider@cancer.org](mailto:hilary.schneider@cancer.org) or 207-373-3707.

Sincerely,



Hilary Schneider

Government Relations Director

American Cancer Society Cancer Action Network Maine

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<sup>10</sup> The most recent minutes posted to the MGARA website are for the October 16, 2017 Board meeting. See Maine Guaranteed Access Reinsurance Association, Board of Directors. Available at <http://www.mgara.org/BoardOfDirectors.htm> (accessed April 25, 2018). According to the minutes, the Board noted the next formal quarterly meeting would take place on January 8, 2018. See Maine Guaranteed Access Reinsurance Association, Minutes of Board of Directors, October 16, 2017. Available at <http://www.mgara.org/mins10.16.17.pdf> (accessed April 25, 2018). The website does not include any information regarding a January meeting.



May 2, 2018 (submitted electronically)

Mr. Eric A. Cioppa  
Superintendent  
Maine Bureau of Insurance  
34 State House Station  
Augusta, ME 04333-0334

Re: Maine Section 1332 State Innovation Waiver

Dear Superintendent Cioppa:

On behalf of the American Heart Association and the American Stroke Association (AHA/ASA), we would like to thank you for the opportunity to provide written comments on the Maine Bureau of Insurance's Section 1332 waiver proposal.

As the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke, our nonprofit and nonpartisan organization represents over 100 million patients with cardiovascular disease (CVD) and includes over 40 million volunteers and supporters committed to our goal of improving the cardiovascular health of all Americans. AHA has worked diligently for many years to support and advance strong public health policies in addition to providing critical tools and information to providers, patients, and families in order to prevent and treat these deadly diseases.

The AHA believes everyone should have quality and affordable healthcare coverage and a strong, robust marketplace is essential for people with CVD to access the coverage that they need. To that end, a well-designed reinsurance program can help offset the costs of enrollees with expensive health care needs. Additionally, implementing a reinsurance program could help to alleviate other systemic problems within the state insurance exchange including smaller provider networks and low issuer participation. The AHA would like to express our support for the proposal but suggest that it could benefit from additional improvements such as increased transparency and public accountability.

As you are aware, reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.<sup>1</sup> We are pleased to see that the Maine Bureau of Insurance estimates that the proposed reinsurance program will reduce premiums by 9 percent in 2019 with similar rates for each year thereafter until 2029.<sup>2</sup>

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<sup>1</sup> American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf).

<sup>2</sup> State of Maine Bureau of Insurance, *Executive Summary - Application for Waiver under Section 1332 of the Patient Protection and Affordable Care Act*. April 2018. Retrieved from <http://www.maine.gov/pfr/insurance/mgara/State%20of%20Maine%20Executive%20Summary%20Application%20for%20Waiver%20Under%20Section%201332.pdf>

The AHA is also pleased that the state acknowledges that the comprehensiveness and affordability of coverage offered on the individual markets will not be altered by the 1332 waiver proposal. The patient protections extended to individuals with pre-existing conditions under the Affordable Care Act (ACA) including the ten essential health benefit categories, guaranteed issue, out of pocket maximums and many other critical consumer protections are the bedrock of care for our patients. These guarantees make our healthcare system navigable for CVD patients and we commend the state for ensuring that the waiver proposal does not alter the integrity of these requirements.

The AHA also urges the Bureau to include additional transparency requirements on the body responsible for administering the program, the Maine Guaranteed Access Reinsurance Association (MGARA). We believe it is critical that the processes governing the state's activities in the individual market incorporate the patient voice and experience in addition to adhering to transparency standards that allow the public to comment on any proposals. As such, the AHA requests that the Bureau incorporate robust public comment periods and public hearings into its existing proposal.

On behalf of the American Heart Association and American Stroke Association, thank you for reviewing our comments. We appreciate the opportunity to provide feedback on this application. If you have any questions, please contact Becky Smith, Director of Government Relations, at [becky.smith@heart.org](mailto:becky.smith@heart.org) or 207-380-9171.

Sincerely,

Becky Smith  
Director of Government Relations, Maine  
American Heart Association  
51 US Route One, Suite M  
Scarborough, ME 04074



May 2, 2018

Mr. Eric A. Cioppa, Superintendent  
Maine Bureau of Insurance  
ATTN: 1332 Proposed Waiver Application  
34 State House Station  
Augusta, ME 04333-0034

Re: Application for a Waiver under Section 1332 of the Affordable Care Act

Dear Superintendent Cioppa:

Thank you for the opportunity to submit comments on the proposed Application for a Waiver under Section 1332 of the Affordable Care Act.

Anthem believes that consumers who do not have the option of health coverage through an employer or access to a government program should have access to affordable, quality health plan options in the individual market. Throughout implementation of the Affordable Care Act (ACA), Anthem has consistently asserted that the reformed individual market could only work if three conditions, which are fundamental to any insurance market, are met: (1) a balanced risk pool that includes enough consistently enrolled healthy individuals; (2) a predictable and stable regulatory environment with sufficient time to react to any changes; and (3) predictable and stable sources of funding that ensure affordability. Unfortunately, these conditions have not been fully met, resulting in an unstable individual market in need of significant changes. In addition to measures such as a state-based reinsurance program, we also believe it is also important to recognize that other reforms are needed and necessary at both the state and federal level. For example, delivery system and payment reforms are critical to address the underlying cost of care which is a central factor driving health insurance premium increases.

Anthem would like to take this opportunity to thank the Superintendent for his willingness to explore options that could serve to bring a degree of stability to the individual market in Maine.

As we understand it, key elements of the application include the following:

- The waiver, if approved, would be effective January 1, 2019 for a five year period (with option to renew for an additional five years);
- The Maine Guaranteed Access Reinsurance Association (“MGARA”) would resume operations and begin providing re-insurance for the individual market in Maine for policies with effective dates on or after January 1, 2019;
- That the following reinsurance thresholds will be used:
  - 90% of claims paid in excess of \$47,000 through and including \$77,000; and
  - 100% of claims paid in excess of \$77,000.

- That the total reinsurance funding for 2019 is estimated to be approximately \$93 million:
  - \$33 million from federal pass-through funding (based on net premium tax credit savings to the federal government)
  - \$22.6 million from assessments of \$4.00 PMPM on health insurers and third-party administrators in the individual, small group, large group and self-insured markets (excluding State and Federal employees).
  - \$37 million in ceded premiums paid by member insurers (90% of the premium paid to the ceding insurer)
- That the resumption of MGARA will result in a 9% net premium reduction for the Maine individual market in 2019 relative to what rates would be without the waiver and reinsurance program.

Based upon that understanding, Anthem Health Plans of Maine, Inc., d/b/a Blue Cross and Blue Shield, offers the following comments with respect to the waiver application:

1. CMS made changes to the commercial risk adjustment program in 2018 to include a high-cost risk pooling mechanism in the risk-adjustment transfer, under which carriers are reimbursed 60% of claim costs above \$1,000,000 for members whose claims exceed that threshold. The current claim threshold of \$1,000,000, set for the 2019 benefit year via recently finalized regulations, is subject to adjustment through rulemaking. The 1332 waiver application does not address how this high-cost pooling under the federal risk adjustment program will work in conjunction with the MGARA program. We would recommend that the MGARA program coordinate with the federal risk adjustment program; for example, with respect to claims that exceed the federal pooling threshold (currently \$1,000,000), the federal risk adjustment program could pay 60% and the MGARA program could pay 40%.
2. Although the market assessments proposed in the proposed waiver application<sup>1</sup> are the same assessments that were used to fund the MGARA program in 2012 and 2013, we continue to have concerns about an assessment on fully insured and self-funded accounts. Although the application states that the assessment of \$4.00 PMPM is not expected to have a material impact on the premium rates for employer-sponsored coverage,<sup>2</sup> we would note that our group customers also struggle with the affordability of health insurance benefits. Any proposal that serves to increase costs, particularly without a corresponding benefit, is a source of concern.

This concern is particularly acute with respect to Maine's small group market, which has decreased significantly in size in recent years and is now smaller than the individual market. When MGARA first began operations in 2012, there were approximately 33,000 members in the individual market and 91,000 members in the small group market; however, as of 2017, there were approximately 81,500 members in the individual market and only 63,600 members in the small group market. The small group market is steadily decreasing in size, which in turn leads to higher prices and increased instability. We are concerned that an

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<sup>1</sup> "State of Maine Executive Summary Application for Waiver Under Section 1332 of the Patient Protection and Affordable Care Act," Section III (A), pp. 3-4.

<sup>2</sup> *Id.* at Section V (B), p. 9.

assessment on the small group market in particular will have a detrimental impact on that market.

Although we recognize that it would require a change to the statutory provisions that govern MGARA, we believe it is important that the funding source be broad-based, rather than an assessment on any health insurance market that would only serve to make coverage in those markets less affordable. Any premium or provider taxes simply result in higher premiums and serve to destabilize the markets being assessed.

3. We would note that the modeling in support of the waiver proposal assumes the full annual value of a \$4 PMPM assessment and projects that the MGARA program would receive \$22.6 million in assessments in calendar year 2019.<sup>3</sup> However, the existing rates for plans issued or renewing in calendar year 2018 do not include an assessment for the MGARA program and, given the estimated timeline for action on the waiver application, it would be impossible to build the assessment into the rates that will apply to most plans issued or renewing in 2018. A “ramp-up” period is required, as carriers cannot begin to collect the \$4 PMPM assessment until the waiver application has been approved and the MGARA Board of Directors has voted to move forward with resuming operations for 2019.

This very issue was discussed in the Milliman analysis:

Our modeling has assumed that the full annual value of the \$4 PMPM assessment (i.e., \$48 per member per year [PMPY]) charged to the assessed markets is paid by all assessable lives. In practice, depending on the timing associated with the reinstatement of MGARA, the actual assessment collections may be affected by durational effects including policy lapses and mid-year renewals; for 2019 in particular, the \$48 annual assessment may only be partially paid by policies priced prior to the reinstatement of MGARA and/or renewed after January 1, 2019. Depending on timing of assessments relative to approval data from the BOI, the modelling may need to reflect a partial year assessment for MGARA’s first year of operation, or an alternative delay for the first year of operation.<sup>4</sup>

The application must be amended to reflect the fact that the full amount of the MGARA assessment will not be recognized until 2020. In turn, the assumptions about the amount of the federal pass through dollars and the premium impact on 2019 rates must be revised accordingly. While this will reduce the impact of the MGARA program in 2019, it is the only viable option, short of delaying a restart until 2020.

3. The MGARA program, as currently structured, is dependent on the ability of carriers to identify members who have a condition that warrants being ceded to MGARA. The Health Statement developed by the MGARA Board is an important tool in that process; however, it is unclear how health statements can be collected for members who purchase coverage through the federally facilitated marketplace. The effectiveness of the program is directly impacted if carriers do not have the ability to properly identify members who should be ceded to the reinsurance program.

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<sup>3</sup> “Section 1332 State Innovation Waiver Actuarial Analyses and Certification and Economic Analyses,” Milliman, March 20, 2018, Section I (2), p. 9.

<sup>4</sup> *Id.* (emphasis added).

4. The waiver proposes an effective date of January 1, 2019; however, the implementation of the internal systems and processes required for carriers to implement and comply with the requirements of the program are significant. Although some carriers may have had that infrastructure in place at one time, it will now need to be recreated. We are concerned whether the MGARA Board and carriers will have sufficient time to take the steps necessary to implement a restart of the program on January 1, 2019.
5. Although MGARA previously operated under a “conditions based” or prospective model, given that traditional (retrospective) reinsurance models are more straightforward, more predictable for pricing, and easier to administer, perhaps a traditional model should also be considered. We recognize that this would require a change in the statutory provisions that govern the operations of MGARA; nonetheless, it may be appropriate for consideration.
6. The modeling in support of the 1332 waiver application is premised on an assumption that an expansion of Medicaid will be implemented by January 1, 2019<sup>5</sup>; however, at the present time, that seems uncertain at best. This raises the question of whether the appropriate attachment points, and the corresponding impact on the individual market, are set forth in the proposed application.

Once again, we would like to thank the Superintendent for his efforts to pursue alternatives that may help to stabilize the individual market in Maine, and for the opportunity to share these comments. Please do not hesitate to contact me if you have any questions.

Sincerely,



Kristine M. Ossenfort, Esq.  
Senior Director, Government Relations

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<sup>5</sup> *Id.* p. 2.



April 30, 2018

Superintendent Eric Cioppa  
Maine Bureau of Insurance  
34 State House Station  
Augusta, ME 04333

Re: Maine Section 1332 State Innovation Waiver

Dear Superintendent Cioppa:

The Epilepsy Foundation and Epilepsy Foundation New England appreciate the opportunity to submit comments on Maine's Section 1332 State Innovation Waiver.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the at least 3.4 million Americans with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 American will develop epilepsy at some point in their lifetime, and 1 in 3 individuals with epilepsy rely on Medicaid for their health care needs. For the majority of people living with epilepsy, prescription medications are the most common and cost-effective treatment for controlling and/or reducing seizures, and they must have meaningful and timely access to physician-directed care.

The Epilepsy Foundation and Epilepsy Foundation New England believe everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with epilepsy to access the coverage that they need. The Epilepsy Foundation and Epilepsy Foundation New England support Maine's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.<sup>1</sup>

Maine's proposal will create a reinsurance program starting for the 2019 plan year and continuing for 5 years. This program is projected to reduce premiums by 9 percent and increase the number of individuals obtaining health insurance through the individual market by 1.1 percent. When Maine ran its own reinsurance program in 2012 and 2013, it generated an estimated 20 percent reduction in requested premium rates. This would help patients with pre-existing conditions, including patients with epilepsy, obtain affordable, comprehensive coverage.



The Epilepsy Foundation and Epilepsy Foundation New England believe the 1332 State Innovation Waiver will help stabilize the individual market in Maine and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Susan Linn".

Susan Linn  
President/CEO  
Epilepsy Foundation New England

A handwritten signature in black ink, appearing to read "Philip M. Gattone".

Philip M. Gattone, M.Ed.  
President & CEO  
Epilepsy Foundation

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<sup>i</sup> American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf).



MAINE ASSOCIATION  
OF  
HEALTH PLANS

April 17, 2018

Superintendent Eric Cioppa  
Maine Bureau of Insurance  
34 State House Station  
Augusta, ME 04333-0034

ATTN: 1332 Proposed Waiver Application

Dear Superintendent Cioppa,

I am writing on behalf of the Maine Association of Health Plans (“MeAHP”) to offer comments on the 1332 Proposed Waiver Application and the potential subsequent restart of the Maine Guaranteed Access Reinsurance Program (MGARA).

Like you, the members of MeAHP are concerned about escalating premiums in the non-group market and favor efforts that will serve to stabilize the market and to moderate increases in health insurance premiums. Our industry has expressly offered support at the federal level for premium reduction and market stabilization programs. These include a long-term funding solution for Cost-sharing Reduction (CSR) subsidies, increased flexibility for 1332 waivers, and additional aid for states seeking to restart or establish high risk pools, like MGARA.

**Concerns About the Funding Mechanism**

As currently proposed, the waiver application relies on the availability and receipt of roughly \$33 million in so-called “pass through” dollars. This funding would be realized as a result of the waiver itself, whereby the federal government would “pass through” the loss of advanced premium tax credit dollars flowing into Maine because the impact of the MGARA program reduced individual market rates. It is important to note that these dollars are projected to equal roughly one-third of the \$93 million in revenues estimated for the Association to pay claims ceded to the pool in 2019. According the Bureau’s application and the Milliman analysis, the remaining revenue for 2019, and beyond, will result from ceded premium (\$37M) and from a statutory \$4 PMPM assessment on all market segments (\$20-22M).

Consequently, the receipt of these federal “pass through” dollars is tantamount to the solvency of MGARA. Understandably, MeAHP’s members have significant concerns about

programs, such as that contemplated in the waiver application, that involve substantial risk should the federal government fail to pay in a timely and consistent fashion. Health insurers have directly experienced the failure of the federal government to follow through on its commitments. Two recent examples include the termination of CSR payments of about \$2 billion and non-payment of \$12.3 billion in risk corridor payments owed to insurers. As a result, it is understandable that health plans operating in Maine may have concerns about a proposal that relies so heavily on financing from the federal government.

It is important to also recognize that the amount of federal “pass through” dollars is projected based on an assumed rate reduction in the individual market attributable to the restart of MGARA. According to the Bureau’s application and Milliman analysis, the proposed re-start of the MGARA program under the proposed waiver application corresponds to a projected 9% average rate reduction in the individual market. Setting aside the question of whether this will impact the purchasing decisions of nonsubsidized individuals in Maine, the actual amount of rate reduction resulting from MGARA will greatly depend on the unique characteristics of each carrier’s individual members.

### **Overall Structure of the Program**

Notwithstanding the granting of a 1332 waiver, P.L. 2017, c. 124 requires that the MGARA board propose and adopt a revised plan of operation prior to a restart. Yet, the details of that plan of operation will impact the average rate reduction realized in the individual market and several factors will need to be considered to set up an effective and successful program that works in today’s marketplace.

First, it would be appropriate for the MGARA board to review the mandatory ceding conditions to determine if the list of codes requiring ceding are appropriate in today’s market. As currently constructed, the eight mandatory ceded conditions contrast greatly with other state high-risk pools seeking to operate through a 1332 waiver (see Section 1332 State Innovation Waiver Actuarial Analyses and Certification & Economic Analyses, page 30). For example, Alaska’s high-risk pool covers 33 unique conditions, including hemophilia and premature newborns, as well as conditions for which pharmacy spending has exploded in recent years – for example, drugs used to treat multiple sclerosis.

Second, MGARA should review the suitability of a voluntary ceding process. MGARA ran before the advent of the Affordable Care Act and before most of Maine’s individual market was enrolling through the federally facilitated exchange and qualifying for subsidies. In 2011, participating plans had the benefit of collecting health statements from members; however, there is no mechanism on the Exchange to collect this information, leaving carriers without health status information to make voluntary ceding decisions.

Lastly, MGARA needs to review whether the premium ceded to the pool and the proposed attachment points for coverage provide the greatest impact to the goal of reducing rates in the individual market. Under the application, when MGARA reinsures a policy, the Association will pay 90% of claims between \$47,000 and \$77,000 and 100% of claims above \$77,000 in a year, while the carrier will cede 90% of the underlying policy premium to the pool. This contrasts greatly with the federal reinsurance program which had a low-

end attachment point of \$90,000 in its last year of operation. Furthermore, in an environment in which Silver plans have rates “loaded” to account for the loss of CSR funding, is it appropriate for carriers to cede 90% of this “loaded” premium? In practice, a portion of Silver plan premium attributed to CSR is simply a means to “buy-down” member cost sharing for individual eligible for CSR subsidy.

#### Characteristics of Maine’s Health Insurance Market

The data described on page 5, “B” accurately describes the characteristics of Maine’s Individual Health Insurance Market. In fact, the data highlights that availability and value of APTCs, as intended, brought many into meaningful coverage in the Maine Individual market. However, the application is noticeably silent other issues which have impacted individual market participation and premiums beyond the cessation of the Federal reinsurance program.

It is our understanding that states may seek federal waivers for other continuous coverage requirements, intended to stabilize the risk pool, as part of a 1332 waiver application. The waiver application does not contemplate any other actions to ensure stability which might mirror some of those in the ACA, most notably an individual coverage mandate.

#### Implementation Plan and Timeline

Finally, the timing envisioned for the application process, rate filings, and potential program commencement is very, and perhaps unrealistically, tight. We are concerned about the likelihood that all these moving parts will come together and enable a program restart on 1/1/19 and provide carriers with an adequate opportunity to take the steps that would be required in time for 2019. Furthermore, if the Association does restart in 2019, the Bureau will need to reopen group rate filings to accommodate the \$4 PMPM assessment for groups that were issued policies in 2018, but whose plan year includes a portion of 2019.

Thank you for the opportunity to offer these comments. We would be pleased to respond to any questions you may have.

Sincerely,



Katherine Pelletreau  
Executive Director



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May 1, 2018

Eric Cioppa, Superintendent  
Maine Bureau of Insurance  
34 State House Station  
Augusta, ME 04333-0034  
ATTN: 1332 Waiver Application

Dear Superintendent Cioppa:

Please accept this comment letter on behalf of the Maine Hospital Association regarding the State of Maine's Proposed Section 1332 State Innovation Waiver.

The Maine Hospital Association represents all 36 community-governed hospitals in the state including 33 general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital. In addition to the acute hospital facilities, our hospitals represent 11 home health agencies, 18 skilled nursing facilities, 19 nursing facilities, 12 residential care facilities, and more than 300 physician practices employing thousands of medical professionals.

One of Maine hospitals' highest priorities is seeing that the patients we serve in our communities have access to high-quality, affordable healthcare. The Affordable Care Act provides many ways by which the state and federal governments can provide such healthcare including Section 1332 State Innovation Waivers. These waivers are tools by which states are encouraged to improve patient access to care, increase affordability of coverage and choices offered, and provide improved market stability.

We believe that Maine's proposed 1332 State Innovation Waiver meets all of these goals and would provide more affordable healthcare coverage to hundreds, if not thousands, of Maine people. Importantly, there would be no negative policy changes for these consumers; they would simply receive less expensive healthcare coverage than they would have absent the waiver.

Over the past two years, I have attended the Bureau's rate review hearings where health insurance rate increases exceeding 20 percent have been considered and reviewed. As you recall, many people at these hearings testified they did not qualify for subsidies through the federal exchange and, therefore, had to pay the full cost of health insurance purchased through the exchange or the individual market. Most of the people who testified were self-employed small-business people that provide the backbone of Maine's economy. Their testimony was heartbreaking to hear and will unfortunately continue to get worse and more untenable absent some government intervention such as a 1332 State Innovation Waiver.

Although the Maine Guaranteed Access Reinsurance Association (MGARA) was in operation for only approximately 18 months after it was created by Public Law 90, the evidence is quite clear that MGARA had a significant moderating affect on health insurance

premiums during this period. From 2014 through 2016 when MAGARA was operational, the average cost of health insurance on the individual market in Maine decreased. Since MGARA ceased operations, the average cost of health insurance on the individual market increased by over 20% per year. There are many factors that impact the cost of healthcare, so these large untenable increases cannot be entirely attributed to MGARA ceasing operations. However, it seems clear to us that MGARA provided a significant positive and moderating impact on costs. We have reviewed the actuarial modeling that Milliman Inc. performed for MGARA for the period 2019 through 2028 and find their estimates that individual market premiums will be reduced by approximately 9% relative to what they otherwise would have been to be credible and likely quite conservative.

In addition to serving as the largest providers of healthcare in Maine, hospitals also provide health insurance to over 30,000 of our employees so we are well aware of the \$4 per member, per month payment to fund MGARA. Although this expense is significant, we believe the benefits of maintaining a viable individual health insurance market in the state outweigh the additional costs incurred by those that purchase through the large group market such as hospitals and other large employers.

We have heard the concerns from some of the state's health insurance carriers that the federal government's recent actions to eliminate the Cost Sharing Reduction and Risk Corridor Programs creates a high level of uncertainty about the government's commitment to follow through with a Section 1332 State Innovation Waiver. Although we are sympathetic to the health insurance carriers concerns, it seems like the Bureau of Insurance has enough tools available to mitigate any risks in this area and that uncertainty about future decisions should not stop MGARA and the Bureau of Insurance from pursuing a waiver that is clearly permissible and envisioned under the Affordable Care Act.

Thank you for the opportunity to comment on the Section 1332 State Innovation Waiver and please feel free to contact me at (207) 622-4794 or via email at [dwinslow@themha.org](mailto:dwinslow@themha.org) with any questions about this letter.

Sincerely,



David S. Winslow  
Vice President of Financial Policy

Mr. Eric Cioppa, Superintendent  
Maine Bureau of Insurance  
34 State House Station  
Augusta, ME 04333-0034

May 1, 2018

RE: 1332 Proposed Waiver Application until 5:00 p.m. on May 2, 2018

Dear Superintendent Cioppa:

Please accept these written comments as supporting materials to the oral comments I made on behalf of the Maine State Chamber of Commerce at your April 13, 2018, Public Information Meeting held in Portland.

As I indicated to you at the Public Information Meeting, while the Chamber is not in a position to *at this time* oppose allowing the re-start of the Maine Guaranteed Access Reinsurance Association (MGARA), we must be on record as expressing concern with regard to rising health insurance costs, and the potential that exists for the resumption of the MGARA surcharge to add to those higher costs.

As you know, in March we held our annual Health Care Forum event for our members and any interested small business. At that forum it was abundantly clear the cost of health insurance is a major issue for small businesses. Information provided by your staff shows that since 2015, the small group market – the group that will in part be assessed the MGARA surcharge – has been steadily eclipsed in size by the individual market. In fact, in 2017 the number of insured lives in the small group market was at its lowest at just shy of 64,000 lives. While 2018 numbers were not available at the time, there is no reason to think this trend would have changed.

Clearly we think this market is shrinking due in part to higher premiums and the inability of small employers and their workers to keep pace with increases. Costs will only become more problematic as the market continues to contract.

The resumption of MGARA will result in the resumption of the \$4 per member per month assessment authorized by law, in order to act as a re-insurance mechanism for the individual market. Certainly this is a well-intended purpose, and one can argue that a stable individual market benefits the entire state of Maine. But it is a purpose for which small and large businesses cannot themselves access, nor will they ever directly benefit. In doing so, it may also add to the problems of health insurance affordability for businesses paying the surcharge – particularly small businesses.

It is our understanding that it is estimated that resuming the \$4 PMPM surcharge will result in the collection by MGARA of \$22.6 million. Backing the roughly \$3,750,000 that will be collected from the individual portion of the market out of the \$22.6 million results in an \$18,852,000 assessment paid by the remaining employers in this state. The fact is, all employers are being asked to subsidize one segment of the insurance market by paying a substantial assessment, when they themselves are struggling to pay for their own policies. As I said to you and your staff on April 13, we recognize that there are no easy answers here, but we felt that we must speak up for all our business members as you consider a re-start of MGARA.

Thank you for taking the time to read these comments. Should you have any questions please do not hesitate to reach out to me.

Sincerely,



Peter M. Gore, Vice President, Advocacy and Government Relations



National  
Multiple Sclerosis  
Society

May 2, 2018

Superintendent Eric A. Cioppa

Department of Professional & Financial Regulation  
Bureau of Insurance  
#34 State House Station  
Augusta, ME 04333-003

Re: Section 1332 Proposed Waiver Application

Dear Superintendent Cioppa:

The National MS Society (the Society) is grateful for the opportunity to submit comments on Maine's Section 1332 State Innovation Waiver application.

Multiple sclerosis is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

The National MS Society believes that everyone should have quality and affordable healthcare coverage. Since 2014, the Affordable Care Act (ACA) health insurance marketplace has been an extremely important avenue to affordable, quality coverage for people living with MS. A strong, robust marketplace is essential for people with MS to access the coverage and care that they need.

However, ACA insurance premiums are rising, and the Society is committed to ensuring that people living with MS have access to comprehensive health insurance plans with affordable premiums, deductibles, and out-of-pocket costs. Without market stabilization measures like reinsurance, citizens of Maine currently relying on the marketplace for their health insurance could lose their only affordable coverage option. The Society supports Maine's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize the health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums more affordable for all individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also

established under the Affordable care Act and reduced premiums by an estimated 10 to 14 percent in its first year.<sup>1</sup>

Maine's proposal will create a reinsurance program starting in January 2019. This program is projected to reduce premiums by 9% and modestly increase the number of individuals obtaining health insurance through the individual market. This would help people with pre-existing conditions, including those living with MS, obtain affordable, comprehensive coverage.

The Society believes the 1332 State Innovation Waiver will help stabilize the individual market in Maine and protect patients and consumers. Thank you for the opportunity to provide comments. If you have any questions, please contact Michelle Dickson at [michelle.dickson@nmss.org](mailto:michelle.dickson@nmss.org).

Sincerely,

Michelle Dickson  
Sr. Manager, Advocacy  
National MS Society

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<sup>1</sup> American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf)

**From:** Record, Thomas M  
**Sent:** Tuesday, April 24, 2018 10:30 AM  
**To:** 'katie.espling@ihs.gov' <katie.espling@ihs.gov>  
**Subject:** Request for Tribal Consultation

Dear Ms. Espling:

Thank you for your time on the telephone this morning. Please find attached links to several documents which describe, in various degrees of detail, the Maine Bureau of Insurance's forthcoming application to federal CMS for a Section 1332 innovation waiver. The application process requires a tribal consultation and we look forward to your advice as to how best to proceed to interact with the Penobscot Nation regarding this matter.. .

In very brief summary, the Maine Bureau of Insurance is applying to federal CMS for a Section 1332 Innovation Waiver. The goal of the project is to provide premium relief and market stability to Maine's individual health insurance market. This would be accomplished through the reactivation of the Maine Guaranteed Access Reinsurance Association (MGARA) which has been in hiatus since January 1, 2014. Resultant premium savings would directly result in a reduction in premium tax credits provided to Maine residents of the federal government and the premium tax credits would "pass through" or be returned to the program for the purpose of further premium reductions.

Linked documents include:

- A Powerpoint which provides a high level overview of the proposal; <http://www.maine.gov/pfr/insurance/mgara/Power%20Point%20re%20Section%201332%20Innovation%20Waiver.pptx>
- A draft Executive Summary/narrative describing the proposal, <http://www.maine.gov/pfr/insurance/mgara/State%20of%20Maine%20Executive%20Summary%20Application%20for%20Waiver%20Under%20Section%201332.pdf>, and
- The economic and actuarial modeling for the program which has been performed by Milliman, Inc. <http://www.maine.gov/pfr/insurance/mgara/Section%201332%20State%20Innovation%20Waiver%20Actuarial%20Analyses%20and%20Certification%20and%20Economic%20Analyses.pdf>

Nothing in the proposal affects the provision of tribal health care services nor does it affect the benefits or coverages of any health insurance policies that tribal members may be enrolled in. It does however seek to lower premiums in the individual health insurance market through a combination of three funding sources – (1) reinsurance premiums which insurers would pay to the Maine Guaranteed Access Reinsurance Association (MGARA), (2) \$4 per member per month on both individual and group health insurance as well as self-funded plans administered by third parties and (3) savings to the federal government in the form of a reduction in the amount of premium tax credits provided to Maine residents as a result of MGARA's operation.

Please feel free to contact me if there is anything else I can provide which you may find helpful in connection with this proposal.

We look forward to working with the MicMac Tribe. We are open to receipt of written comments from you or would be open to in-person consultation if preferable.

Sincerely,

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance  
(207)624-8424  
[thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov)

**From:** Record, Thomas M  
**Sent:** Tuesday, May 01, 2018 9:03 AM  
**To:** 'katie.espling@ihs.gov' <katie.espling@ihs.gov>  
**Subject:** Request for Tribal Consultation; Bureau of Insurance Section 1332 Innovation Waiver

Dear Ms. Espling:

Good morning.

This is to follow up on my e-mail to you of April 24. As noted at that time, the Maine Bureau of Insurance is seeking a tribal consultation with the MicMac tribe regarding the Bureau's forthcoming application to CMD for a Section 1332 Innovation Waiver. We would appreciate receipt of any comments the tribe may have by Friday, May 4.

To reiterate, the goal of the project is to provide premium relief and market stability to Maine's individual health insurance market. This would be accomplished through the reactivation of the Maine Guaranteed Access Reinsurance Association (MGARA) which has been in hiatus since January 1, 2014. Resultant premium savings would directly result in a reduction in premium tax credits provided to Maine residents of the federal government and the premium tax credits would "pass through" or be returned to the program for the purpose of further premium reductions.

Linked documents include:

- A Powerpoint which provides a high level overview of the proposal; <http://www.maine.gov/pfr/insurance/mgara/Power%20Point%20re%20Section%201332%20Innovation%20Waiver.pptx>
- A draft Executive Summary/narrative describing the proposal, <http://www.maine.gov/pfr/insurance/mgara/State%20of%20Maine%20Executive%20Summary%20Application%20for%20Waiver%20Under%20Section%201332.pdf>, and
- The economic and actuarial modeling for the program which has been performed by Milliman, Inc. <http://www.maine.gov/pfr/insurance/mgara/Section%201332%20State%20Innovation%20Waiver%20Actuarial%20Analyses%20and%20Certification%20and%20Economic%20Analyses.pdf>

Nothing in the proposal affects the provision of tribal health care services nor does it affect the benefits or coverages of any health insurance policies that tribal members may be enrolled in. It does however seek to lower premiums in the individual health insurance market through a combination of three funding sources – (1) reinsurance premiums which insurers would pay to the Maine Guaranteed Access Reinsurance Association (MGARA), (2) \$4 per member per month on both individual and group health insurance as well as self-funded plans administered by third parties and (3) savings to the federal government in the form of a reduction in the amount of premium tax credits provided to Maine residents as a result of MGARA's operation.

Please feel free to contact me if there is anything else I can provide which you may find helpful in connection with this proposal.

Sincerely,

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance  
(207)624-8424  
[thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov)

**From:** Record, Thomas M  
**Sent:** Wednesday, April 25, 2018 11:48 AM  
**To:** 'csabattis@maliseets.com' <csabattis@maliseets.com>  
**Cc:** Bear, Henry <henry.bear@legislature.maine.gov>  
**Subject:** Request for Tribal Consultation

Dear Chief Sabattis:

Please find attached a request for tribal consultation/comment as well as several other supporting documents which describe, in various degrees of detail, the Maine Bureau of Insurance's forthcoming application to the U.S. government for an Affordable Care Act Section 1332 innovation waiver.

In very brief summary, the goal of the project is to provide premium relief and market stability to Maine's individual health insurance market. This would be accomplished through the reactivation of the Maine Guaranteed Access Reinsurance Association (MGARA) which has been in hiatus since January 1, 2014. Resultant premium savings would directly result in a reduction in premium tax credits provided to Maine residents of the federal government and the premium tax credits would "pass through" or be returned to the program for the purpose of further premium reductions.

The attached supporting documents include:

- A Powerpoint which provides a high-level project overview;
- A draft Executive Summary/project narrative
- Economic and Actuarial Modeling performed by Milliman, Inc.

Nothing in the proposal affects the provision of tribal health care services nor does it affect the benefits or coverages of any health insurance policies that tribal members may be enrolled in.

Please feel free to contact me if there is anything else I can provide which you may find helpful in connection with this proposal. Bureau staff can be available for in-person or telephonic discussion if helpful.

We would appreciate receipt of any written comments which the Houlton Band of Maliseets may have by May 4.

Thank you. We look forward to working with you regarding this matter.

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance  
(207)624-8424  
[thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov)



Paul R. LePage  
GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BUREAU OF INSURANCE  
34 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0034

Eric A. Cioppa  
Superintendent

April 25, 2018

Clarissa Sabattis, Chief  
Houlton Band of Maliseets  
88 Bell Road  
Littleton, Maine 04730

RE: Section 1332 Innovation Waiver  
Request for Tribal Consultation

Dear Chief Sabattis:

On behalf of the Maine Bureau of Insurance (BOI), I am writing to inform you of a proposed Affordable Care Act (ACA) 1332 State Innovation Waiver, in keeping with waiver requirements to conduct tribal consultation.

The Maine Guaranteed Access Reinsurance Association (MGARA) was created through legislation (Public Law chapter 90) and actively operated in 2012-2013. During that time, it provided about \$66 million in insurance premium relief to Maine's individual health insurance market. By example, one insurer's 2013 individual rate increase was 20% less than it would have been but for MGARA. MGARA was funded by a combination of reinsurance premiums charged health insurance carriers and a \$4 per member per month assessment on individual and group insurance coverage as well as on self-funded plans administered by third parties. Beginning in 2014, MGARA ceased active operations due to the presence of the federal government's transitional reinsurance program which was substantially duplicative of MGARA. Since the federal transitional program ended after 2016, individual health insurance rates have risen sharply.

Under the Affordable Care Act, states may request a 1332 Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. States must adhere to the following guardrails; the waiver must provide coverage to at least as many people as the ACA would provide without the waiver, coverage must be as comprehensive as provided under the ACA, coverage must be as affordable as coverage under the ACA, and the waiver cannot increase the federal deficit.



PRINTED ON RECYCLED PAPER

OFFICES LOCATED AT 76 NORTHERN AVENUE, GARDINER, MAINE 04345  
[www.maine.gov/insurance](http://www.maine.gov/insurance)

Phone: (207) 624-8475

TTY: Please call Maine Relay 711

Customer Complaint: 1-800-300-5000

Fax (207)624-8599

The Section 1332 Waiver doesn't change existing waiver authority for provisions in other Federal health programs such as Medicaid or Medicare (including waiver authorities under 3021 or under 1115), although states may apply for such waivers under a coordinated application process.

Maine's waiver request is fairly straightforward. MGARA's active operations would be reactivated. Its previous funding sources of reinsurance premiums charged insurers and assessments on all health insurance market segments would be augmented by federal funding. Under the proposed waiver, Maine would receive federal pass-through funding to subsidize MGARA, based on savings that would be generated as a result of a reduction in Advanced Premium Tax Credits (APTCs) compared to APTCs absent the reinsurance program. The State Innovation Waiver would be effective January 1, 2019 for an initial period of five years, with an option to renew for an additional five years.

There are not any projected impacts to Indian Health Services resulting from this waiver.

I am enclosing several other documents with this letter which provide further detail regarding the project. These include a Powerpoint which contains a high-level description of the program, a draft project executive summary/narrative and the economic and actuarial modeling for the program which has been performed by Milliman, Inc.

We would be pleased to respond to any questions you may have or to receive any comments you. If you would like to arrange an in-person or telephonic discussion, please advise at your earliest convenience. We would appreciate any written comments you may have prior to May 4, 2018. Comments may be directed to my attention, Thomas Record, Senior Staff Attorney, Maine Bureau of Insurance, 34 State House Station, Augusta, ME 04333-0034, by e-mail at [thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov). If you wish to speak to me by telephone, my number is (207)624-8424.

Sincerely,



Thomas M. Record  
Senior Staff Attorney

Cc Rep. Henry John Bear

**From:** Record, Thomas M  
**Sent:** Tuesday, May 01, 2018 8:48 AM  
**To:** 'adriennelola24@gmail.com' <adriennelola24@gmail.com>  
**Subject:** RE: Maine Guaranteed Access Reinsurance Association (MGARA); Request for Tribal Consultation

Good morning Ms. Lola:

We would appreciate receipt of any comments the Passamaquoddy Tribe may have regarding the Maine Bureau of Insurance's application to CMS for a Section 1332 Innovation Waiver by Friday, May 4. As always, we stand ready to discuss the project with you or other tribal representatives as helpful.

Sincerely,

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance  
(207)624-8424  
[thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov)

**From:** Record, Thomas M  
**Sent:** Tuesday, April 24, 2018 10:35 AM  
**To:** 'adriennelola24@gmail.com' <[adriennelola24@gmail.com](mailto:adriennelola24@gmail.com)>  
**Subject:** RE: Maine Guaranteed Access Reinsurance Association (MGARA); Request for Tribal Consultation

Good morning Ms. Lola:

I'm just forwarding up on my email of last week. Have you had an opportunity to speak with your supervisor? If so, would the Tribe have any questions or comments regarding the proposal? Is there anything I can do to assist you?

Thanks,

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance  
(207)624-8424  
[thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov)

**From:** Record, Thomas M  
**Sent:** Thursday, April 19, 2018 10:10 AM

To: 'adriennelola24@gmail.com' <[adriennelola24@gmail.com](mailto:adriennelola24@gmail.com)>

Subject: Maine Guaranteed Access Reinsurance Association (MGARA); Request for Tribal Consultation

Dear Ms. Lola:

Thank you for your time on the telephone this morning. Please find enclosed several documents which provide various forms regarding the Bureau's forthcoming application to federal CMS for a Section 1332 innovation waiver. The application process requires a tribal consultation and we look forward to your advice as to how best to handle this. .

As I mentioned on the phone, nothing in the proposal affects the provision of tribal health care services nor does it affect the benefits or coverages of any health insurance policies that tribal members may be enrolled in. It does however seek to lower premiums in the individual health insurance market through a combination of three funding sources – (1) reinsurance premiums which insurers would pay to MGARA, (2) \$4 per member per month on both individual and group health insurance as well as self-funded plans administered by third parties and (3) savings to the federal government in the form of a reduction in the amount of premium tax credits provided to Maine residents as a result of MGARA's operation.

Linked documents include:

- A Powerpoint which provides a high level overview of the proposal; <http://www.maine.gov/pfr/insurance/mgara/Power%20Point%20re%20Section%201332%20Innovation%20Waiver.pptx>
- A draft Executive Summary narrative describing the proposal, <http://www.maine.gov/pfr/insurance/mgara/State%20of%20Maine%20Executive%20Summary%20Application%20for%20Waiver%20Under%20Section%201332.pdf> and
- The economic and actuarial modeling for the program which has been performed by Milliman, Inc. <http://www.maine.gov/pfr/insurance/mgara/Section%201332%20State%20Innovation%20Waiver%20Actuarial%20Analyses%20and%20Certification%20and%20Economic%20Analyses.pdf>

Please feel free to contact me if there is anything else I can provide which you may find helpful in connection with this proposal.

It is my understanding that you will speak with your supervisor and get back to me regarding this matter. We look forward to working with the Passamaquoddy Tribe.

Sincerely,

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance  
(207)624-8424  
[thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov)



**From:** Record, Thomas M  
**Sent:** Tuesday, May 01, 2018 8:56 AM  
**To:** 'mary.settles@penobscotnation.org' <mary.settles@penobscotnation.org>  
**Subject:** RE: Request for Tribal Consultation

Dear Ms. Settles:

This is to follow-up on my April 24 e-mail to you. As noted at that time, the Maine Bureau of Insurance is seeking a tribal consultation regarding the Bureau's proposed Application to CMS for a Section 1332 Innovation Waiver. We would appreciate any thoughts regarding this matter which the Penobscot Nation may have by Friday, May 4. We stand ready to discuss the matter with tribal representatives if helpful.

Sincerely,

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance  
(207)624-8424  
[thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov)

**From:** Record, Thomas M  
**Sent:** Tuesday, April 24, 2018 10:16 AM  
**To:** 'mary.settles@penobscotnation.org' <[mary.settles@penobscotnation.org](mailto:mary.settles@penobscotnation.org)>  
**Subject:** Request for Tribal Consultation

Dear Ms. Settles:

Thank you for your time on the telephone this morning. Please find attached links to several documents which describe, in various degrees of detail, the Maine Bureau of Insurance's forthcoming application to federal CMS for a Section 1332 innovation waiver. The application process requires a tribal consultation and we look forward to your advice as to how best to proceed to interact with the Penobscot Nation regarding this matter.. .

In very brief summary, the Maine Bureau of Insurance is applying to federal CMS for a Section 1332 Innovation Waiver. The goal of the project is to provide premium relief and market stability to Maine's individual health insurance market. This would be accomplished through the reactivation of the Maine Guaranteed Access Reinsurance Association (MGARA) which has been in hiatus since January 1, 2014. Resultant premium savings would directly result in a reduction in premium tax credits provided to Maine residents of the federal government and the premium tax credits would "pass through" or be returned to the program for the purpose of further premium reductions.

Linked documents include:

- A Powerpoint which provides a high level overview of the proposal; <http://www.maine.gov/pfr/insurance/mgara/Power%20Point%20re%20Section%201332%20Innovation%20Waiver.pptx>
- A draft Executive Summary/narrative describing the proposal, <http://www.maine.gov/pfr/insurance/mgara/State%20of%20Maine%20Executive%20Summary%20Application%20for%20Waiver%20Under%20Section%201332.pdf>, and
- The economic and actuarial modeling for the program which has been performed by Milliman, Inc. <http://www.maine.gov/pfr/insurance/mgara/Section%201332%20State%20Innovation%20Waiver%20Actuarial%20Analyses%20and%20Certification%20and%20Economic%20Analyses.pdf>

Nothing in the proposal affects the provision of tribal health care services nor does it affect the benefits or coverages of any health insurance policies that tribal members may be enrolled in. It does however seek to lower premiums in the individual health insurance market through a combination of three funding sources – (1) reinsurance premiums which insurers would pay to the Maine Guaranteed Access Reinsurance Association (MGARA), (2) \$4 per member per month on both individual and group health insurance as well as self-funded plans administered by third parties and (3) savings to the federal government in the form of a reduction in the amount of premium tax credits provided to Maine residents as a result of MGARA’s operation.

Please feel free to contact me if there is anything else I can provide which you may find helpful in connection with this proposal.

It is my understanding that you will refer me to the appropriate tribal representative regarding this matter. We look forward to working with the Penobscot Nation. We are open to receipt of written comments from you or would be open to in-person consultation if preferable.

Sincerely,

Thomas M. Record  
Senior Staff Attorney  
Maine Bureau of Insurance  
(207)624-8424  
[thomas.m.record@maine.gov](mailto:thomas.m.record@maine.gov)

## **Federal Maine 1332 Waiver Application Questions and Responses**

1) What measures will you take to address concerns raised in comments received during the federal public notice and comment period related to transparency of the MGARA program?

**Maine:** By way of background, Maine law provides for consumer representation on the MGARA Board, and after extensive input from a wide range of interested parties, the Maine Legislature established specific transparency requirements in 2013 at 24-A M.R.S. §§ 3953(2)(E) through (G). The comments expressed concerns that the Board might not always be fulfilling its responsibilities in a timely manner. The Maine Bureau of Insurance will work with the Board to ensure that the information on MGARA's Web site is kept complete and up to date, and we will facilitate a dialogue between the Board and consumers on how best to address any other transparency issues that might arise.

The ACS Cancer Action Network also specifically requested "that public comment is warranted on the nature and scope of the health questionnaire, should MGARA continue the use of this practice. We urge CMS to encourage MGARA use a robust public comment process in implementing this questionnaire and process." This request seems reasonable to the Bureau, and we will work with the Board and consumers on an appropriate process for public input if the Board considers reinstating some form of health questionnaire.

The statutory transparency provisions cited above read as follows:

E. The board shall establish regular places and times for meetings and may meet at other times at the call of the chair. The board shall post notice of scheduled meetings, meeting agendas and minutes of meetings on a publicly accessible website maintained by the association.

F. The board shall establish a mechanism on its publicly accessible website for the public to submit comments on matters related to the operations of the association.

G. The board shall establish a process for taking public comment at selected board meetings to be held at such time and place as the board may determine. The opportunity for public comment must be made available not less often than quarterly. Except as specified in this paragraph, meetings of the board are not open to the public.

2) Will you allow for public participation in MGARA Board meetings or take other measures to provide for consumer input and sharing information on the meetings that occur?

**Maine:** As discussed in our answer to the previous question, the Legislature has established minimum statutory requirements for public access and input, and we will work with the Board and consumers to facilitate a dialogue on further initiatives in this area that the Board might consider.

3) Given the uncertainty around whether Medicaid expansion will happen for 2019, what are your views and assumptions regarding non-group market enrollment and premiums?

**Maine:** The Milliman analysis assumes that Medicaid expansion will be in place throughout 2019. Pages 30-33 of the Milliman analysis provide alternative estimates assuming no Medicaid expansion. The attachment points would change from \$47k to \$55k at 90% and \$77k to \$85K for 100%. Ceded premium in 2019 is estimated to increase from \$37M to \$46.7M due to more individuals covered and slightly higher premiums. Enrollment would be 486,000 compared to 471,000 for assessments.

[http://www.maine.gov/pfr/insurance/mgara/exhibit\\_a\\_milliman\\_modeling\\_final.pdf](http://www.maine.gov/pfr/insurance/mgara/exhibit_a_milliman_modeling_final.pdf).

4) At what point will Maine make a decision to adjust the MGARA parameters to account for potentially no Medicaid expansion in 2019?

**Maine:** The MGARA Board of Directors has flexibility to adjust attachment points. Medicaid expansion still has some hurdles to overcome but we may know more in August.

5) Insurers would be required to automatically cede premiums for any enrollee with at least one of the eight conditions. However, insurers may also voluntarily cede premiums at their discretion. What is the basis for including voluntary ceding? How does voluntary ceding of premiums factor into the amount of funding available to operate the program?

**Maine:** Voluntary ceding is included in the Milliman analysis. Page 9 of the analysis stated that “high cost individuals that carriers would likely cede to the reinsurance pool voluntarily” were included in the estimated costs. Carriers have multiple sources of information such as claim history and risk scores available to assess the risk of their policyholders. Many of the carriers have been in the individual market for multiple years and have built up a database of information on the block. The ceding premium is set at a level that, when combined with the carrier’s retention, discourages excessive voluntary ceding but gives carriers a chance to buy protection at a reasonable price for high-risk enrollees. Voluntary ceding is important because the listed conditions do not capture all the high-risk enrollees that a program reinsures. Adding conditions could mitigate the problem but would not eliminate it and could add cost and complexity to the system.

6) Given insurers cannot require enrollees to fill out a health questionnaire or receive health information from applicants, if they were to voluntarily cede, would they be doing it “blindly” in some ways?

**Maine:** No, we expect the voluntary ceding to be efficient due to the disincentive of losing 90% of the premium for any ceded individuals and the high attachment points for reinsurance benefits. There is also the possibility to gather health information after an individual is enrolled.

7) The application include 8/1 as the target date for approval. Could the state explain why that date was selected?

**Maine:** Maine requested two set of rate filings from our insurance carriers for the individual and small group markets. Both sets of rates are being reviewed but only one can be submitted to CMS/CCIIO by the deadline of August 22, 2018. In addition, re-activating MGARA for 2019 operations would need to start by September so that MGARA could have the necessary systems in place and member insurers could build assessments into their group rates. For these reasons we had set an August date for approval for a 2019 restart of the MGARA program. If approval comes later the program may need to start in 2020. Our preference would be 2019 but there are still benefits to the program if it is delayed until 2020.

8) Please provide a revised timeline that includes additional information such as when you will establish parameters for each year and the timing and mechanism and general pay out for future years of the waiver.

**Maine:** Our preference would be to coordinate the funding with the normal pace of rate filing preparations by the carriers. Attached is an estimated annual calendar. Several of the dates may need to be adjusted to account for dates that are set annually, but in general we believe the calendar is responsive to your request.

9) The state’s application states that “The State Program provides reinsurance for policies covering high-risk individuals, as identified by medical diagnosis or by the insurance carrier’s underwriting judgment.” Could the state explain what it means by the “carrier’s underwriting judgement.”

**Maine:** We used the term ‘underwriting judgment’ to refer to the processes by which insurers use the available information to classify insureds by their level of risk. In general, the policies insurers will cede to MGARA are those they would not have voluntarily chosen to issue before Maine enacted guaranteed-issue and community-rating laws, or would only have issued at prices substantially higher than their standard rates.