



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

Janet T. Mills
Governor

Eric A. Cioppa
Superintendent

February 10, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Lily Batchelder
Assistant Secretary for Tax Policy
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20200

Re: State of Maine – Section 1332 State Innovation Waiver


Dear Administrator Brooks-LaSure and Assistant Secretary Batchelder:

The State of Maine submits for your review and consideration a Section 1332 State Innovation Waiver application.

Maine currently has an approved section 1332 waiver that waived Section 1312(c)(1) of the Patient Protection and Affordable Care Act (PPACA) for a period of five years beginning January 1, 2019 to permit reinstatement of the Maine Guaranteed Access Reinsurance Association (MGARA) reinsurance program for the individual health insurance market. Maine now seeks waiver of PPACA Section 1312(c) for a new period starting January 1, 2023 to allow extension of MGARA to a pooled individual and small group market, as well as quarterly adjustments for small group plans that do not renew on a calendar year basis. The waiver would not affect any other PPACA provision.

We respectfully ask that you grant this application as soon as possible. This is urgent because the Maine Bureau of Insurance will start reviewing health insurers' plan rates for the 2023 plan year this summer.

We believe that granting the waiver will lower premiums in and bring greater stability to Maine's health insurance market.

Sincerely,

Benjamin Yardley
Senior Attorney

State of Maine
Section 1332 Waiver Amendment Application

February 10, 2022

Department of Professional and Financial Regulation

Bureau of Insurance

Superintendent Eric A. Cioppa

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Section I – Executive Summary

Request

The State of Maine, through its Department of Professional and Financial Regulation, Bureau of Insurance (the “Bureau of Insurance”), submits this application for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act (“section 1332 waiver”) to the Department of the Treasury and the Centers for Medicare & Medicaid Services in the Department of Health and Human Services (collectively, “the Departments”).

Maine currently has an approved section 1332 waiver that waived Section 1312(c)(1) of the Patient Protection and Affordable Care Act (“PPACA”) for a period of five years beginning January 1, 2019 to permit reinstatement of the Maine Guaranteed Access Reinsurance Association (“MGARA”) reinsurance program for the individual health insurance market.

In a letter to the Departments dated October 2, 2020, Maine expressed its intent to submit an application seeking approval of a section 1332 waiver amendment that would waive PPACA Section 1312(c)(1) for a new waiver period of five years beginning January 1, 2023 to permit extension of the MGARA reinsurance program to a pooled individual and small group market and transition to a retrospective claims cost-based reinsurance program. The Departments confirmed on December 28, 2020 that the application would be reviewed as a waiver amendment application.

On March 12, 2021, the State opened the public comment period and announced public hearings on the draft 1332 waiver amendment application as it was proposed in the State's letter of intent to the Departments. However, on March 25, 2021, the State made the decision to delay pooling the individual and small group markets and extending MGARA reinsurance to that pooled market until 2023, but to proceed with transitioning to a retrospective claims cost-based reinsurance program for 2022. As advised by the Departments, Maine has proceeded with a technical change to its existing section 1332 waiver to transition MGARA reinsurance to a retrospective model beginning January 1, 2022. The 1332 waiver amendment application as originally drafted was revised to reflect these developments.

Accordingly, this application seeks approval of a section 1332 waiver amendment that would waive PPACA Section 1312(c) for a new waiver period of five years beginning January 1, 2023 to permit extension of the MGARA reinsurance program to a pooled individual and small group market. The requested amendment would also permit quarterly rate adjustments for small group plans that do not renew on a calendar year basis.

This waiver would not affect any other provision of the PPACA. The waiver is expected to result in a lower market-wide index rate, thereby lowering gross (*i.e.*, prior to the application of federal premium tax credits) individual premiums from what they would have been without the reinsurance program, thereby reducing the federal cost of the premium tax credits (PTCs).

Background

In 2011, Maine passed the “Maine Guaranteed Access Reinsurance Association Act” as part of Public Law 2011, Chapter 90. This law established MGARA, a private nonprofit organization responsible for operating a reinsurance program for the higher-risk segment of Maine's individual health insurance market. In 2013, the MGARA reinsurance program limited what otherwise would have been a 22 percent rate increase to only a 2 percent increase. Despite its success, this reinsurance program was placed in suspension due to the PPACA, in order to avoid redundant costs to the Maine market because of parallel federal and state reinsurance programs.

In 2018, Maine applied for, and the Departments approved, the state's current section 1332 waiver, which allowed for reinstatement of the MGARA reinsurance program for the individual market beginning January 1, 2019. By reimbursing insurers for high-cost claims, the reinsurance program spread risk across the broader Maine health insurance market, thereby lowering gross premiums and increasing access to affordable private coverage. Since the waiver became effective, average premium rates for the individual market have moderated each year: a 1.1% increase in 2019, a 0.5% decrease in 2020, and a 12.5% decrease in 2021.

As explained below, the State has transitioned MGARA from a prospective to a retrospective reinsurance program for 2022.

Basis for Request and Goal of Reinsurance Program

In recent years, the small group market in Maine has experienced significant declines in membership, due in part to high medical cost trends and associated premium increases. From March 2017 to March 2020, there was an 18% reduction in small group membership from 61,200 to 50,200. The average annual premium rate increase for the small group market was 11% in 2019, 8.8% in 2020, and 5.5% in 2021. On its current trajectory, the small group market may continue to see membership decline, and only those that truly need health care services may stay enrolled in the market, which will lead to a continued escalation in premiums. Because of this trend, Maine has been considering ways to help stabilize and lower premiums for the small group market. One way is to extend the positive impacts the MGARA reinsurance program has had on individual health insurance to small group health insurance.

As explained more fully in Section II, Maine Public Law 2019, Chapter 653, “An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine,” provides legislative authorization for Maine's Superintendent of Insurance to adopt rules to pool the individual and small group markets in Maine and to apply for a section 1332 waiver amendment that extends the MGARA reinsurance program to this pooled market. Pooling the markets is contingent upon the Superintendent adopting rules, as well as the Departments approving a section 1332 waiver amendment.

Maine is submitting this section 1332 waiver amendment application in accordance with Public Law 2019, Chapter 653. As proposed, this waiver would allow Maine to extend the MGARA reinsurance program to a pooled individual and small group market. Maine would continue to

receive federal pass-through funding in the amount of the savings that would be generated from the resulting reduction in PTCs.

Extending the MGARA reinsurance program to a pooled individual and small group health insurance market would bring increased certainty and stability to small group health insurance in Maine through a positive effect on premium levels. By reinsuring high-cost claims for small group health insurance in addition to individual health insurance, the MGARA reinsurance program would spread risk across the broader Maine health insurance market, thereby lowering premiums. The MGARA reinsurance program would also spread the most volatile component of the risk within the pooled market, thereby providing stability, and it is also expected to encourage insurers to continue offering individual and small group health insurance in Maine.

Funding and Impact of the Reinsurance Program

Maine estimates that pooling the markets and applying a retrospective reinsurance program will lower the average individual market premium by 8.1% and will lower the average small group market premium by 6.0%, compared to the baseline of no section 1332 waiver and no reinsurance program for 2023. The reduction in individual market premium would generate \$22.9 million in net federal savings in 2023. This net reduction in federal spending from lower PTCs will be used to fund the retrospective reinsurance program covering the pooled market.

For 2023, an additional \$8.6 million in reinsurance program funding that was received by Maine in 2021 as a result of the American Rescue Plan Act (ARPA) will be used to further reduce premiums in the first year of the waiver.

In addition to federal funds generated from the reduction in PTCs, Maine would also continue to use the \$4.00 per member per month (PMPM) assessment across Maine's fully-insured and self-insured commercial health insurance markets that the MGARA reinsurance program uses now under the state's current section 1332 waiver. With an assessment base of approximately 503,000 covered lives, the \$4.00 PMPM assessment is expected to generate \$26.7 million in revenue in 2023, the first year of the waiver. A portion of the funds (estimated to be \$300,000 annually) will be used to administer the reinsurance program.

Based on these two funding sources, the total funding for the MGARA reinsurance program for 2023 is estimated to be approximately \$58.2 million.

For purposes of this application, the State modeled the 2023 MGARA reinsurance program assuming reimbursement to insurers of 55% of claims costs between \$90,000 and \$275,000, with the portion of claims exceeding \$275,000 being the full responsibility of the insurer. These parameters may be adjusted to ensure that MGARA maintains adequate surplus to assure its solvency on an actuarially sound basis and that its reinsurance program will operate in a manner designed both to provide reduction in premium rates and to enhance overall market stability. Pursuant to state law, the MGARA Board of Directors (MGARA Board) is responsible for making the final determination of attachment points, subject to approval by the Superintendent of Insurance.

Compliance with Section 1332 Waiver Guardrails

Granting the section 1332 waiver amendment will not impact the comprehensiveness, affordability, or scope of coverage in the Maine insurance markets and will not increase spending by the federal government.

Section II – Authorizing Legislation

On March 18, 2020, Public Law 2019, Chapter 653, “An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine” became effective in Maine. This legislation authorizes the submission to the Departments of an amendment to Maine's current section 1332 waiver. Under this authority, Maine is submitting a section 1332 waiver amendment application. The legislation includes the provisions outlined below.

Title 24-A M.R.S. § 2781 authorizes the State of Maine to enter into “state-federal health coverage partnerships,” which includes state innovation waivers under Section 1332 of the PPACA, that support the availability of affordable health coverage in Maine.

Title 24-A M.R.S. § 2792 authorizes the Superintendent of Insurance to establish a pooled market for all individual and small group health plans offered in Maine beginning January 1, 2023, based on projections by the Superintendent that both average individual premium rates and average small group premium rates would be the same or lower than they would have been absent this section. The implementation of this section is also contingent upon the Superintendent's adoption of rules to implement the pooled market, as well as Federal approval of a state innovation waiver amendment that extends reinsurance under Title 24-A M.R.S. § 3953 to the pooled market. The state has recently adopted a rule to implement the pooled market, which establishes the necessary conditions and procedures for implementation of the pooled market and the extension of MGARA reinsurance to small group health insurance. On October 12, 2021, the state held a rulemaking hearing on proposed 02-031 CMR ch. 856, *Combination of the Individual and Small Business Health Insurance Risk Pools*. The comment period ended on October 25, 2021, and the rule has been adopted with an effective date of January 24, 2022. Rule 856 is available at this link:

<https://www.maine.gov/pfr/insurance/legal/rules/index.html>

Title 24-A M.R.S. § 3953(1) authorizes MGARA to operate a reinsurance program contingent on the approval of, or continued approval of, a 1332 waiver submitted by the Superintendent of Insurance.

Title 24-A M.R.S. § 3958(A-1) requires MGARA to operate a retrospective reinsurance program for the pooled market, if such pooled market is implemented in accordance with the requirements set forth in Title 24-A M.R.S. § 2792. This subsection also allows MGARA to operate a retrospective reinsurance program for individual health plans beginning in 2022 if the pooled market has not been implemented, subject to the Superintendent's approval.

On June 23, 2021, Public Law 2021, Chapter 361, “An Act To Clarify the Deferral of the Pooled Market and Link Small Employer Clear Choice to Pooling in the Made for Maine Health Coverage” was signed by the Governor. This legislation became effective on October 18, 2021 and includes the changes outlined below.

In 24-A M.R.S. § 2792, the legislation changes the effective date of the pooled market from January 1, 2022 to January 1, 2023. Also in that section, the legislation amends the preconditions required for the pooled market by clarifying that establishment of the pooled market is to be based on projections by the Superintendent that both average individual premium rates and average small group premium rates would be the same or lower than they would have been absent this section, and absent Chapter 54-A, which is the chapter of the Maine Insurance Code that establishes and governs MGARA.

A copy of Public Law 2019, Chapter 653 can be found online at the following link www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC653.asp.

A copy of Public Law 2021, Chapter 361 can be found online at the following link <http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0570&item=4&snum=130>.

Both are included in **Appendix A: Authorizing Legislation.**

Section III – Provision(s) of the Law that the State Seeks to Waive

In order to achieve its goals of reducing premiums and ensuring stability for the pooled individual and small group markets, Maine requests a waiver of section 1312(c) of the ACA as implemented at 45 C.F.R. § 156.80, and any other provisions necessary, to the extent that they would otherwise require excluding expected state reinsurance payments through MGARA when establishing the market-wide index rate and to the extent that they would otherwise prohibit quarterly adjustments of small group rates in a pooled market.

The Single Risk Pool provision of the ACA (PPACA § 1312(c)) and implementing regulations (45 CFR 156.80) require a health insurance issuer to consider “all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.” 45 CFR 156.80(d)(2) provides that an “issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors.” These regulations enumerate specific factors, and limit an issuer's ability to set premiums to only those factors to make plan-level premium adjustments to the market-wide index rate for premiums. The permitted factors include actuarial value and cost-sharing design; provider network, delivery system characteristics, and utilization management practices; benefits provided in addition to EHBs; and administrative costs. The enumerated factors apply to all plans in the applicable single risk pool.

The permitted factors above do not include expected state reinsurance payments through MGARA. Excluding those payments from consideration would overstate issuers' net cost of providing coverage and result in inappropriately high premiums, defeating the purpose of the reinsurance program. Therefore, Maine is requesting a waiver of PPACA §§ 1312(c)(1) and (2) as implemented at 45 CFR 156.80, and any other provisions necessary to enable the consideration of total expected state reinsurance payments when determining the market-wide index rate in the newly pooled individual and small group markets into a single risk pool for rate setting and risk adjustment purposes.

In addition, 45 CFR 156.80(d)(4) provides that when the individual and small group risk pools have been merged pursuant to PPACA § 1312(c)(3), the provisions allowing quarterly small group rate adjustments do not apply. To permit the market to continue effectively serving employers with non-calendar-year business cycles, Maine is requesting a waiver of these provisions and any other provisions necessary to permit issuers to continue applying quarterly rate adjustments for small group coverage that is not issued on a calendar-year basis.

The state is seeking federal pass-through funding to support its MGARA reinsurance program. Both the reinsurance program and the pooling of the individual and small group markets are expected to reduce rates in the individual market, compared to the rates that would be charged without a section 1332 waiver in effect. The reduction in individual market rates will lower federal spending for PTC, which represents the difference between the second lowest cost Silver plan (SLCSP) premium and the maximum amount an individual or family is expected to pay based on their family income and size. The net reduction in federal spending on PTC from the reinsurance program and pooled market will result in pass-through funding which will be used to fund the state reinsurance program, including eligible reinsurance claims and administration of the program on an actuarially sound basis.

MGARA's enabling legislation, at 24-A M.R.S. § 3957, establishes funding mechanisms to spread the costs associated with the MGARA reinsurance program across the fully-insured and self-insured markets. Under the proposed waiver amendment, pass-through funds received by the state would continue to be contributed to MGARA as an additional revenue source to enhance its ability to make insurance more affordable for Maine residents and increase market stability for insurers. The funding mechanisms are described in Table 1 below.

Table 1. Funding Mechanisms

<u>Funding Mechanism</u>	<u>Description</u>
Base Market Assessment	Assessment to health insurers and third-party administrators based on the number of insured lives covered by each in the fully-insured individual, small group, and large group and self-insured markets (excluding State and Federal employees), at a rate of up to \$4 PMPM or a total of \$26.7M in 2023.
Deficit Assessment	Optional Assessments to cover any Net Losses — up to a maximum of \$2 PMPM or an additional \$13M if needed in 2023. assessed to health insurers based on the number of insured lives covered by each
Pass-Through Funding	Under the proposed waiver amendment, all pass-through funds will be contributed to MGARA to enhance its capabilities. Estimated at \$22.8M for 2023.

Insurer premiums	Premiums may be charged to member insurers to reinsure persons eligible for coverage under a retrospective program if charged on an equitable basis to all member insurers and approved by the Superintendent of Insurance. MGARA does not currently plan to charge a premium in 2023.
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The MGARA reinsurance program operates pursuant to a statutorily required plan of operation that the MGARA Board must adopt and the Superintendent of Insurance must approve.¹ The current approved MGARA Plan of Operation is included in **Appendix B: Maine Guaranteed Access Reinsurance Association Plan of Operation**.

The MGARA reinsurance program currently provides reinsurance for individual policies. Prior to 2022, carriers ceded policies covering high-risk individuals using a prospective model that relied on carriers identifying policies with ICD-10 codes associated with mandatory ceding conditions specified by the MGARA Board and also allowed for discretionary ceding. When a carrier ceded a policy to MGARA, it operated like a traditional reinsurance program with the ceding carrier paying MGARA a premium, and in return, MGARA paying a portion of the carrier's claims if the claims exceed the specified attachment point. Beginning in 2022, the MGARA program was converted to a retrospective program reimbursing carriers at a specified coinsurance rate for claims that meet or exceed a specified attachment point and are not in excess of a specified reinsurance limit. For 2022 carriers are reimbursed for 100% of claims costs in excess of \$76,000 up to a limit of \$250,000. Claims costs below \$76,000 and in excess of \$250,000 are the responsibility of the carriers. These reinsurance thresholds are determined annually by the MGARA Board, subject to approval by the Superintendent.

The amended waiver would extend the MGARA reinsurance program to a pooled individual and small group market. The legislation authorizing the pooled individual and small group market, as well as this section 1332 waiver amendment application to provide reinsurance to that pooled market, also requires transition to a retrospective claims cost-based reinsurance program. As previously noted, the State has already transitioned MGARA reinsurance to a retrospective model beginning January 1, 2022, as permitted by the authorizing legislation and authorized by the Departments. MGARA has adopted a revised plan of operation reflecting the retrospective reinsurance program and incorporating the updated payment parameters discussed above, which the Superintendent of Insurance approved for implementation as of January 1, 2022.

If this section 1332 waiver amendment application is approved, the plan of operation will need to be revised further to reflect the applicability of MGARA reinsurance to the pooled market prior to the January 1, 2023 effective date. The amended plan of operation will also need to incorporate further updated payment parameters for pooled market reinsurance, as adopted by the MGARA Board and approved by the Superintendent of Insurance.

¹ See Title 24-A M.R.S. § 3953.

The authorizing legislation establishes some of the parameters for operating the pooled market. This includes a requirement that a carrier offering a pooled market plan must offer the same plan to all individuals and small employers within any service area where the carrier has made the plan available. As such, carriers must offer both individual and small group coverage; however, it does not require carriers to market all pooled market plans in the same manner to all customers. The legislation also establishes a consolidated procedure under which premium rates for pooled market plans are filed and reviewed in accordance with the State's requirements for individual plans. Additionally, Maine intends to continue using its existing practice of using the federal age rating curve, and has codified that age curve by rule at 02-031 CMR ch. 942. Maine intends that the market will operate as a pooled market for purposes of risk adjustment. Rule 942 is available at this link: <https://www.maine.gov/pfr/insurance/legal/rules/index.html>

As mentioned above, the Bureau of Insurance has adopted rule 02-031 CMR ch. 856 to establish further operational requirements. These include a process for the actuarial review the Superintendent is required to conduct to determine whether the pooled market with subsidized reinsurance will lower premiums for both individuals and small employers, and to solicit public input on both the pooled market proposal and other alternatives to improve the stability and affordability of the small group market. The rule also authorizes the continued operation of MGARA for individual coverage, on either a prospective or retrospective basis, if implementation of the pooled market is deferred for any reason.

The Bureau of Insurance will communicate with issuers participating on the Marketplace that issuers should include state-operated reinsurance payments in rate setting. The implementation of this waiver will be straightforward, as claims for enrollees through the reinsurance program will still be collected. A single MLR will be calculated for the merged market, instead of two separate MLRs for the individual and small group markets.

Section IV – Compliance with Section 1332 Guardrails: Data, Analyses, and Certifications

Maine utilized Gorman Actuarial, Inc. (Gorman) to perform actuarial and economic analyses related to the changes that would occur after this section 1332 waiver amendment application is approved and implemented beginning in 2023. The actuarial and economic analyses and certifications that support the state's findings that all four of the section 1332 guardrails will be met are included in **Appendix C: Gorman Associates Actuarial and Economic Report**.

A. Comprehensiveness Requirement (Section 1332(b)(1)(A))

The first guardrail is comprehensiveness, which refers to the scope of benefits provided under the section 1332 waiver, as measured by the extent to which coverage meets essential health benefits (EHB) requirements as defined in PPACA § 1302(b) and 45 CFR 156.110. Information about Maine's EHB benchmark, which is the same with or without the section 1332 waiver, can be found at the following link:

www.maine.gov/pfr/insurance/regulated/insurance_companies/rate_form_checklists/life_health/plan_year_qhp-sadp.html

Maine has determined that the proposed section 1332 waiver amendment will not result in any changes to the EHB benchmark or actuarial value requirements, and therefore, will have no impact on the comprehensiveness of coverage available in the individual and small group markets.

B. Affordability Requirement (Section 1332(b)(1)(B))

The second guardrail is affordability, which refers to the ability of state residents to pay out-of-pocket for healthcare expenses relative to their income and specifies that 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 provided without the waiver. Maine has determined that the proposed section 1332 waiver amendment 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 from a standpoint of cost-sharing for coverage. The waiver will increase affordability by reducing average premiums by 8.1% in the individual market and by 6.0% in the small group market. Although the pooled market by itself, without subsidized reinsurance, would result in lower individual premiums but higher small group premiums, the extension of MGARA to the entire pooled market allows significant premium reductions for both individuals and small employers.

C. Scope of Coverage Requirement (Section 1332(b)(1)(C))

The third guardrail is scope of coverage, which specifies that the section 1332 waiver must provide meaningful healthcare coverage to a comparable number of state residents as would be provided without the waiver. Maine projects that for each year the proposed section 1332 waiver amendment will be in effect, the number of individuals that will have healthcare coverage under the waiver is comparable to the number of individuals that would have had healthcare coverage absent the waiver. Maine has examined the short and long-term effects of the waiver, and while the state conservatively projects that the number of individuals covered will remain stable, lower premiums could increase the number of individuals covered.

Membership in the small group market is driven primarily by three market forces: (1) the cost of coverage; (2) the labor market and the ability of employers to attract and retain workers; and (3) the availability of alternative health coverage arrangements. As premiums increase, employers find it difficult to continue to offer employees affordable health benefits. Over the past several years, premiums in Maine's small group market have increased and the number of employees and dependents covered has declined. The expected premium reductions resulting from the waiver could slow or reverse this adverse trend.

The reduction of covered lives in the small group market is largely due to a decrease in the number of employers offering health coverage in the fully-insured (ACA-compliant) market but may also be affected by a drop in the number of employees that choose to enroll when offered coverage (known as the "take up" rate). Those residents that obtain coverage through other means, such as Medicaid, the Children's Health Insurance Program (CHIP), large group market insurance, or other types of coverage, will have the same access to coverage.

D. Deficit Neutrality Requirement (Section 1332(b)(1)(D))

The fourth guardrail is deficit neutrality, which specifies that the section 1332 waiver must not increase federal spending that would occur absent the waiver. Maine has determined that the proposed section 1332 waiver amendment will not increase federal spending.

The administrative costs to facilitate the section 1332 waiver amendment will be paid from the revenue generated by the \$4.00 PMPM state assessment that applies across Maine's fully-insured and self-insured commercial health insurance markets.

Maine's estimates show the amount of federal spending will be less than or equal to what the federal government would have paid during each year of the required 10-year budget period. Maine estimates that federal savings will be: \$22,906,147 for 2023; \$18,373,604 for 2024; \$19,230,946 for 2025; \$20,137,717 for 2026; \$21,086,381 for 2027; \$22,067,667 for 2028; \$23,093,758 for 2029; \$24,166,684 for 2030; \$25,288,566 for 2031 and \$26,461,620 for 2032.

Section V – Health Equity Issues

Many health policy- and certificateholders have affordability concerns related to the cost of premiums and their premiums, deductibles, copayments, and coinsurance, as well as challenges related to health literacy and the ability for the insured to find and access in-network providers. Chronic conditions and social risk factors including poverty, minority race and/or ethnicity, social isolation, and limited community resources exacerbate these problems even for people who have health insurance.

- Maine's section 1332 waiver will promote health equity in the insured population through competitive private coverage. Extending the MGARA reinsurance program to a pooled individual and small group market would bring increased certainty and stability to small group health insurance in Maine through a positive impact on premium levels and spreading the most volatile component of the risk within the pooled market.
- Outside of the section 1332 waiver, Maine is also encouraging health plan simplicity and clarity through 24-A M.R.S. § 2793, which requires issuers in the individual market to offer standardized cost-sharing designs; this program will apply to both individual and small group coverage once the pooled market is implemented. On June 11, 2021, Maine issued Bulletin 458, Clear Choice Designs for the 2022 Individual Health Insurance Market, to guide insurers in preparing their plan filings for that year. Bulletin 458 is available at this link: <https://www.maine.gov/pfr/insurance/legal/bulletins/pdf/458.pdf>
- Public Law 2019, Chapter 522, enacted 24-A M.R.S. § 4326, which established Maine's Consumer Health Assistance Program.
- Public Law 2021, Chapter 80, has amended 24-A M.R.S. § 2809-A to require individuals whose group coverage is terminated to be given notice of their coverage options, including special enrollment periods and the possibility that they might qualify for

premium assistance or Medicaid, along with information on how to contact the Consumer Assistance Program.

- Public Law 2021, Chapter 291, updates various laws relating to telehealth services to facilitate access to care delivered through telehealth.
- Public Law 2021, Chapter 483, includes a provision allocating \$39 million of Maine's ARP funding to establish a temporary premium support program for small group health insurance.

Section VI – Reporting Targets

MGARA will submit all required quarterly, annual, and cumulative targets for the guardrail requirements in accordance with 31 CFR 33.108(f)(4)(vi) and 45 CFR 155.1308(f)(4)(vi).

MGARA will assume responsibility for the reporting requirements, including the following:

- Quarterly reports (31 CFR 33.124(a) and 45 CFR 155.1324 (a)): To the extent required by the Departments, MGARA will submit quarterly reports, including reports of ongoing operational challenges, if any, and plans for, and results of, associated corrective actions.
- Annual reports (31 CFR 33.124(b) and 45 CFR 155.1324(b)): MGARA will submit annual reports documenting the following:
 - (1) The current state and the progress of the section 1332 waiver to date.
 - (2) Data on the state's compliance with the guardrails in PPACA section 1332(b)(1)(A)-(D), 31 CFR 33.108(f)(3)(iv)(A)-(D), and 45 CFR 155.1308(f)(3)(iv)(A)-(D).
 - (3) Premiums for the second lowest-cost silver plan under the section 1332 waiver and an estimate of the premium as it would have been without the waiver for a representative consumer in each rating area.
 - (4) A summary of the annual public forum required by 31 CFR 33.120(c) and 45 CFR 155.1320(c) and a summary of actions taken in response to public input.

Section VII – Implementation Plan and Timeline

The State of Maine will establish a waiver to be administered by MGARA, an existing entity.

Maine has reviewed the list of implementation questions posed by the Departments in the 2018 Discussion Paper. In order to comprehensively address implementation challenges, Maine provides responses to the applicable questions below.

- 1) What is the entity that will administer the program? Is it a new or existing entity? To what extent will the entity be subject to state insurance laws?

MGARA, an existing entity that is already providing reinsurance to the individual market under Maine's existing section 1332 waiver, will continue to administer the program. MGARA was established by, and is subject to, Chapter 54-A of the Maine Insurance Code, which is enforced by the Bureau of Insurance. See Title 24-A M.R.S., Chapter 54-A, "Maine Guaranteed Access Reinsurance Association Act."

- 2) What will be the data collection timing and mechanism for collecting claims information and generally for pay-out?

The MGARA Board will amend the MGARA Plan of Operation to adjust these operations as necessary to cover the pooled market. The Plan has already been amended to effectuate the transition from a prospective to a retrospective insurance program. The existing plan calls for quarterly claims reporting with final annual adjudication of all claims.

- 3) If pursuing a reinsurance waiver, will the state be using a conditions-based list and/or an attachment point model?

An attachment point model, as described above.

- 4) Will the program include incentives for providers, enrollees, and plan issuers to continue managing health care cost and utilization for individuals eligible for the described reinsurance program (if any)?

Yes. The authorizing legislation for this reinsurance program requires member insurers to report for each plan year the name of each high-priced item or service for which its payment exceeded the amount allowed for eligible claims and the name of the provider that received this payment, and requires MGARA to annually compile and publish a list of all reported names. See Title 24-A M.R.S. § 3958(1)(B).

- 5) Will the state specify a co-insurance amount, or a cap, based on available funds, similar to the federal reinsurance program?

The MGARA program will specify a co-insurance amount applicable to claims costs within the reinsurance thresholds determined in advance of each year. These thresholds set an upper per-claim limit, but there is no overall “cap” on total reinsurance payments based on available funds. The MGARA Board is charged with maintaining adequate capital (determined in an actuarially sound basis) to cover projected reimbursement payments. MGARA maintains a surplus based on a targeted RBC ratio in order to provide adequate assurance of funding for reimbursement payments over time.

- a. When will the parameters be finalized?

The parameters will be finalized when MGARA files with Maine's Superintendent of Insurance an amended Plan of Operation that sets forth final parameters, and the Superintendent approves the amended Plan of Operation.

- 6) Further, does the state have the ability to adjust the parameters to account for market changes? If so, what is the schedule and process for finalizing the parameters on a year by year basis?

Yes. Subject to the approval of Maine's Superintendent of Insurance, MGARA has the statutory authority to annually adjust the level of claims and maximum limit to be retained by insurers to reflect changes in cost, utilization, available funding, and any other factors affecting the sustainable operation of the association. The

MGARA Board must annually review the attachment points and coinsurance percentages and make any necessary adjustments to ensure that the retrospective reinsurance program operates on an actuarially sound basis. See Title 24-A M.R.S. § 3958.

- 7) Will the state require issuers to include the impact of the reinsurance program and/or high-risk pool in initial and/or final rates?

Yes, in both initial and final rates. Maine requires this now for its existing section 1332 waiver.

- 8) Are there any legislation and/or regulations related to the state reinsurance program?

Yes. The governing legislation is Chapter 54-A of the Maine Insurance Code, as amended by Public Law 2019, Chapter 653, “An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine,” effective March 18, 2020, and further amended by Public Law 2021, Chapter 361, “An Act To Clarify the Deferral of the Pooled Market and Link Small Employer Clear Choice to Pooling in the Made for Maine Health Coverage Act,” effective October 18, 2021. The Bureau of Insurance’s regulation 02-031 CMR ch. 856, Combination of the Individual and Small Business Health Insurance Risk Pools, effective January 24, 2022, also contains provisions relating to the reinsurance program and this Section 1332 waiver.

- a. Are any additional regulations needed? If so, what is the timing of those regulations?

No.

Maine submits the proposed waiver implementation timeline, which is detailed in Table 2 below.

Table 2. Implementation Timeline

End Date	Milestone
Section 1332 Waiver Application Process	
March 12, 2021	Publish draft section 1332 waiver application on state website and notify the public.
March 12, 2021	Begin public comment period.
March 12, 2021	Initiate tribal consultation.
March 22, 2021	Conduct first public hearing virtually.
March 29, 2021	Conduct second public hearing virtually.
April 19, 2021	End public comment period.
January 27, 2022	Submit final section 1332 waiver application to the Departments.

End Date	Milestone
June 2022	Target to receive approval from the Departments for the section 1332 waiver.
July 2022	Initial Rate Filings for Merged Market
October 2022	Rates Finalized for Merged Market
Legal Authority and Governance	
September 10, 2021	File proposed rule to implement pooled market in 2023 with state authority.
January 24, 2022	File final adopted rule to implement pooled market in 2023 with state authority.
Design	
September 2022	MGARA submits amended Plan of Operation for pooled market implementation to the Bureau of Insurance.
December 2022	Bureau of Insurance approves amended Plan of Operation.
March 2023	MGARA sends out assessments to carriers
May 2023	Insurers pay first quarterly assessment
Implementation	
January 1, 2023	Pooled market with MGARA reinsurance program extended to the pooled market begins.

Section VIII – Public Notice, Comment Process, and Communication Plan

A. Public Notice

On March 12, 2021, Maine opened the public comment period for this section 1332 waiver amendment application and posted the notice of the opportunity to comment on the state website www.maine.gov/pfr/insurance/legal/notices/public_meetings_events.html. Also on March 12, 2021, Maine sent notice via GovDelivery to its list of interested parties and stakeholders. The notice scheduled public hearings for March 22, 2021 and March 29, 2021 and set a deadline for written comments of April 12, 2021. The notice is included in **Appendix D: Notice for Public Comment Period and Public Forum**.

B. Public Comment Process

Due to the COVID-19 public health emergency, Maine submitted a request to the Departments pursuant to 31 CFR 33.118 and 45 CFR 155.1318 to modify, in part, the state public notice requirements specified in 31 CFR 33.112 and 45 CFR 155.1312. Specifically, Maine sought to modify the requirement to hold more than one public hearing in more than one location, and

proposed to hold two public hearings virtually, rather than in-person. The Departments granted this request, and Maine held two public hearings virtually.

On March 22, 2021, Maine held a public hearing virtually. Representatives of the following entities attended the hearing: MGARA, Maine Association of Health Plans, Anthem BCBS, Community Health Options, Consumers for Affordable Health Care, Maine People Before Politics, and Maine State Legislature. Two of the attendees testified: Maine Association of Health Plans and Anthem BCBS. The presentation from this hearing is included in **Appendix E: Presentations from the Public Hearings**.

After this hearing, the State made the decision to delay pooling the markets and extending MGARA reinsurance to the pooled market until 2023. The State informed interested insurers, consumer advocate groups, MGARA, as well the Departments.

On March 29, 2021, Maine held a second public hearing virtually. Representatives of the following entities attended the hearing: MGARA, Maine Association of Health Plans, Anthem BCBS, Community Health Options, Consumers for Affordable Health Care, and Maine Credit Union League Insurance Trust. Two of the attendees, Maine Association of Health Plans and Anthem BCBS, asked the State procedural questions about the application going forward. Two other attendees testified: Community Health Options and MGARA. The presentation from this hearing is included in **Appendix E: Presentations from the Public Hearings**.

In response to MGARA and insurer requests for additional time to submit written comments, the State extended the deadline for written comments to April 19, 2021. Notice of this extension was posted on the state website (previously provided) and sent via GovDelivery to its list of interested parties and stakeholders on March 31, 2021. The notice is included in **Appendix D: Notice for Public Comment Period and Public Forum**.

Five members of the public submitted written comments. These comments are included in **Appendix F: Written Public Comments**.

At the first hearing, insurer representatives from the Maine Association of Health Plans and Anthem BCBS raised concerns about pooling the markets. They questioned whether the preconditions of the state law authorizing the pooled market had been met. They asserted that the appropriate baseline for assessing the impact on premiums under that law is no pooled market and the current MGARA program reinsuring the individual market, rather than the State's interpretation that the baseline is no pooled market and no MGARA reinsurance program. Based on this interpretation, they stated that expanding MGARA reinsurance to the pooled market diminishes the positive premium impact on the individual market. Additionally, insurer representatives raised concerns about the implementation timeline, noting that insurers need to know the payment parameters now in order to effectively participate in the market. They also raised concerns about implementing all of the State's various initiatives at once (*i.e.*, pooling the markets and amending the 1332 waiver, establishing standardized plan requirements, and transitioning to a full State-Based Exchange). Due to these concerns, they encouraged the State to delay pooling the markets and the associated waiver amendment until 2023. Anthem BCBS reiterated these concerns in written comments.

In response to these comments, the State notes that in June 2021, the Maine Legislature passed legislation, P.L. 2021, Chapter 361 (discussed in Section II of this application), which clarified

the preconditions required to establish the pooled market, making it clear that the baseline for assessing the impact on premiums is no pooled market and no subsidized reinsurance program. This legislation also delayed pooling the market until January 1, 2023. These legislative changes address the concerns raised.

At the second hearing, an insurer representative from Community Health Options (“CHO”) provided comments on the application as originally drafted, which echoed the concerns raised by the other insurer representatives that testified at the first hearing. CHO did express appreciation for the State’s decision to delay pooling the markets but also raised concerns about the decision to proceed with the transition to the retrospective program for 2022. CHO claimed that, although the retrospective model has a distinct advantage as to ease and simplicity, its claims recovery would be reduced under this model. CHO also noted that payment parameters in the draft application do not reflect the ultimate structure to be adopted by MGARA, and therefore, insurers do not know what numbers to use to establish pricing. For these reasons, CHO urged Maine to keep its existing model until further evaluation can be made. CHO reiterated these concerns in written comments.

MGARA’s general counsel also testified and expressed concerns about proceeding with the transition to a retrospective program for 2022. He stated that the MGARA Board decided at its last board meeting that, should the pooled market not be implemented in 2022, the Board’s preference would be to keep the program as it is for 2022 and to make the transition to a retrospective model if the pooled market is ultimately implemented. He noted that moving to a retrospective program for 2022 would still create uncertainty, and it would be helpful to have a stable environment while the other State initiatives (previously mentioned) are taking place. At the time those comments were submitted, the MGARA Board had not yet had the opportunity to discuss the decision to delay the pooled markets until 2023 and proceed with the retrospective program for 2022.

In response to these comments, the State concluded that transitioning MGARA to a retrospective program for 2022 would be beneficial because it will give MGARA a year of experience with a retrospective program before any additional change is made to extend the program to a pooled market for 2023. Making these changes incremental will lessen disruption to the program. Ultimately, MGARA has made the decision to proceed with a technical change to the existing section 1332 waiver to transition MGARA reinsurance to a retrospective model beginning January 1, 2022. Regarding the concern about the payment parameters provided in the draft application, those have been updated in light of the State’s decision to delay pooling the market and the waiver amendment application to allow for further analysis.

In written comments, AARP Maine, the American Lung Association, and Consumers for Affordable Health Care (“CAHC”) supported the amendment application as originally drafted, believing it would help the groups they represent obtain affordable, comprehensive coverage by lowering health care premiums and would help stabilize the health insurance markets. CAHC expressed concern about delaying the pooled market until 2023, believing it will result in a missed opportunity created by the expanded subsidies for 2022 under the American Rescue Plan Act. CAHC also questioned whether reinsurance is still an effective use of the money derived from the \$4 PMPM state assessments given the expanded subsidies, or whether other initiatives would be a more effective use of the funds. AARP Maine stated that the public forum that is

required within six months of the waiver's implementation should include an assessment on the waiver's impact on Maine's older residents.

In response to these comments, as the State noted in its Notice of Public Comment Period Extension, the State delayed implementation of the pooled market and the associated waiver amendment in order to better understand and address the impact of COVID-19 and the premium tax credit changes made by the American Rescue Plan Act of 2021. Regarding AARP's request that the annual public forum include an assessment of the waiver's impact on older residents, the State notes that the public forum is intended to receive public comments on the progress of an approved waiver and does not require the State to undertake any new assessment of the program at that time.

In addition to the Section 1332 comment process, the Bureau of Insurance held a public hearing on October 12, 2021, on its proposed regulation to establish procedures for implementation of the pooled market, which has now been adopted as 02-031 CMR ch. 856. The most significant issue raised at that hearing was the unintended consequences of the State's original proposal to make an annual January 1 rate adjustment applicable to all plans in the pooled market, including in-force small group plans with non-calendar-year renewal dates. Comments from across the spectrum of stakeholders, including issuers, employer associations, brokers, and consumer advocates, all objected that it would be disruptive and unworkable to require rate adjustments to take effect in the middle of a plan year rather than at renewal. They noted that Massachusetts successfully operates a merged market with plan-year rating and quarterly small group rate adjustments. Based on these comments, language requiring calendar-year rating was not included in the adopted rule, and Maine is requesting a rating framework under which the market-wide rates approved through the annual review process would apply to individual plans and to those small group plans with effective dates of coverage in January, February, and March. For small group plans with effective dates of coverage on or after April 1, issuers would be able to adjust rates on a quarterly basis, subject to the approval of the Superintendent, in the same manner as they are currently permitted to do under 45 CFR 156.80(d)(4)(ii). This would provide rate stability for employers with non-calendar-year plans, and would not have an adverse impact on affordability. While these employers would pay more than individuals and calendar-year employers in the first months of their plan year, they would be paying less after January 1 in the typical scenario where rates increase with the passage of time. On average, the total expected monthly cost would be the same, maintaining rate parity across the entire merged risk pool.

On January 28, 2022, the Bureau of Insurance held a public forum at which Gorman Associates presented its Actuarial and Economic Report. Notice of the forum is included in **Appendix D: Notice for Public Comment Period and Public Forum**. Attending the forum were representatives from, among others, the Legislature, MGARA, Maine Association of Health Plans, Maine Chamber of Commerce, Anthem BCBS, Community Health Options, Consumers for Affordable Health Care, and Maine Credit Union League Insurance Trust. The Bureau of Insurance gave attendees until February 4, 2022 to submit written comments. The two submitted comments appear in **Appendix F: Written Public Comments**. On February 1, 2022, the Bureau of Insurance and Gorman Associates made a similar presentation to the Legislature's Joint Standing Committee on Health Coverage, Insurance and Financial Services (the "HCIFS Committee").

C. Tribal Consultation

Maine has four federally recognized tribes: the Aroostook Band of Micmacs; the Houlton Band of Maliseet Indians; the Passamaquoddy Tribe; and the Penobscot Nation. On March 12, 2021, Maine contacted representatives of each of these tribes in writing and provided information about the section 1332 waiver amendment application and solicited consultation with, or comments from, the tribes. No comments were received from any of the tribes. Communications with each tribe are included in **Appendix G: Tribal Consultation Communications**.

D. Communication Plan

To educate insurers eligible for reinsurance reimbursement, MGARA will provide information about the new retrospective program through meetings and updates to information provided on the MGARA website. As with Maine's current reinsurance program, there will be no impact on how consumers enroll in and receive coverage. However, if consumers have questions about the 1332 waiver amendment, they may contact the Bureau of Insurance.

Section IX – Additional Information

A. Administrative Burden

The section 1332 waiver amendment will cause no additional administrative burden to employers and individual consumers because the MGARA reinsurance program does not relate to the administrative functions or requirements typically undertaken by employers or individuals. Health insurers will experience additional administrative burden and associated expense as a result of the operation of the MGARA reinsurance program resulting from submission of reinsurance claims; however, the waiver itself will not result in any additional administrative burden or cost, and the monetary benefit from the MGARA reinsurance program will exceed any resulting administrative expense.

MGARA and the Bureau of Insurance, collectively, have the resources and staff necessary to absorb the following administrative tasks that the waiver will require the state to perform:

- Administer the reinsurance program.
- Collect and apply federal pass-through funds.
- Monitor compliance with federal law.
- Collect and analyze data related to the waiver.
- Perform reviews of the implementation of the waiver.
- Submit quarterly and annual reports to the federal government.

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

- Review documented complaints, if any, related to the waiver.
- Review state reports.
- Periodically evaluate the state's waiver.
- 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 waiver does not necessitate any changes to Maine's State-Based Marketplace and will not affect how PTC or cost-sharing reduction payments are calculated or paid.

B. Effect on PPACA Provisions Not Being Waived

The section 1332 waiver amendment will not affect the implementation of PPACA provisions not being waived.

C. Impact on Residents Who Need to Obtain Healthcare Services Out-of-State

Most 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. Approving the section 1332 waiver amendment will not affect insurer networks or service areas that provide coverage for services performed by out-of-state providers.

D. State Reporting Requirements and Targets

MGARA 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, MGARA and the Bureau of Insurance will hold a public forum six months after the section 1332 waiver amendment is granted and annually thereafter. The date, time, and location of each public forum will be posted on the MGARA website and the Bureau of Insurance website.

MGARA 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 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 waiver.

MGARA 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 waiver.

E. 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 of Insurance and the HCIFS Committee. 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 up to a maximum of \$2 PMPM to aid in maintaining solvency. MGARA is also required to report annually to the HCIFS Committee regarding its operations and financial condition. MGARA will administer the reinsurance 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 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 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.

Section X – Administration

Name: Benjamin Yardley

Title: Senior Attorney

Telephone Number: 207-624-8537

Email address: Benjamin.Yardley@maine.gov

Appendices

The appendices are separate pdfs from the Waiver Amendment Application:

Appendix A: Authorizing Legislation

Appendix B: MGARA Amended and Restated Plan of Operation

Appendix C: Gorman Associates Actuarial and Economic Report

Appendix D: Notice for Public Comment Period and Public Forum

Appendix E: Presentations from the Public Hearing

Appendix F: Written Public Comments

Appendix G: Tribal Consultation Communications

Appendix A: **Authorizing Legislation**

STATE OF MAINE

—
IN THE YEAR OF OUR LORD
TWO THOUSAND TWENTY

—
H.P. 1425 - L.D. 2007

**An Act To Enact the Made for Maine Health Coverage Act and Improve
Health Choices in Maine**

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

PART A

Sec. A-1. 22 MRSA c. 1479 is enacted to read:

CHAPTER 1479

MADE FOR MAINE HEALTH COVERAGE ACT

§5401. Short title

This Act may be known and cited as "the Made for Maine Health Coverage Act."

§5402. Definitions

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

1. Educated health care consumer. "Educated health care consumer" means an individual who is knowledgeable about the health care system, has no financial interest in the delivery of health care services or sale of health insurance and has a background or experience in making informed decisions regarding health, medical or scientific matters.

2. Federal Affordable Care Act. "Federal Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to or regulations or guidance issued under those acts.

3. Marketplace. "Marketplace" means the Maine Health Insurance Marketplace established by this chapter.

4. Marketplace trust fund. "Marketplace trust fund" means the Maine Health Insurance Marketplace Trust Fund established by this chapter.

5. Superintendent. "Superintendent" means the Superintendent of Insurance.

§5403. Maine Health Insurance Marketplace established

The Maine Health Insurance Marketplace is established to conduct the functions defined in 42 United States Code, Section 18031(d)(4). The purpose of the marketplace is to benefit the State's health insurance market and persons enrolling in health insurance policies, facilitate the purchase of qualified health plans, reduce the number of uninsured individuals, improve transparency and conduct consumer education and outreach.

§5404. Powers and duties of the commissioner

1. Powers. In addition to any other powers specified in this chapter and subject to any limitations contained in this chapter or in any other law, the commissioner:

A. Has and may exercise powers necessary to carry out the purposes for which the marketplace is organized or to further the functions in which the marketplace may lawfully be engaged, including the creation and operation of the marketplace;

B. May charge user fees to health insurance carriers that offer qualified health plans in the marketplace or otherwise secure funding necessary to support the functions of the marketplace subject to the limitations imposed by section 5406;

C. May apply for and receive funds, grants or contracts from public and private sources to be used for marketplace functions;

D. May enter into interagency agreements with state or federal entities as considered necessary to efficiently and effectively perform marketplace functions; and

E. May enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out marketplace functions.

2. Duties. The commissioner shall:

A. Direct the operations of the marketplace as provided in this chapter;

B. Consult with stakeholders regarding the execution of the functions of the marketplace required under this chapter. Stakeholders include, but are not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) Representatives and members of the MaineCare program;

(5) Advocates for enrolling hard-to-reach populations;

(6) Representatives of the Passamaquoddy Tribe, the Penobscot Nation, the Houlton Band of Maliseet Indians and the Aroostook Band of Micmacs, appointed by the tribes' respective chiefs in consultation with their tribal councils;

(7) Representatives of health care providers;

(8) Representatives of insurance carriers;

(9) Representatives of insurance producers; and

(10) Any other groups or representatives required by the federal Affordable Care Act and recommended by the commissioner;

C. Accept recommendations from the superintendent on certification of qualified health plans and shall exercise the discretion to delegate to the superintendent authority and duties as appropriate for effective administration of the marketplace, including but not limited to the responsibility for plan management. Authority delegated pursuant to this paragraph is in addition to any other powers or duties of the superintendent established by statute with respect to the marketplace; and

D. Initially and subsequently as needed assess and report to the joint standing committee of the Legislature having jurisdiction over health insurance coverage matters on the feasibility and cost of the State's using the federal platform as described in 45 Code of Federal Regulations, Section 155.200(f) compared to the State's performing all the functions of a state-based marketplace as described in 45 Code of Federal Regulations, Section 155.200. These reports must consider the availability of federal grants, whether existing user fees are sufficient to create and operate state-run functions and whether use of a state-run platform would improve the accessibility and affordability of health insurance in the State.

§5405. Maine Health Insurance Marketplace Trust Fund

1. Establishment. The Maine Health Insurance Marketplace Trust Fund is established as a special fund within the State Treasury for the deposit of any funds generated by user fees, any funds secured by the commissioner for marketplace functions, federal funds and any funds received from any public or private source. The marketplace trust fund must be administered by the commissioner for the purposes set forth in this chapter, including the deposit of money that may be received pursuant to and disbursements permitted by this chapter.

2. Deposit and use of money. Money deposited into the marketplace trust fund must be held solely for the purposes set forth in this chapter as determined by the commissioner, including but not limited to costs of initial start-up and creation of the marketplace, marketplace operations, outreach, enrollment and other functions supporting the marketplace, including any efforts that may increase market stabilization and that may result in a net benefit to the participants in the marketplace. All interest earned from the investment or deposit of money in the marketplace trust fund must be deposited into the marketplace trust fund. All accrued and future earnings from money held by the marketplace trust fund, including but not limited to money obtained from the Federal Government and fees, must be available to the marketplace. Any unexpended balance in the marketplace trust fund at the end of a year may not lapse and must be carried forward

to be available for expenditure by the commissioner in the subsequent year for marketplace functions.

§5406. User fees

The commissioner shall charge a user fee to all carriers that offer qualified health plans in the marketplace. The user fee must be paid monthly by the carrier and deposited into the marketplace trust fund and may be used only for marketplace functions. The user fee must be applied at a rate that is a percentage of the total monthly premium charged by a carrier for each qualified health plan sold in the marketplace and may not exceed the total user fee rate charged by the Federal Government for use of the federally facilitated exchange during plan year 2020. The rate is 0.5% during any period that the State is using the federal platform as described in 45 Code of Federal Regulations, Section 155.200(f) and 3% during any period that the State is performing all the functions of a state-based marketplace as described in 45 Code of Federal Regulations, Section 155.200.

§5407. Rulemaking

The commissioner may adopt rules as necessary for the proper administration and enforcement of this chapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Rules adopted pursuant to this section must be consistent with the federal Affordable Care Act and state law.

§5408. Technical assistance from other state agencies

State agencies, including but not limited to the Department of Professional and Financial Regulation, Bureau of Insurance, the Department of Administrative and Financial Services, Bureau of Revenue Services and the Maine Health Data Organization, shall provide technical assistance and expertise to the marketplace upon request.

§5409. Records

Except as provided in this section or by other provision of law, information obtained by the marketplace under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

1. Financial information. Any personally identifiable financial information, supporting data or tax return of any person obtained by the marketplace under this chapter is confidential and not open to public inspection pursuant to 26 United States Code, Section 6103 and Title 36, section 191.

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

§5410. Relation to other laws

Nothing in this chapter and no action taken by the marketplace pursuant to this chapter may be construed to preempt or supersede the authority of the superintendent to regulate the business of insurance within this State.

§5411. Reporting

Beginning in 2021 and annually thereafter, the marketplace shall submit a report to the Governor and the joint standing committee of the Legislature having jurisdiction over health insurance coverage matters summarizing enrollment, the affordability of health insurance for consumers using the marketplace, marketing activity and operations. This report must be submitted no later than 45 days after the end of the open enrollment period.

PART B

Sec. B-1. 24-A MRSA c. 34-A is enacted to read:

CHAPTER 34-A

STATE-FEDERAL HEALTH COVERAGE PARTNERSHIPS

§2781. State-federal health coverage partnerships

1. Partnerships authorized. The State may enter into state-federal health coverage partnerships that support the availability of affordable health coverage in the State in accordance with this section. As used in this chapter, "state-federal health coverage partnership" means a program established or authorized under federal law that provides or reallocates federal funding or that provides for the waiver or modification of otherwise applicable provisions of federal laws governing health insurance. "State-federal health coverage partnership" includes, but is not limited to, innovation waivers under Section 1332 of the federal Affordable Care Act.

2. Application. Unless the applicable federal laws, regulations or administrative guidelines require a different state official to be the applicant, the superintendent may apply to the appropriate federal agency or agencies to establish or participate in a state-federal health coverage partnership or to modify the terms and conditions of an existing partnership if the superintendent determines that the application, if approved, is likely to improve the affordability, availability or quality of health coverage in this State and the Governor approves the submission of the application.

3. Notice and consultation. The superintendent shall ensure that all federally required notices and opportunities for consultation with respect to a state-federal health coverage partnership or proposed partnership are provided. The superintendent shall take any additional measures that may be necessary to identify persons and constituencies likely to be materially affected by a state-federal health coverage partnership or proposed partnership and to provide such persons and constituencies with reasonable notice and opportunity for input.

4. **MaineCare program and Maine Health Insurance Marketplace.** A state-federal health coverage partnership may coordinate with the MaineCare program or the Maine Health Insurance Marketplace established in Title 22, chapter 1479 and incorporate provisions affecting these programs, including but not limited to a joint Medicaid Section 1115 demonstration waiver and state innovation waiver, with the approval or joint application of the Commissioner of Health and Human Services.

Sec. B-2. 24-A MRSA c. 34-B is enacted to read:

CHAPTER 34-B

POOLED MARKET AND CLEAR CHOICE DESIGN

§2791. Definitions

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

1. **Individual health plan.** "Individual health plan" has the same meaning as in section 2736-C, subsection 1, paragraph C.

2. **Small group health plan.** "Small group health plan" has the same meaning as in section 2808-B, subsection 1, paragraph G.

§2792. Affordable health coverage for individuals, families and small businesses

1. **Pooled market established.** Subject to the requirements of subsection 5, all individual and small group health plans offered in this State with effective dates of coverage on or after January 1, 2022 must be offered through a pooled market. A health insurance carrier offering an individual health plan subject to this section shall make the plan available to all eligible small employers within the plan's approved service area, and a health insurance carrier offering a small group health plan subject to this section shall make the plan available to all eligible individuals residing within the plan's approved service area. This subsection does not require the Maine Health Insurance Marketplace established in Title 22, chapter 1479 to offer identical choices of health plans to individuals and to small employers under Title 22, chapter 1479.

2. **Premium rates.** Premium rates for a health plan offered in the pooled market described in subsection 1 may not vary based on whether the plan is issued to an individual or to a small employer. Rate filings and review for the pooled market are subject to the provisions of sections 2736 to 2736-C. For health plans that are issued on other than a calendar year basis, rates applicable on and after January 1st of any plan year must be the approved rates for the most similar plan offered during the new calendar year, adjusted by a factor, approved by the superintendent as part of the rating plan, that appropriately accounts for any differences in plan design.

3. **Harmonization of mandated benefit laws.** In addition to the requirements of chapter 56-A, a health plan subject to this section must comply with the applicable mandated benefit provisions in chapter 33 or the corresponding provisions of chapter 35. A health maintenance organization or a nonprofit hospital and medical service

organization may offer any health plan approved by the superintendent for sale in the pooled market established pursuant to this section, notwithstanding any provision of chapter 56 or Title 24 to the contrary.

4. Conforming references. All references in this Title to the individual health insurance market, the small group health insurance market or any equivalent terminology refer to the pooled market established pursuant to this section.

5. Preconditions for pooled market. This section may not be implemented unless routine technical rules as defined in Title 5, chapter 375, subchapter 2-A are adopted to implement this section and the Federal Government approves a state innovation waiver amendment that extends reinsurance under section 3953 to the pooled market established pursuant to this section based on projections by the superintendent that both average individual premium rates and average small group premium rates would be the same or lower than they would have been absent the provisions of this section. If this section is not implemented, the superintendent shall conduct an analysis of alternative proposals to improve the stability and affordability of the small group market.

§2793. Clear choice designs

The superintendent shall develop clear choice designs for the individual and small group health insurance markets in order to reduce consumer confusion and provide meaningful choices for consumers by promoting a level playing field on which carriers compete on the basis of price and quality.

1. Clear choice design. For the purposes of this section, "clear choice design" means a set of annual copayments, coinsurance and deductibles for all or a designated subset of the essential health benefits. An individual or small group health plan subject to section 2792 must conform to one of the clear choice designs developed pursuant to this section unless an opt-out request is granted under subsection 4.

2. Development of clear choice designs. The superintendent shall develop clear choice designs in consultation with working groups consisting of consumers, carriers, health policy experts and other interested persons. The superintendent shall adopt rules for clear choice designs, taking into consideration the ability of plans to conform to actuarial value ranges, consumer needs and promotion of benefits with high value and return on investment. The superintendent shall develop at least one clear choice design for each tier of health insurance plan designated as bronze, silver, gold and platinum in accordance with the federal Affordable Care Act. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Clear choice designs apply to all individual and small group health plans offered in this State with effective dates of coverage on or after January 1, 2022.

3. Annual review. The superintendent shall consider annually whether to revise, discontinue or add any clear choice designs for use by carriers in the following calendar year, including but not limited to considering whether deductible and copayment levels should be changed to reflect medical inflation and conform with actuarial value and annual maximum out-of-pocket limits.

4. Alternative plan designs. In addition to one or more health plans that include cost-sharing parameters consistent with a clear choice design developed pursuant to this section, a carrier may offer up to 3 health plans that modify one or more specific cost-sharing parameters in a clear choice design if the carrier submits an actuarial certification to the satisfaction of the superintendent that the alternative plan design offers significant consumer benefits and does not result in adverse selection. An alternative plan design may be offered only in a service area where the carrier offers at least one clear choice design plan at the same tier.

Sec. B-3. 24-A MRSA §2808-B, sub-§2, ¶E, as amended by PL 2019, c. 96, §1, is repealed and the following enacted in its place:

E. The superintendent may authorize a carrier to establish a separate community rate for an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 consistent with the provisions of this paragraph and applicable federal law.

(1) Association group membership or eligibility for participation in the trustee group may not be conditioned on health status, claims experience or other risk selection criteria.

(2) All health plans offered by the carrier through that association or trustee group must be made available on a guaranteed issue basis to all eligible employers that are members of the association or are eligible to participate in the trustee group except that a professional association may require that a minimum percentage of the eligible professionals employed by a subgroup be members of the association in order for the subgroup to be eligible for issuance or renewal of coverage through the association. The minimum percentage must not exceed 90%. For purposes of this subparagraph, "professional association" means an association that:

(a) Serves a single profession that requires a significant amount of education, training or experience or a license or certificate from a state authority to practice that profession;

(b) Has been actively in existence for 5 years;

(c) Has a constitution and bylaws or other analogous governing documents;

(d) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(e) Is not owned or controlled by a carrier or affiliated with a carrier;

(f) Has at least 1,000 members if it is a national association; 200 members if it is a state or local association;

(g) All members and dependents of members are eligible for coverage regardless of health status or claims experience; and

(h) Is governed by a board of directors and sponsors annual meetings of its members.

(3) The aggregate rate charged by the carrier to the association or trustee group is considered a large group rate, and the terms of coverage are considered a large group health plan. Rates for participating employers within the group may vary only as permitted by paragraphs B to D-2.

(4) Producers may only market association memberships, accept applications for membership or sign up members in a professional association in which the individuals are actively engaged in or directly related to the profession represented by the professional association.

(5) Carriers may not be reinsured under section 3958 for coverage issued under this paragraph.

(6) Except for employers with plans that have grandfathered status under the federal Affordable Care Act, this paragraph does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014 until December 31, 2019. To the extent permitted under the federal Affordable Care Act, this paragraph applies to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2020.

Sec. B-4. 24-A MRSA §2808-B, sub-§2-A, ¶B, as amended by PL 2009, c. 439, Pt. D, §1, is further amended to read:

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to subsection 2-B, paragraph B or F section 2792, subsection 2.

Sec. B-5. 24-A MRSA §2808-B, sub-§2-A, ¶C, as amended by PL 2007, c. 629, Pt. M, §6, is further amended to read:

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C or section 2792, as applicable, for premium rates effective on or after July 1, 2004, except that the ~~filing of~~ rates for small group health plans are not required to account for any payment or any recovery of that payment pursuant to subsection 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005.

Sec. B-6. 24-A MRSA §2808-B, sub-§2-B, as amended by PL 2011, c. 364, §15, is further amended to read:

2-B. Rate review and hearings. Except as provided in subsection 2-C and section 2792, rate filings are subject to this subsection.

A. Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans

maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any payments paid pursuant to former section 6913 must be treated as incurred claims.

B. If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

D. A carrier that adjusts its rate shall account for the savings offset payment or any recovery of that savings offset payment in its experience consistent with this section and former section 6913.

Sec. B-7. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2011, c. 364, §16, is further amended to read:

2-C. Guaranteed loss ratio. Notwithstanding subsection 2-B, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B, except as otherwise provided in section 2792. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is considered credible if the anticipated average number of members during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than needed to meet the credibility standard, the filing is subject to subsection 2-B.

Sec. B-8. 24-A MRSA §3952, sub-§4-A is enacted to read:

4-A. Eligible claim. "Eligible claim" means either:

A. For a high-priced item or service, a claim amount that is no greater than 200% of the allowed charge determined for the item or service under the original Medicare fee-for-service program under Part A and Part B of Title XVIII of the Social Security Act for the applicable year; or

B. For all other items or services, a claim paid by the member insurer in accordance with the terms of the policy.

Sec. B-9. 24-A MRSA §3952, sub-§5-A is enacted to read:

5-A. High-priced item or service. "High-priced item or service" means an item or service covered under the original Medicare fee-for-service program under Part A and Part B of Title XVIII of the Social Security Act that the board, in consultation with and based on analysis by the Department of Health and Human Services and Maine Health Data Organization, has identified in advance of a plan year that contributes to association costs and offers an opportunity for savings.

Sec. B-10. 24-A MRSA §3952, sub-§6, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

6. Insurer. "Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in this State. For the purposes of this chapter, "insurer" includes 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 section 2848-A, a 3rd-party administrator, a multiple-employer welfare arrangement, a reinsurer that reinsures health insurance in this State; or a captive insurance company established pursuant to chapter 83 that insures the health coverage risks of its members; ~~the Dirigo Health Program established in chapter 87 or any other state sponsored health benefit program whether fully insured or self-funded.~~

Sec. B-11. 24-A MRSA §3952, sub-§9, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

9. Member insurer. "Member insurer" means an insurer that offers individual health plans and is actively marketing individual health plans in this State. In any calendar year in which the association reinsures small group health plans, "member insurer" also includes an insurer that offers small group health plans and is actively marketing small group health plans in this State.

Sec. B-12. 24-A MRSA §3953, sub-§1, as amended by PL 2017, c. 124, §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.~~

~~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. The association may operate a reinsurance program contingent on the approval of, or continued approval of, a state innovation waiver under Section 1332 of the federal Affordable Care Act submitted by the superintendent as provided for in section 2781.~~

~~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.~~

Sec. B-13. 24-A MRSA §3955, sub-§1, ¶D, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

D. Establish procedures for the handling and accounting of association assets; and

Sec. B-14. 24-A MRSA §3955, sub-§1, ¶E, as amended by PL 2011, c. 621, §2, is repealed.

Sec. B-15. 24-A MRSA §3955, sub-§2, ¶H, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

H. Apply for Accept and administer funds or grants from public or private sources, including federal grants, and apply for such funding.

Sec. B-16. 24-A MRSA §3956, sub-§3, ¶C, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

C. Following the close of each calendar year in which premiums are collected for reinsurance, 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

Sec. B-17. 24-A MRSA §3957, sub-§9, as enacted by PL 2011, c. 90, Pt. B, §8, is repealed.

Sec. B-18. 24-A MRSA §3958, as amended by PL 2011, c. 621, §§4 and 5, is further amended to read:

§3958. Reinsurance; premium rates

1. Reinsurance amount. A member insurer offering an individual health plan under section 2736-C must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for ~~the~~ any applicable reinsurance premium at the rate established in accordance with subsection 2. For calendar year 2022 and subsequent calendar years, the association shall also reinsure member insurers for small group health plans issued under section 2808-B, unless otherwise provided in rules adopted by the superintendent pursuant to section 2792, subsection 5.

A. Beginning July 1, 2012, except as otherwise provided in paragraph A-1, the association shall reimburse a member insurer for claims incurred with respect to a person designated for reinsurance by the member insurer pursuant to section 3959 ~~or 3964~~ after the insurer has incurred an initial level of claims for that person of \$7,500 for covered benefits in a calendar year. In addition, the insurer is responsible for 10% of the next \$25,000 of claims paid during a calendar year. The amount of reimbursement is 90% of the amount incurred between \$7,500 and \$32,500 and 100% of the amount incurred in excess of \$32,500 for claims incurred in that calendar year with respect to that person. For calendar year 2012, only claims incurred on or after July 1st are considered in determining the member insurer's reimbursement. ~~The~~ With the approval of the superintendent, the association may annually adjust the initial level of claims and the maximum limit to be retained by the insurer to reflect increases changes in costs and, utilization ~~within the standard market for individual health plans within the State.~~ The adjustments may not be less than the annual change in the Consumer Price Index for medical care services unless the superintendent approves a lower adjustment factor as requested by, available funding and any other factors affecting the sustainable operation of the association.

A-1. In any plan year in which a pooled market is operating in accordance with section 2792, the association shall operate a retrospective reinsurance program providing coverage to member insurers for all individual and small group health plans issued in this State in that plan year. For plan years beginning in 2022, if the pooled market has not been implemented pursuant to section 2792, subsection 5, the association may operate a retrospective reinsurance program for individual health plans, subject to the approval of the superintendent.

(1) The association shall reimburse member insurers based on the total eligible claims paid during a calendar year for a single individual in excess of the

attachment point specified by the board. The board may establish multiple layers of coverage with different attachment points and different percentages of claims payments to be reimbursed by the association.

(2) Eligible claims by all individuals enrolled in individual or small group health plans in this State may not be disqualified for reimbursement on the basis of health conditions, predesignation by the member insurer or any other differentiating factor.

(3) The board shall annually review the attachment points and coinsurance percentages and make any adjustments that are necessary to ensure that the retrospective reinsurance program operates on an actuarially sound basis.

(4) The board shall ensure that any surplus in the retrospective reinsurance program at the conclusion of a plan year is used to lower attachment points, increase coinsurance rates or both for that plan year, consistent with its responsibility to ensure that the program operates on an actuarially sound basis.

B. ~~An~~ A member insurer shall apply all managed care, utilization review, case management, preferred provider arrangements, claims processing and other methods of operation without regard to whether claims paid for coverage are reinsured under this subsection. A member insurer shall report for each plan year the name of each high-priced item or service for which its payment exceeded the amount allowed for eligible claims and the name of the provider that received this payment. The association shall annually compile and publish a list of all reported names.

2. Premium rates. The association, as part of the plan of operation under section 3953, subsection 3, shall establish a methodology for determining premium rates to be charged member insurers to reinsure persons eligible for coverage under this chapter. The methodology must include a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C, together with any additional rating factors the association determines to be appropriate. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that, together with other funds available to the association, will be sufficient to meet the anticipated costs of the association. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by an insurer. This subsection does not apply to reinsurance with respect to any calendar year for which the association operates a retrospective reinsurance program under subsection 1, paragraph A-1. With the approval of the superintendent, the association's plan of operation for a retrospective reinsurance program may include a provision for charging premium on an equitable basis to all member insurers.

Sec. B-19. 24-A MRSA §3959, sub-§1, ¶A, as enacted by PL 2011, c. 621, §6, is amended to read:

A. By using the health statement developed by the board pursuant to section 3955, subsection 1, paragraph E or by using the person's claims history or risk scores or any other reasonable means;

Sec. B-20. 24-A MRSA §3959, sub-§5 is enacted to read:

5. Inapplicability. This section does not apply to reinsurance with respect to any calendar year for which the association operates a retrospective reinsurance program under section 3958, subsection 1, paragraph A-1.

Sec. B-21. 24-A MRSA §3961, as amended by PL 2011, c. 621, §§7 and 8, is repealed.

Sec. B-22. 24-A MRSA §3962, as amended by PL 2015, c. 404, §§2 and 3, is repealed.

Sec. B-23. 24-A MRSA §3963 is enacted to read:

§3963. State-federal health coverage partnerships involving the association

1. Consultation with board. The superintendent shall consult with the board before developing any proposal to apply for a state-federal health coverage partnership as defined in section 2781, subsection 1 or to modify the terms of an existing state-federal health coverage partnership involving federal funding for the association or otherwise significantly affecting the operations of the association. The superintendent shall give prompt notice to the board if the superintendent becomes aware of a new federal program or material changes to an existing program with the potential for a significant effect on the operations of the association.

PART C

Sec. C-1. 24-A MRSA §4320-A, as amended by PL 2017, c. 343, §1, is further amended to read:

§4320-A. Coverage of preventive and primary health services

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State shall, at a minimum, provide coverage for and may not impose cost-sharing requirements for preventive and primary health services as required by this section.

1. Preventive services. A health plan must, at a minimum, provide coverage for:

A. The evidence-based items or services that have a rating of A or B in the recommendations of the United States Preventive Services Task Force or equivalent rating from a successor organization;

B. With respect to the individual insured, immunizations that have a recommendation from the federal Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices and that are consistent with the recommendations of the American

Academy of Pediatrics, the American Academy of Family Physicians or the American College of Obstetricians and Gynecologists or a successor organization;

C. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal Department of Health and Human Services, Health Resources and Services Administration that are consistent with the recommendations of the American Academy of Pediatrics or a successor organization; and

D. With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal Department of Health and Human Services, Health Resources and Services Administration women's preventive services guidelines that are consistent with the recommendations of the American College of Obstetricians and Gynecologists women's preventive services initiative.

2. Change in recommendations. If a recommendation described in subsection 1 is changed during a health plan year, a carrier is not required to make changes to that health plan during the plan year.

3. Primary health services. An individual or small group health plan with an effective date on or after January 1, 2021 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any copays for the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year count toward the deductible. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent shall conduct a study analyzing the effects of this subsection on premiums based on experience in plan years 2020 and 2021. The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. C-2. Notification regarding fulfillment of contingency. Upon adoption of routine technical rules and notification from the Federal Government of its approval of a state innovation waiver amendment in accordance with the Maine Revised Statutes, Title 24-A, section 2792, subsection 5, the Superintendent of Insurance shall notify the Secretary of State, the Secretary of the Senate, the Clerk of the House of Representatives and the Revisor of Statutes that the contingencies set forth in section 2792, subsection 5 have been met.

Sec. C-3. Revisor's review; cross-references. The Revisor of Statutes shall review the Maine Revised Statutes and include in the errors and inconsistencies bill submitted to the First Regular Session of the 130th Legislature pursuant to Title 1, section

94 any sections necessary to correct and update any cross-references in the statutes to provisions of law repealed in this Act.

PART D

Sec. D-1. Appropriations and allocations. The following appropriations and allocations are made.

**HEALTH AND HUMAN SERVICES, DEPARTMENT OF
Maine Health Insurance Marketplace Trust Fund N343**

Initiative: Provides allocation for one Executive Director position, beginning July 1, 2020.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	\$0	\$186,547
All Other	\$0	\$10,804
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$197,351

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Public Service Executive II position to serve as chief technology officer, beginning January 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	\$0	\$69,306
All Other	\$0	\$5,402
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$74,708

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Public Service Manager III position to handle communications and outreach duties, beginning January 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	\$0	\$64,455
All Other	\$0	\$5,402
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$69,857

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Public Service Coordinator II position to handle finance and compliance duties, beginning January 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	\$0	\$56,316
All Other	\$0	\$5,402
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$61,718

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Comprehensive Health Planner II position to serve as a project manager and policy analyst, beginning June 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	\$0	\$7,556
All Other	\$0	\$901
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$8,457

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Secretary Specialist position to serve as administrative assistant, beginning January 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	\$0	\$40,878
All Other	\$0	\$5,402
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$46,280

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides a one-time allocation for a website development contract.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	\$0	\$15,000
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$15,000

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for an annual contract for navigator grants.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	\$0	\$150,000
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$150,000

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for a contract for an annual audit.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	\$0	\$65,000
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$65,000

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides a one-time allocation for an independent verification and validation vendor contract.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	\$0	\$200,000
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$200,000

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for the STA-CAP plan.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	\$0	\$19,751
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$19,751

**HEALTH AND HUMAN SERVICES,
DEPARTMENT OF
DEPARTMENT TOTALS**

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
	\$0	\$908,122
DEPARTMENT TOTAL - ALL FUNDS	\$0	\$908,122

**PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF
Administrative Services - Professional and Financial Regulation 0094**

Initiative: Provides allocation to establish one part-time Insurance Actuarial Assistant position and All Other costs.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	\$0	\$2,340
OTHER SPECIAL REVENUE FUNDS TOTAL	<u>\$0</u>	<u>\$2,340</u>

Insurance - Bureau of 0092

Initiative: Provides allocation to establish one part-time Insurance Actuarial Assistant position and All Other costs.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	0.500
Personal Services	\$0	\$39,605
All Other	\$0	\$7,691
OTHER SPECIAL REVENUE FUNDS TOTAL	<u>\$0</u>	<u>\$47,296</u>

**PROFESSIONAL AND FINANCIAL
REGULATION, DEPARTMENT OF
DEPARTMENT TOTALS**

	2019-20	2020-21
OTHER SPECIAL REVENUE FUNDS	\$0	\$49,636
DEPARTMENT TOTAL - ALL FUNDS	<u>\$0</u>	<u>\$49,636</u>

SECTION TOTALS

	2019-20	2020-21
OTHER SPECIAL REVENUE FUNDS	\$0	\$957,758
SECTION TOTAL - ALL FUNDS	<u>\$0</u>	<u>\$957,758</u>

STATE OF MAINE

—
IN THE YEAR OF OUR LORD
TWO THOUSAND TWENTY-ONE

—
S.P. 570 - L.D. 1725

**An Act To Clarify the Deferral of the Pooled Market and Link Small
Employer Clear Choice to Pooling in the Made for Maine Health Coverage
Act**

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

Sec. 1. 24-A MRSA §2792, sub-§1, as enacted by PL 2019, c. 653, Pt. B, §2, is amended to read:

1. Pooled market established. Subject to the requirements of subsection 5, all individual and small group health plans offered in this State with effective dates of coverage on or after January 1, ~~2022~~ 2023 must be offered through a pooled market. A health insurance carrier offering an individual health plan subject to this section shall make the plan available to all eligible small employers within the plan's approved service area, and a health insurance carrier offering a small group health plan subject to this section shall make the plan available to all eligible individuals residing within the plan's approved service area. This subsection does not require the Maine Health Insurance Marketplace established in Title 22, chapter 1479 to offer identical choices of health plans to individuals and to small employers under Title 22, chapter 1479.

Sec. 2. 24-A MRSA §2792, sub-§5, as enacted by PL 2019, c. 653, Pt. B, §2, is amended to read:

5. Preconditions for pooled market. This section may not be implemented unless routine technical rules as defined in Title 5, chapter 375, subchapter 2-A are adopted to implement this section and the Federal Government approves a state innovation waiver amendment that extends reinsurance under section 3953 to the pooled market established pursuant to this section based on projections by the superintendent that both average individual premium rates and average small group premium rates would be the same or lower than they would have been absent the provisions of this section and chapter 54-A. If this section is not implemented, the superintendent shall conduct an analysis of alternative proposals to improve the stability and affordability of the small group market.

Sec. 3. 24-A MRSA §2793, as enacted by PL 2019, c. 653, Pt. B, §2, is amended to read:

§2793. Clear choice designs

The superintendent shall develop clear choice designs for ~~the individual and small group health insurance markets~~ health plans in order to reduce consumer confusion and provide meaningful choices for consumers by promoting a level playing field on which carriers compete on the basis of price and quality.

1. Clear choice design. For the purposes of this section, "clear choice design" means a set of annual copayments, coinsurance and deductibles for all or a designated subset of the essential health benefits. An individual health plan subject to section 2736-C or ~~small group~~ a pooled market health plan subject to section 2792 must conform to one of the clear choice designs developed pursuant to this section unless ~~an opt-out request is granted~~ it is approved as an alternative plan under subsection 4.

2. Development of clear choice designs. The superintendent shall develop clear choice designs in consultation with working groups consisting of consumers, carriers, health policy experts and other interested persons. The superintendent shall adopt rules for clear choice designs, taking into consideration the ability of plans to conform to actuarial value ranges, consumer needs and promotion of benefits with high value and return on investment. The superintendent shall develop at least one clear choice design for each tier of health insurance plan designated as bronze, silver, gold and platinum in accordance with the federal Affordable Care Act. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Clear choice designs apply to all individual ~~and small group~~ health plans offered in this State with effective dates of coverage on or after January 1, 2022 and to all small group health plans offered through the pooled market under section 2792.

3. Annual review. The superintendent shall consider annually whether to revise, discontinue or add any clear choice designs for use by carriers in the following calendar year, including but not limited to considering whether deductible and copayment levels should be changed to reflect medical inflation and conform with actuarial value and annual maximum out-of-pocket limits.

4. Alternative plan designs. In addition to one or more health plans that include cost-sharing parameters consistent with a clear choice design developed pursuant to this section, a carrier may offer up to 3 health ~~plans~~ plan designs that modify one or more specific cost-sharing parameters in a clear choice design if the carrier submits an actuarial certification to the satisfaction of the superintendent that the alternative plan design offers significant consumer benefits and does not result in adverse selection. An alternative plan design may be offered only in a service area where the carrier offers at least one clear choice design plan at the same tier.

Sec. 4. 24-A MRSA §3957, sub-§7, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

7. Excess funds. If assessments and other receipts by the association, board or administrator selected pursuant to section 3956 exceed the actual losses and administrative expenses of the association, the board shall hold the excess as at interest and shall use those excess funds to offset future losses or to ~~reduce reinsurance premiums~~ make adjustments to a reinsurance program operated pursuant to section 3953. As used in this subsection, "future losses" includes reserves for claims incurred but not reported.

Sec. 5. 24-A MRSA §3958, sub-§1, as amended by PL 2019, c. 653, Pt. B, §18, is further amended to read:

1. Reinsurance amount. A member insurer offering an individual health plan under section 2736-C must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for any applicable reinsurance premium at the rate established in accordance with subsection 2. For calendar year ~~2022~~ 2023 and subsequent calendar years, the association shall also reinsure member insurers for small group health plans issued under section 2808-B, unless otherwise provided in rules adopted by the superintendent pursuant to section 2792, subsection 5.

A. Beginning July 1, 2012, except as otherwise provided in paragraph A-1, the association shall reimburse a member insurer for claims incurred with respect to a person designated for reinsurance by the member insurer pursuant to section 3959 after the insurer has incurred an initial level of claims for that person of \$7,500 for covered benefits in a calendar year. In addition, the insurer is responsible for 10% of the next \$25,000 of claims paid during a calendar year. The amount of reimbursement is 90% of the amount incurred between \$7,500 and \$32,500 and 100% of the amount incurred in excess of \$32,500 for claims incurred in that calendar year with respect to that person. For calendar year 2012, only claims incurred on or after July 1st are considered in determining the member insurer's reimbursement. With the approval of the superintendent, the association may annually adjust the initial level of claims and the maximum limit to be retained by the insurer to reflect changes in costs, utilization, available funding and any other factors affecting the sustainable operation of the association.

A-1. In any plan year in which a pooled market is operating in accordance with section 2792, the association shall operate a retrospective reinsurance program providing coverage to member insurers for all individual and small group health plans issued in this State in that plan year. For plan years beginning in 2022, if the pooled market has not been implemented pursuant to section 2792, subsection 5, the association may operate a retrospective reinsurance program for individual health plans, subject to the approval of the superintendent.

(1) The association shall reimburse member insurers based on the total eligible claims paid during a calendar year for a single individual in excess of the attachment point specified by the board. The board may establish multiple layers of coverage with different attachment points and different percentages of claims payments to be reimbursed by the association.

(2) Eligible claims by all individuals enrolled in individual or small group health plans in this State may not be disqualified for reimbursement on the basis of health conditions, predesignation by the member insurer or any other differentiating factor.

(3) The board shall annually review the attachment points and coinsurance percentages and make any adjustments that are necessary to ensure that the retrospective reinsurance program operates on an actuarially sound basis.

(4) The board shall ensure that any surplus in the retrospective reinsurance program at the conclusion of a plan year is used to lower attachment points,

increase coinsurance rates or both for that plan year, consistent with its responsibility to ensure that the program operates on an actuarially sound basis.

B. A member insurer shall apply all managed care, utilization review, case management, preferred provider arrangements, claims processing and other methods of operation without regard to whether claims paid for coverage are reinsured under this subsection. A member insurer shall report for each plan year the name of each high-priced item or service for which its payment exceeded the amount allowed for eligible claims and the name of the provider that received this payment. The association shall annually compile and publish a list of all reported names.

**Appendix B: Maine Guaranteed Access Reinsurance Association Plan of
Operation**



MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

AMENDED AND RESTATED PLAN OF OPERATION

Conversion to Retrospective Program

Effective: January 1, 2022

Preface

Pursuant to 24-A M.R.S. §3958(1)(A-1) the Board has resolved to convert the MGARA reinsurance program from the current prospective model to a retrospective model as of January 1, 2022. This Amended and Restated Plan of Operation amends and restates MGARA’s existing Plan of Operation to convert to a retrospective reinsurance model. The existing Plan of Operation shall remain in force as required in connection with the close-out of the prospective reinsurance program operated during the years 2019 through 2021.

MGARA’s enabling legislation is set forth at 24-A M.R.S. Chapter 54-A §§ 3951 – 3963 (the “Enabling Act”). MGARA’s original Plan of Operation was adopted effective June 12, 2012 (“Original Plan”). Pursuant to legislative action, effective January 1, 2014, MGARA’s operations were suspended during the pendency of the transitional reinsurance program pursuant to Section 1341 of the Patient Protection and Affordable Care Act (“Federal Program”) in order to avoid redundancy with the Federal Program. Pursuant to such suspension, MGARA filed an Amended Plan of Operation with the Superintendent of Insurance on June 5, 2014 pursuant to 24-A M.R.S. §3962, which required MGARA to file with the Superintendent for approval an Amended Plan of Operation (“Suspension Plan”) within 6 months following the implementation of the Federal Program.

On July 30, 2018, the State of Maine received approval from the United States Department of Health & Human Services, Centers for Medicare & Medicaid Services (“CMS”) of its Application for State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act which is incorporated herein by reference (“Section 1332 Waiver Application”). On August 21, 2018 the State of Maine accepted the Section 1332 Waiver by executing and delivering to CMS the Specific Terms and Conditions of the Section 1332 Waiver, which are also incorporated herein by reference (“STCs”). The Section 1332 Waiver Application and the STCs are collectively referred to as the “Section 1332 Waiver”.

On August 18, 2018, the MGARA Board approved the re-initiation of MGARA operations as of January 1, 2019, and the submission of an amended and restated Plan of Operation for approval by the Maine Superintendent of Insurance. In December 2018 MGARA received approval of its Amended and Restated Plan of Operation for a January 1, 2019 re-start of operations and has been operating under that plan from January 1, 2019 to the present.

Pursuant to Section 3958(1)(A-1) of the Enabling Act, as amended, the Board resolved on May 24, 2021 to convert the MGARA reinsurance program from the current prospective model to a retrospective model effective as of January 1, 2022.

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ARTICLE I **NAME**

- 1.1 The Maine Guaranteed Access Reinsurance Association, hereinafter referred to as the “Association” or “MGARA,” 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**

- 1.2 The members of MGARA (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**

- 1.3 MGARA 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**

- 1.4 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 MGARA pursuant to the applicable provisions of the Enabling Act.

“Annual Claims Report” is defined in Section 9.8.

“Association” is defined in Section 1.1.

“Attachment Point” is defined in Section 9.3.

“Board” is defined in Section 7.2.

“Board Petition” is defined in Section 13.6(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.

“Claims Reports” is defined in Section 9.8.

“CMS” is defined in the Preface.

“Coinsurance Rate” is defined in Section 9.3.

“Covered Person” means an individual covered as a policyholder, participant or Dependent under an Eligible Health Plan.

“Deficit Assessment” is defined in Section 10.3.

“Dependent” means a spouse, a domestic partner as defined in 24 M.R.S. § 2319-A and 24-A M.R.S. §§ 2741-A and 4249, or a child under 26 years of age.

“Dispute Notice” is defined in Section 13.6(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. Chapter 54-A §§ 3951 et seq.

“Enrolled Person” is defined in Section 10.2.

“Executive Dispute Process” is defined in Section 13.6(b).

“Federal Pass-Through Payments” means payments made by CMS and/or the United States Treasury Department pursuant to the Federal Program and the Section 1332 Waiver.

“Federal Program” is defined in the Preface.

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

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

“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 11.5.

“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 13.6(c).

“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.

“Nonprofit Act” means the Maine Nonprofit Corporation Act, M.R.S. Title 13-B.

“Open Claims Report” is defined in Section 9.8(b).

“Organizational Assessment” is defined in Section 10.1.

“Petition” is defined in Section 13.6(c).

“Quarterly Assessment Report” is defined in Section 10.6(b).

“Quarterly Claims Report” is defined in Section 9.8.

“Regular Assessment” is defined in Section 10.2.

“Reinsurance Layer” is defined in Section 9.3.

“Reinsurance Limit” is defined in Section 9.3.

“Reinsurance Program” is defined in Section 9.1.

“Reinsurance Reimbursement” is defined in Section 9.4 and refers to the reinsurance proceeds to which the Member Insurers are entitled under the Enabling Act upon compliance with the terms and conditions thereof and the terms and conditions of this Plan.

“Reinsurance Thresholds” is defined in Section 9.3.

“Reinsured Losses” is defined in Section 9.3.

“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.

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

“Section 1332 Reporting” is defined in Section 6.5.

“Section 1332 Waiver” is defined in the Preface.

“Section 1332 Waiver Application” is defined in the Preface.

“STCs” is defined in the Preface.

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

“Suspension Plan” is defined in the Preface.

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

The term “year” refers to a calendar year unless otherwise specified.

4.1 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.

ARTICLE V **POWERS OF MGARA**

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

ARTICLE VI **PLAN OF OPERATION AND FUNDING MODEL**

- 6.1 MGARA shall perform its functions pursuant to and in accordance with this Plan of Operation, the Enabling Act and the Section 1332 Waiver. This Plan is intended to assure the fair, reasonable and equitable administration of MGARA’s Reinsurance Program. This Plan shall be effective upon the adoption by the Board and approval of the Superintendent.
- 6.2 Beginning January 1, 2022, the MGARA reinsurance program will transition from a prospective model to the retrospective model described herein, subject to approval by the Superintendent of this Amended and Restated Plan of Operation.
- 6.3 MGARA’s funding model is summarized in the following Table.

Funding Mechanism	Description
Base Market Assessment	Assessment to health insurers and third party administrators based on the number of insured lives covered by each at a rate of up to \$4 per Enrolled Person per month (“PMPM”) for all insureds in the Individual, Small Group, Large Group and Self-insured Markets (excluding State and Federal employees)
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 as required under Section 3957(5) of the Enabling Act.
Federal Pass-Through Payments	Payments made by CMS and the US Treasury Department pursuant to the Section 1332 Waiver.

- 6.4 Pursuant to the Section 1332 Waiver, the State of Maine is to receive Federal Pass-Through Payments in an amount equal to the net reduction in federal expenditures due to the operation of the MGARA Reinsurance Program each year during the term of the Section 1332 Waiver. Federal

Pass-Through Payments will be made directly to MGARA under the Section 1332 Waiver.

6.5 MGARA shall develop procedures to support the State of Maine's required periodic reporting to CMS pursuant to the Section 1332 Waiver, including:

(a) Required quarterly, annual and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive requirement, and the federal deficit requirement - 45 CFR 155.1308(f)(4);

(b) Quarterly reports - 45 CFR 155.1324(a); and

(c) Annual reports - 45 CFR 155.1324(b)

(collectively referred to as "Section 1332 Reporting").

ARTICLE VII GOVERNANCE

7.1 Governing Documents. The activities of MGARA shall be governed pursuant to and in accordance with the Nonprofit Act and the Enabling Act, the Articles of Incorporation and Bylaws of MGARA, 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. MGARA's Articles of Incorporation are attached hereto as Exhibit B, and its Bylaws are attached hereto as Exhibit C.

7.2 Board of Directors. MGARA is governed by a Board of Directors (the "Board") appointed by the Superintendent and Member Insurers as provided in MGARA'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 MGARA'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 Reinsurance Thresholds and Coinsurance Rates, as well as reinsurance premium rates (if any); and
 - ii. Review, determine and report to the Board the incurred claim losses of MGARA, 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 MGARA’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 MGARA 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 MGARA’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 MGARA’s operations, including proposed contracts and operational practices;

- ii. Be familiar with, and provide assistance to the Board concerning, litigation and other disputes involving MGARA and its operations;
- iii. Participate in the dispute resolution procedures set forth in Section 13.6 hereof; and
- iv. Assist the Board in other legal-related matters as appropriate.

Any or all Committees may be organized as committees of the whole Board, as determined by the Board.

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 MGARA.
- (b) Confidentiality Policy. The Confidentiality Policy shall be designed to protect MGARA's confidential information from improper disclosure.
- (c) Whistleblower Policy. The Whistleblower Policy shall be designed to protect directors, officers, and employees of MGARA from retaliation or victimization for raising, in good faith, concerns or complaints that activities of MGARA, 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 MGARA while limiting costs to MGARA 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 MGARA and such other annual reports as the Board may require from the Administrator regarding the financial position of MGARA, 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 MGARA.
- (e) Review and duly consider the performance of MGARA in support of its purpose.
- (f) Review the Reinsurance Thresholds and Coinsurance Rates (and rates for MGARA's Reinsurance Program, if any).
- (g) Review MGARA'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 MGARA.

ARTICLE VIII ADMINISTRATOR

- 8.1 Role. The Administrator performs administrative functions associated with the operations of MGARA 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 MGARA 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 MGARA, 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 MGARA, 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 (if any) less any administrative expense allowance, the expense of administration pertaining to the reinsurance operations

of MGARA 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 MGARA, 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 implementing the operations of MGARA consistent with this Plan and the Enabling Act. The Administrator shall be charged with working with the Board and other professional service providers to expedite the foregoing, including:

(i) Assisting the Board in developing financial modeling and determination of appropriate Reinsurance Thresholds and Coinsurance Rates, levels of assessments and premiums, if any;

(ii) Assisting the Board in selection and development of a work plan for actuarial support;

(iii) Assisting the Board in developing rules, protocols and other requirements associated with claims submission and reporting by Member Insurers; and

(iv) Analysis of potential reinsurance of MGARA'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 MGARA's Reinsurance Program, under the direction of the Board, and working in conjunction with the other professional service providers retained by MGARA, and shall ensure the efficient and effective operation of MGARA, 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 MGARA;

- (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 collection of premium (if any) and submission and processing of claims for reimbursement, as more specifically described below;
- (v) Assisting the Board and MGARA's actuarial consultants in the determination of assessment levels, premiums (if any) 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 (if any);
- (vi) Establish procedures and install and maintain the systems needed to properly administer the operations of MGARA 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;
- (xi) Prepare Board required reports and maintain all records pertaining to MGARA and the operation of its business in

accordance with record retention policies adopted by the Board; and

- (xii) Provide all necessary assistance to the Board and the Superintendent with respect to Section 1332 Reporting.

- (c) Financial Services. The Administrator shall be responsible for managing the financial affairs of MGARA. 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 MGARA, 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 (if any);
 - (vii) Working with MGARA'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 MGARA 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 MGARA 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 consistent with this Plan;
 - (xi) Issue checks or drafts on and/or approve charges against bank accounts of MGARA;
 - (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 MGARA in establishing and maintaining any necessary lines of credit or other credit facilities necessary for the operation of MGARA'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 MGARA'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 MGARA's operations;
 - (ii) Implement and maintain information and network security controls reasonably designed to safeguard the confidentiality of MGARA's records and information, protect against any anticipated threats or hazards to the security or integrity of such records, and protect against unauthorized access to or use of such records or information that could result in harm or inconvenience to MGARA, Member Insurers, or Covered Persons;

- (iii) Create, host, maintain and update MGARA's website, with basic public information and public relations data on MGARA; and
 - (iv) Maintain a complete database of all information related to the business of MGARA and the Reinsurance Program, including Insurers, Member Insurers, assessments, billing and collection, claims payments, Section 1332 Waiver administration, including accessing the federal PMS on behalf of MGARA, and such other information as is relevant to MGARA'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 MGARA's legal counsel to maintain compliance by MGARA with all laws and regulations applicable to MGARA 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 MGARA.
- 8.7 Confidentiality. The Administrator shall maintain the confidentiality of all information pertaining to Insurers and/or Covered Persons in accordance herewith and pursuant to 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 MGARA 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 that identifies a specific Covered Person shall be retained or used by the Administrator or disclosed to any third party.

ARTICLE IX REINSURANCE PROGRAM

- 9.1 Reinsurance Program. MGARA shall provide reinsurance in accordance with the requirements of the Enabling Act and this Plan (the “Reinsurance Program”). The Reinsurance Program will commence operation as of January 1, 2022. The Reinsurance Program shall be operated on a calendar year basis with all Eligible Health Plans in force during a calendar year being eligible for participation in the Reinsurance Program to the extent of any Eligible Claims.
- 9.2 Eligible Health Plans. Upon request by the Administrator, each Member Insurer shall provide to MGARA a summary of each plan of Medical Insurance offered by the Member Insurer in the individual market in the State of Maine during a calendar in which the Reinsurance Program is operated (each, an “Eligible Health Plan”), and if requested by the Administrator, a copy of each new Eligible Health Plan, and each amendment, change or revision to any existing plan, shall be provided within sixty (60) days following such request.
- 9.3 Reinsurance Provided. The reinsurance provided under the retrospective program will reimburse Member Insurers at the applicable Coinsurance Rate based on the total Eligible Claims for each Covered Person under an Eligible Health Plan in force during each calendar year, subject to the applicable Reinsurance Threshold. Entitlement to reinsurance is determined on a cumulative per Covered Person basis, and not on a per claim basis. The Reinsurance Thresholds and Coinsurance Rate are as follows:

- (a) Reinsurance Thresholds. The reinsurance provided hereunder shall reimburse Member Insurers at the Coinsurance Rate for Eligible Claims payments actually paid by the Member Insurer on account of a given Covered Person that meet or exceed the attachment point set forth on Exhibit A hereto (“Attachment Point”) and are not in excess of the reinsurance limit set forth on Exhibit A hereto (“Reinsurance Limit”). There is no entitlement to reinsurance payments for Eligible Claims payments below the Attachment Point or above the Reinsurance Limit per Covered Person. The Attachment Point and Reinsurance Limit are referred to collectively as the “Reinsurance Thresholds”. Eligible Claims payments within the Reinsurance Thresholds are referred to as “Reinsured Losses.”
- (b) Coinsurance Rate. The rate of reinsurance payments (“Coinsurance Rate”) is the coinsurance rate percentage set forth on Exhibit A hereto, applied to claims payments within the Reinsurance Thresholds.
- (c) Annual Exhibit A Update. The Reinsurance Thresholds and Coinsurance Rate are subject to annual adjustment, as determined by the Board in its discretion and approved by the Superintendent. Each annual adjustment shall be entered on Exhibit A for the relevant calendar year and the revised Exhibit A will be promptly distributed to the Member Insurers.

9.4 Reinsurance Reimbursement. MGARA shall pay reinsurance payments to Member Insurers as follows:

- (a) Quarterly Payments. MGARA shall reimburse Member Insurers on a calendar quarter basis at the Coinsurance Rate for Reinsured Losses (“Reinsurance Reimbursement”). Reinsurance Reimbursement shall be paid as promptly as reasonably possible following the submission of Claims Reports.
- (b) Annual Payments. On or before June 30 of each calendar year the Member Insurers shall submit to MGARA a final Claims Report for all Eligible Claims for the preceding calendar year. On or before July 31 of each calendar year a final adjudication of Reinsured Losses for the preceding calendar year shall be conducted and final payment of reimbursement for Reinsured Losses shall be made to Member Insurers, subject to the provisions set forth in Section 9.8(b) below regarding claims included in an Open Claims Report.

9.5 Annual Determination of Reinsurance Thresholds and Coinsurance Rate.

On an annual basis, the Board will determine the applicable Reinsurance Thresholds and Coinsurance Rate and submit the same to the Bureau for approval as an amendment to this Plan of Operation. The Association will exercise commercially reasonable efforts to notify Member Insurers of annual changes in the Reinsurance Thresholds and Coinsurance Rate prior to March 31 of each year for the following calendar year, and will in any event will notify Member Insurers not later than July 31 of each year for the following calendar year, except to the extent there are changes in federal or state laws, rules or regulations, or interpretations or applications thereof, that, in the Board's discretion, necessitate a later notification of adjustment; provided, however, that the Association will exercise commercially reasonable efforts to collaborate with the Member Insurers and the Bureau to determine and notify Member Insurers of any adjustments as early as reasonably possible in order to facilitate an orderly rate filing and determination process.

9.6 Premium Calculation and Payment. MGARA reserves the right (subject to approval by the Bureau) to amend this Plan to provide for the payment of premiums as a precondition to participation in the Reinsurance Program. Any such change will be made at the same time as the annual determination of Reinsurance Thresholds and Coinsurance Rate pursuant to Section 9.4 above.

9.7 Eligible Claims. "Eligible Claims" are only those amounts that are actually paid by a Member Insurer for benefits provided to a Covered Person for the applicable calendar year pursuant to an Eligible Health Plan. Eligible Claims do not include such amounts as administrative expenses, attorneys' fees, or non-medical benefits. 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;
- (f) Non-medical benefits, such as stand-alone dental, vision, disability, or other non-medical benefits or services; provided, however, that coverages embedded in the Health Plan, such as pediatric dental and vision or non-EHB adult vision are included in Eligible Claims; or
- (g) Claims expenses that are subject to reimbursement through any other reinsurance agreement, plan or program.

9.8 Claims Reporting.

- (a) Members Insurers shall provide a report of all Eligible Claims to MGARA on a calendar quarter basis within 20 days following the end of each calendar quarter in a form approved by the Board (“Quarterly Claims Reports”). A final Claims Report shall be submitted on or before July 20 with a June 30 cut-off date for each calendar year for all Eligible Claims for the preceding calendar year (“Annual Claims Report” and generically referred to together with the Quarterly Claims Reports as “Claims Reports”). Claims Reports shall be in a form approved by MGARA and shall contain the following information for each claim reported:
 - (i) the Covered Person’s name;
 - (ii) the Covered Person’s identification number;
 - (iii) the Covered Person’s date of birth;
 - (iv) the claim incurred date and paid date;
 - (v) any claim payment and the reinsurance claim amount;
 - (vi) any reversals of claims payments previously reported;
 - (vii) any other reinsurance, subrogation or other reimbursement amounts received by the Member Insurer with respect to a reported claim; and

(viii) such other information as may be required by the Board.

- (b) Open Claims. Together with the Annual Claims Report, Member Insurers shall submit to MGARA a list of any claim that remains open for the preceding calendar year that the Member Insurer projects is reasonably likely to meet or exceed the Reinsurance Thresholds, together with an estimate of expected payments associated with the relevant open claim ("Open Claims Report"). Claims reported as open claims shall be eligible for reimbursement at such time as Reinsured Losses are finally determined, subject to a final cut-off date of September 30 of the year in which the applicable Annual Claims Report was due. The final Claims Reports on Open Claims is due October 20. Any claims (i) for which Reinsured Losses are not finally determined and submitted for Reinsurance Reimbursement by July 20, and (ii) that are not included in the Open Claims Report and submitted for reimbursement by October 20, shall not be eligible for Reinsurance Reimbursement.
- (c) Additional Reporting. MGARA reserves the right to require additional reporting from Member Insurers as the Board deems appropriate from time to time.

9.9 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, without regard to whether claims are eligible for Reinsurance Reimbursement by MGARA. Upon the request of MGARA, Member Insurers shall promptly forward to MGARA copies of such reports of investigation.
- (b) Member Insurers shall adjudicate all claims subject to Reinsurance Reimbursement by MGARA in a manner consistent with the Member Insurer's non-reinsured business, without regard to whether claims are eligible for Reinsurance Reimbursement by MGARA.
- (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 eligible for Reinsurance Reimbursement by MGARA.

- (d) Failure to satisfy the requirements of Sections 9.9(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 13.6 hereof.
- (e) MGARA shall have the right, at its own expense, to participate jointly with a Member Insurer in the investigation, adjustment or defense of any primary coverage 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 MGARA's rights to deny or reduce reinsurance claims payments pursuant to Section 9.9(d) above.
- (f) MGARA shall have the right (1) to inspect the records of the Member Insurer in connection with Eligible Health Plans or claims reimbursed by MGARA and (2) to request Member Insurers to provide to MGARA records, data, or other information relevant to the operation of MGARA. Member Insurers shall submit to MGARA any additional information within their possession or control that MGARA may request in connection with claims submitted to MGARA for Reinsurance Reimbursement or otherwise in connection with the operation of MGARA. Member Insurers shall exercise reasonable efforts to secure necessary authorization from Covered Person(s) for this purpose, such as including MGARA, or reinsurers generally, in any information disclosure authorizations.
- (g) All information disclosed to MGARA by the Member Insurer or to the Member Insurer by MGARA in connection with operations pursuant to this Plan shall be considered by both the Member Insurer and MGARA to be confidential information.
- (h) In the event that the Member Insurer is reimbursed by another party for claims previously reimbursed by MGARA, the Member Insurer shall reimburse MGARA for the amount of any duplicate reimbursement from sources such as co-ordination of benefits, excess loss reinsurance obtained by the carrier, and payments under the federal high cost risk pool, to the extent such are applicable. 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 notifying MGARA of any actions that may be required by MGARA.

- (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 subject to Reinsurance Reimbursement by MGARA.

9.10 Audit and Inspection Rights. As a condition of each Member Insurer's membership in MGARA and as a condition of the Member Insurer's ability to obtain Reinsurance Reimbursement by MGARA, MGARA 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 or claims eligible for Reinsurance Reimbursement, the issuance and administration of primary coverage, 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 9.9(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 MGARA'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.

9.11 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.

- 9.12 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 **ASSESSMENTS**

- 10.1 Organizational Assessment. The Board assessed each Insurer a one-time initial organizational assessment in in 2012 (“Organizational Assessment”). No further Organizational Assessment is permitted.
- 10.2 Regular Assessments. On an annual basis, the Board shall assess each Insurer an amount (“Regular Assessment”) 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 (each, an “Enrolled Person”). Absent a change in assessment rate by the Board, the prior year assessment rate shall continue in force. MGARA will exercise commercially reasonable efforts to notify Member Insurers of annual changes in the rate of assessments prior to March 31 of each year for the following calendar year, and will in any event will notify Member Insurers not later than July 31 of each year for the following calendar year, except to the extent there are changes in federal or state laws, rules or regulations, or interpretations or applications thereof, that, in the Board’s discretion, necessitate a later notification of adjustment; provided, however, that MGARA will exercise commercially reasonable efforts to collaborate with the Member Insurers and the Bureau to determine and notify Member Insurers of any adjustments in assessment rates as early as reasonably possible in order to facilitate an orderly rate filing and determination process. Regular Assessments shall be payable on a quarterly basis, due within forty-five (45) days after the end of each calendar quarter.
- 10.3 Assessments to Cover Net Losses. In addition to the Regular Assessments described in Sections 10.1 and 10.2, the Board may 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 Enrolled Person (“Deficit Assessment”).
- 10.4 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 MGARA (i) the calculation of the assessment applicable to such Insurer,

together with (ii) the payment required under Sections 10.2 or 10.3 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 MGARA, either through audit or through any other independent means available to MGARA for verification of Insurer enrollment. Notwithstanding the self-reporting process described herein, MGARA 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.

10.5 Federal or State Employees. An Insurer shall not be subject to assessments pursuant to Sections 10.2 or 10.3 on policies or contracts insuring federal or state employees, except with respect to coverage of Maine state legislators and their dependents.

10.6 Determination and Payment of Assessments.

- (a) Basis. The Regular Assessment payable by each Insurer pursuant to Section 10.2, and the Deficit Assessment payable by each Insurer pursuant to Section 10.3, will each be calculated based upon the rate of assessment determined by the Board and each Insurer's Enrolled Person enrollment.
- (b) Calculation of Assessments. For purposes of calculating their Regular Assessments, Insurers shall report to MGARA their Enrolled Person enrollment (determined on a basis consistent with Section 10.6(f) below) within forty-five (45) 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 MGARA.
- (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 Enrolled Person 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 MGARA shall have a right to adjust enrollment reported by Insurers to reflect any additional information obtained or provided to MGARA 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 Enrolled Person 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, MGARA 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 MGARA. 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 MGARA 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 Enrolled Person for assessment purposes:
 - (i) The Board shall make reasonable efforts to ensure that each Enrolled 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 Enrolled Person 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 Enrolled Person 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 an Enrolled Person and a Third Party Administrator that administers such insurance (or provides any related service) with respect to such Enrolled Person on behalf of such insurance carrier, the payment of Regular Assessments and Deficit Assessments based on the coverage of such Enrolled 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.

10.7 Late Payment of Assessments. Assessment payments paid after the applicable due date shall be subject to interest at the rate of 12% per annum, to be charged on and after the applicable due date.

10.8 Deferral of Assessments. An Insurer may apply to the Superintendent for a deferral of all or part of an assessment imposed by MGARA. 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 MGARA for the amount deferred and is prohibited from reinsuring any person through MGARA until such time as the Insurer pays the assessments.

10.9 Failure to Pay Assessment.

(a) MGARA 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.

10.10 Excess Funds. If assessments and other receipts by MGARA exceed the actual losses and administrative expenses of MGARA, the Board shall

hold the excess in an interest bearing account or otherwise invested in accordance with MGARA's Investment Policy and shall use those excess funds to offset future losses or to reduce reinsurance premiums (if any), or adjust the Reinsurance Thresholds or Coinsurance Rate, as determined by the Board in its discretion and approved by the Superintendent. As used in this Section 10.10, "future losses" includes reserves for IBNR.

- 10.11 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 MGARA, the Administrator will act on behalf of MGARA 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 13.6 hereof.

ARTICLE XI FINANCIAL ADMINISTRATION

- 11.1 Books and Records. MGARA 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 MGARA 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 MGARA in accordance with generally accepted accounting principles (as applicable).
 - (c) Assets and liabilities of MGARA, other than cash, shall be accounted for and described in itemized records.
 - (d) For each Insurer, the net balance due to/from MGARA 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 MGARA. 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 (if any) due from the Member Insurer to MGARA.
 - (v) If the Insurer is a Member Insurer, the amount of Reinsurance Reimbursement due from MGARA to the Member Insurer.
 - (vi) Such other records as may be required by the Board.
- (e) MGARA shall maintain a general ledger whose balances are used to produce MGARA's financial statements in accordance with generally accepted accounting principles (as applicable).
 - (f) MGARA shall maintain all records as to premium (if any), Reinsurance Reimbursements, and administrative expenses with respect to a given calendar year for a period of seven (7) years following the end of such calendar year.

11.2 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.

11.3 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.

11.4 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.

11.5 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 MGARA, together with any applicable limitations on such investments. All cash shall be invested in accordance with the Investment Policy.

ARTICLE XII AUDIT FUNCTION

12.1 Statutory Reporting. On an annual basis, MGARA shall provide the following audits and reports to the parties indicated:

- (a) Annual Audit. The Board shall cause an audit of MGARA 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. MGARA shall report to the Joint Standing Committee not later than March 15th of each year. The report shall include information on the financial solvency of MGARA and the administrative expenses of MGARA.
- (c) Annual Review for Solvency. The Board shall cause a review of MGARA for solvency to be conducted annually and shall submit the results of such review to the Superintendent. Before April 1st of each year, MGARA shall determine and report to the Superintendent (i) MGARA'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 MGARA in the previous calendar year, including IBNR reserves.

12.2 Audit Scope. The audit shall review both MGARA and the relevant operations of the Administrator. The audit report shall include the auditor's opinion as to whether the financial statements of MGARA fairly present in all material respects the financial position of MGARA. Auditors of MGARA 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 MGARA. Each of the Board or Audit Committee may at its discretion request copies of audit programs and details of audit testing from the auditor.

12.3 Auditor. MGARA'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, MGARA, or the Administrator. MGARA'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 (as applicable).

12.4 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 MGARA with all applicable laws, rules, regulations and industry standards; and the adequacy of internal financial and operating controls and procedures.

ARTICLE XIII **PENALTIES AND DISPUTE RESOLUTION**

- 13.1 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 MGARA, it is expected that all Insurers will exercise the highest degree of good faith and due diligence in all aspects of their relationship with MGARA.
- 13.2 Common Administrative Errors. There are certain common administrative errors that, notwithstanding the exercise of good faith and due diligence can be expected to occur. MGARA and Member Insurers shall exercise good faith efforts to resolve any administrative errors. Any errors in Reinsurance Reimbursements shall be promptly paid by MGARA to Member Insurers or returned by Member Insurers to MGARA , as applicable.
- 13.3 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 MGARA's right to take any action or exercise any remedies provided in this Plan, the Enabling Act or other applicable law.
- 13.4 Other Errors. All additional sums due to MGARA 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 MGARA's right to take any action or exercise any remedies provided in this Plan, the Enabling Act or other applicable law.
- 13.5 Interest and Administrative Charges. Usual and ordinary errors and corrections shall not result in interest or administrative charges. In the event MGARA determines that errors are the result of intentional, negligent or habitual behavior, then interest and administrative charges may be imposed in MGARA's discretion. Any such charges shall require Board approval. All interest payments required under this Article XIII 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.
- 13.6 Dispute Resolution. In the event of any dispute between MGARA 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, MGARA 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 MGARA written notice of such dispute (a "Dispute Notice"). The executive of the Administrator and counsel for MGARA 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 13.6 are pending and for fifteen (15) calendar days thereafter. The parties will take such action, if any, required to effectuate such tolling.

ARTICLE XIV **INDEMNIFICATION AND LIABILITY**

- 14.1 Indemnification. MGARA shall indemnify directors and officers of MGARA, and may indemnify employees and agents of MGARA, pursuant to and as provided in the Bylaws of MGARA.
- 14.2 Liability. Liability of directors and employees of MGARA and others is limited as set forth in the Enabling Act.

ARTICLE XV **AMENDMENT**

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

ARTICLE XVI **REPORTING REQUIREMENTS**

- 16.1 General. This Plan sets forth certain reports and reporting requirements for Insurers summarized in Section 16.2 below. MGARA 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 in this Plan of reports and the information contained therein shall not limit MGARA's ability to establish additional reporting requirements, as determined necessary to effectively implement this Plan.

- 16.2 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) Claims Reports. Described in Section 9.8 are the Quarterly Claims Report, Annual Claims Report, and Open Claims Report to be submitted by each Member Insurer.
- (b) Quarterly Assessment Report. Described in Section 10.6(b) is the Quarterly Assessment Report of each Insurer's Enrolled Person enrollment utilized to calculate the Insurer's Regular Assessment payment, and any Deficit Assessment.

ARTICLE XVII **TERMINATION**

- 17.1 MGARA 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 MGARA, MGARA 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 MGARA 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 MGARA, 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 MGARA, 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 MGARA shall be transferred to a trust, non-profit corporation or other fund established pursuant to the Plan of Termination to be used and applied for the general purposes for which MGARA was originally organized, and provided that no part of the remaining assets or net earnings of MGARA shall inure to the benefit of any private entity or individual.

ARTICLE XVIII MATERIAL CHANGES

18.1 MGARA will exercise commercially reasonable efforts to collaborate with the Member Insurers and the Bureau to determine and notify Member Insurers of any material changes or adjustments in this Plan, its operations or its reinsurance program as early as reasonably possible in order to facilitate an orderly rate filing and determination process.

EXHIBIT A

Reinsurance Thresholds and Coinsurance Rate Percentage

2022

Attachment Point	\$76,000
Reinsurance Limit	\$250,000
Coinsurance Rate percentage	100%

EXHIBIT B

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.

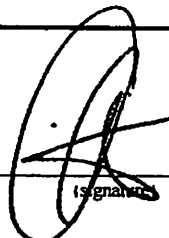
SEVENTH: (Optional) (Check if this article is to apply)

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*



(signature)

Christopher E. Howard

(type or print name)

Dated January 20, 2012

Street 89 Whites Point Road

(residence address)

Standish, ME 04084

(city, state and zip code)

Street _____

(residence address)

(signature)

(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: TE.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> <u>(in years)</u>	<u>Address</u>
Jennifer Juke	1	585 Winthrop Road, Deep River, CT 06417
Edward J. Kane	2	1 Market Street, 3 rd 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 C

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 of the Corporation, for any lawful purpose. 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.

Appendix C: **Gorman Associates Actuarial and Economic Report**

**1332 Waiver
Actuarial and Economic Report**

**Prepared for the Maine Bureau of
Insurance**

January 26, 2022

Gorman Actuarial, Inc.

Bela Gorman, FSA, MAAA

Jenn Smagula, FSA, MAAA

Bob Carey



Gorman Actuarial, Inc.

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1. Executive Summary

This report addresses section 45 CFR 155.1308(f)(4)(i)-(iii) and applicable federal regulations and policies related to section 1332 waiver applications. It includes actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. The report was prepared in consultation with the Maine Bureau of Insurance (BOI) and the Maine Department of Health and Human Services. The report is part of Maine's Section 1332 waiver application to the Centers for Medicare and Medicaid Services (CMS), and it should be reviewed within the broader context of the state's waiver application.

Overview of Maine's Waiver Application

The State of Maine is seeking approval for a Section 1332 waiver that would result in the establishment of a single risk pool that includes both the individual market and small group market, and the establishment of a reinsurance program that reduces premiums in both market segments, thereby making health insurance more affordable for a broad group of Maine residents and small employers. These changes will be particularly beneficial to individuals not eligible for subsidized coverage and small employers (and their employees), both of whom should experience lower premiums.

Combining the individual and small group markets into a single risk pool should provide greater stability to these market segments, and may increase the number of insurers offering health plans to individuals.¹ Lowering premiums and stabilizing the markets should slow the decline in membership that has recently occurred in both the individual and small group markets. By addressing underlying issues in the individual and small group markets, Maine seeks to strengthen the Affordable Care Act (ACA) and increase enrollment in comprehensive, affordable health coverage.

If this waiver application is approved by CMS, the state would transition the current individual market retrospective reinsurance program into a retrospective reinsurance program that will apply to the newly pooled individual and small group markets. The current reinsurance program's waiver request was approved by CMS in July 2018 and took effect January 1, 2019. Pending approval of this Section 1332 waiver application, Maine will continue to operate the existing reinsurance program under the terms and conditions delineated by CMS.

¹ As noted in the body of this report, three insurers currently offer coverage in the individual market and five insurers participate in the small group market. Combining the markets may increase the number of insurers offering coverage to individuals.

Pooling the Markets

As of March 2021, roughly 63,000 residents obtained health insurance through Maine's individual market, a decrease of 20,000 or 24% from March 2017.² The small group market in Maine has also experienced significant reductions in membership over the past four years due in part to high medical cost trends and the associated premium increases. Enrollment fell from 61,200 in March 2017 to 48,300 in March 2021, a 21% reduction.

Both the individual and small group markets are relatively small, with a combined membership of approximately 111,300 as of March 2021. As market membership declines, enrollees that remain in the market are typically less healthy and use more health care resources, which further drives up premiums.³ In addition, the smaller the size of the risk pool the less predictable and less stable premiums will be for that pool.^{4, 5} It is this dynamic that is of increasing concern to Maine policymakers and is a key factor driving this 1332 waiver application.

Maine proposes to combine the individual and small group markets into a single risk pool for rate setting, risk adjustment, and medical loss ratio (MLR) purposes. Pooling the markets alone would reduce rates in the individual market but increase rates in the small group market compared to the baseline, which assumes there is no section 1332 waiver in effect.⁶ The reduction in individual market rates would lower federal spending for Premium Tax Credits (PTCs), which represents the difference between the second lowest cost Silver plan (SLCSP) premium and the maximum premium amount an individual or family is expected to pay based on their family income and size.⁷ As Silver plan premiums decline, PTCs fall, which lowers federal spending.

² As discussed in the body of this report, Maine expanded eligibility for its Medicaid program (MaineCare) in 2019, which shifted thousands of residents from the individual market to MaineCare.

³ "Anatomy of a Slow-Motion Health Insurance Death Spiral," H.E. French III and Michael P. Smith, North American Actuarial Journal, 2015.

⁴ "Risk Pooling: How Health Insurance in the Individual Market Works," American Academy of Actuaries, <https://www.actuary.org/content/risk-pooling-how-health-insurance-individual-market-works-0>, accessed on December 7, 2020.

⁵ "Health Insurance Markets 101," The Sycamore Institute., <https://www.sycamoreinstitute.org/about-us/> accessed on December 7, 2020.

⁶ For the purpose of this actuarial analysis, the baseline estimate excludes premium reductions associated with Maine's current Section 1332 waiver and assumes there is no waiver in effect and no reinsurance program in the individual market.

⁷ In the event an individual's eligible APTC amount exceeds the full premium of the health plan in which the individual is enrolled, APTC is capped at the full premium amount. For example, a Bronze plan's premium may be lower than the APTC an individual is eligible to receive.

Reinsurance Program Design

Under the second part of the waiver application, Maine would establish a reinsurance program applicable to the newly-pooled individual and small group markets effective January 1, 2023. The proposed reinsurance program would reduce premiums across the newly-pooled individual and small group market. As premiums are reduced, premium subsidies provided by the federal government in the form of PTCs decline.

Premium and Membership Impacts

Pooling the markets and applying a retrospective reinsurance program is expected to lower the average individual market premium by 8.0% compared to the baseline in 2023. In the small group market, the average premium is projected to decrease 6.0% in 2023 compared to the baseline. In 2024, the average individual market premium is expected to be 6.1% lower than baseline and the average small group market premium is expected to be 3.9% lower than baseline.

Membership is projected to be higher in each year under the “with wavier” scenario compared to the “no waiver” scenario. In 2023, the individual market membership will be higher by 1,600 members or 2.7% and the small group market membership will be higher by 2,482 members or 5.3% Under the “with wavier” scenario compared to the “no waiver” scenario. In 2024, the individual market membership will be higher by 1,146 members or 2.0% and the small group market membership will be higher by 1,610 members or 3.5% under the “with wavier” scenario compared to the “no waiver” scenario.

Funding and Reinsurance Program Design

The net reduction in federal expenses from lower PTCs due to a reduction in individual market premiums will be used to fund a portion of the retrospective reinsurance program. In addition to the use of federal pass-through funds, Maine plans to use the \$4.00 per member per month (PMPM) assessment that is currently used for the Maine Guaranteed Access Reinsurance Association (MGARA) reinsurance program to support the individual market retrospective reinsurance program.⁸ Based on recent assessment estimates provided by MGARA, the \$4.00 PMPM assessment is expected to generate \$27.0 million in revenue in the first year of the waiver (CY 2023).⁹ A portion of these funds – estimated to be \$300,000 annually – will be used to administer the reinsurance program.

⁸ The \$4.00 PMPM assessment is statutorily established and not directly tied to the existence of a 1332 waiver or a reinsurance program.

⁹ Based on Milliman’s Report to the MGARA Board October 18, 2021.

For CY 2023, an additional \$8.6 million in reinsurance program funding that was received by Maine in 2021 as a result of the American Rescue Plan Act (ARPA) will be used to further reduce premiums in the first year of the waiver.¹⁰ This funding, in conjunction with the \$4.00 PMPM assessment and federal pass-through funds generated from the reduction in PTCs, would be used to fund the newly structured reinsurance program in 2023.

In subsequent years, the reinsurance funding will be supported by the \$4.00 PMPM assessment and federal pass-through funding from the reduction in PTCs. Based on current federal law, we are assuming the ACA's premium subsidy schedule is in effect for the duration of the waiver period (i.e., CY 2023 through CY 2032) and enhanced subsidies provided for under ARPA are not extended beyond CY 2022. In addition, we do not assume any additional ARPA-related funds, beyond the \$8.6 million noted above, will be available to support the program in CY 2024 and beyond.

Premiums in the individual market are estimated to decline 8.0% compared to the baseline in 2023, which would generate \$22.8 million in net federal savings. These savings would be combined with the state assessment and the ARPA revenues to fund the reinsurance program in 2023, which would result in a total of \$58.0 million available to fund the reinsurance program. Starting in 2024, it is assumed that additional ARPA funds will not be available. The table below lays out the main funding sources for the first five years of the program. Ten year projections are included in Section 6 of this report.

Reinsurance Program Funding 2023 - 2027					
	2023	2024	2025	2026	2027
Federal Funding	\$22,785,550	\$18,021,369	\$18,863,890	\$19,755,030	\$20,687,374
2021 ARPA Funds	\$8,562,238	\$0	\$0	\$0	\$0
State Funding	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>
Total Reinsurance	\$58,047,788	\$44,721,369	\$45,563,890	\$46,455,030	\$47,387,374

Table 1: Reinsurance Program Funding – 2023 through 2027¹¹

¹⁰ CMS Website: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#Section_1332_State_Application_Waiver_Applications

¹¹ It was assumed that the state funding assumption of \$26.7 million would remain level in future periods. While it is assumed that the individual and small group market enrollment increases in 2023 and then subsequently decreases 2024 through 2032, the enrollment changes are minimal and it is assumed that the majority of the enrollees are coming from or staying within the assessed commercial health insurance market.

For 2023, the retrospective reinsurance program has been initially structured to reimburse insurers 55% of claims costs between \$90,000 and \$275,000, with the portion of claims exceeding \$275,000 the full responsibility of the health insurers. For 2024, the retrospective reinsurance program is initially structured to reimburse insurers 45% of claims costs between \$90,000 and \$240,000, with the portion of claims exceeding \$240,000 the full responsibility of the health insurers.

These initial parameters are subject to adjustment based on actual revenues received from the state assessment and federal pass-through funds generated from lower PTCs to ensure reinsurance reimbursements to insurers do not exceed available funding. On an annual basis, the Maine Guaranteed Access Reinsurance Association (MGARA), in consultation with the Maine Bureau of Insurance (BOI), will establish the reinsurance program's parameters to reflect funding available in order to maintain the financial solvency of the program.

Meeting the Section 1332 Waiver Guardrails

In order for a Section 1332 waiver to be approved by CMS, the waiver must demonstrate that the proposed market modifications will meet four guardrails pertaining to comprehensiveness, affordability, scope, and deficit neutrality. As discussed further in the body of this report, the proposed waiver meets all four guardrails:

1. The waiver will not result in any changes to the essential health benefit (EHB) benchmark or actuarial value requirements and will therefore have no impact on the comprehensiveness of coverage available in the individual and small group markets.
2. Pooling the individual and small group markets and applying a retrospective reinsurance program will reduce premiums, compared to the baseline, thereby increasing the affordability of health insurance. The waiver does not alter cost-sharing and out-of-pocket limits currently in place, ensuring overall affordability of coverage is improved for individuals and small group members.
3. More residents will be covered under ACA-compliant plans with the waiver than would be covered without the waiver, which satisfies the scope guardrail.
4. The proposed waiver does not increase net spending by the federal government, thereby addressing the deficit neutrality requirement.

2. Background

Overview of Section 1332 requirements

Section 1332 of the Affordable Care Act (ACA) permits a state to apply to CMS for a State Innovation Waiver (now also referred to as a State Relief and Empowerment Waiver) to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the protections of the ACA. Since 2017, State Innovation Waivers have allowed states to implement programs to provide residents with access to health care that is at least as comprehensive as coverage provided absent the waiver; provides coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver; provides coverage to at least a comparable number of residents as would be covered absent a waiver; and will not increase the federal deficit.¹²

As of August 2021, CMS had approved waivers in 16 states,¹³ including Maine. Fourteen (14) states received approval to waive the single risk pool requirement under Section 1312 of the ACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate.¹⁴

While each state's reinsurance program varies, 12 states¹⁵ apply a claims cost-based model, under which insurers are reimbursed for a portion of the costs of enrollees whose claims exceed an attachment point; one state – Alaska – uses a conditions-based model under which insurers are reimbursed for claims costs for individuals with one or more pre-determined high-cost condition; and prior to 2022 Maine used a hybrid conditions and claims cost-based model. Beginning in 2022, Maine has transitioned from a hybrid conditions and claims cost-based model to a full retrospective claims cost-based model.

Guardrails

Pursuant to Section 1332, states must demonstrate that the waiver meets the following four guardrails:

¹² Centers for Medicare and Medicaid Services, Programs and Initiatives, State Innovation Waivers.

¹³ Centers for Medicare and Medicaid Services, CCIIO Data Brief Series, “State Innovation Waivers: State-Based Reinsurance Programs,” August 2021.

¹⁴ CMS, CCIIO Data Brief Series, August 2021.

¹⁵ Colorado, Delaware, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, and Wisconsin.

Comprehensiveness – a 1332 waiver must demonstrate that health coverage is required to be forecast to be at least as comprehensive overall for residents as the coverage provided absent the waiver;

Affordability – coverage under the waiver will be at least as affordable for residents as coverage absent the waiver (including premiums, deductibles, co-pays, and co-insurance);

Scope – the waiver must provide coverage to a comparable number of residents as would be covered without the waiver; and

Deficit Neutrality – projected federal spending net of federal revenues is equal to or lower than projected federal spending in the absence of the waiver.

Consistent with federal regulations and CMS guidance, waivers that impact the individual market should use a baseline in which there is no waiver plan in effect, and should compare premiums, comprehensiveness, and coverage under the baseline for each year to those projected under the waiver. As described further in this report, the guardrails analysis uses the “no waiver plan in effect” scenario to establish the baseline against which coverage, affordability, scope, and deficit neutrality under the waiver are compared.

Actuarial Certification

This report is a supplement to Maine's 1332 waiver application. It addresses requirements under section 45 CFR 155.1308(f)(4)(i)-(iii), including actuarial analyses, actuarial certifications, economic analyses, and data and assumptions. The actuarial certification is included in Section 8 of this report.

Maine Demographics

Maine had a total population of 1.36 million in 2020¹⁶, an increase of 34,000 residents (+2.6%) since the 2010 census. By comparison, the United States population increased by approximately 7.4% over this 10-year period. Maine’s population growth rate continues a pattern of modest increases compared to the rest of the country. While the U.S. population increased by 33% from 1990 - 2020, Maine’s population grew 11%.

Compared to the country, Maine residents are older – with a median age of 45.1 years versus 38.5 for the U.S. as a whole. While close to 22% of Mainers are age 65+, across the country 17% of the population is 65 years or older. The table below provides a

¹⁶ United States Census, 2020.

breakdown of Maine's age demographics, which is based on the results of the 2020 American Community Survey.¹⁷

Maine Population by Age (2020 estimate)		
Age Range	Number	Percentage
Under 18 years	245,455	18.2%
18 to 24 years	108,059	8.0%
25 to 34 years	164,268	12.2%
35 to 44 years	156,920	11.6%
45 to 54 years	171,038	12.7%
55 to 64 years	210,048	15.6%
65 years and over	294,353	21.8%
	1,350,141	

Source: American Community Survey, 2020

Table 2: Maine Population

Median household income in Maine was estimated to be \$57,918 in 2020, which was approximately 14% below the median household income for the United States (\$67,521).¹⁸ A breakdown of household income distribution for Maine is shown in the table below.

Maine Household Income (2020 estimate)		
Household Income Range	Number	Percentage
Less than \$20,000	90,173	15.4%
\$20,000 to \$39,999	111,635	19.1%
\$40,000 to \$59,999	95,561	16.4%
\$60,000 to \$99,999	134,047	23.0%
\$100,000 to \$149,999	85,743	14.7%
\$150,000 to \$199,999	36,008	6.2%
\$200,000 or more	30,890	5.3%
	584,057	

	<u>Maine</u>	<u>United States</u>
Median Household Income	\$57,918	\$67,521

Source: American Community Survey, 2020

¹⁷ American Community Survey, Demographic and Housing Estimate, 2020.

¹⁸ American Community Survey, Selected Social Characteristics in the United States, 2020.

Table 3: Maine Household Income

As is the case throughout the United States, slightly less than half of all Maine residents (46%) obtain health insurance through an employer, while seven percent purchase coverage in the individual market. Public health insurance programs cover 38% of Maine residents, split between Medicaid (18%) and Medicare (20%). Approximately 5% of Maine residents are uninsured.¹⁹ The chart below provides a breakdown of insurance status by coverage type for Maine residents in 2020.

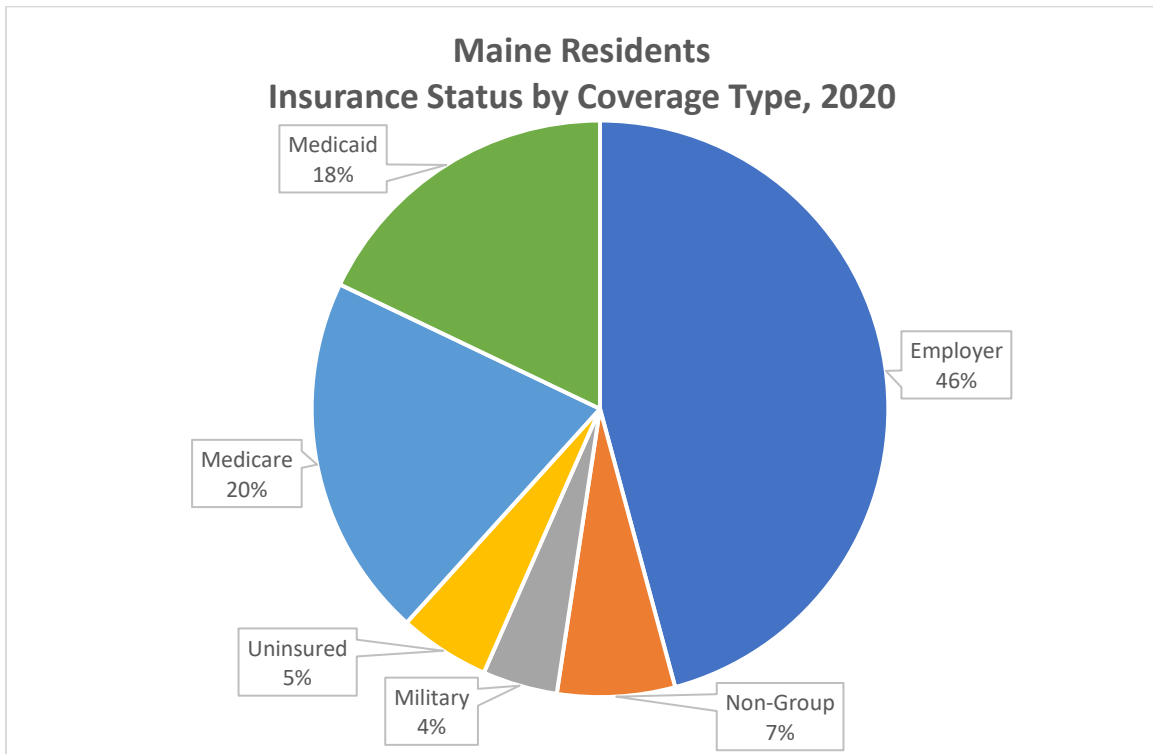


Figure 1: Maine Residents Insurance Status by Coverage Type

Maine and the Affordable Care Act

Over the past few years, Maine has taken a number of proactive steps designed to expand access to comprehensive health coverage to more residents, with a particular emphasis on expanding access to health care for underserved and vulnerable lower-income Mainers. In November 2017, Maine voters approved a referendum to expand Medicaid – known in the state as MaineCare. The eligibility expansion extended coverage to adult residents with incomes up to 138% of the Federal Policy Level (FPL). Enrollment started on a rolling basis in early 2019 and was largely completed during the

¹⁹ Kaiser Family Foundation, State Health Facts, 2020.

individual market open enrollment period for plan year 2020. As of October 2021, approximately 84,900 residents were covered through the MaineCare eligibility expansion, and a total of 366,695 Maine residents were receiving health coverage through the MaineCare program.²⁰

Prior to the plan year 2022 open enrollment, Maine used the federal health insurance exchange, Healthcare.gov, to enable residents to determine if they are eligible for advanced premium tax credits (APTC) and to enroll in a qualified health plan (QHP). The state had adopted the federal marketplace plan management model, which allowed Maine officials to certify and oversee the QHPs that are sold on the exchange.

Legislation enacted during the 129th Legislative Session²¹ the "Made for Maine Health Coverage Act," made a number of substantive changes to Maine's approach to ACA implementation, including establishment of the Maine Health Insurance Marketplace. The Marketplace's purpose is to allow Maine to operate a state-based exchange to benefit the state's insurance market and persons enrolling in health plans, facilitate the purchase of QHPs, reduce the number of uninsured, improve transparency, and conduct consumer education and outreach. In addition, Maine is transitioning the individual market reinsurance program to a claims-based retrospective reinsurance model effective January 1, 2022.

The state spent the past 18+ months developing the administrative apparatus and technical infrastructure to operate a state-based exchange. Effective for the plan year 2022 open enrollment, Maine transitioned from the federal health insurance marketplace and now operates its own state-based marketplace.

The law also authorizes the state to enter into state-federal health coverage partnerships that support the availability of affordable health coverage. In this case, a partnership "means a program established or authorized under federal law that provides or reallocates federal funding or that provides for the waiver or modification of otherwise applicable provisions of federal laws governing health insurance."²² This includes, but is not limited to, a section 1332 waiver.

²⁰MaineCare, like all Medicaid programs, is subject to continuity of coverage and maintenance of effort rules tied to the increased Federal Medical Assistance Percentages (FMAP) provided to states during the current public health emergency. These rules have likely increased the number of residents covered by state Medicaid programs.

²¹PL 2020, c. 653, "An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine," signed by the Governor on March 18, 2020.

²² 24-A Maine Revised Statutes Annotated (MRSA) chapter 34-A, "State-Federal Health Coverage Partnerships."

Individual Market

As of March 2021, approximately 63,000 residents obtained health insurance through Maine's individual market, a decrease of 20,000 or 24% from March 2017. With the expansion of MaineCare eligibility to adults with income up to 138% of the FPL in 2019, a number of adults that had previously obtained coverage in the individual market shifted to the MaineCare program. As noted in the chart below, the number of residents purchasing insurance in the individual market has declined each of the past four years, although enrollment has been more stable over the past two years.

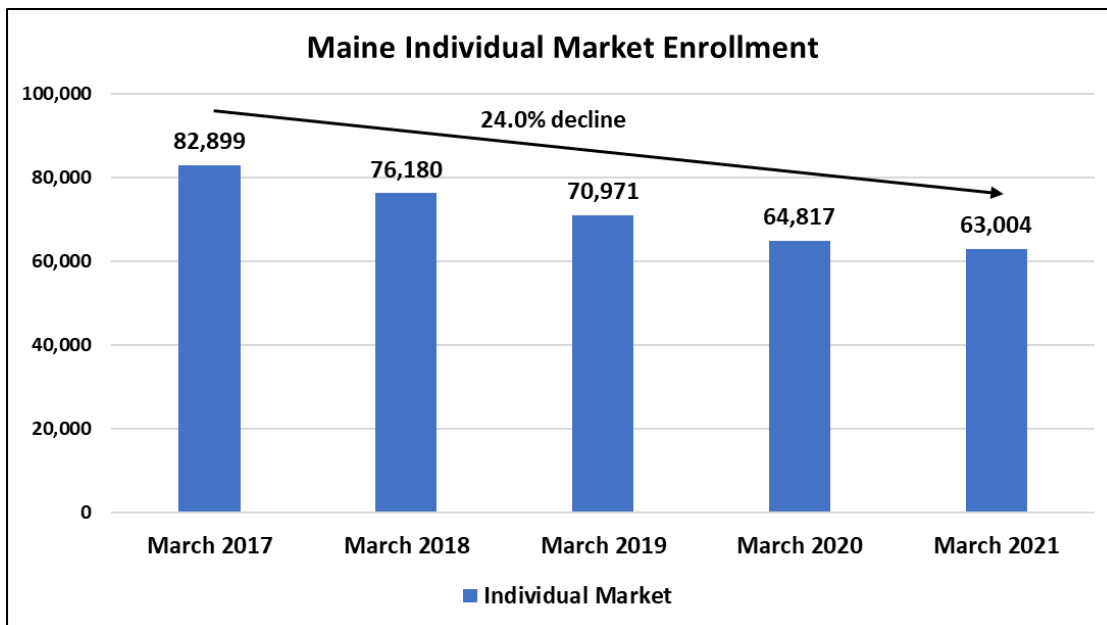


Figure 2: Maine Individual Market Enrollment Snapshot²³

More recently, the individual market has been helped by the MGARA reinsurance program, which was reactivated in 2019. From 2019 through 2021, this program used a hybrid-model reinsurance program with components of both a traditional attachment-point reinsurance program and a conditions-based reinsurance program. High-risk enrollees with one of eight conditions are automatically ceded to the program, and insurers are permitted to voluntarily cede other high-risk enrollees to the program.

In 2021, the program covers 90% of ceded members' claims costs from \$65,000 to \$95,000; and 100% of claims costs beyond that point up to \$1 million. For claims costs that exceed \$1 million, MGARA covers the net amount of claims not otherwise covered by the federal high-cost risk pool program within the risk adjustment program.

²³ Membership snapshot as of March of each year. These figures differ from the member months information displayed in Table 4.

Starting in 2022, the MGARA reinsurance program will transition to a claims-based retrospective reinsurance model and will cover 100% of claims between \$76,000 and \$250,000. There is no reinsurance for claims that exceed \$250,000.

The MGARA program is funded in two ways: (1) a \$4.00 PMPM assessment that applies across Maine's fully insured and self-insured commercial health insurance markets; and (2) federal pass-through funds obtained through a section 1332 waiver.

The MGARA reinsurance program and the expansion of MaineCare appear to have mitigated the need for rate increases and helped stabilize the individual market. Overall average rates declined (-12.5%) in 2021 and (-2.4%) in 2022, based on insurers' rate filings, which follows modest changes in rates in 2019 (1.1%) and 2020 (-0.5%).²⁴ The rate reduction in 2021 is primarily due to insurers more accurately accounting for the impact of the MGARA program, as well as improved morbidity and lower claims trend in the individual market. The improved morbidity and lower claims trend are likely due in part to higher-cost members shifting out of the individual market and into the MaineCare program.

Three insurers participate in the individual market – Anthem, Community Health Options, and Harvard Pilgrim Health Care.²⁵ The tables below show annual membership for CY 2017 through CY 2020 and average annual rate changes for 2019 through 2022.

²⁴ For 2019 through 2021, this estimate is based on a weighted average of renewing plan rate changes weighted by experience period or current enrollment from Worksheet 2 of the URRTs and includes both on and off exchange plans. For 2022, the estimate is based on average rate changes by insurer reported by the Maine BOI weighted by March 2021 enrollment.

²⁵ Aetna Health, Inc.(AHI) offered non-exchange coverage in the Maine individual market in 2017 but exited in 2018. AHI had 11,170 member months (or approximately 930 members) in 2017 which are not shown in the table.

Individual Market Average Members by Year and Insurer				
	CY 2017	CY 2018	CY 2019	CY 2020
Anthem				
Exchange	21,024	0	20,346	23,087
Non Exchange	<u>4,568</u>	<u>3,056</u>	<u>2,976</u>	<u>3,123</u>
Total	25,592	3,056	23,322	26,210
CHO				
Exchange	28,038	38,774	25,501	14,429
Non Exchange	<u>3,054</u>	<u>3,467</u>	<u>2,863</u>	<u>2,148</u>
Total	31,092	42,242	28,364	16,576
Harvard Pilgrim				
Exchange	17,243	25,480	13,395	17,552
Non Exchange	<u>2,153</u>	<u>1,294</u>	<u>1,165</u>	<u>1,391</u>
Total	19,396	26,774	14,560	18,943
Total All Insurers				
Exchange	66,305	64,255	59,243	55,068
Non Exchange	<u>9,775</u>	<u>7,817</u>	<u>7,003</u>	<u>6,662</u>
Total	76,080	72,071	66,246	61,729

Table 4: Individual Market Average Members by Year and Insurer²⁶

Individual Market Average Rate Changes				
	2019	2020	2021	2022
Anthem	-4.9%	-1.5%	-11.9%	-2.9%
CHO	2.2%	3.9%	-12.9%	-5.4%
Harvard Pilgrim	<u>1.9%</u>	<u>-6.9%</u>	<u>-13.0%</u>	<u>1.1%</u>
Total All Insurers	1.1%	-0.5%	-12.5%	-2.4%

Table 5: Individual Market Average Rate Changes by Year and Insurer²⁷

²⁶ Average members is equal to annual member months divided by 12. These figures differ from membership snapshot noted in Figure 2.

²⁷ For 2019 through 2021, this estimate is based on a weighted average of renewing plan rate changes weighted by experience period or current enrollment from Worksheet 2 of the URRTs and includes both on and off exchange plans. For 2022, the estimate is based on average rate changes by insurer reported by the Maine BOI weighted by March 2021 enrollment.

Small Group Market

The small group market in Maine has also experienced significant reductions in membership over the past four years, which is due in part to high medical cost trends and the associated premium increases. Enrollment fell from 61,200 in March 2017 to 48,300 in March 2021, a 21% decline.

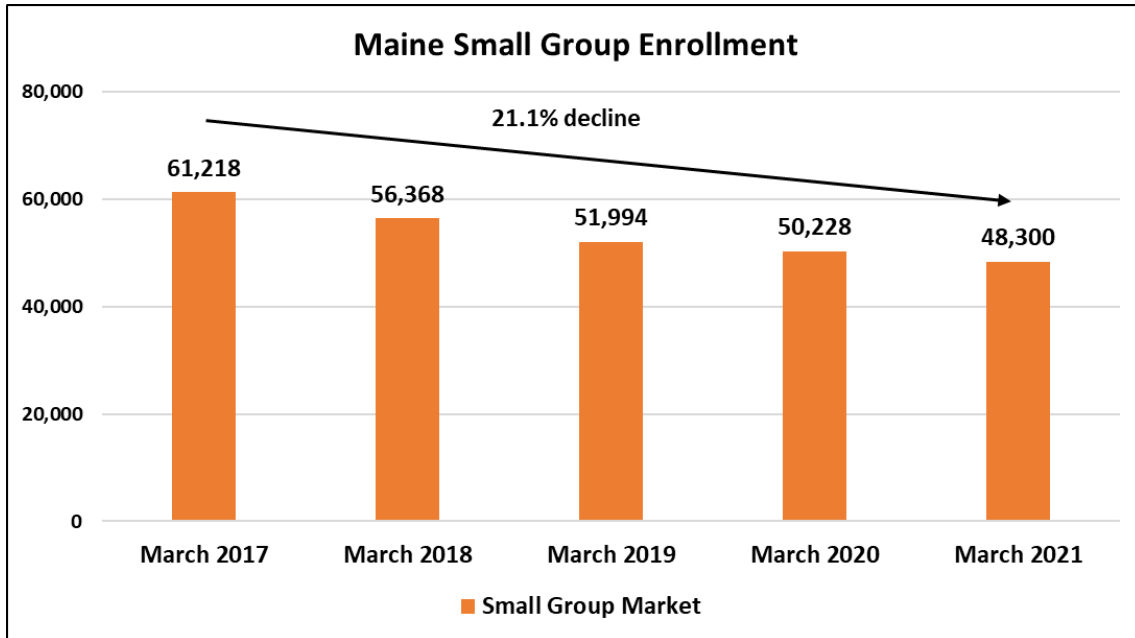


Figure 3: Maine Small Group Market Enrollment Snapshot²⁸

Five insurers participate in the small group market – Aetna²⁹, Anthem, Community Health Options, Harvard Pilgrim Health Care³⁰, and United Healthcare. The tables below show annual membership for CY 2017 through CY 2020 and average rate changes for 2019 through 2022.

²⁸ Membership snapshot as of March of each year. These figures differ from the member months information displayed in Table 6.

²⁹ There are two Aetna companies operating in the Maine small group market, Aetna Life Insurance Company and Aetna Health, Inc. For purposes of this analysis, the information provided for Aetna is combined across both companies.

³⁰ There are two Harvard Pilgrim companies operating in the Maine small group market, Harvard Pilgrim Health Care, Inc. and HPHC Insurance Company, Inc. For purposes of this analysis, the information provided is combined across both companies.

Small Group Market Average Membership by Year and Insurer				
	CY 2017	CY 2018	CY 2019	CY 2020
Aetna	13,028	4,773	968	484
Anthem	13,481	11,636	12,056	11,610
CHO	8,128	8,676	8,698	9,098
Harvard Pilgrim	18,364	26,500	27,054	25,537
United	<u>129</u>	<u>617</u>	<u>2,656</u>	<u>2,759</u>
Total All Insurers	53,129	52,202	51,432	49,487

Table 6: Small Group Market Historical Membership by Insurer³¹

The average annual rate increase in the small group market was 11.0% in 2019, 8.8% in 2020, 5.5% in 2021, and 3.2% in 2022, representing a cumulative increase of 31%.

Small Group Market Average Rate Changes				
	2019	2020	2021	2022
Aetna	8.4%	19.9%	7.6%	-10.1%
Anthem	10.9%	8.1%	4.9%	2.4%
CHO	7.2%	9.7%	3.6%	2.1%
Harvard Pilgrim	14.7%	8.2%	7.2%	2.8%
United	<u>3.6%</u>	<u>12.1%</u>	<u>-4.7%</u>	<u>11.3%</u>
Total All Insurers	11.0%	8.8%	5.5%	3.2%

Table 7: Small Group Market Average Rate Changes by Year and Insurer³²

On its current trajectory, the small group market may experience a continued loss of members. Insurers have also expressed concern that small groups with relatively healthier members are choosing to self-insure and purchase low threshold stop-loss policies to lower their health care premiums and avoid some of the requirements of the ACA. As this market segment contracts, there is growing concern that the risk profile of the small group market will deteriorate, causing a further escalation in premiums and a reduction in membership.

³¹ Average members is equal to annual member months divided by 12. These figures differ from membership snapshot noted in Figure 3.

³² For 2019 through 2021, this estimate is based on a weighted average of renewing plan rate changes weighted by experience period or current enrollment from Worksheet 2 of the URRTs and includes both on and off exchange plans. For 2022, the estimate is based on average rate changes by insurer reported by the Maine BOI weighted by March 2021 enrollment. Aetna's average rate change in 2022 is a blend of the rate changes for Aetna Health Inc. and Aetna Life Insurance Company.

In general, as market membership declines, enrollees that remain in the market are typically less healthy and use more health care resources, which further drives up premiums.³³ In addition, the smaller the size of the risk pool the less predictable and less stable premiums will be for that pool.^{34, 35} It is this dynamic that is of increasing concern to Maine policymakers and is a key factor driving this 1332 waiver application.

Looking Ahead

Maine's current section 1332 waiver has been effective in lowering premiums in the individual market and appears to have stabilized this market segment. However, the small group market continues to experience a loss of membership and increasing premiums.

A more holistic view of the challenges facing Maine's ACA marketplace – particularly for small employers – has led Maine to propose changes to the ACA marketplace structure which it believes can benefit a broader group of Maine residents, providing market stability for both individual purchasers and small employers.

3. Maine's 1332 Waiver

Pooling the Markets and Applying a Reinsurance Program

Maine proposes to combine the individual and small group markets into a single risk pool for rate setting, risk adjustment, and medical loss ratio (MLR) purposes, and to overlay a retrospective reinsurance program across the newly pooled market. In combination, these changes will lower premiums for both market segments and generate savings to the federal government, which Maine proposes to leverage to benefit the broader ACA marketplace.

Pooling the markets would reduce rates in the individual market but increase rates in the small group market compared to the baseline.³⁶ The reduction in individual market rates would lower federal spending for PTCs, which generally represents the difference

³³ "Anatomy of a Slow-Motion Health Insurance Death Spiral," H.E. French III and Michael P. Smith, North American Actuarial Journal, 2015.

³⁴ "Risk Pooling: How Health Insurance in the Individual Market Works," American Academy of Actuaries <https://www.actuary.org/content/risk-pooling-how-health-insurance-individual-market-works-0>, accessed on December 7, 2020.

³⁵ "Health Insurance Markets 101," The Sycamore Institute, <https://www.sycamoreinstitute.org/about-us/>, accessed on December 7, 2020.

³⁶ For the purpose of this actuarial analysis, the baseline estimate excludes the premium reductions associated with Maine's current Section 1332 waiver and assumes there is no reinsurance program in the individual market.

between the second lowest cost silver plan (SLCSP) premium and the maximum amount an individual or family is expected to pay based on their family income and size. As Silver plan premiums decline, PTCs fall, which lowers federal spending.

The second component of the waiver is the establishment of a retrospective reinsurance program that would reduce premiums across the newly-pooled individual and small group market. As premiums in the individual market are further reduced, there is a reduction in premium subsidies provided by the federal government in the form of PTCs.

In combination, pooling the markets and applying a retrospective reinsurance program is expected to lower the average individual market premium by 8.0% compared to the baseline in 2023. In the small group market, the average premium in 2023 is projected to decrease 6.0% compared to the baseline. In 2024, the average individual market premium is expected to be 6.1% lower than baseline and the average small group market premium is expected to be 3.9% lower than baseline.

Membership is projected to be higher in each year under the “with wavier” scenario compared to the “no waiver” scenario. In 2023, the individual market membership will be higher by 1,600 members or 2.7% and the small group market membership will be higher by 2,482 members or 5.3% under the “with wavier” scenario compared to the “no waiver” scenario. In 2024, the individual market membership will be higher by 1,146 members or 2.0% and the small group market membership will be higher by 1,610 members or 3.5%.

The net reduction in federal spending from lower PTCs will be used to fund a portion of the retrospective reinsurance program for the pooled market. In addition to the use of federal pass-through funds, Maine proposes to use the \$4.00 PMPM assessment that is currently used for the MGARA reinsurance program for the individual market to support the reinsurance program for the pooled market. If Maine's proposed 1332 waiver application is approved, the current MGARA reinsurance program would be replaced by a reinsurance program that would apply to the newly-pooled market. Pending CMS approval of this section 1332 waiver, Maine will continue to operate the individual market reinsurance program pursuant to the terms and conditions of its existing 1332 waiver.

Based on estimates provided by MGARA, the \$4.00 PMPM assessment is expected to generate \$27.0 million in revenue in the first year of the waiver (CY 2023).³⁷ A portion of the funds – estimated to be \$300,000 annually – will be used to administer the

³⁷ Based on Milliman’s Report to the MGARA Board October 18, 2021.

reinsurance program. An additional \$8.6 million³⁸ in reinsurance program funding received by Maine in 2021 from the enhanced premium subsidies under ARPA would also be used to support the 2023 reinsurance program. Premiums in the individual market are estimated to decline 8.0% compared to the baseline in 2023, which would generate \$22.8 million in net federal savings. These savings would be combined with the state assessment and the ARPA funds to fund the reinsurance program in 2023.

In subsequent years, the reinsurance funding will be supported by the \$4.00 PMPM assessment and federal pass-through funding from the reduction in PTCs. Based on current federal law, we are assuming the ACA's premium subsidy schedule is in effect for the duration of the waiver period (i.e., CY 2023 through CY 2032) and enhanced subsidies provided for under ARPA are not extended beyond CY 2022.

In 2023, a total of \$58.0 million would be available to fund the reinsurance program. Based on current projections, the retrospective reinsurance program was initially structured to reimburse insurers 55% of claims costs between \$90,000 and \$275,000, with the portion of claims exceeding \$275,000 the full responsibility of the health insurer. In 2024, a total of \$44.7 million would be available to fund the reinsurance program. For 2024, the retrospective reinsurance program was initially structured to reimburse insurers 45% of claims costs between \$90,000 and \$240,000, with the portion of claims exceeding \$240,000 the full responsibility of the health insurers. Based on actual revenues received from the assessment and federal pass-through funds from lower PTCs, these parameters may be adjusted to ensure reinsurance reimbursements to insurers do not exceed available funding. On an annual basis, the Maine Guaranteed Access Reinsurance Association (MGARA), in consultation with the Maine BOI, will set the reinsurance program's parameters to reflect funding available in order to maintain the financial solvency of the program.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance. "Invisible" reinsurance allows enrollees to remain in the individual market with their current plan and insurer, but a portion of their claims may be reimbursed to the insurer by the reinsurance program. The enrollee is not aware that their claims are being paid via the reinsurance pool; meaning there is no effect on the enrollee as the task of submitting claims for reimbursement to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.

Pooling the markets and overlaying a reinsurance program is designed to stabilize both the individual and small group markets, which will benefit a larger number of Maine

³⁸ CMS Website: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#Section_1332_State_Application_Waiver_Applications

residents. Larger insurance pools have less premium volatility from one year to the next, in part because large "shock" claims can be spread over a greater number of members, which provides for greater market stability. Maine's individual and small group markets are both relatively small, with a combined membership of approximately 111,300 as of March 2021. Combining the risk pools and overlaying a reinsurance program will reduce premiums for both the individual and small group markets compared to baseline, helping to stabilize both market segments. The result should mean more individuals and small group members remain covered through the ACA marketplace.

4. Actuarial Analysis Process and Assumptions

Methodology

To model this policy, data were collected directly from the insurers, insurance carrier actuaries were interviewed, Maine's individual and small group market rate filings were analyzed, and publicly available reports from CMS and the Maine Bureau of Insurance were evaluated. The goal of the modeling exercise was to: (1) analyze the impact of pooling the individual and small group markets; (2) quantify the effect on premiums from the introduction of a retrospective reinsurance program to the newly pooled market; and (3) project the impact on membership in the (pooled) individual and small group market resulting from a reduction in premiums

The modeling approach is summarized in the following steps:

- I. Develop a model that estimates the 2020 Advance Premium Tax Credits (APTC) funded by the federal government. The model projects 2020 APTC by insurer, income category, metal level, age category, and rating area. The results were then compared to reported 2020 APTC from the 2020 CMS open enrollment period public use files to measure alignment between the model and the actual results.³⁹
- II. Project 2023 APTC assuming no MGARA reinsurance program in place for the individual market. This scenario is referred to as the "baseline." In order to establish a baseline premium under a "no waiver" scenario, individual market rates are adjusted to account for the current reinsurance program. Using data provided by the insurers as part of the annual rate filing, individual market premiums were increased by removing the premium reduction that the insurers attributed to the existing reinsurance program. 2023 premium rates were projected by utilizing 2022 rates and rate filing assumptions.

³⁹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files>.

- III. Using the adjusted individual market rates and the actual small group market rates, we then develop an estimate of the impact on rates from pooling the individual and small group markets in 2023 for each insurer. In light of COVID-19's impact on medical claims in CY 2020, claims data for CY 2019 were used as a starting point with adjustments made to the individual market for morbidity changes resulting from the MaineCare expansion, which took effect in 2019 and resulted in thousands of individual market enrollees shifting to MaineCare. Individual and small group market claims data were combined for each insurer and normalized for rating factors. This established the starting point or "base claims" for premium rate development in a pooled market. These results were then compared to the normalized base claims for each market separately to estimate the premium impact of pooling the markets. These premium impacts were further adjusted for projected changes in risk adjustment. Assumptions were made regarding the impact of changing enrollment resulting from the waiver on morbidity for both the individual and small group markets and sensitivity analysis was performed on these assumptions.
- IV. Project 2023 APTC assuming markets are pooled and a new retrospective reinsurance program is implemented, which reduces the pooled market premiums. The model accounted for changes in the second lowest cost Silver level plan by rating region as a result of the pooled market. Several iterations were performed to ensure that funding from the assessment and the section 1332 waiver would support the premium rate reductions stemming from the reinsurance program.
- V. Calculate APTC savings by comparing the final 2023 APTC in the previous step to baseline results for 2023.
- VI. Adjust the APTC savings to account for actual PTC. Using data provided by CMS, PTC is projected to be 96.46% of APTC.⁴⁰
- VII. Include the \$4.00 PMPM assessment in both the baseline premium rates and the rates with the program when determining APTC savings.⁴¹

⁴⁰ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Key-Components-Pass-through-Estimate-Feb-2021.xlsx>

⁴¹ PL 653 (LD 2007) changed the \$4.00 PMPM assessment so that it is no longer contingent on the Section 1332 Innovation Waiver.

Enrollment Projections and Assumptions - Individual Market

Table 8 breaks out the March 2021 enrollment for the individual market. Data were provided by insurer, income category, age category, metal level and region. In addition, information from CMS open enrollment reports on federal poverty levels (FPL) was incorporated. Table 9 shows March 2021 APTC enrollment by FPL level. Modeling of APTC for the baseline scenario and the waiver scenario was performed at the insurer, income category, age category, metal level, and region level.

Individual Market Enrollment	
	March 2021
On Exchange	
Members w/APTC	44,160
Members w/out APTC	<u>11,262</u>
Total On Exchange	55,422
Off Exchange Total Off Exchange	7,593
Total On & Off Exchange	63,015

Table 8: Maine Individual Market Enrollment, March 2021

Individual Market Enrollment	
	March 2021
On Exchange- Members with APTC	
138% FPL to 150% FPL	6,309
>150% to ≤200% of FPL	14,343
>200% to ≤250% of FPL	10,720
>250% to ≤300% of FPL	6,027
>300%- ≤400% of FPL	<u>6,762</u>
Total	44,160

Table 9: Maine APTC Individual Market Enrollment by FPL, March 2021⁴²

⁴² Based on the 2021 Marketplace Open Enrollment Period Public Use Files. <https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files>. Accessed November 16, 2021.

Membership projections for the individual market are affected by a number of key factors, including: (1) whether the individual is eligible for APTCs; (2) the availability of other health coverage programs; (3) the change in individual market premiums; and (4) the offer of affordable coverage by employers. Each factor is discussed briefly below.

Individuals that obtain coverage through the ACA marketplace and receive premium subsidies are largely shielded from rate changes – either positive or negative – due to the structure of APTCs. The share of the premium paid by individuals eligible for APTCs is based on their income and family size, irrespective of the underlying health plan premium (assuming the individual selects the second lowest cost Silver level plan or a less expensive plan). As a result, subsidy-eligible individuals are likely to retain coverage regardless of changes in premiums.

MaineCare expansion took effect in early 2019 and shifted some lower-income adult residents from the individual market to the state's Medicaid program. During the 2020 individual market open enrollment period (November – December 2019), a majority of MaineCare expansion-eligible enrollees had already shifted to that program, therefore the modeling does not anticipate any further material impacts to membership in the individual market stemming from the MaineCare eligibility expansion.

It is worth noting that MaineCare enrollment has increased by 61,000 members (+20%) over the past 18 months. In addition, the individual market continued to experience a small decline in APTC membership in 2021. This is most likely due in part to restrictions on eligibility redeterminations tied to the declaration of a public health emergency for COVID-19.

For individuals that do not have access to premium subsidies, the model projects a slight reduction in membership under the “no waiver” scenario. We have also assumed that a reduction in premiums resulting from the 1332 waiver will incent some people to enter the market. Under both the “with waiver” and “no waiver” scenarios, the model assumes membership reductions over time based on historical patterns and annual premium rate increases.

In addition, as noted above, Maine's population increased only modestly over the past decade (+2.6% or 34,000 residents from 2010 to 2020) and is not projected to significantly increase over the next ten years.⁴³ Accordingly, the model does not anticipate an increase in individual market membership resulting from population growth.

⁴³ Maine's State Economist projects 2.1% growth from 2018 – 2028 and 2.3% growth from 2018 – 2038.-
<https://www.maine.gov/dafs/economist/demographic-projections>

Finally, stabilizing the small group market by pooling the markets and applying a reinsurance program should reduce the number of individuals who otherwise may have migrated from the small group market due to their employer no longer offering health insurance. In addition, almost all large employers offer employer-sponsored insurance and are expected to continue to do so for the foreseeable future.⁴⁴

Individual Market Membership and Premium Projections – No Waiver

With a section 1332 waiver currently in place, and a reinsurance program in effect since 2019, it is necessary to develop membership projections under a “no waiver” scenario. The baseline “no waiver” membership projections need to reflect what the membership would have been in the absence of the current MGARA reinsurance program.

The table below shows the CY 2020 average premiums PMPM for the individual market, which is used as the starting point for the overall individual market membership projections.

Individual Market Average Premium PMPM	
	CY 2020
On Exchange	
Members w/APTC	
Member Share of Premium	\$111.80
<u>APTC Share of Premium</u>	<u>\$544.44</u>
Gross Premiums	\$656.23
Members w/out APTC	<u>\$514.00</u>
Total On Exchange	\$636.59
Off Exchange	
Total Off Exchange	\$606.43
Total On & Off Exchange	\$633.34

Table 10: Maine Individual Market Average Premium PMPM CY 2020

⁴⁴ Kaiser Family Foundation's 2020 Health Benefits Survey reports that 99% of firms with 200 or more employees offered health insurance to their employees, a percentage that has remain largely unchanged for the past 20 years.

2023 individual market premiums are developed by starting with 2020 actual reported premiums by insurer. Using data submitted by each insurer as part of the annual rate filing for plan years 2019 through 2022, the model adjusted premiums in the individual market for 2019 through 2022 to account for the impact of the reinsurance program. The table below summarizes the reinsurance program impact and shows the estimated average rate change excluding the impact of the current MGARA reinsurance program.⁴⁵

Individual Market Rate Change Adjustments					
	2018	2019	2020	2021	2022
Average Rate Change <u>including</u> impact of Current MGARA Program	16.8%	1.2%	-0.5%	-12.5%	-2.4%
MGARA Reinsurance Impact	n/a	-5.7%	-6.0%	-9.6%	-13.8%
Average Rate Change <u>excluding</u> impact of Current MGARA Program	16.8%	7.3%	-0.1%	-9.0%	2.4%

Table 11: Individual Market Rate Changes Including and Excluding Current MGARA Program

Premiums are then trended forward from 2020 to 2022 using average rate changes from the 2021 and 2022 rate filings, adjusted for any change in the current MGARA reinsurance program impact assumptions. For the period from 2023 through 2032, based on guidance provided in the preamble to federal regulations pertaining to section 1332 waivers (finalized in September 2021), the model uses trend projections from the most recent National Health Expenditures (NHE)⁴⁶ report as the basis for projecting premium trends. The model uses the average of the NHE’s projected spending per enrollee trends for direct purchase and employer-sponsored insurance for years 2023 to 2028. For years beyond 2028 – the last year for which NHE projections are available – the model uses the projected increase from 2028. The table below shows the premium trends used in the modeling.

⁴⁵ MGARA was reestablished in 2019. After reviewing 2019 individual market rate filings, we estimate the impact of the reinsurance program in the individual market to be a 5.7% reduction in premiums. Since 2020 was the second year of MGARA, the incremental impact of the reinsurance program is equal to the change in the reinsurance assumption from 2019 to 2020 (i.e., 5.7% to 6.0%) or approximately 0.3% further reduction to premium due to MGARA. Therefore, the impact to the rate change from MGARA in 2020 is equivalent to the year-over-year change in the MGARA assumption, or -0.3%. The -0.3% is applied to the 2020 average rate change including MGARA to calculate the average rate change excluding MGARA. This calculation is repeated in subsequent years.

⁴⁶ Center for Medicare and Medicaid Services, National Health Expenditures, Projected 2019 – 2028: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

Calendar Year	National Health Expenditure Trends
2023	5.3%
2024	5.2%
2025	4.5%
2026	4.6%
2027	4.6%
2028+	4.5%

Table 12: National Health Expenditure Trends Used in Modeling

The adjusted rate changes shown in Table 11 were then used as the starting point to project baseline membership in the individual market under a “no waiver” scenario. As noted above, because members that receive APTC are largely shielded from the underlying change in premiums, the membership affected by a rise in premiums are the unsubsidized individuals. Approximately 30% of the individual market (18,900 individuals as of March 2021) purchased insurance without receiving APTC subsidies.

Using the adjusted rate changes from Table 11 and NHE trends from Table 12, unsubsidized membership in the individual market was projected using three methodologies:

- A regression model using Maine’s individual market data based on actual membership and average rate changes for the period from 2017 – 2021.
- An elasticity by metal level function presented at a Society of Actuaries meeting in June 2017 that modeled membership changes based on premium changes using CMS open enrollment public use files from 2017.⁴⁷
- An elasticity model used by the Council of Economic Advisors in a January 2017 Issue Brief on enrollment changes in the individual market that showed that the average elasticity of individual market enrollment with respect to premiums is - 0.4 which means that a 1% increase in premiums reduces enrollment by 0.4%.⁴⁸

For each of these membership projection methodologies, two starting points were used: March 2018, which was prior to implementation of the current individual market reinsurance program and Maine’s Medicaid eligibility expansion; and March 2021, which is the most recent enrollment data available and reflects the impact of the MaineCare expansion and COVID-19.

⁴⁷ Murawski, Engel, Liner. Session 76 L, “Understanding Stakeholder Behavior: Hidden Forces in the U.S. Healthcare System,” June 12-14, 2017.

⁴⁸ Council of Economic Advisors Issue Brief, “Understanding Recent Developments in the Individual Health Insurance Market,” January 2017. https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf. Accessed November 16, 2021.

Six sets of membership projections were generated, with all of the results within +/-9% of the average. To establish a single membership projection, the average of the six results was used. The projections focused on the unsubsidized population. As noted above, members receiving APTC are largely unaffected by premium increases.

A final adjustment was made to individual market membership projections. Based on recent experience, members attrit over the course of a plan year. Since the starting point for the projections utilizes March (either 2018 or 2021) membership, a 5% reduction was applied to project membership for the full calendar year.⁴⁹ The table below shows membership projections under a “no waiver” scenario for 2023 – 2032.

Individual Market Membership Projections- Baseline (No Waiver)						
		2023	2024	2025	2026	2027
Average Annual Enrollment						
On Exchange						
	Members w/APTC	41,952	41,952	41,952	41,952	41,952
	Members w/out APTC	<u>9,319</u>	<u>8,978</u>	<u>8,738</u>	<u>8,507</u>	<u>8,287</u>
	Total On Exchange	51,271	50,930	50,690	50,459	50,239
Off Exchange	Total Off Exchange	7,490	7,216	7,011	6,812	6,622
Total On & Off Exchange		58,761	58,146	57,701	57,271	56,861
		2028	2029	2030	2031	2032
Average Annual Enrollment						
On Exchange						
	Members w/APTC	41,952	41,952	41,952	41,952	41,952
	Members w/out APTC	<u>8,081</u>	<u>7,886</u>	<u>7,699</u>	<u>7,522</u>	<u>7,352</u>
	Total On Exchange	50,033	49,838	49,651	49,474	49,304
Off Exchange	Total Off Exchange	6,445	6,275	6,113	5,959	5,811
Total On & Off Exchange		56,478	56,113	55,765	55,432	55,115

Table 13: Individual Market Membership Projections- Baseline (No Waiver)

The model also assumes that the morbidity of the risk pool worsens over time and assumes the average claims costs for enrollees leaving the market was 73% of the average claims costs for those staying in the market.⁵⁰ This resulted in an increase of 0.3% in morbidity in 2023 and an increase of 0.5% in morbidity in 2024.⁵¹

⁴⁹ This is based on reviewing historical enrollment patterns for March 2019 and November 2019.

⁵⁰ Council of Economic Advisors Issue Brief, “Understanding Recent Developments in the Individual Health Insurance Market,” January 2017.

https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf. Accessed November 16, 2021.

⁵¹ It was assumed that there would be no additional morbidity changes beyond 2024 and that any morbidity changes in the years after 2024 were negligible to the overall modeling.

Individual Market Membership and Premium Projections – With Waiver

Using the “no waiver” membership as the starting point, the model first adjusts the individual market premiums to reflect pooling the individual market risk pool with the small group market risk pool. A reinsurance program is then layered on top of the pooled market, which results in a net premium reduction of 8.0% in 2023 and a net premium reduction of 6.1% in 2024 compared to the “no waiver” scenario.

For the period from 2025 through 2032, the model uses the NHE trend projections noted above. Pooling the markets and instituting a reinsurance program lowers the baseline or starting point. It does not, however, impact medical trend over time, which is why the NHE trend is appropriately used in each scenario.

Individual Market			
CY	Baseline- No Waiver Premium PMPM	After Waiver with Pooled Market and Reinsurance Premium PMPM	Percentage Difference between No Waiver and After Waiver
2023	\$636.41	\$585.55	-8.0%
2024	\$670.15	\$629.13	-6.1%
2025	\$700.79	\$657.94	-6.1%
2026	\$733.17	\$688.40	-6.1%
2027	\$767.03	\$720.24	-6.1%
2028	\$802.04	\$753.17	-6.1%
2029	\$838.63	\$787.59	-6.1%
2030	\$876.88	\$823.55	-6.1%
2031	\$916.84	\$861.15	-6.1%
2032	\$958.61	\$900.43	-6.1%

Table 14: Individual Market Premium PMPMs and Percentage Impact from Waiver Reinsurance Program 2023-2032⁵²

⁵² It was assumed that the premium PMPM reductions in 2025 and beyond would be consistent with 2024. The state assessment of \$4.00 PMPM is a fixed amount. The value of the state assessment may diminish over time as premiums continue to rise due to health care trend, but it was assumed that the impact to the overall modeling was negligible.

Using the three models described previously and the rate changes resulting from the waiver, membership projections were developed using two starting points: March 2018, which was prior to implementation of the current individual market reinsurance program and the Medicaid eligibility expansion; and March 2021, which is the most recent enrollment data available and reflects the impact of the MaineCare expansion and COVID-19.

Six sets of membership projections were generated, with all of the results within +/-10% of the average. To establish a single membership projection, the average of the six results was used. The projections focused on the unsubsidized population. The 2023 membership in the “with waiver” scenario is 2.8% higher than the membership in the “no waiver” scenario.

Individual Market Membership Projections- After Waiver with Pooled Market and Reinsurance						
		2023	2024	2025	2026	2027
Average Annual Enrollment						
On Exchange						
	Members w/APTC	41,952	41,952	41,952	41,952	41,952
	Members w/out APTC	<u>10,205</u>	<u>9,612</u>	<u>9,353</u>	<u>9,104</u>	<u>8,866</u>
	Total On Exchange	52,157	51,564	51,305	51,056	50,818
Off Exchange	Total Off Exchange	8,203	7,727	7,505	7,290	7,085
Total On & Off Exchange		60,361	59,292	58,811	58,346	57,903
		2028	2029	2030	2031	2032
Average Annual Enrollment						
On Exchange						
	Members w/APTC	41,952	41,952	41,952	41,952	41,952
	Members w/out APTC	<u>8,644</u>	<u>8,433</u>	<u>8,232</u>	<u>8,041</u>	<u>7,859</u>
	Total On Exchange	50,596	50,385	50,184	49,993	49,811
Off Exchange	Total Off Exchange	6,893	6,711	6,536	6,369	6,210
Total On & Off Exchange		57,490	57,096	56,720	56,362	56,020

Table 15: Individual Market Membership Projections- After Waiver

It was assumed that the morbidity of the enrollees entering the insurance market in 2023 as a result of the waiver would be healthier than the morbidity of the enrollees currently enrolled. Using the same relationship described above⁵³, the membership

⁵³ Council of Economic Advisors Issue Brief, “Understanding Recent Developments in the Individual Health Insurance Market,” January 2017.
https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf. Accessed November 16, 2021.

increases as a result of the waiver improved the morbidity by 0.3% in 2023. The subsequent membership decrease in 2024 will increase morbidity by 0.1% in 2024.^{54, 55}

Enrollment Projections and Assumptions – Small Group Market

Table 16 shows the March 2021 enrollment for the small group market. While data on individual market enrollment by family income level is available through the Marketplace (see Table 9 above), a comparable dataset is not available for the small group market.

However, according to the 2019 American Community Survey results for Maine,⁵⁶ roughly 73% of Maine residents (or approximately 950,000 individuals) have annual income below 500% FPL. Of this number, approximately 360,000 have income between 300% - 500% FPL. It is reasonable to assume the family income levels of members of the small group market reflect the broader Maine economy.

Small Group Market	
	March 2021
Total Enrollment	48,300

Table 16: Maine Small Group Market Enrollment March 2021⁵⁷

Membership in the small group market is driven primarily by three market forces: (1) the cost of coverage; (2) the labor market and the ability of employers to attract and retain workers; and (3) the availability of alternative health coverage arrangements. Each is discussed below.

As premiums increase, employers find it difficult to continue to offer employees affordable health benefits. Over the past several years, as noted previously, premiums in Maine's small group market have increased and the number of employees and dependents covered has declined. This is largely due to a decrease in the number of employers offering health coverage in the fully insured (ACA) market but may also be

⁵⁴ The lower morbidity improvement in 2024 is a result of the smaller premium reductions in 2024 since the 2021 ARPA funds are used for 2023 and not for subsequent years.

⁵⁵ It was assumed that there would be no additional morbidity changes beyond 2024 and that any morbidity changes in the years after 2024 were negligible to the overall modeling.

⁵⁶ U.S. Census Bureau, 2019 American Community Survey 1-Year Estimates.

⁵⁷ In March 2021, approximately 0.3% of the Maine small group enrollment was on exchange. The small group on exchange population was not analyzed separately and is included as part of the overall small group analysis throughout this report.

affected by a drop in the number of employees that choose to enroll when offered coverage (known as the "take up" rate).

The second key factor affecting membership in the small group market is the condition of the labor market and the ability of employers to attract and retain workers. As labor markets tighten – and employers struggle to fill open positions and/or retain workers – employer-sponsored health benefits become an important consideration for current and prospective workers. Conversely, as the number of unemployed workers increases, the offer of health benefits by employers may become less of a factor in attracting and retaining employees.

A final factor influencing small group market membership is the availability of alternative coverage arrangements. These can take the form of public programs – such as premium tax credits for lower income individuals purchasing qualified health plans through the exchange and the expansion of MaineCare eligibility – as well as employers opting to self-fund their health benefits and leave the fully insured (ACA) market.

In addition, changes to federal health reimbursement arrangement (HRA) rules that permit employees to use (pre-tax) HRA funds to pay premiums for individual market coverage may encourage some small employers to contribute to an Individual Coverage Health Reimbursement Arrangement (ICHRA) rather than purchase insurance on behalf of their employees. Employer contributions to ICHRAs can be combined with pre-tax contributions by employees, which can then be used to pay premiums, thereby lowering the net cost of coverage to the employee.

While each of these factors can influence membership in the small group market, the change in health insurance premiums is the largest driver. By establishing a reinsurance program that applies across the newly pooled individual and small group markets, and leveraging broad-based state funds and federal pass-through funds, the model projects a premium decrease of 6.0% below the baseline in 2023 for the small group market and a premium decrease of 3.9% below the baseline in 2024. As discussed below, this rate reduction will help stabilize the small group market, and the small group market membership could increase slightly as a result of the waiver.

Small Group Market Membership and Premium Projections – No Waiver

The small group market does not currently have a reinsurance program, so there is no need to make adjustments to the rates and the average rate changes from 2019 – 2022 as was described above for the individual market. In addition, there is no APTC available to small group market members. As a result, membership projections apply to the entire small group market.

The table below shows the CY 2020 average premiums PMPM for the small group market, which is used as the starting point for the overall small group market projections.

Small Group Market Average Premium PMPM	
	CY 2020
Total	\$521.10

Table 17: Maine Small Group Market Average Premium PMPM CY 2020^{58, 59}

2023 small group market premiums are developed by starting with 2020 actual reported premiums. Premiums are then trended forward from 2020 to 2022 using average rate changes from the 2021 and 2022 rate filings and adjusting for benefit buy down.⁶⁰

Consistent with the individual market, the 2022 premiums are then trended forward at 5.3% to develop the 2023 baseline premiums. The 5.3% is the average of the NHE’s projected spending per enrollee trends for employer-sponsor insurance and direct purchase. The remainder of the ten-year projection period (2024 through 2032) uses NHE trends as shown in Table 12.

Small group membership projections used the same three methodologies noted above, with the exception of using small group specific data for the Maine regression model. Because the small group market does not have a reinsurance program and has been less affected by the MaineCare expansion, there was no need to use two different starting points as was the case for the individual market. March 2021 actual enrollment served as the starting point for membership projections.

Membership projections from each of the three methodologies were within +/-5% of the average. The average of the three projections was used to establish a single membership projection. The table below displays membership projections for the period from 2023 – 2032 under a “no waiver” scenario.

⁵⁸ Note that the benchmark plan in the Small Group Market in 2022 is the Anthem Silver 3500/30%/8500 PPO plan (HIOS ID: 48396ME0780100) with a 2022 calibrated plan adjusted index rate of \$410.94.

⁵⁹ CY 2020 premium is gross of premium credits provided in 2020 due to COVID. This only impacted the Small Group Market in Maine.

⁶⁰ Benefit buy down was estimated by comparing 2019 and 2020 average rate changes from the rate filings to actual 2019 and 2020 premium yield.

Small Group Market Membership Projections- Baseline (No Waiver)					
	2023	2024	2025	2026	2027
Average Annual Enrollment	46,824	45,741	44,946	44,148	43,365
	2028	2029	2030	2031	2032
Average Annual Enrollment	42,616	41,881	41,160	40,452	39,759

Table 18: Small Group Market Membership Projections- Baseline (No Waiver)

It was assumed that the morbidity of the enrollees leaving the small group market would be healthier than the morbidity of the enrollees staying in the small group market. In the small group market, the average claims costs for enrollees leaving the market were assumed to be 90% of the claims costs of those staying in the market.⁶¹ This resulted in an increase in morbidity of 0.3% in 2023, and an increase in morbidity of 0.5% in 2024.⁶²

Small Group Membership and Premium Projections – With Waiver

Using the “no waiver” membership as the starting point, the model first adjusts the small group market premiums to reflect pooling with the individual market. A reinsurance program is then layered on top of the merged market, which results in a net premium reduction of 6.0% in 2023 and 3.9% in 2024 compared to the “no waiver” scenario.

For the period from 2025 through 2032, the model uses the NHE trend projections noted above. Pooling the markets and instituting a reinsurance program lowers the baseline or starting point. It does not, however, impact medical trend over time, which is why NHE trend is appropriately used in each scenario.

⁶¹ Council of Economic Advisors Issue Brief, “Understanding Recent Developments in the Individual Health Insurance Market,” January 2017. https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf. Accessed November 16, 2021. The Issue Brief assumes that the average claims costs for enrollees leaving the individual market is 73% of the claims costs of enrollees that stay in the individual market. Since it is the employer group making the purchasing decision, anti-selection will be less significant in the small group market compared to the individual market. The average claims costs for enrollees leaving the small group market are assumed to be 90% of the claims costs for enrollees that stay in the small group market. These assumptions were tested to ensure reasonability of the results.

⁶² It was assumed that there would be no additional morbidity changes beyond 2024 and that any morbidity changes in the years after 2024 were negligible to the overall modeling.



Small Group Market			
CY	Baseline- No Waiver Premium PMPM	After Waiver with Pooled Market and Reinsurance Premium PMPM	Percentage Difference between No Waiver and After Waiver
2023	\$580.62	\$545.92	-6.0%
2024	\$610.82	\$587.09	-3.9%
2025	\$638.30	\$613.51	-3.9%
2026	\$667.34	\$641.42	-3.9%
2027	\$697.71	\$670.61	-3.9%
2028	\$729.11	\$700.79	-3.9%
2029	\$761.92	\$732.32	-3.9%
2030	\$796.20	\$765.28	-3.9%
2031	\$832.03	\$799.71	-3.9%
2032	\$869.47	\$835.70	-3.9%

Table 19: Small Group Market Premium PMPMs and Percentage Impact from Waiver Reinsurance Program 2023-2032⁶³

Using the three different models described previously and the rate changes resulting from the waiver, three sets of membership projections were generated, with all of the results within +/-6% of the average. To establish a single membership projection, the average of the three results was used. The 2023 membership under the “with waiver” scenario is 5.3% higher than the membership in the “no waiver” scenario.

Small Group Market Membership Projections- After Waiver with Pooled Market and Reinsurance					
	2023	2024	2025	2026	2027
Average Annual Enrollment	49,305	47,352	46,532	45,709	44,901
	2028	2029	2030	2031	2032
Average Annual Enrollment	44,129	43,371	42,627	41,898	41,183

Table 20: Small Group Market Membership Projections- After Waiver

⁶³ It was assumed that the premium PMPM reductions in 2025 and beyond would be consistent with 2024. The state assessment of \$4.00 PMPM is a fixed amount. The value of the state assessment may diminish over time as premiums continue to rise due to health care trend, but it was assumed that the impact to the overall modeling was negligible.

It was assumed that the morbidity of the enrollees entering the insurance market in 2023 as a result of the waiver would be healthier than the morbidity of the enrollees currently enrolled. Using the same 90% assumption used in the “no waiver” scenario, the morbidity improved by 0.2% in 2023 but did not affect pool morbidity in 2024.^{64, 65}

APTC and PTC

The Gross Premium for members eligible for APTC is generally equivalent to the premium for the second lowest cost Silver plan (SLCSP) adjusted for the enrollee’s age and rating region. As defined in the ACA and subsequent federal regulations, a household's required premium contribution ranges from 3.1% of income for a family at 133% of the federal poverty level (FPL) to 9.83% of income for a family with income of 300% or more of the FPL.

However, ARPA - enacted by Congress and signed by President Biden in March 2021 – changed the required premium contribution schedule, increased federal subsidies for individuals and families with income below 400% FPL, and extended subsidies to those with earnings above 400% FPL. These changes are in effect for 2021 and 2022. Congress is considering legislation that would extend the ARPA premium contribution schedule beyond 2022.

Based on current law, this report does not assume the enhanced premium subsidies will continue beyond 2022. However, scenario testing using the ARPA premium subsidies was conducted. These results are included in the Appendix to this report.

APTC is calculated as the difference between the gross premium and the amount an individual is expected to pay based on family size and income. If an individual enrolls in a health plan with a premium that is lower than the SLCSP (e.g., a Bronze plan), the APTC an individual is eligible to receive may exceed the gross premium of the selected health plan. In this case, APTC is capped at the full premium amount. The Maine market includes a significant portion of APTC eligible enrollees that have purchased a Bronze plan. The model accounts for the lower APTC for these enrollees.

The model projects the 2023 SLCSP rate under the baseline (no waiver) scenario and under the waiver scenario. For the baseline, we utilize the 2022 SLCSP from the 2022 rate filing, remove the impact of the current MGARA program from the rate, and then

⁶⁴ The lower morbidity improvement in 2024 is a result of the smaller premium reductions in 2024 since the 2021 ARPA funds are used for 2023 and not for subsequent years.

⁶⁵ It was assumed that there would be no additional morbidity changes beyond 2024 and that any morbidity changes in the years after 2024 were negligible to the overall modeling.

project the rate to 2023 using a 5.3% trend^{66, 67} For the waiver scenario, we adjust these projected 2023 SLCSF rates for the impact of pooling the markets and applying a retrospective reinsurance program. The SLCSF rates under the baseline and waiver scenarios are adjusted for rating region distribution and age to calculate the gross premium for APTC eligible members. As shown in Table 21, for 2023, the gross premium in the baseline is \$660 PMPM and the gross premium in the waiver scenario is \$610 PMPM, a 7.5% reduction.⁶⁸

For 2023, the model assumes a 2.0% increase in FPL and 0.3% increase in the sliding scale percentages compared to 2022 which are based on the actual change over the past three years. For the period from 2024 through 2032, the model assumes 2.0% annual increase in the premium that an individual is expected to pay.⁶⁹

APTC is based on income expectations for a future period. That is, an individual's APTC is determined in advance of the plan year, based primarily on prior year earnings. When an individual files taxes at the end of the year, the advance premium tax credit the individual received during the course of the year is then reconciled to actual earnings to determine the premium tax credit (PTC) an individual is eligible to receive based on their actual year-end earnings and family size. The tax filer receives a tax credit (if APTC is less than PTC) or a payment is due (if APTC is greater than PTC).

To determine PTC, the model makes an adjustment to account for differences between APTC and PTC. CMS reported that PTCs provided to Maine residents in 2019 were 96.46% of APTCs, which is the percentage used for this report.⁷⁰

For the waiver scenario, pooling the individual and small group markets and overlaying a reinsurance program is expected to reduce the SLCSF premium, which reduces PTC. The difference in premiums for the SLCSF – comparing the baseline scenario to the waiver

⁶⁶ Center for Medicare and Medicaid Services, National Health Expenditures, Projected 2019 – 2028: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

⁶⁷ Under a pooled market that includes both individual purchasers and employer groups, the model uses the average NHE projected trends for direct purchase and employer-sponsored insurance.

⁶⁸ The reduction in gross premium PMPMs for subsidized enrollees is 7.5% rather than 8.0% because modeling was done at the insurer level and results vary by insurer. The 8.0% represents the overall average reduction in the individual market premium PMPMs in 2023. The 7.5% represents the reduction in the subsidized population only whose enrollment is based on a different mix of insurers than the mix of insurers in the overall individual market.

⁶⁹ In 2021, the FPL (at 100%) is \$12,880 for an individual and \$4,540 for each additional member of the family. For the past three years, the individual FPL amount has increased an average of 2.0% per year, while the average change for each additional member of the family has been 1.7% . [Prior HHS Poverty Guidelines and Federal Register References | ASPE](#)

⁷⁰ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Key-Components-Pass-through-Estimate-Feb-2021.xlsx>

scenario – for individuals receiving subsidies through the marketplace represents the reduction in federal spending in PTCs that can then be passed through to the state to support the reinsurance program.

State Assessment

The state's contribution to the reinsurance program consists of an assessment on health insurers and third-party administrators based on the number of lives covered by each entity at a rate of \$4.00 PMPM. The assessment applies to all covered lives in the individual, small group, and large group, including both the fully insured and self-insured markets, but excluding employees and dependents covered by state and federal government employers.

Claims Trend and Reinsurance Program

Reinsurance parameters were initially established such that the total reinsurance program funding and the estimated average premium reductions across the pooled individual and small group market would equal the projected reinsurance funding available in 2023 (\$58.0 million) and 2024 (\$44.7 million).

Member level annual incurred claims were collected for CY 2019 for both the individual and small group market. This data was trended forward to 2023 based on a review of historical allowed claims and premium trends for the past several years for both the individual and small group markets. The average annual allowed claims trend in the combined individual and small group market for 2017 to 2019 was 4.6%. Projected premium trends from 2020 to 2023 for the combined individual and small group markets is 4.0% cumulative over these three years. This information was evaluated and GA assumed a 4.0% overall trend to project the 2019 member level claims to 2023 and 2024 for reinsurance modeling purposes.

The proposed reinsurance parameters were applied to each member's annual claims to determine the estimated reinsurance amount in CY 2023 and CY 2024.⁷¹ For 2023, the retrospective reinsurance program was initially structured to reimburse insurers 55% of claims costs between \$90,000 and \$275,000, with the portion of claims exceeding \$275,000 the full responsibility of the health insurers. For 2024, the retrospective reinsurance program was initially structured to reimburse insurers 45% of claims costs between \$90,000 and \$240,000, with the portion of claims exceeding \$240,000 the full

⁷¹ The CY 2019 individual market claims includes claims experience for enrollees who will transition to MaineCare expansion throughout the year in 2019. We are able to identify the enrollees in cost sharing reduction (CSR) 94% plans. It is assumed that the enrollees eligible for MaineCare expansion will primarily come from the CSR 94% population. The reinsurance parameters were tested, both including and excluding the CSR 94% population, and there was no material impact.

responsibility of the health insurers. The Maine Guaranteed Access Reinsurance Association (MGARA), in consultation with the Maine BOI, will establish the reinsurance parameters each year based on available funding to ensure the financial solvency of the program.

2023 and 2024 Membership and Premium Projections- Individual Market

2023 and 2024 individual market membership and premium projections are shown below for both the baseline (no waiver) and the proposed waiver (including the pooled market and retrospective reinsurance program). As explained previously, the Maine market includes a significant portion of APTC eligible enrollees that have purchased a Bronze plan, which has gross premiums that are lower than the APTC. The model accounts for the lower APTC for these enrollees. Under the waiver in 2023, enrollment among individual market members is projected to be 2.7% greater (an additional 1,600 members) than under the "no waiver" scenario; and premiums are projected to be 8.0% lower. Under the waiver in 2024, enrollment among individual market members is projected to be 2.0% greater (an additional 1,146 members) than under the "no waiver" scenario; and premiums are projected to be 6.1% lower.

2023 Individual Market Projections			
	Baseline- without waiver	With Pooled Market & Reinsurance - After Waiver	% Change
Average Annual Enrollment			
On Exchange			
Members w/APTC	41,952	41,952	0.0%
Members w/out APTC	<u>9,319</u>	<u>10,205</u>	<u>9.5%</u>
Total On Exchange	51,271	52,157	1.7%
Off Exchange			
Total Off Exchange	7,490	8,203	9.5%
Total On & Off Exchange	58,761	60,361	2.7%
Average Premium PMPM			
On Exchange			
Members w/APTC			
Member Share of Premium	\$129.50	\$126.95	-2.0%
<u>APTC Share of Premium</u>	<u>\$530.10</u>	<u>\$483.17</u>	<u>-8.9%</u>
Gross Premiums	\$659.59	\$610.12	-7.5%
Members w/out APTC	<u>\$536.87</u>	<u>\$490.45</u>	<u>-8.6%</u>
Total On Exchange	\$637.29	\$586.71	-7.9%
Off Exchange			
Total Off Exchange	\$630.43	\$578.18	-8.3%
Total On & Off Exchange	\$636.41	\$585.55	-8.0%
Total Annual Premium			
On Exchange			
Members w/APTC			
Member Share of Premium	\$65,192,719	\$63,909,715	-2.0%
<u>APTC Share of Premium</u>	<u>\$266,862,750</u>	<u>\$243,240,990</u>	<u>-8.9%</u>
Gross Premiums	\$332,055,469	\$307,150,704	-7.5%
Members w/out APTC	<u>\$60,036,797</u>	<u>\$60,062,078</u>	<u>0.0%</u>
Total On Exchange	\$392,092,266	\$367,212,783	-6.3%
Off Exchange			
Total Off Exchange	\$56,664,099	\$56,917,050	0.4%
Total On & Off Exchange	\$448,756,365	\$424,129,833	-5.5%

Table 21: Maine Individual Market 2023 Projections- Baseline (No Waiver) and With Waiver⁷²

⁷² Note that the average member share of premium increased in 2023 compared to 2020 due to several factors: (1) trend of the FPL and sliding scale percentages; (2) a small number of lower income enrollees

2024 Individual Market Projections			
	Baseline- without waiver	With Pooled Market & Reinsurance - After Waiver	% Change
Average Annual Enrollment			
On Exchange			
Members w/APTC	41,952	41,952	0.0%
Members w/out APTC	<u>8,978</u>	<u>9,612</u>	<u>7.1%</u>
Total On Exchange	50,930	51,564	1.2%
Off Exchange			
Total Off Exchange	7,216	7,727	7.1%
Total On & Off Exchange	58,146	59,292	2.0%
Average Premium PMPM			
On Exchange			
Members w/APTC			
Member Share of Premium	\$132.09	\$129.49	-2.0%
<u>APTC Share of Premium</u>	<u>\$561.80</u>	<u>\$524.69</u>	<u>-6.6%</u>
Gross Premiums	\$693.89	\$654.18	-5.7%
Members w/out APTC	<u>\$564.79</u>	<u>\$526.64</u>	<u>-6.8%</u>
Total On Exchange	\$671.14	\$630.41	-6.1%
Off Exchange			
Total Off Exchange	\$663.22	\$620.59	-6.4%
Total On & Off Exchange	\$670.15	\$629.13	-6.1%
Total Annual Premium			
On Exchange			
Members w/APTC			
Member Share of Premium	\$66,496,573	\$65,187,909	-2.0%
<u>APTC Share of Premium</u>	<u>\$282,825,780</u>	<u>\$264,143,042</u>	<u>-6.6%</u>
Gross Premiums	\$349,322,354	\$329,330,951	-5.7%
Members w/out APTC	<u>\$60,845,738</u>	<u>\$60,746,119</u>	<u>-0.2%</u>
Total On Exchange	\$410,168,091	\$390,077,070	-4.9%
Off Exchange			
Total Off Exchange	\$57,432,366	\$57,545,655	0.2%
Total On & Off Exchange	\$467,600,458	\$447,622,725	-4.3%

Table 22: Maine Individual Market 2024 Projections- Baseline (No Waiver) and With Waiver

who transitioned to MaineCare expansion; (3) the cumulative SLCSP trend was negative from 2019 to 2022 and as SLCSP rates decrease, APTC decreases and the members share of premium for APTC eligible members in Bronze plans increases.

2023 and 2024 Membership and Premium Projections - Small Group Market

2023 and 2024 small group market membership and premium projections are shown below for both the baseline (no waiver) and the proposed waiver (including the pooled market and retrospective reinsurance program). Under the waiver in 2023, enrollment among small group members is projected to be 5.3% greater (an additional 2,482 members) than under the "no waiver" scenario; and premiums are projected to be 6.0% lower. Under the waiver in 2024, enrollment among small group members is projected to be 3.5% greater (an additional 1,610 members) than under the "no waiver" scenario; and premiums are projected to be 3.9% lower.

2023 Small Group Market Projections			
	Baseline- without waiver	With Pooled Market & Reinsurance - After Waiver	% Change
Average Annual Enrollment	46,824	49,305	5.3%
Average Premium PMPM	\$580.62	\$545.92	-6.0%
Total Annual Premium	\$326,243,308	\$322,998,162	-1.0%

Table 23: Maine Small Group Market 2023 Projections- Baseline (No Waiver) and With Waiver

2024 Small Group Market Projections			
	Baseline- without waiver	With Pooled Market & Reinsurance - After Waiver	% Change
Average Annual Enrollment	45,741	47,352	3.5%
Average Premium PMPM	\$610.82	\$587.09	-3.9%
Total Annual Premium	\$335,275,188	\$333,596,534	-0.5%

Table 24: Maine Small Group Market 2024 Projections- Baseline (No Waiver) and With Waiver

5. Meeting the Section 1332 Guardrails

In order for a Section 1332 waiver to be accepted, the waiver must demonstrate that the changes will: (1) provide coverage of benefits that is as comprehensive overall for residents of the state as the coverage provided absent the waiver (*Comprehensiveness*); (2) not result in changes in coverage, premiums, and cost-sharing protections that reduce the affordability of health plans (*Affordability*); (3) provide coverage to at least as many residents as would be covered without the waiver (*Scope*); and (4) not increase federal spending that would occur absent the waiver (*Deficit Neutrality*).

With regard to *Comprehensiveness* of coverage, the waiver will not result in any changes to the essential health benefit (EHB) benchmark or actuarial value requirements and will therefore have no impact on the comprehensive coverage available in the individual and small group markets.

Pooling the individual and small group markets and applying a retrospective reinsurance program will reduce premiums, compared to the baseline, thereby increasing the *Affordability* of health insurance. The model projects 2023 premiums will decline 8.0% in the individual market and 6.0% in the small group market. The waiver will not alter the ACA's cost-sharing protections, including overall limits on out-of-pocket spending. While we did not make any explicit projections regarding the selection of plans by members, lower premiums should allow more members to select qualified health plans with lower member cost-sharing, thereby reducing out-of-pocket costs.

By stabilizing premiums, the model projects that more residents will be covered under the waiver as would be covered without the waiver (*Scope*). Under a “no waiver” scenario – based on recent experience in both the individual and small group markets – membership is projected to decline. Approval of the waiver will mean more Maine residents will be covered under ACA-compliant health plans than would be covered without the waiver.

Finally, the proposed waiver will achieve *Deficit Neutrality*. It will not increase spending by the federal government. Federal pass-through funding will be calculated based on actual PTC. Premiums in the individual market will be 8.0% lower than premiums under the baseline scenario in 2023. The tables on the following pages demonstrate how the waiver proposal addresses the deficit neutrality requirement.

Note that throughout the report, all of the premium PMPMs including the gross premiums are representative of the average demographics, plan designs and regions represented in the baseline data. The Appendix includes an illustrative example of

premiums in 2023 for a family of four at specific ages in a specific region for the second lowest cost silver plan under the “no waiver” and “with waiver” scenarios.

Deficit Neutrality Projection, 2023-2027					
	2023	2024	2025	2026	2027
Baseline (without waiver)- Individual Market Total Annual Premium					
Members w/APTC					
Gross Premiums	\$332,055,469	\$349,322,354	\$365,041,860	\$381,651,264	\$399,016,397
<u>Member Share of Premium</u>	<u>\$65,192,719</u>	<u>\$66,496,573</u>	<u>\$67,826,505</u>	<u>\$69,183,035</u>	<u>\$70,566,695</u>
APTC Share of Premium	\$266,862,750	\$282,825,780	\$297,215,355	\$312,468,229	\$328,449,701
Total PTC	\$257,415,809	\$272,813,748	\$286,693,931	\$301,406,854	\$316,822,582
Total On & Off Exchange	\$448,756,365	\$467,600,458	\$485,239,304	\$503,873,672	\$523,373,213
Baseline (without waiver)- Small Group Market Total Annual Premium					
Total	\$326,243,308	\$335,275,188	\$344,270,940	\$353,542,468	\$363,075,802
After Waiver With Pooled Market & Reinsurance- Individual Market Total Annual Premium					
Members w/APTC					
Gross Premiums	\$307,150,704	\$329,330,951	\$344,150,844	\$359,809,707	\$376,181,049
<u>Member Share of Premium</u>	<u>\$63,909,715</u>	<u>\$65,187,909</u>	<u>\$66,491,667</u>	<u>\$67,821,500</u>	<u>\$69,177,930</u>
APTC Share of Premium	\$243,240,990	\$264,143,042	\$277,659,177	\$291,988,207	\$307,003,118
Total PTC	\$234,630,259	\$254,792,378	\$267,830,042	\$281,651,824	\$296,135,208
PTC Savings	\$22,785,550	\$18,021,369	\$18,863,890	\$19,755,030	\$20,687,374
2021 ARPA Funds	\$8,562,238	\$0	\$0	\$0	\$0
State Assessment	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>
Total Reinsurance	\$58,047,788	\$44,721,369	\$45,563,890	\$46,455,030	\$47,387,374
Total On & Off Exchange	\$424,129,833	\$447,622,725	\$464,329,299	\$481,980,036	\$500,453,027
After Waiver With Pooled Market & Reinsurance- Small Group Market Total Annual Premium					
Total	\$322,998,162	\$333,596,534	\$342,572,765	\$351,823,531	\$361,336,253

Deficit Neutrality Projection, 2028-2032					
	2028	2029	2030	2031	2032
Baseline (without waiver)- Total Annual Premium					
Members w/APTC					
Gross Premiums	\$416,972,135	\$435,735,881	\$455,343,995	\$475,834,475	\$497,247,026
<u>Member Share of Premium</u>	<u>\$71,978,029</u>	<u>\$73,417,590</u>	<u>\$74,885,942</u>	<u>\$76,383,661</u>	<u>\$77,911,334</u>
APTC Share of Premium	\$344,994,105	\$362,318,291	\$380,458,054	\$399,450,814	\$419,335,693
Total PTC	\$332,781,314	\$349,492,223	\$366,989,838	\$385,310,256	\$404,491,209
Total On & Off Exchange	\$543,574,747	\$564,698,501	\$586,783,900	\$609,872,137	\$634,006,248
Baseline (without waiver)- Total Annual Premium					
Total	\$371,097,683	\$381,136,334	\$391,460,419	\$402,078,409	\$412,999,029
After Waiver With Pooled Market & Reinsurance- Total Annual Premium					
Members w/APTC					
Gross Premiums	\$393,109,196	\$410,799,110	\$429,285,070	\$448,602,898	\$468,790,028
<u>Member Share of Premium</u>	<u>\$70,561,489</u>	<u>\$71,972,719</u>	<u>\$73,412,173</u>	<u>\$74,880,417</u>	<u>\$76,378,025</u>
APTC Share of Premium	\$322,547,707	\$338,826,391	\$355,872,897	\$373,722,481	\$392,412,003
Total PTC	\$311,129,518	\$326,831,937	\$343,274,996	\$360,492,705	\$378,520,618
PTC Savings	\$21,651,796	\$22,660,286	\$23,714,842	\$24,817,550	\$25,970,591
2021 ARPA Funds	\$0	\$0	\$0	\$0	\$0
State Assessment	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>	<u>\$26,700,000</u>
Total Reinsurance	\$48,351,796	\$49,360,286	\$50,414,842	\$51,517,550	\$52,670,591
Total On & Off Exchange	\$519,595,339	\$539,613,983	\$560,546,309	\$582,431,339	\$605,309,844
After Waiver With Pooled Market & Reinsurance- Small Group Market Total Annual Premium					
Total	\$371,097,683	\$381,136,334	\$391,460,419	\$402,078,409	\$412,999,029

Table 25: Deficit Neutrality Projection, 2023-2032

6. Ten Year Projections

The tables below show the membership and premium projections for 2023 through 2032 for both the baseline (no waiver) and waiver scenarios. The assumptions used to develop these projections are described throughout the earlier parts of this report.

2023-2027 Baseline (without Waiver)					
	2023	2024	2025	2026	2027
Individual Market Average Annual Enrollment					
On Exchange					
Members w/APTC	41,952	41,952	41,952	41,952	41,952
Members w/out APTC	<u>9,319</u>	<u>8,978</u>	<u>8,738</u>	<u>8,507</u>	<u>8,287</u>
Total On Exchange	51,271	50,930	50,690	50,459	50,239
Off Exchange					
Total Off Exchange	7,490	7,216	7,011	6,812	6,622
Total On & Off Exchange	58,761	58,146	57,701	57,271	56,861
Small Group Market Average Annual Enrollment					
	46,824	45,741	44,946	44,148	43,365
Individual Market Average Premium PMPM					
On Exchange					
Members w/APTC					
Member Share of Premium	\$129.50	\$132.09	\$134.73	\$137.42	\$140.17
<u>APTC Share of Premium</u>	<u>\$530.10</u>	<u>\$561.80</u>	<u>\$590.39</u>	<u>\$620.69</u>	<u>\$652.43</u>
Gross Premiums	\$659.59	\$693.89	\$725.12	\$758.11	\$792.61
Members w/out APTC	<u>\$536.87</u>	<u>\$564.79</u>	<u>\$590.20</u>	<u>\$617.06</u>	<u>\$645.14</u>
Total On Exchange	\$637.29	\$671.14	\$701.86	\$734.33	\$768.28
Off Exchange					
Total Off Exchange	\$630.43	\$663.22	\$693.06	\$724.60	\$757.56
Total On & Off Exchange	\$636.41	\$670.15	\$700.79	\$733.17	\$767.03
Small Group Market Average Premium PMPM					
	\$580.62	\$610.82	\$638.30	\$667.34	\$697.71
Individual Market Total Annual Premium					
On Exchange					
Members w/APTC					
Member Share of Premium	\$65,192,719	\$66,496,573	\$67,826,505	\$69,183,035	\$70,566,695
<u>APTC Share of Premium</u>	<u>\$266,862,750</u>	<u>\$282,825,780</u>	<u>\$297,215,355</u>	<u>\$312,468,229</u>	<u>\$328,449,701</u>
Gross Premiums	\$332,055,469	\$349,322,354	\$365,041,860	\$381,651,264	\$399,016,397
Members w/out APTC	<u>\$60,036,797</u>	<u>\$60,845,738</u>	<u>\$61,886,570</u>	<u>\$62,990,196</u>	<u>\$64,155,131</u>
Total On Exchange	\$392,092,266	\$410,168,091	\$426,928,430	\$444,641,460	\$463,171,528
Off Exchange					
Total Off Exchange	\$56,664,099	\$57,432,366	\$58,310,874	\$59,232,212	\$60,201,685
Total On & Off Exchange	\$448,756,365	\$467,600,458	\$485,239,304	\$503,873,672	\$523,373,213
Small Group Market Total Annual Premium					
	\$326,243,308	\$335,275,188	\$344,270,940	\$353,542,468	\$363,075,802

2028-2032 Baseline (without Waiver)						
		2028	2029	2030	2031	2032
Individual Market Average Annual Enrollment						
On Exchange						
	Members w/APTC	41,952	41,952	41,952	41,952	41,952
	Members w/out APTC	<u>8,081</u>	<u>7,886</u>	<u>7,699</u>	<u>7,522</u>	<u>7,352</u>
	Total On Exchange	50,033	49,838	49,651	49,474	49,304
Off Exchange	Total Off Exchange	6,445	6,275	6,113	5,959	5,811
Total On & Off Exchange		56,478	56,113	55,765	55,432	55,115
Small Group Market Average Annual Enrollment		42,616	41,881	41,160	40,452	39,759
Individual Market Average Premium PMPM						
On Exchange						
	Members w/APTC					
	Member Share of Premium	\$142.98	\$145.84	\$148.75	\$151.73	\$154.76
	<u>APTC Share of Premium</u>	<u>\$685.30</u>	<u>\$719.71</u>	<u>\$755.74</u>	<u>\$793.47</u>	<u>\$832.97</u>
	Gross Premiums	\$828.27	\$865.54	\$904.49	\$945.20	\$987.73
	Members w/out APTC	<u>\$674.17</u>	<u>\$704.50</u>	<u>\$736.21</u>	<u>\$769.34</u>	<u>\$803.96</u>
	Total On Exchange	\$803.38	\$840.06	\$878.40	\$918.46	\$960.33
Off Exchange	Total Off Exchange	\$791.65	\$827.28	\$864.51	\$903.41	\$944.06
Total On & Off Exchange		\$802.04	\$838.63	\$876.88	\$916.84	\$958.61
Small Group Market Average Premium PMPM		\$729.11	\$761.92	\$796.20	\$832.03	\$869.47
Individual Market Total Annual Premium						
On Exchange						
	Members w/APTC					
	Member Share of Premium	\$71,978,029	\$73,417,590	\$74,885,942	\$76,383,661	\$77,911,334
	<u>APTC Share of Premium</u>	<u>\$344,994,105</u>	<u>\$362,318,291</u>	<u>\$380,458,054</u>	<u>\$399,450,814</u>	<u>\$419,335,693</u>
	Gross Premiums	\$416,972,135	\$435,735,881	\$455,343,995	\$475,834,475	\$497,247,026
	Members w/out APTC	<u>\$65,378,275</u>	<u>\$66,665,427</u>	<u>\$68,018,472</u>	<u>\$69,439,379</u>	<u>\$70,930,203</u>
	Total On Exchange	\$482,350,410	\$502,401,307	\$523,362,467	\$545,273,854	\$568,177,230
Off Exchange	Total Off Exchange	\$61,224,337	\$62,297,194	\$63,421,434	\$64,598,284	\$65,829,019
Total On & Off Exchange		\$543,574,747	\$564,698,501	\$586,783,900	\$609,872,137	\$634,006,248
Small Group Market Total Annual Premium		\$372,856,146	\$382,913,421	\$393,255,813	\$403,891,755	\$414,829,942

Table 26: 2023-2032 Projections Baseline (without Waiver)

2032-2027 After Waiver With Pooled Market & Reinsurance					
	2023	2024	2025	2026	2027
Individual Market Average Annual Enrollment					
On Exchange					
Members w/APTC	41,952	41,952	41,952	41,952	41,952
Members w/out APTC	<u>10,205</u>	<u>9,612</u>	<u>9,353</u>	<u>9,104</u>	<u>8,866</u>
Total On Exchange	52,157	51,564	51,305	51,056	50,818
Off Exchange					
Total Off Exchange	8,203	7,727	7,505	7,290	7,085
Total On & Off Exchange	60,361	59,292	58,811	58,346	57,903
Small Group Market Average Annual Enrollment					
	49,305	47,352	46,532	45,709	44,901
Individual Market Average Premium PMPM					
On Exchange					
Members w/APTC					
Member Share of Premium	\$126.95	\$129.49	\$132.08	\$134.72	\$137.41
<u>APTC Share of Premium</u>	<u>\$483.17</u>	<u>\$524.69</u>	<u>\$551.54</u>	<u>\$580.00</u>	<u>\$609.83</u>
Gross Premiums	\$610.12	\$654.18	\$683.62	\$714.72	\$747.24
Members w/out APTC	<u>\$490.45</u>	<u>\$526.64</u>	<u>\$550.34</u>	<u>\$575.38</u>	<u>\$601.56</u>
Total On Exchange	\$586.71	\$630.41	\$659.32	\$689.88	\$721.83
Off Exchange					
Total Off Exchange	\$578.18	\$620.59	\$648.52	\$678.02	\$708.87
Total On & Off Exchange	\$585.55	\$629.13	\$657.94	\$688.40	\$720.24
Small Group Market Average Premium PMPM					
	\$545.92	\$587.09	\$613.51	\$641.42	\$670.61
Individual Market Total Annual Premium					
On Exchange					
Members w/APTC					
Member Share of Premium	\$63,909,715	\$65,187,909	\$66,491,667	\$67,821,500	\$69,177,930
<u>APTC Share of Premium</u>	<u>\$243,240,990</u>	<u>\$264,143,042</u>	<u>\$277,659,177</u>	<u>\$291,988,207</u>	<u>\$307,003,118</u>
Gross Premiums	\$307,150,704	\$329,330,951	\$344,150,844	\$359,809,707	\$376,181,049
Members w/out APTC	<u>\$60,062,078</u>	<u>\$60,746,119</u>	<u>\$61,769,384</u>	<u>\$62,855,280</u>	<u>\$64,002,648</u>
Total On Exchange	\$367,212,783	\$390,077,070	\$405,920,228	\$422,664,987	\$440,183,697
Off Exchange					
Total Off Exchange	\$56,917,050	\$57,545,655	\$58,409,071	\$59,315,049	\$60,269,330
Total On & Off Exchange	\$424,129,833	\$447,622,725	\$464,329,299	\$481,980,036	\$500,453,027
Small Group Market Total Annual Premium					
	\$322,998,162	\$333,596,534	\$342,572,765	\$351,823,531	\$361,336,253

2028-2032 After Waiver With Pooled Market & Reinsurance					
	2028	2029	2030	2031	2032
Individual Market Average Annual Enrollment					
On Exchange					
Members w/APTC	41,952	41,952	41,952	41,952	41,952
Members w/out APTC	<u>8,644</u>	<u>8,433</u>	<u>8,232</u>	<u>8,041</u>	<u>7,859</u>
Total On Exchange	50,596	50,385	50,184	49,993	49,811
Off Exchange					
Total Off Exchange	6,893	6,711	6,536	6,369	6,210
Total On & Off Exchange	57,490	57,096	56,720	56,362	56,020
Small Group Market Average Annual Enrollment					
	44,129	43,371	42,627	41,898	41,183
Individual Market Average Premium PMPM					
On Exchange					
Members w/APTC					
Member Share of Premium	\$140.16	\$142.97	\$145.83	\$148.74	\$151.72
APTC Share of Premium	<u>\$640.71</u>	<u>\$673.04</u>	<u>\$706.90</u>	<u>\$742.36</u>	<u>\$779.49</u>
Gross Premiums	\$780.87	\$816.01	\$852.73	\$891.10	\$931.20
Members w/out APTC	<u>\$628.63</u>	<u>\$656.91</u>	<u>\$686.47</u>	<u>\$717.37</u>	<u>\$749.65</u>
Total On Exchange	\$754.86	\$789.38	\$825.46	\$863.16	\$902.56
Off Exchange					
Total Off Exchange	\$740.77	\$774.11	\$808.94	\$845.35	\$883.39
Total On & Off Exchange	\$753.17	\$787.59	\$823.55	\$861.15	\$900.43
Small Group Market Average Premium PMPM					
	\$700.79	\$732.32	\$765.28	\$799.71	\$835.70
Individual Market Total Annual Premium					
On Exchange					
Members w/APTC					
Member Share of Premium	\$70,561,489	\$71,972,719	\$73,412,173	\$74,880,417	\$76,378,025
APTC Share of Premium	<u>\$322,547,707</u>	<u>\$338,826,391</u>	<u>\$355,872,897</u>	<u>\$373,722,481</u>	<u>\$392,412,003</u>
Gross Premiums	\$393,109,196	\$410,799,110	\$429,285,070	\$448,602,898	\$468,790,028
Members w/out APTC	<u>\$65,208,722</u>	<u>\$66,478,980</u>	<u>\$67,815,311</u>	<u>\$69,219,690</u>	<u>\$70,694,180</u>
Total On Exchange	\$458,317,919	\$477,278,090	\$497,100,380	\$517,822,588	\$539,484,208
Off Exchange					
Total Off Exchange	\$61,277,420	\$62,335,894	\$63,445,928	\$64,608,751	\$65,825,635
Total On & Off Exchange	\$519,595,339	\$539,613,983	\$560,546,309	\$582,431,339	\$605,309,844
Small Group Market Total Annual Premium					
	\$371,097,683	\$381,136,334	\$391,460,419	\$402,078,409	\$412,999,029

Table 27: 2023-2032 Projections After Waiver

7. Considerations and Limitations

Users of this report must possess a reasonable level of expertise and understanding of health care, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of the Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

The results presented in this report are estimates based on complex actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. Actual experience will most likely not conform exactly to the assumptions used in this analysis. Actual results will differ from projected results to the extent that actual experience deviates from expected experience.

GA performed sensitivity testing on many of the assumptions to verify that varying the assumptions would not significantly change results. Actual federal pass-through funding will be based on the filed premiums and projected enrollment and may vary from the estimates in this report. Actual issuer 2023 through 2032 developed rates may also vary from what was assumed.

8. Actuarial Certification

Reliance

In the analysis described in this report, Gorman Actuarial (GA) relied on information provided by health insurers, the Maine BOI, MGARA, and publicly available information. GA has not audited this information for accuracy. GA has performed a limited review of the data for reasonableness and consistency. If the underlying data are inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

Subsequent Events

While GA performed scenario testing considering potential changes due to COVID-19, the testing was not exhaustive. Actual results may differ due to the wide range of possible outcomes due to the impact of COVID-19 on health care expenses and the economy.

GA also considered the impact of Clear Choice products, which became effective in 2022 in the Maine individual markets. This initiative establishes standardized plan designs in the individual market, and in 2023 will also standardize products in the small group market. GA compared the metal AV's and enrollment information from the 2021 rate filings to the proposed Clear Choice plans and determined that, on average, there would be minimal overall premium impacts to the individual market and the small group market and therefore minimal impact to the estimates in this report. Results at the individual insurer level may vary.

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing regulatory environment as of January 2022. If subsequent changes are made, these statements may not appropriately represent the expected future state.

ASOPS

GA used sound actuarial methodologies, principles, and judgement and have complied with all current Actuarial Standards of Practice (ASOPs). In particular, GA has complied with ASOP 23 Data Quality and ASOP 41 Actuarial Communication.

Actuarial Certification

This study includes results based on actuarial analyses conducted by Bela Gorman and Jennifer Smagula, both of whom are members of the American Academy of Actuaries

and Fellows of the Society of Actuaries. They both meet the qualification standards for performing the actuarial analyses presented in this report.

This report is solely for the use of supporting Maine’s 1332 Waiver application. The intended users of this report are the Maine BOI and those federal agencies to which the application is submitted. Distribution of this report to any other parties does not constitute advice from or by us to those parties. GA assumes no duty or liability to any third parties who receive the information herein.

We believe the current Maine Waiver proposal complies with the following:

- The coverage provided under this 1332 Waiver is at least as comprehensive as the coverage available absent the 1332 Waiver.
- The coverage provided under this 1332 Waiver is at least as affordable as the coverage available absent the 1332 Waiver.
- The 1332 Waiver will provide coverage to at least a comparable number of residents as would be available absent the 1332 Waiver.
- The 1332 Waiver will not increase the federal deficit.

Bela Gorman, FSA, MAAA

Date

Jenn Smagula, FSA, MAAA

Date

9. Appendices

Illustrative Premiums for a Family of Four

In 2023, the estimated monthly premium (prior to any APTC subsidies) for the second low cost Silver plan for a family of four in Portland, Maine with two forty year olds and two ten year olds is \$1,495 without a waiver and \$1,404 with a waiver.⁷³

American Rescue Plan Act

On March 11, 2021, President Biden signed into law the American Rescue Plan Act (ARPA) of 2021. One of the key provisions is a significant increase in premium subsidies for the purchase of health plans offered on the Affordable Care Act's (ACA) exchanges.

For Calendar Years 2021 and 2022, ARPA makes two significant changes in the manner by which premium subsidies are determined. The first change reduces the percentage of annual income that individuals and families with income below 400% of the federal poverty level (FPL) are expected to pay for the second lowest cost Silver plan (SCLSP); and the second change expands premium subsidies to individuals and families with income that exceeds 400% FPL.

The ACA and ARPA establish sliding scale thresholds as a percent of one's income. These thresholds represent an enrollee's expected premium contribution for the SLCS. The table below shows these sliding scale percentages for members eligible for APTCs by various income levels under the ACA and under ARPA.

⁷³ The with waiver premium of \$1,404 is 6.1% lower than the without waiver premium of \$1,495. These results are specific to the Portland region and to the SLCS plan in that region. Modeling was conducted at the insurer level and results vary by insurer. The 8.0% shown previously represents the overall average reduction to the individual market premium PMPMs in 2023. This is based on enrollment from the mix of insurers in the overall individual market.

Income Level as a Percentage of Federal Poverty Level (FPL)	Expected Premium Contribution for SLCSF Sliding Scale Percentage by Income Level	
	ACA (before legislative changes) “Current”	ARP
100-133%	2.07%	0%
133-150%	3.10% – 4.14%	0%
150-200%	4.14% – 6.52%	0% - 2.0%
200-250%	6.52% – 8.33%	2.0% – 4.0%
250-300%	8.33% – 9.83%	4.0% – 6.0%
300-400%	9.83%	6.0 %– 8.5%
400+%	Not eligible for subsidies	8.5%

Table 28: Expected Premium Contribution for SLCSF by Income Level⁷⁴

For purposes of modeling throughout this report, the APTC and subsequent pass-through funding was calculated based on the provisions of the ACA for the projection period 2023 through 2032. GA performed sensitivity testing on the results under the assumption that the provisions under ARPA continued into 2023 and beyond. GA also collected enrollment data as of August 2021 in addition to March 2021 to understand the increase in APTC enrollment. APTC enrollment increase by approximately 3,000 enrollees during this timeframe and presumably the majority of this increase is due to ARPA.

GA’s analysis shows that the additional premium subsidies under ARPA will decrease pooled market premiums by an additional 0.3% to 0.8% in 2023 and by an additional 0.2% to 0.7% in 2024 on top of the current premium reductions outlined in this report under the “with waiver” scenario. This is equivalent to an additional \$2.4 to \$5.9 million in federal pass-through funding in 2023 and an additional \$2.0 to \$5.0 million in pass-through funding in 2024.

⁷⁴ <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>. Accessed November 18, 2021.

Definitions and Abbreviations

Actuarial Value (AV) – The percentage of total average costs for covered benefits that a health plan will cover. For example, if a plan has an actuarial value of 70%, on average, a person enrolled in the plan would be responsible for 30% of the costs of all covered benefits and the health plan would cover the rest of the costs of covered benefits.

Advance Premium Tax Credit (APTC) – A tax credit provided by the federal government to help individuals pay their monthly health insurance premium. Individuals that apply for coverage through the health insurance marketplace can estimate their income for the year, and if they qualify for a premium tax credit, they can use the credit in advance to lower their premium. If at the end of the year they've taken more premium tax credit in advance than they are due based on their actual annual income, they are required to pay back the excess credit when they file their federal tax return. If they've taken less than they qualify for, they are refunded the difference.

Affordable Care Act (ACA) – The comprehensive federal health reform law enacted in March 2010, also referred to as The Patient Protection and Affordable Care Act (PPACA) or "Obamacare." The law has three primary goals: (1) make affordable health insurance available to more people by subsidizing premiums and cost-sharing for lower income households; (2) expand the Medicaid program to cover adults with income below 138% of the federal poverty level; and (3) support innovative medical care delivery methods designed to lower the costs of health care generally.

American Rescue Plan Act (ARPA) – Legislation enacted in March 2021 to combat the COVID-19 pandemic, including public health and economic impacts.

Attachment Point – In the context of reinsurance, attachment point is the amount of claims that a health insurer is responsible for covering before the reinsurer will step in and pay the excess or a portion of the excess. For example, if the attachment point is \$75,000 and an enrollee incurs \$100,000 in claims during the plan year, the health insurer covers \$75,000 in claims costs and the reinsurer pays for claims beyond the attachment point, or in this case \$25,000.

Centers for Medicare and Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards, among other responsibilities.

Code of Federal Regulations (CFR) – The codification of the general and permanent rules published in the Federal Register by the departments and agencies of the federal government.

Cost-Sharing – The amount of allowed claims for covered benefits that a health plan member is responsible for paying out of pocket.

Essential Health Benefits (EHB) – A set of ten (10) categories of services health insurance plans must cover under the ACA, including doctors' services, inpatient and outpatient hospital care, prescription drugs, pregnancy and childbirth, mental health services, and other core health care services.

Exchange User Fees – A fee charged by the federal government to fund and support the federal health insurance marketplace. The fee is set annually and is a percentage of the premiums charged by health insurers that sell health plans through the federal health insurance marketplace.

Federal Medical Assistance Percentage (FMAP) – The percentage rates used to determine the matching funds rate allocated annually to certain medical and social service programs. FMAP varies by state and is determined by a formula that takes into consideration the average per capita income for each state relative to the national average.

Federal Poverty Level (FPL) – A measure of income issued every year by the U.S. Department of Health and Human Services to determine eligibility for certain programs and benefits, including subsidies for ACA marketplace health insurance plans and Medicaid.

Gross Premium – The total premium charged by a health insurer for a health plan, prior to any subsidies for which an individual may be eligible.

Health Insurance Marketplace or Exchange – A shopping and enrollment platform that offers health plans to individual, families and small businesses. The ACA established the Marketplace as a means to extend health insurance coverage to millions of uninsured Americans. In most states, the federal government runs the Marketplace, while some states have established their own.

Individual Coverage Health Reimbursement Arrangement (ICHRA) – A federal rule that allows employers to establish a health reimbursement arrangement (HRA) and contribute funds on a pre-tax basis into an account that employees can then use to purchase individual health insurance policies.

Individual Market – In the context of health insurance, individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Insurers offering coverage in the individual market establish a single risk pool that includes all individual market members.

Maine Guarantee Access Reinsurance Association (MGARA) – A legislatively established private non-profit organization that operates a reinsurance program for the higher-risk segment of Maine's individual health insurance market.

MaineCare – The state's Medicaid program that provides health coverage for Maine's children and adults who are elderly, disabled, or with low incomes.

Medicare Supplement Plans – Private health insurance plans for Medicare enrollees that help pay the member's share of health care costs under Medicare Part A and Part B. For example, a Medicare Supplement Plan (also referred to as a Medigap plan) may pay Part B coinsurance for doctor visits and lab tests.

National Health Expenditure (NHE) – Estimates and projections that measure annual health spending in the U.S. by type of good or service delivered (e.g., hospital care, physician and clinical services), sources of funding for those services (e.g., private health insurance, Medicare, Medicaid) and by sponsor (e.g., businesses, households, governments). NHE data is produced by CMS.

Per Member Per Month (PMPM) – The average cost of services or health insurance premiums per individual per month.

Premium – An amount, commonly established on a monthly basis, charged by a health insurer for coverage under a health insurance plan.

Premium Tax Credit (PTC) – The tax credit an individual or family is eligible to receive from the federal government to help lower the cost of health insurance. In contrast with APTC, the premium tax credit (PTC) is determined after the calendar year to which the PTC applies based on the actual annual income of an individual or family.

Qualified Health Plan (QHP) – a health insurance plan that is certified by the Health Insurance Marketplace that provides coverage of essential health benefits, follows established limits on cost-sharing, and meets other requirements of the ACA. All QHPs meet the ACA requirement for having health coverage, known as "minimum essential coverage."

Risk Pool – in the context of health insurance, a risk pool is a group of individuals whose medical costs are combined to calculate premiums. Pooling risks together allows the

higher costs of the less healthy to be offset by the relatively lower costs of the healthy. In general, the larger the risk pools the more predictable and stable the premiums.

Small Group Market – In the context of health insurance, small group market means the market for health insurance coverage offered to employers with 50 or fewer eligible employees. Insurers offering coverage in the small group market establish a single risk pool that includes all small group members.

Second Lowest Cost Silver Plan (SLCSP) – The SLCSP is the second-lowest priced health insurance plan sold through the Marketplace to individuals. The premium for the SLCSP is used to determine an individual's premium tax credit.

Appendix D: **Notice for Public Comment Period and Public Forum**



Notice of Public Comment Period and Public Hearings on Proposed Section 1332 Waiver Amendment Application

The Maine Bureau of Insurance will hold virtual public hearings and accept public comments on a proposed application to the federal government for an amendment to its waiver under Section 1332 of the Patient Protection and Affordable Care Act to support extending the Maine Guaranteed Access Reinsurance Association (MGARA) reinsurance program to a pooled individual and small group market and transitioning to a retrospective claims cost-based reinsurance program.

Background

Section 1332 of the federal Patient Protection and Affordable Care Act permits a state to apply for a waiver (1332 waiver) to pursue innovative strategies to provide its residents with access to quality, affordable health insurance.

In 2018, Maine received federal approval for a 1332 waiver in order to allow MGARA to operate a reinsurance program for the individual health insurance market in Maine with the support of federal pass-through funding, beginning January 1, 2019. The goal of the reinsurance program was to bring increased certainty and stability to Maine's individual health insurance market through a positive impact on premium levels. Since the waiver became effective, average premium rates for the individual market have moderated each year: 1.1% in 2019, -0.5% in 2020, and -12.5% in 2021.

In recent years, the small group market in Maine has experienced significant declines in membership, due in part to high medical cost trends and associated premium increases. On its current trajectory, the small group market may continue to see membership decline, and only those that truly need health care services may stay enrolled in the market, which will lead to a continued escalation in premiums. Because of this trend, Maine has been considering ways to help stabilize and lower premiums for the small group market.

In 2020, the Maine Legislature enacted a law that allows the Superintendent of Insurance to pool the individual and small group markets into a single risk pool and to seek federal approval of an amendment to its 1332 waiver that would allow extension of the MGARA reinsurance program to the pooled market and transition of the reinsurance program from a prospective model to a retrospective model. The change is contingent upon federal approval of the proposed 1332 waiver amendment.

Under the proposed 1332 waiver amendment, Maine would continue to receive federal pass-through funding to support the reinsurance program in the amount of the savings that would be generated from the resulting reduction in premium tax credits. Extending the MGARA reinsurance program to a pooled individual and small group health insurance market would

bring increased certainty and stability to small group health insurance in Maine through a positive effect on premium levels. This 1332 waiver amendment, if approved, would be effective as of January 1, 2022, for a period of five years.

More detailed information regarding the proposed 1332 waiver amendment application may be viewed at the following link: www.maine.gov/pfr/insurance/mgara/index.html

Public Hearings

Due to the COVID-19 public health emergency in Maine, the federal government has approved the state's request to modify public notice requirements to allow the state to conduct the required public hearings virtually. Therefore, the Bureau of Insurance will hold virtual public hearings on the following days:

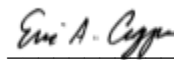
- **March 22, 2021, 11:00 am - 12:30 pm**
- **March 29, 2021, 10:00 am - 11:30 am**

Instructions for registering for and attending the hearing remotely, by either audio-visual link or telephone, are on the Bureau of Insurance [website](#).

All interested persons are invited to provide oral comments at the hearings or to submit written comments. Written comments must be received no later than **April 12, 2021 at 4:30 p.m.** and should be addressed to Brittnee Greenleaf at Brittnee.L.Greenleaf@maine.gov or at 34 State House Station, Augusta, ME 04333-0034.

Individuals in need of auxiliary aid for effective communication in the hearing are invited to make their needs and preference known to Ms. Greenleaf either by e-mail or telephone at (207) 624-8491 sufficiently in advance of the hearings so that appropriate arrangements can be made.

DATED: March 12, 2021



Eric A. Cioppa
Superintendent of Insurance



Notice of Public Comment Period Extension on Proposed Section 1332 Waiver Amendment Application

On March 12, 2021, the Maine Bureau of Insurance issued a [Notice](#) of Public Comment Period and Public Hearings on a proposed Section 1332 Waiver Amendment Application. The Notice invited written comments from the public by April 12, 2021 at 4:30 p.m. The Bureau is extending the deadline for written comments, as set forth below.

As originally drafted, the 1332 waiver amendment application proposed to extend MGARA reinsurance to a pooled individual and small group market and transition the program to a retrospective claims cost-based model, beginning January 1, 2022. Maine is now delaying the pooling of the individual and small group markets until 2023. Therefore, the proposal to extend MGARA reinsurance to a pooled individual and small group market is delayed until 2023. Maine still intends to proceed with the proposal to transition MGARA reinsurance to a retrospective model beginning January 1, 2022. The draft application is available at the following link: www.maine.gov/pfr/insurance/mgara/index.html.

The delay of part of the 1332 waiver amendment is for two reasons. First, over the last year, the COVID-19 pandemic has created a public health emergency that has had a major economic impact in this state. Significant resources have been expended by the State and small businesses in responding to this pandemic, and it has introduced significant disruption to insurance markets. The full scope of the pandemic's economic impact, particularly for small businesses, is still unknown. The delay will allow the State to better understand the economic impact of COVID-19 and how best to proceed with its plan to improve access and affordability of coverage and avoid adverse consequences.

Second, on March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 into law. This legislation makes significant improvements to the affordability of Marketplace health coverage by increasing premium tax credits to help pay for coverage and expanding eligibility for those tax credits. The substantial changes in the structure of the tax credits make estimating the impact of the pooled markets and Federal pass-through amounts challenging. The delay will allow the State to fully analyze the legislation's impact and determine the best way to maximize this opportunity.

Written comments will now be accepted until **April 19, 2021 at 4:30 p.m.** and should be addressed to Brittnee Greenleaf at Brittnee.L.Greenleaf@maine.gov or at 34 State House Station, Augusta, ME 04333-0034.

DATED: March 30, 2021

Eric A. Cioppa
Superintendent of Insurance



**Notice of Public Forum on
Gorman 1332 Waiver Actuarial and Economic Report
January 28, 2022 1:00 pm**

The Maine Bureau of Insurance (MBOI) will hold a virtual public forum to present the updated Gorman 1332 Waiver Actuarial and Economic Report on Friday, January 28, 2022 at 1:00 pm.

Background

The State of Maine will be applying for a State Innovation Waiver under Section 1332 of the federal Patient Protection and Affordable Care Act to merge the individual and small group health insurance markets in Maine and extend the operation of the Maine Guaranteed Access Reinsurance Association (MGARA) reinsurance program to small employer coverage.

The updated Gorman Actuarial and Economic report along with detailed information regarding the Section 1332 Waiver and MGARA may be viewed on the Maine Bureau of Insurance website maine.gov/pfr/insurance/mgara and at the MGARA website <https://mgara.org>.

Virtual Meeting

Due to the COVID-19 pandemic, the Bureau will hold this meeting virtually using Microsoft Teams. Please visit the [Public Events page](#) of the Bureau's website to register to attend either by audio-visual link or by telephone.

Individuals in need of auxiliary aid for effective communication in the hearing are invited to make their needs and preference known to Ms. Greenleaf either by e-mail or telephone at (207) 624-8491 sufficiently in advance of the meeting so that appropriate arrangements can be made.

DATED: January 12, 2022

Eric A. Cioppa
Superintendent of Insurance

Appendix E: **Presentations from Public Hearings**



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

Section 1332 Waiver Amendment Application

MAINE BUREAU OF INSURANCE

MARCH 2021

Section 1332 Waiver

- Section 1332 of the Affordable Care Act (ACA) allows a state to apply to the federal government for a waiver of certain ACA provisions to pursue innovative strategies to provide access to quality, affordable health insurance.
- A waiver must meet four guardrails:
 - Provide coverage that is at least as comprehensive as would be provided absent the waiver;
 - Must not result in changes in coverage, premiums, and cost-sharing protections that reduce the affordability of coverage;
 - Provide coverage to at least as many residents as would be covered absent the waiver; and
 - Must not increase federal spending that would occur absent the waiver.

Maine's Current 1332 Waiver

- Maine currently has a 1332 waiver that allows the Maine Guaranteed Access Reinsurance Association (MGARA) to operate a reinsurance program for the individual health insurance market.
- Through this waiver, Maine receives federal pass-through funding to support the MGARA reinsurance program.
 - Federal pass-through funds are generated from the reduction in premium tax credits paid as a result of the reinsurance program lowering individual premiums from what they would have been absent reinsurance.
- Since this waiver became effective on January 1, 2019, average premium rates for the individual market have moderated each year: 1.1% in 2019, -0.5% in 2020, and -12.5% in 2021.

MGARA Reinsurance

- MGARA is governed by Title 24-A, Chapter 54-A of the Maine Revised Statutes.
- MGARA currently reinsures individual policies covering high-risk individuals using a prospective model:
 - A carrier cedes a policy to MGARA for reinsurance when the carrier identifies an individual has one of eight specified medical conditions.
 - The carrier pays MGARA a premium for ceded policies, and in return, MGARA pays a portion of the carrier's claims if the claims exceed the specified attachment point.
- In addition to the federal funds from the 1332 waiver, MGARA assesses Maine's fully-insured and self-insured commercial health insurance markets \$4.00 per covered person per month.

Public Law 2019, Chapter 653

- In 2020, the Maine Legislature enacted PL 2019, Chapter 653 to allow the state to:
 - pool the individual and small group markets into a single risk pool; and
 - seek federal approval of an amendment to its 1332 waiver in order to extend the MGARA reinsurance program to the pooled market and transition to a retrospective reinsurance model.
- The purpose of this law is to address the decline of the small group market in Maine by extending the positive premium impacts that MGARA reinsurance has had on the individual market to the small group market.
 - From March 2017 to March 2020, there was an 18% reduction in small group membership from 61,200 to 50,200.
 - The average annual premium rate increase for the small group market was 11% in 2019, 8.8% in 2020, and 5.5% in 2021.

Proposed 1332 Waiver Amendment

- The proposed 1332 waiver amendment would extend MGARA reinsurance to a pooled individual and small group market and transition the program to a retrospective claims cost-based model, beginning January 1, 2022.
- The retrospective model would reimburse carriers for a portion of the costs of covered individuals whose claims exceed the designated attachment point.
 - The current process requiring carriers to prospectively identify high-risk individuals for reinsurance based on health conditions would no longer be required.
- Maine would continue to receive federal pass-through funding to support the MGARA reinsurance program in the amount of federal savings that would be generated from the resulting reduction in premium tax credits.
- The goal is to bring increased certainty and stability to small group insurance through a positive effect on premium levels by spreading risk across the broader health insurance market.

Actuarial & Economic Analyses

- Gorman Actuarial performed actuarial and economic analyses for the proposed 1332 waiver amendment for 2022 through 2031.
- Gorman modeled the reinsurance program to reimburse carriers 50% of claims costs between \$90,000 and \$250,000. (These parameters may be adjusted.)
- Gorman estimated that pooling the markets and applying a retrospective reinsurance program will:
 - lower the average individual market premium by **6.6%**, as compared to the baseline of no section 1332 waiver and no reinsurance program;
 - lower the average small group market premium by **4.2%**, as compared to the same baseline; and
 - generate **\$21.6 million** in net federal savings in 2022 – the amount of pass-through funding that will be used to support the MGARA reinsurance program.
- Gorman demonstrated that the proposed waiver amendment meets the four guardrails pertaining to comprehensiveness, affordability, scope, and federal deficit neutrality.

MGARA Results

During years of operation in 2019-2021 MGARA:

MGARA	Federal Pass Through	Premium	Assessment	Total Funds	Claims and Expenses
2019	\$62.3	\$44.9	\$24.9	\$132.1	\$106.4
2020	\$26.3	\$39.2	\$27.3	\$93.3	\$81.5 (\$70.2 YTD)
2021	\$30.7	\$39.3*	\$27.3*	\$91.3*	\$80.9*
2022 Gorman Projected	\$21.6*	\$0.0	\$24.1*	\$45.7*	\$45.7

- Kept premium increases about 8-19% lower than they otherwise would have been for 2021.

*indicates estimates or projections

Implementation Contingencies

Going forward, implementation is contingent upon two things:

- Federal approval of the proposed 1332 waiver amendment application; and
- Adoption of rules to implement the pooled market by the Superintendent of Insurance.
 - The state is in the process of developing a rule to implement the pooled market.
 - The rule will establish the necessary conditions and procedures for implementing the pooled market and extending MGARA reinsurance to small group health insurance.
 - The state anticipates formally proposing the rule and initiating the state's rulemaking process in March of 2021.

Timeline

End Date	Milestone
Section 1332 Waiver Application Process	
March 12, 2021	Publish draft section 1332 waiver application on state website and notify the public.
March 12, 2021	Begin public comment period and tribal consultation.
March 22, 2021	Conduct first public hearing virtually.
March 29, 2021	Conduct second public hearing virtually.
April 12, 2021	End public comment period and tribal consultation.
April 16, 2021	Submit final section 1332 waiver application to the Departments.
July 2021	Target to receive approval from the Departments for the section 1332 waiver.
Legal Authority and Governance	
March 2021	File proposed rule to implement pooled market with state authority.
July 2021	File final adopted rule to implement pooled market with state authority.
Design	
September 2021	MGARA submits amended Plan of Operation to the Bureau of Insurance.
September 2021	Bureau of Insurance approves amended Plan of Operation.
Year One Implementation	
January 1, 2022	Pooled market and retrospective reinsurance program begins.

Maine Bureau of Insurance

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Section 1332 Waiver Amendment Application

MAINE BUREAU OF INSURANCE

MARCH 2021

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- Maine currently has a 1332 waiver that allows the Maine Guaranteed Access Reinsurance Association (MGARA) to operate a reinsurance program for the individual health insurance market.
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 - Federal pass-through funds are generated from the reduction in premium tax credits paid as a result of the reinsurance program lowering individual premiums from what they would have been absent reinsurance.
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 - The state is in the process of developing a rule to implement the pooled market.
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September 2021	Bureau of Insurance approves amended Plan of Operation.
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Maine Bureau of Insurance

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Section 1332 Waiver Amendment Application

MAINE BUREAU OF INSURANCE

MARCH 2021 (updated March 29, 2021)

Section 1332 Waiver

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- The purpose of this law is to address the decline of the small group market in Maine by extending the positive premium impacts that MGARA reinsurance has had on the individual market to the small group market.
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 - The average annual premium rate increase for the small group market was 11% in 2019, 8.8% in 2020, and 5.5% in 2021.

Proposed 1332 Waiver Amendment

- As originally drafted, the 1332 waiver amendment proposed to extend MGARA reinsurance to a pooled individual and small group market and transition the program to a retrospective claims cost-based model, beginning January 1, 2022.
 - Maine is now delaying the pooling of the individual and small group markets until 2023. Therefore, the proposal to extend MGARA reinsurance to a pooled individual and small group market is delayed until 2023.
 - Maine still intends to proceed with the proposal to transition MGARA reinsurance to a retrospective model beginning January 1, 2022.
- The retrospective model would reimburse carriers for a portion of the costs of covered individuals whose claims exceed the designated attachment point.
 - The current process requiring carriers to prospectively identify high-risk individuals for reinsurance based on health conditions would no longer be required.
- Maine would continue to receive federal pass-through funding to support the MGARA reinsurance program in the amount of federal savings that would be generated from the resulting reduction in premium tax credits.

Actuarial & Economic Analyses

- Gorman Actuarial performed actuarial and economic analyses for the 1332 waiver amendment as originally proposed for 2022 through 2031.
- Gorman modeled the reinsurance program to reimburse carriers 50% of claims costs between \$90,000 and \$250,000. (These parameters may be adjusted.)
- Gorman estimated that pooling the markets and applying a retrospective reinsurance program for 2022 would:
 - lower the average individual market premium by **6.6%**, as compared to the baseline of no section 1332 waiver and no reinsurance program;
 - lower the average small group market premium by **4.2%**, as compared to the same baseline; and
 - generate **\$21.6 million** in net federal savings in 2022 – the amount of pass-through funding that will be used to support the MGARA reinsurance program.
- Gorman demonstrated that the waiver amendment as originally proposed met the four guardrails pertaining to comprehensiveness, affordability, scope, and federal deficit neutrality.

MGARA Results

During years of operation in 2019-2021 MGARA:

MGARA	Federal Pass Through	Premium	Assessment	Total Funds	Claims and Expenses
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- Kept premium increases about 8-19% lower than they otherwise would have been for 2021.

*indicates estimates or projections

Implementation Contingencies

Going forward, implementation is contingent upon two things:

- Federal approval of the proposed 1332 waiver amendment application.
 - Gorman will update the actuarial and economic analyses due to the pooled market delay until 2023.
- Adoption of rules to implement the pooled market for 2023 by the Superintendent of Insurance.
 - The state is in the process of developing a rule to implement the pooled market.
 - The rule will establish the necessary conditions and procedures for implementing the pooled market and extending MGARA reinsurance to small group health insurance.

Original timeline modified due to pooled market delay until 2023; subject to further modification.

End Date	Milestone
Section 1332 Waiver Application Process	
March 12, 2021	Publish draft section 1332 waiver application on state website and notify the public.
March 12, 2021	Begin public comment period and tribal consultation.
March 22, 2021	Conduct first public hearing virtually.
March 29, 2021	Conduct second public hearing virtually.
April 12, 2021	End public comment period and tribal consultation.
April 16, 2021	Submit final section 1332 waiver application to the Departments.
July 2021	Target to receive approval from the Departments for the section 1332 waiver.
Legal Authority and Governance	
April 2021	File proposed rule to implement pooled market in 2023 with state authority.
August 2021	File final adopted rule to implement pooled market in 2023 with state authority.
Design	
September 2021	MGARA submits amended Plan of Operation to the Bureau of Insurance.
September 2021	Bureau of Insurance approves amended Plan of Operation.
Implementation	
January 1, 2022	Retrospective reinsurance program begins.
January 1, 2023	Pooled market with reinsurance program extended to the pooled market begins.

Timeline

Maine Bureau of Insurance

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DEPARTMENT OF

Professional &
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STATE OF MAINE

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ACA Section 1332 Waiver Innovation Application Update

Maine Bureau of Insurance

JANUARY 2022

Leveraging a merged market and the Maine Guaranteed Access Reinsurance Association (MGARA) using a Section 1332 Waiver

Authorized by LD 2007 PL 653

Purpose –

- To stabilize and reduce premiums in individual and small group health insurance market by providing reinsurance to insurers in the pooled market.

Funding –

- Merging small group and individual markets and reinsurance reduces individual APTC to provide pass through funds. \$4 per person per month assessment on all market segments.

MGARA –

- Changed from prospective to retrospective model.

Deferred the pooled market under 24-A M.R.S. § 2792 from 2022 to 2023.

The pooled market to be adopted based on the Federal Government approving the state innovation waiver amendment that extends reinsurance to the pooled market and based on projections that both average individual premium rates and average small group premium rates would be the same or lower than they would have been absent the provisions of this section and MGARA.

2021 LD 1725
Public Law c.
361

Rule 856 COMBINATION OF THE INDIVIDUAL AND SMALL BUSINESS HEALTH INSURANCE RISK POOLS

Public hearing for the proposed rule held on October 12, 2021

Comment deadline was October 25, 2021

Finalized January 24, 2022

Today's public forum is being held under Rule 856, § 4(1)(C), and we encourage public input on the expected impact of the pooled market and the reinsurance program, and any suggestions for additional or alternate initiatives to improve the stability and affordability of the small group market.

The Proposal

Pooling the markets reduces rates in the individual market but increase rates in the small group market. The reduction in individual market rates would lower federal spending for Premium Tax Credits (PTC).

The second component of the waiver is the establishment of a reinsurance program that would reduce premiums across the newly-pooled individual and small group market.

Pooling the markets is expected to lower the average individual market premium by 8.1% compared to the baseline. In the small group market, the average premium is projected to decrease 6.0% compared to the baseline.

For the purpose of this actuarial analysis, based on the checklist for Section 1332 waiver applications issued by CMS, the baseline estimate excludes the premium reductions associated with Maine's current Section 1332 waiver and assumes there is no reinsurance program in the individual market.

American Rescue Plan Act (ARPA)

Effective on March 11, 2021, American Rescue Plan Act (ARPA) provides a significant increase in premium subsidies for the purchase of health plans offered on the Affordable Care Act's (ACA) exchanges.

For Calendar Years 2021 and 2022, ARPA reduces the percentage of annual income that individuals and families with income below 400% of the federal poverty level (FPL) are expected to pay for the second lowest cost Silver plan (SCLSP); and the second change expands premium subsidies to individuals and families with income that exceeds 400% FPL.

Because of the increase in premium tax credits, additional pass-through funds were issued as part of the current 1332 waiver to Maine in the amount of \$8,562,238 announced on September 7, 2021. This additional funding was not planned when the rates for 2022 plans were approved so it is anticipated that those funds will be applied to 2023 merged market claims through MGARA.

Maine Section 1332 Waiver Application:

*Pooling Individual & Small Group Markets and
Overlaying a Reinsurance Program*

January 28, 2022

Bela Gorman FSA, MAAA

Jenn Smagula FSA, MAAA

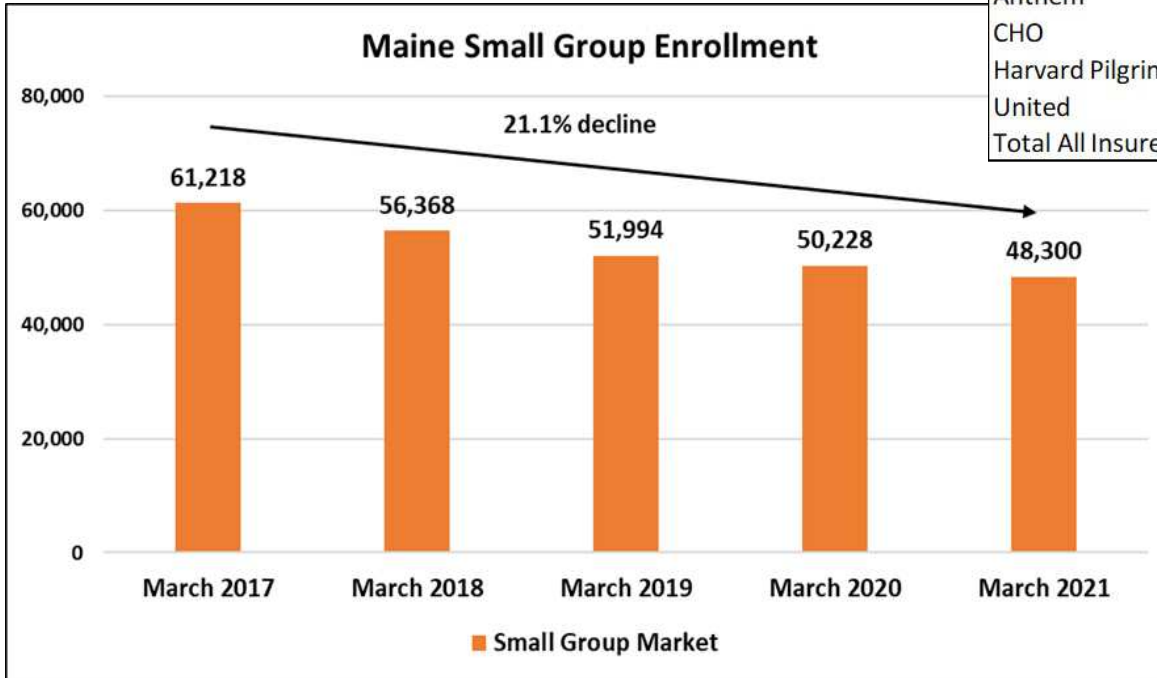
Gorman Actuarial, Inc.



Gorman Actuarial, Inc.

Background

Small Group Market Enrollment and Rate Change

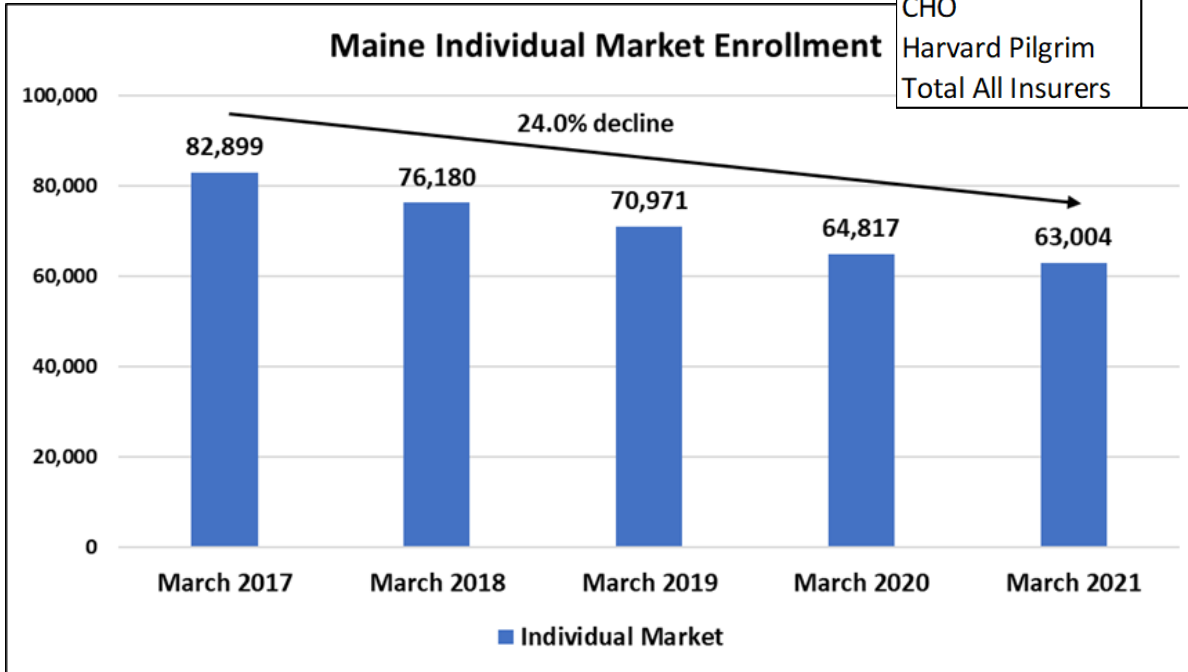


Small Group Market Average Rate Changes				
	2019	2020	2021	2022
Aetna	8.4%	19.9%	7.6%	-10.1%
Anthem	10.9%	8.1%	4.9%	2.4%
CHO	7.2%	9.7%	3.6%	2.1%
Harvard Pilgrim	14.7%	8.2%	7.2%	2.8%
United	<u>3.6%</u>	<u>12.1%</u>	<u>-4.7%</u>	<u>11.3%</u>
Total All Insurers	11.0%	8.8%	5.5%	3.2%

- 21% decline in small group market enrollment between March 2017 and March 2021
- Cumulative average rate change of 31% between 2019 and 2022
- 18.3% increase in claim costs between 2017 and 2019



Individual Market Enrollment and Rate Changes



Individual Market Average Rate Changes				
	2019	2020	2021	2022
Anthem	-4.9%	-1.5%	-11.9%	-2.9%
CHO	2.2%	3.9%	-12.9%	-5.4%
Harvard Pilgrim	<u>1.9%</u>	<u>-6.9%</u>	<u>-13.0%</u>	<u>1.1%</u>
Total All Insurers	1.1%	-0.5%	-12.5%	-2.4%

- 24% decline in individual market enrollment between March 2017 and March 2021 (some of this due to MaineCare expansion)
- Cumulative average rate change of -14% between 2019 and 2022
- 5.5% increase in claim costs between 2017 and 2019

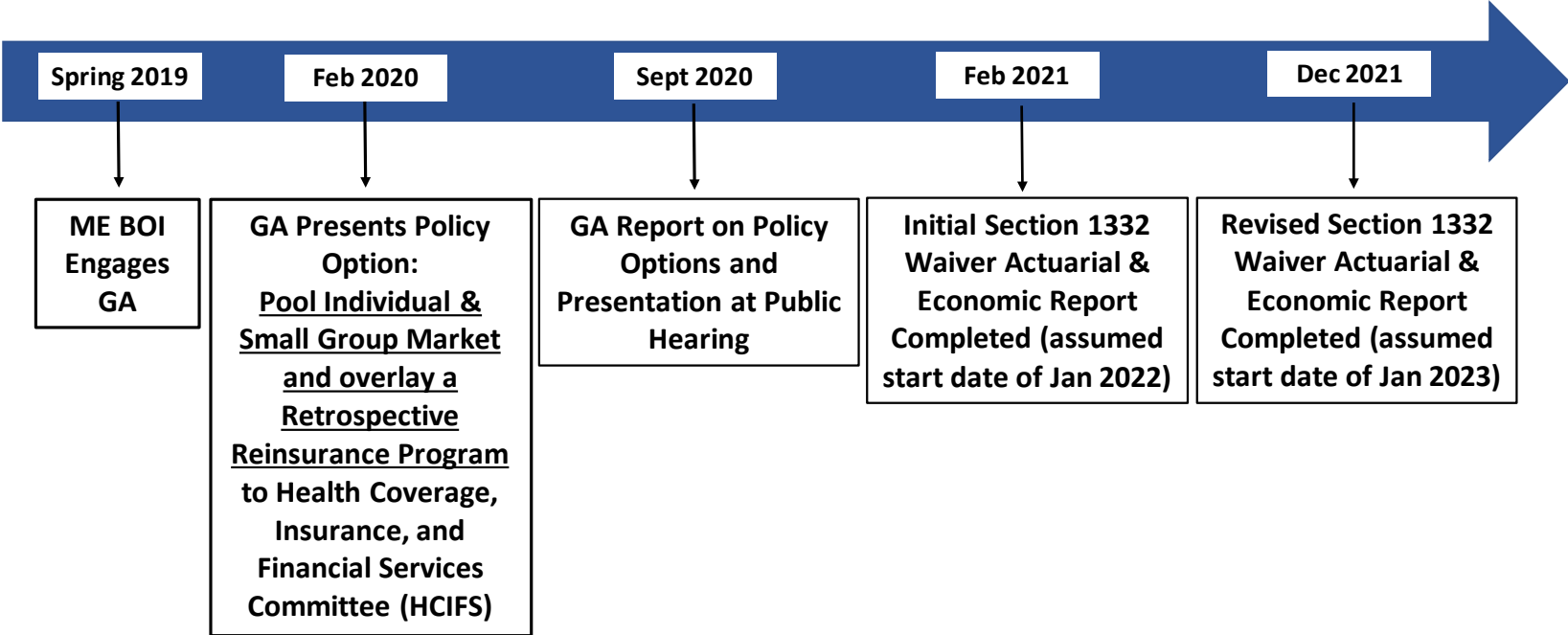


Background Summary

- Maine individual and small group market enrollment declining
- Both markets are small, which can lead to volatility in claims and premiums from year to year
- Small group market enrollment less than individual market with just under 50K enrollees compared to 63K in the individual market
- Claims costs for small group market increasing at a much higher rate than individual market
- Concerns that if the small group market continues to shrink this may lead to even higher premium increases and further reduction in membership.
- Individual market has been stabilized due to MaineCare expansion and the MGARA program

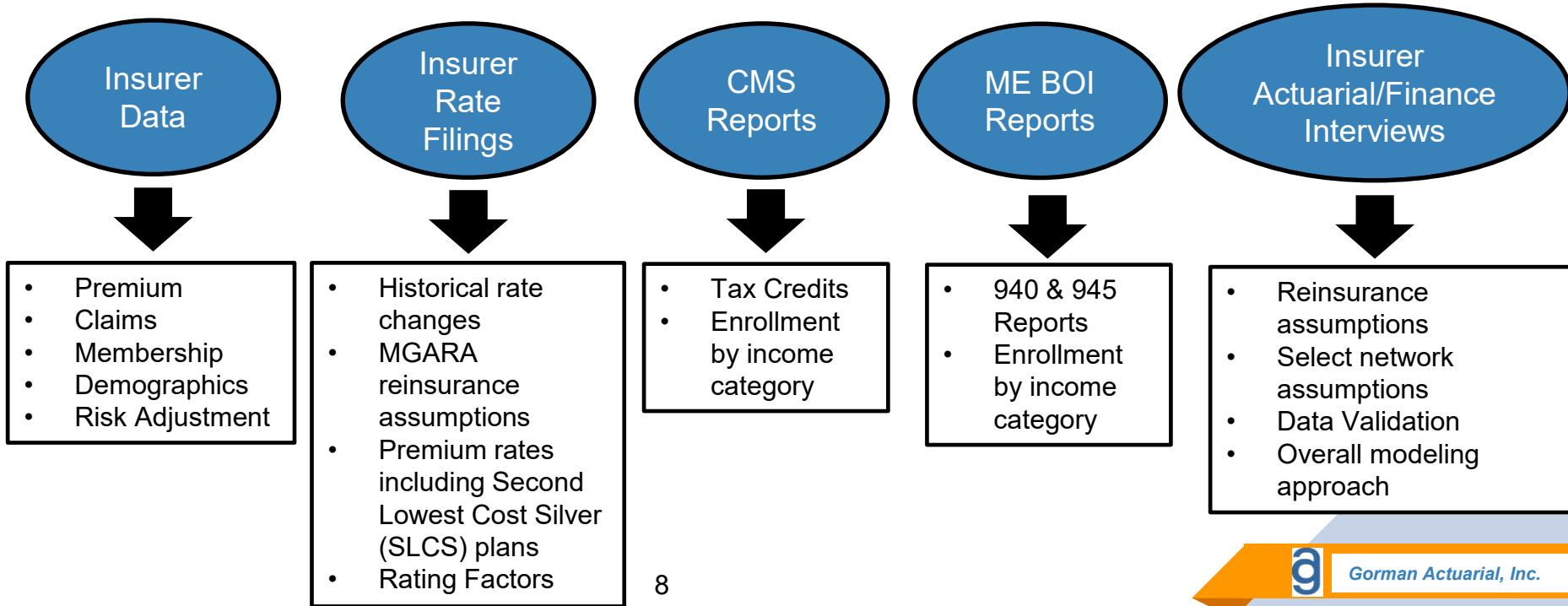
Spring 2019: Maine Bureau of Insurance (ME BOI) engaged Gorman Actuarial (GA) to explore policy options for both markets

History of Actuarial Analysis



Data Sources and Modeling

Data Sources



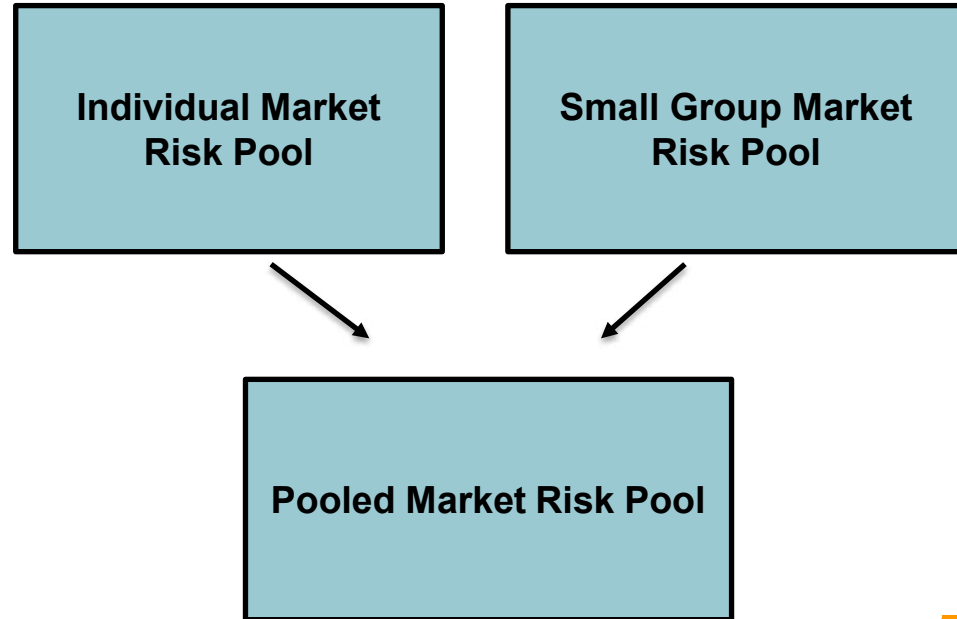
Modeling and Methodology: Pooling Markets

What is a risk pool?

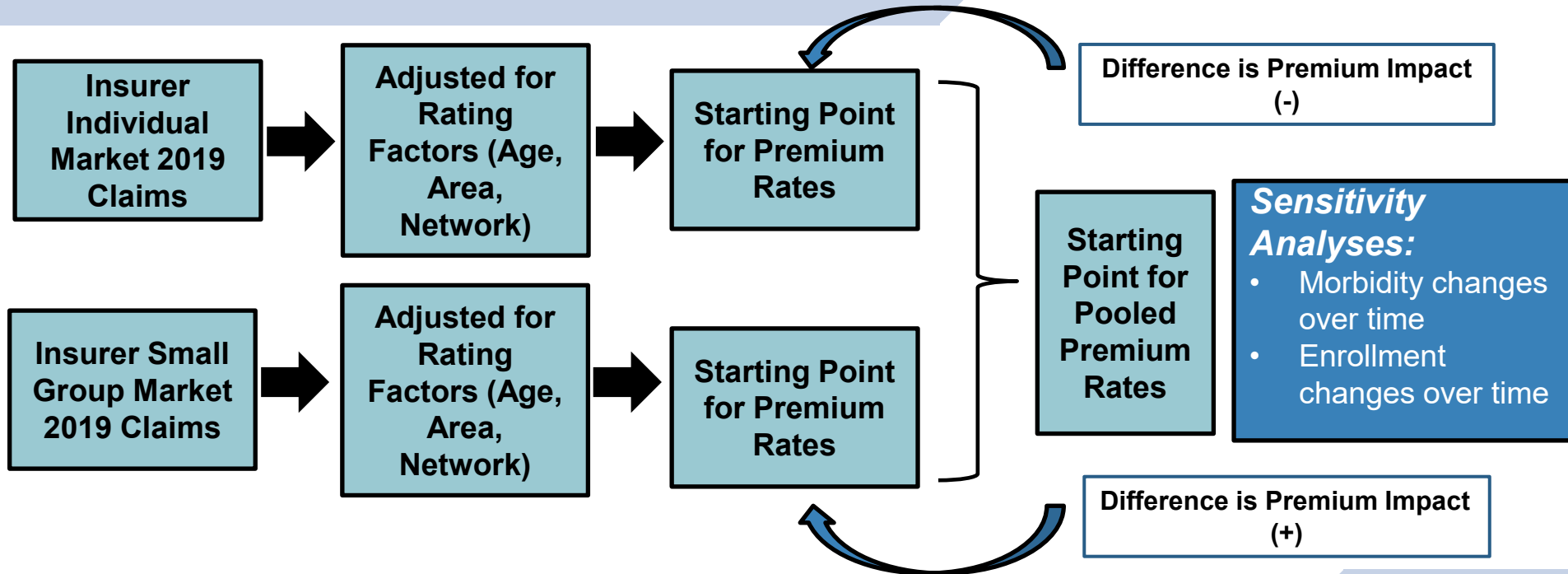
It is how insurers segregate their business when establishing premium rates.

Pooled market base rates are based on **each insurer's** combined individual/small group pool

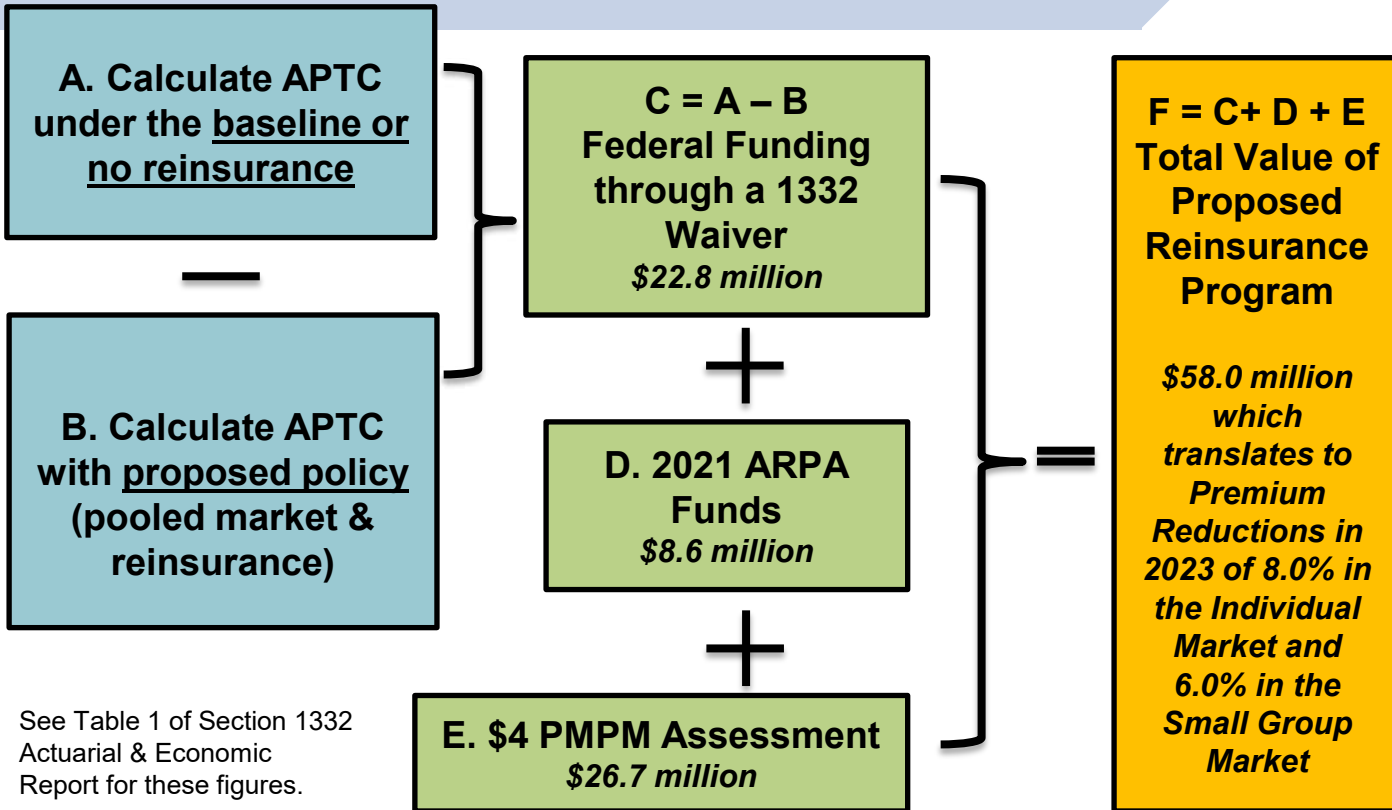
Insurer A



Modeling and Methodology: Pooling Markets



2023 Reinsurance Modeling Approach

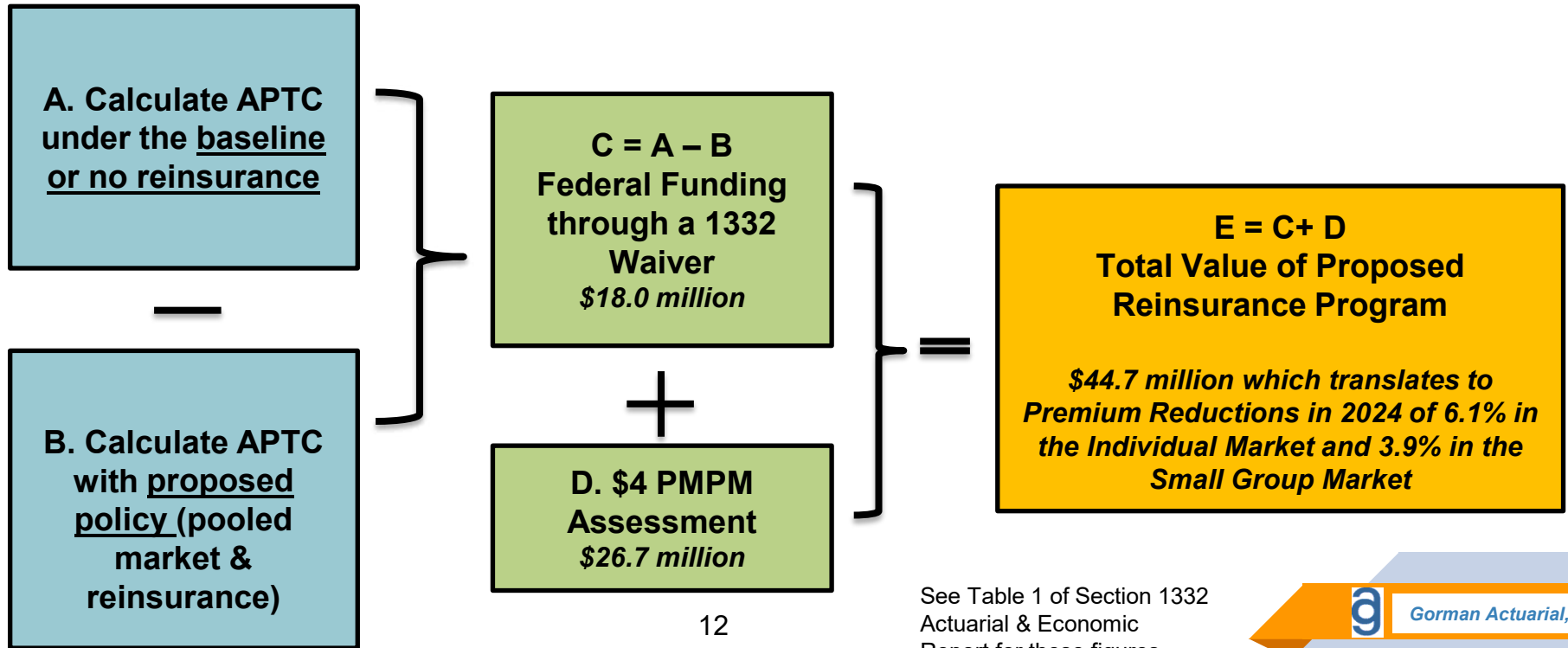


- Iterative process: Target the reinsurance assumption so that total value of the reinsurance program (F) equals the value of the pass through funding plus ARPA funds plus the assessment (C + D + E)
 - GA modeling approach is to maximize federal funding
 - The more the individual market premiums decrease in B, the more federal pass through funding
- SLCS = second lowest cost silver plan**
APTC = advanced premium tax credits

See Table 1 of Section 1332 Actuarial & Economic Report for these figures.



2024 Reinsurance Modeling Approach



American Rescue Plan Act (ARPA)

American Rescue Plan Act Signed into Law March 2021



Temporarily Expands APTC's for 2021 and 2022



Sensitivity Analysis performed if ARPA were extended to 2023+: *0.3% to 0.7% additional premium reductions in 2023*



Maine receives an additional \$8.6 million in pass through funds as result of ARPA for 2021



Additional pass through funds in 2022 due to ARPA not used in modeling (unknown at this time)



\$8.6 million in funds are included in the modeling for 2023

2024 modeling results assumed no additional pass through funds due to ARPA

Modeled Reinsurance Parameters

2023 Parameters

55% of claim costs between \$90,000 and \$275,000

Insurer responsible for claims \$275,000+

2024+ Parameters

45% of claim costs between \$90,000 and \$240,000

Insurer responsible for claims \$240,000+

- MGARA in consultation with the ME BOI will establish final reinsurance parameters on an annual basis
- There are multiple coinsurance percentages and thresholds that can be established which would meet the total funding available

Summary of Differences from Section 1332 Report

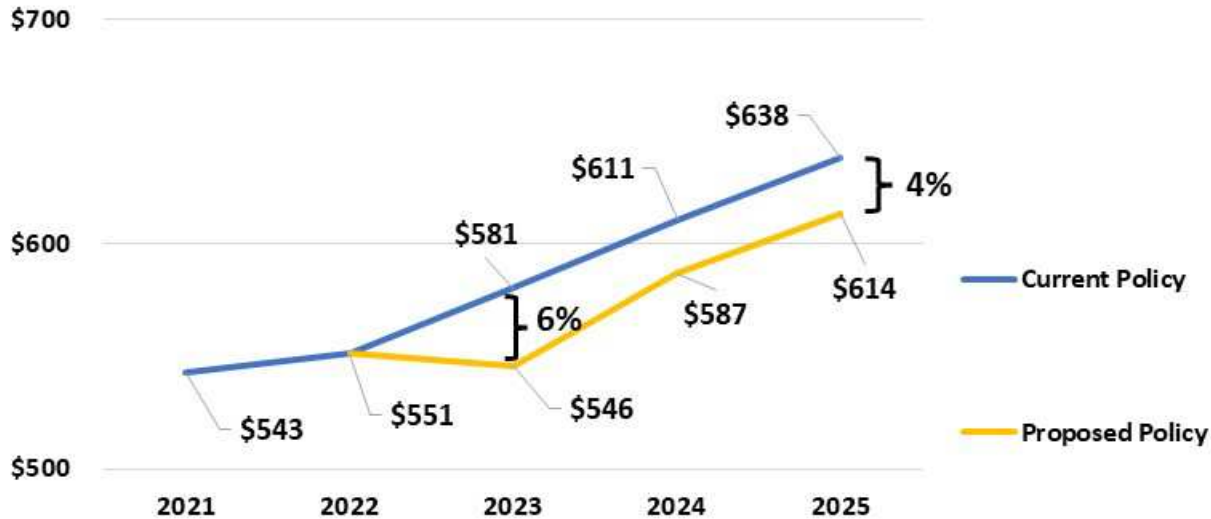
	Report as of February 2021	Report as of December 2021
Program Start Date for Pooled Markets with Reinsurance Program	2022	2023
Data	Medical Claims: 2019 Premium Yields: 2019 Rate Filing Assumptions: 2021 Enrollment Data: 2020	Medical Claims: 2019 Premium Yields: 2020 Rate Filing Assumptions: 2022 Enrollment Data: 2021
Individual Market Premium Reduction (compared to Baseline- no reinsurance program)	2022: 6.6%	2023*: 8.0%; 2024: 6.1%
Small Group Market Premium Reduction	2022: 4.2%	2023*: 6.0%; 2024: 3.9%

**December 2021 report assumes \$8.6m in 2021 ARPA Funds will be used in addition to federal funding and \$4 PMPM assessment to fund 2023 reinsurance program*

Premium and Enrollment Changes

Small Group Market Premium PMPM Res

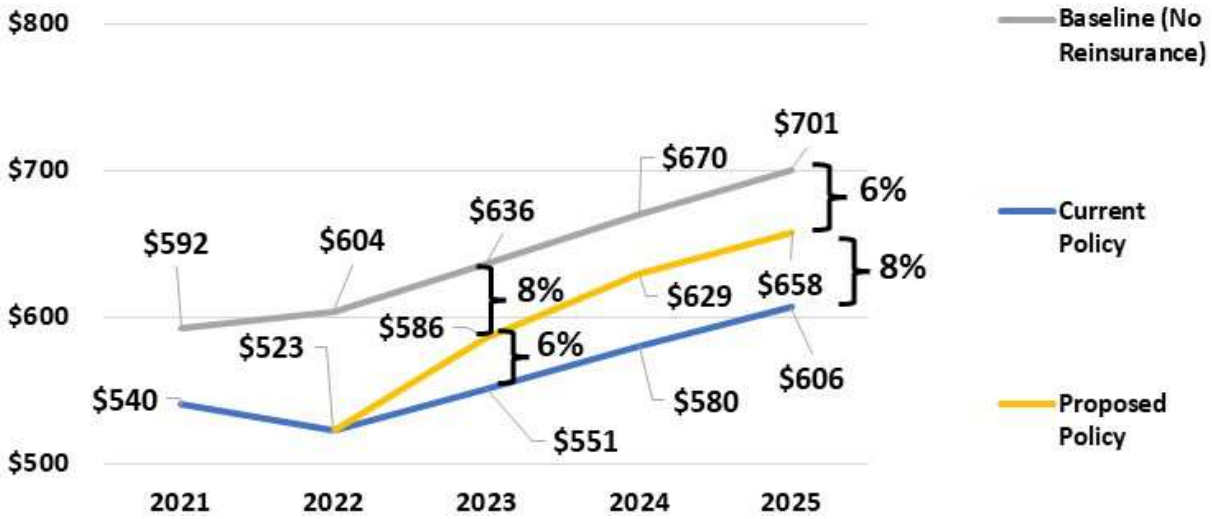
Small Group Market Projected Premiums



- Blue line: Small Group Market with no intervention (Current Policy)
- Yellow line: Small Group Market with policy changes (Proposed Policy) which combines individual and small group markets into one rating pool and overlays retrospective reinsurance program
- GA projects a 6% decrease in the small group market rates as a result of the proposed policy in 2023 and 4% in 2024 and beyond

Individual Market Premium PMPM Results

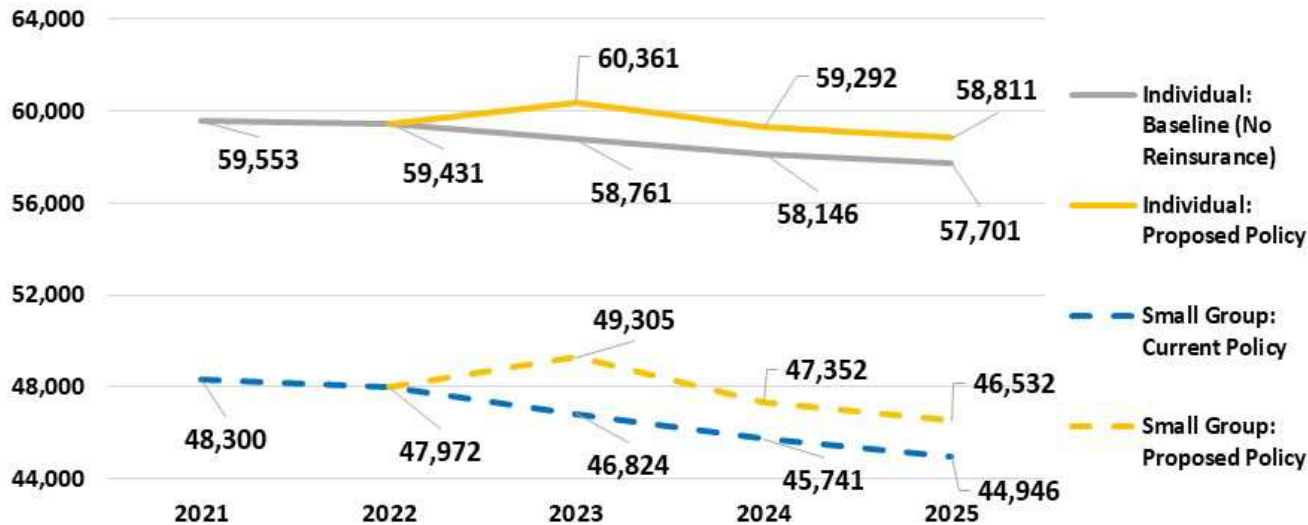
Individual Market Projected Premiums



- Gray Line: Individual Market with no MGARA program or pooled market in place.
- Blue line: Individual Market rates with current MGARA (Current Policy)
- Yellow line: Individual Market with policy changes (Proposed Policy) which combines individual and small group markets into one rating pool and overlays retrospective reinsurance program
- GA projects an 8% decrease in the individual market rates as a result of the proposed policy compared to the baseline (no reinsurance) in 2023 and 6% in 2024 and beyond
- GA projects a 6% increase in rates compared to the current policy in 2023 and 8% in 2024 and beyond

Enrollment Projections

Individual and Small Group Market Enrollment Projections



- Using the projected premiums from the pooled market and reinsurance modeling, GA developed enrollment projections using three different models that generated a range of enrollment results for the individual non-subsidized and small group markets
- Average of the results used in projections
- Morbidity assumptions also developed from this modeling (assuming healthier enrollees will leave the market as premiums increase)

Section 1332 WaiveOverall Results

- **Policy:** Pool the Individual and Small Group Markets and Overlay a Reinsurance Program on the Pooled Market starting in 2023
- **Funding Sources:** Federal Pass-through Funding and \$4 PMPM state assessment. In addition, for 2023 assumed the use of \$8.6 million in 2021 ARPA funds.
- **Premium Reductions:** In 2023, 8.0% in the individual market and 6.0% in the small group market compared to a baseline with no waiver (no reinsurance.) In 2024, 6.1% in the individual market and 3.9% in the small group market compared to a baseline with no waiver (no reinsurance.)
- **Enrollment:** With the waiver, individual market enrollment projected to be 2.7% higher and small group market enrollment 5.3% higher in 2023 compared to the no waiver scenario. In 2024, individual market enrollment will be 2.0% higher and small group market enrollment will be 3.5% higher.

Disclosures and Limitations

Limitations and Data Reliance

Gorman Actuarial prepared this presentation for use by the Maine BOI. While we understand that this document may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive the information herein. This report should only be distributed in its entirety.

Users of this report must possess a reasonable level of expertise and understanding of health care, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of the Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analysis in this report was based on data provided by the Maine BOI, insurers in the Maine health insurance markets, and other public sources. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data are inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The results presented in this report are estimates based on complex actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. Actual experience will most likely not conform exactly to the assumptions used in this analysis. Actual results will differ from projected results to the extent that actual experience deviates from expected experience.

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of January 2022. If subsequent changes are made, these statements may not appropriately represent the expected future state.

While GA performed scenario testing considering potential changes due to COVID-19, the testing was not exhaustive. Actual results may differ due to the wide range of possible outcomes due to the impact of COVID-19 on health care expenses and the economy.

Qualifications

This study includes results based on actuarial analyses conducted by Jennifer Smagula and Bela Gorman, both of whom are members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They both meet the qualification standards for performing the actuarial analyses presented in this report.

Appendix F: **Written Public Comments**



April 19, 2021

Mr. Eric Cioppa, Superintendent
c/o Ms. Brittnee Greenleaf
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: State of Maine Section 1332 Waiver Amendment Application

Dear Superintendent Cioppa:

On behalf of Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield, I would like to thank you for the opportunity to submit comments on the draft Section 1332 Waiver Amendment Application to be submitted by the State of Maine (“the Application”).

As we understand it, key elements of the Application include the following:

- The application seeks to change the Maine Guaranteed Access Reinsurance Association (“MGARA”) program from a prospective reinsurance model to a retrospective model effective January 1, 2022;
- The application proposes to merge the Individual and Small Group markets in Maine effective January 1, 2023 (representing a one-year delay from the original proposal);
- The MGARA program will be funded by Federal Pass through funding and \$4.00 PMPM assessment across the fully insured and self-funded (through an assessment of third-party administrators) markets in Maine; and
- The waiver amendment, if approved, would be effective for a new period of five years, beginning January 1, 2022.

At the outset, Anthem would like to state that it shares the Superintendent’s concerns regarding the deterioration of Maine’s small group market. However, we do not believe that a merger of the markets, coupled with an expansion of the MGARA program to reinsure a merged market, is the best way to address the issue. Not only will the relief to the small group market be very modest, but we are extremely concerned that the individual market will be harmed in the process, which could lead to a deterioration of that market as well.

When L.D. 2007 was introduced last year, we expressed significant reservations about several provisions of the bill, particularly the proposal to merge the individual and small group markets. At that time, we indicated that based on our analysis, we did not believe it would have the desired impact but we felt that it was deserving of thorough analysis, in order to truly understand the

impact it might have on both the individual and small group markets. Those studies have now shown that it is not the right solution.

1. The Individual market will be negatively impacted by a merger of the Individual and Small Group markets

Despite its size in comparison to the individual market, membership in the small group market continues to be healthier than the individual market. As a result, merging the markets without the application of any reinsurance, results in a subsidization of the individual market by the small group market, and serves to increase rates in the small group market. The proposed Application seeks to mitigate this impact by expanding the MGARA program to the merged market. While extension of reinsurance does offset that impact to a small degree, it does so at the expense of the individual market.

The August 2020 report prepared by Gorman Actuarial for the Bureau of Insurance in anticipation of the Application¹ estimated that if the individual and small group markets merge *and* the MGARA program provides reinsurance to the merged market, individual rates will be approximately 4% *higher* than they would be under the existing section 1332 waiver. While small group rates will decrease by approximately 4%, this is a one-time reduction that essentially resets the trendline in the small group market. The very small benefit to the small group market does not justify the corresponding increase in individual market rates that will result from the significant dilution of the value of the reinsurance program or the significant disruption in both markets.

This conclusion is further supported by the analysis conducted by Milliman for the Maine Guaranteed Access Reinsurance Association (“MGARA”).² While the reports take different approaches and use different assumptions, both arrive at the same conclusion—that while there may be a small, one-time benefit to the small group market, it is at the expense of the individual market. The Milliman Report also noted that the proposed retrospective claims-based reinsurance program is worth significantly less than the current program to the individual market--30%-50% less value according to Milliman.

With expansion of the MGARA program to a merged market, and the conversion of MGARA from a prospective to a retrospective model, small group rates are lowered. However, individual rates will be higher than they would be if the markets existed separately and MGARA continued to reinsure only the individual market.

¹ Policy Option for Maine Individual and Small Group Markets, Prepared for the Maine Bureau of Insurance, Gorman Actuarial, LLC, August 25, 2020, https://www.maine.gov/pfr/insurance/legal/notices/pdf/ga_indiv_and_sm_grp_policy_option_report.pdf.

² Individual market small group market merge analysis, Milliman, September 3, 2020, https://www.maine.gov/pfr/insurance/legal/notices/pdf/milliman_individual-smallgrp_merge_analysis.pdf.

The impact will be further exacerbated by the required movement to Clear Choice plan designs—our analysis indicates 89% of our individual members who do not receive a subsidy will see an increase of 4% on average—before any impact associated with a merger of the markets.

Like the Small Group market, the Individual Market in Maine has also experienced a steady decrease in enrollment and can ill afford to have additional increases in premium. While the recent expansion by the Biden Administration of Advanced Premium Tax Credits (APTCs) may help to mitigate the impact, it is important to note that the expansion of APTCs is temporary and only for two years.

2. The State has not used the proper baseline for the purposes of determining whether the statutory prerequisite for a merger of the markets has been met.

It has been suggested that the baseline for determining if the prerequisite articulated in 24-A M.R.S. § 2792(5) has been met is to compare individual rates without MGARA to what those rates would be if the markets merged and MGARA provided reinsurance to the merged market on a retrospective basis. While that may be the appropriate baseline for determining the federal pass-through funding and/or budget neutrality under a 1332 waiver amendment application, it is not the baseline for the purposes of section 2792(5).

Under the Made for Maine Health Coverage Act (L.D. 2007, enacted as P.L. 2019, c. 653), a merger of the markets can only move forward if the Superintendent projects that “***both*** average individual premium rates and average small group premium rates ***would be the same or lower than they would have been absent the provision of this section.***” 24-A M.R.S. § 2792(5). Absent a merger of the markets pursuant to section 2792, MGARA will continue to reinsure the individual market. Therefore, the baseline for determining whether the requirements of section 2792(5) have been met is to compare individual and small group rates with MGARA reinsuring the individual market to the individual and small group rates in a merged market that is reinsured by MGARA.

The premise underlying the provisions of 24-A M.R.S. § 2792(5) was essentially “do no harm”—neither market should be worse off than it is today if the markets are merged. When individuals are considering the impact of L.D. 2007 and a merger of the markets, they will not be comparing what they paid in 2018, when MGARA was not in operation, to what they pay in 2022, they will be comparing their 2021 premium to their 2022 premium.

As a result, we strongly believe that the threshold requirement established in section 2792 to proceed with a merger of the markets has not been met because individual market rates will be increased in a merged market scenario.

3. Stakeholders will not have an opportunity to review an updated draft of the Application or an updated analysis that reflects the delay of a market merger until 2023

During the public comment session on the Application held on March 29, 2021, the Superintendent indicated that the Bureau of Insurance would delay a merger of the Individual and Small group markets until January 1, 2023.

In making the announcement, the Superintendent cited two reasons for delaying a merger of the markets until 2023:

- (1) The COVID-19 pandemic has created a public health emergency that has had a major economic impact and introduced significant disruption to the insurance market, the full scope of which is still unknown. The superintendent suggested that a delay would allow the State to better understand the economic impact of the COVID-19 pandemic and how to best proceed with its plan to improve access and affordability of coverage and avoid adverse consequences.
- (2) The recent changes to the structure of APTCs under the American Rescue Plan Act of 2021 make estimating the impact of merged markets and Federal pass-through funding amounts challenging, and that a delay of the merger will better allow the State to fully analyze the impact and determine the best way to maximize the opportunity.

As a result of the decision to delay a merger of the markets until 2023, the draft Application upon which these comments are based is no longer current. Not only will the MGARA attachment point change, but the factors identified by the Superintendent may impact the analysis of a market merger. Stakeholders do not have the additional analyses that the Bureau has indicated are necessary, nor will they have an opportunity to review and comment on a draft application that reflects such changes or any modeling, making it difficult to provide meaningful comment.

4. Other options should be studied before the State moves forward with a merger of the markets.

There are other initiatives that could be explored to stabilize the small group market. None are without negative consequences. Because these options have not been studied, we cannot say whether we would support or oppose them—we certainly have concerns about some of them. But all options must be studied and compared in order for the State to make a well-reasoned and informed decision. Alternative proposals that could be considered include expanding the definition of small group from 50 to 100 employees.

Finally, the State must also consider solutions that will address the cost of care and reduce costs not only in the small group market, but across all markets. As the Bureau knows well, health insurance premiums reflect health care costs and until costs are addressed, premiums will continue to rise. We would welcome the opportunity to work with the Bureau to identify policy changes that would address rising health care costs.

Mr. Eric A. Cioppa, Superintendent
April 19, 2021
Page 5 of 5

We would again like to express our appreciation for the collaborative process the Bureau has followed, particularly in the midst of such a trying time. Although we are not supportive of the Application, we are very appreciative of the opportunity to have engaged in meaningful discussions with the Superintendent and Bureau of Insurance staff around this issue.

Thank you for the opportunity to share these comments. Please do not hesitate to contact me if you have any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kristine M. Ossenfort". The signature is fluid and cursive, with a prominent initial "K" and a long, sweeping underline.

Kristine M. Ossenfort, Esq.
Senior Government Relations Director



April 12, 2021

Superintendent Eric Cioppa
Maine Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034

RE: s. 1332 waiver amendment application

Dear Superintendent Cioppa:

We appreciate this opportunity to present testimony on the proposed section 1332 waiver amendment application. The application is predicated on the merging of the small group market with the individual market. As noted at the public hearing, we support the decision to defer a merging of the small group and individual markets on the basis of the enduring impact of the pandemic as well as the unknown impacts of the American Rescue Plan Act.

Fundamental to the consideration of merging the two markets is the yardstick by which we measure whether the impact of the market merger meets the statutory guardrails. The proposed application (s. 1332 waiver amendment application) is predicated on a comparison of the merged market results with the state of the market prior to the [original] s. 1332 waiver, i.e., before MGARA was reinstated on the basis of the generation of APTC pass-through funding. We believe the proper baseline for comparison is the current state of operations, in other words, *MGARA as it exists with the current s. 1332 waiver*. Use of a different baseline from a different time period simply obscures the true impact and establishes a faulty set of expectations.

At the center of the policy consideration is participating carriers' reliance upon the program. The confidence among carriers to "price in" the expected results is the flywheel that generates program stability and the steady reduction in premiums that are sustained over time. Reduced premiums lead to lowered APTC which in turn drives the pass through funding. Absent the basis for sufficient premium reductions, the program will simply erode over time.



Milliman has pointed to a very modest one-time improvement for the small group market, but an offsetting burden placed upon individual market rates as compared with existing market conditions. In addition to not meeting the statutory guardrails, this cost shifting casts doubt upon the proposal's ability to achieve the intended effects that have been wished upon the program, but are questioned by a highly reputable source.

Other questions that need to be addressed prior to any commitment to merger include:

- (1) What will be the flight from the small group community-rated market for other forms of coverage such as self-insured variants in advance of the merger and even due to the merger? Those leaving for ERISA styled plans of coverage undoubtedly will have the healthiest profile, leaving a sicker pool behind. This would increase the premiums for the small group segment and undermine one of the precepts that is foundational in the more optimistic view of a market merger.
- (2) How might the application of standardized plans (Clear Choice) to the small group market similarly precipitate market changes, possibly driving those who can afford to leap to alternative coverage solutions to leave the community-rated pool?

Reliance is also fundamental to the issue of changing the existing reinsurance program to a retrospective model from its current prospective one.

Currently, we have no substantial basis for a retrospective model to rely upon – no attachment points and no coinsurance – for which to establish pricing. While the application suggests some numbers, those have little bearing upon the ultimate structure to be adopted by the MGARA board. But that decision for 2022 has to be based upon expectations of risk that are still being informed by 2020 experience and the 2021 forecast.

The retrospective model has a distinct advantage in terms of the ease and simplicity of its administration. In fact, the program could be synchronized with the carriers' EDGE server submissions, avoiding duplicate entry to MGARA.

The major drawback of a retrospective model include the late fulfillment of claims runout and a final understanding of program performance so as to inform the next year's program specifics in time for provider rate-setting. In addition, our analysis of our plan performance under a



retrospective model indicated reduced claims recovery versus the current prospective model. This analysis would change as the attachment points and coinsurance amounts change, but that is just the point: without surety well in advance of rate setting, the desired reliance upon the program will be handicapped to the point of jeopardizing the overall structure.

Given where we are in the lifecycle of rate setting for 2022 and the important aspect of confidence in shoring up carrier reliance, we urge the maintenance of the existing model until further study and evaluation can take place for recommendations to be made for 2023.

Thank you for your consideration of these concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Lewis", written in a cursive style.

Kevin Lewis
Chief Executive Officer



53 Baxter Boulevard, Suite 202 | Portland, ME 04101
Phone: 866-554-5380 | Fax: 207-775-5727 | TTY: 877-434-7598
aarp.org/me | me@aarp.org | twitter: @aarpmaine
facebook.com/aarpmaine | instagram.com/aarpme

March 17, 2021

Superintendent Eric Cioppa
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Testimony in Support of Proposed Section 1332 Waiver Amendment Application

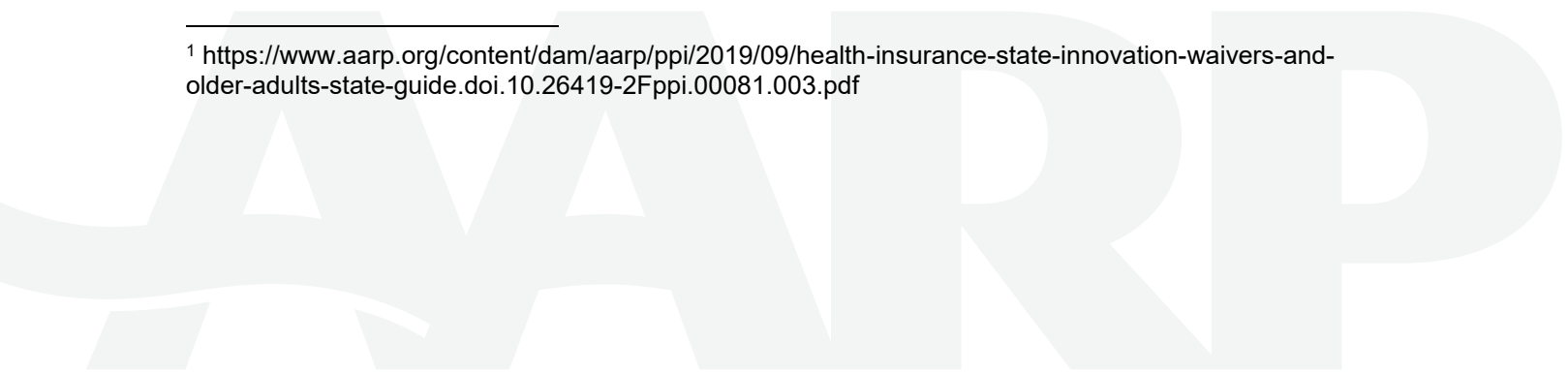
AARP Maine, representing more than 200,000 members 50 and older statewide, supports the proposed Section 1332 Waiver Amendment Application that will expand the Maine Guaranteed Access Reinsurance Association (MGARA) program to include small group markets and extend the program for a period of five years.

MGARA has brought increased certainty and stability to Maine's individual health insurance market. In 2020 the Maine legislature enacted LD 2007 to allow the Insurance Superintendent to add Maine's small group market to MGARA, thus creating a single risk pool for these markets. This will help keep the combined risk pool stable, which is important given Maine's older and small population. The change will also keep health care premiums lower, which will help older Mainers.

An AARP Public Policy Institute report on "Health Insurance State Innovation Waivers and Older Adults: A Guide for States" notes that "Reinsurance programs can be helpful in stabilizing health insurance markets in states experiencing unaffordable premiums or where insurers drop out of the market...and improve access to coverage for enrollees, including older adults."¹

While AARP Maine supports this waiver amendment application, the AARP Policy Institute report also notes that "although states are no longer required to evaluate the potential impact

¹ <https://www.aarp.org/content/dam/aarp/ppi/2019/09/health-insurance-state-innovation-waivers-and-older-adults-state-guide.doi.10.26419-2Fppi.00081.003.pdf>



of a waiver on older adults and other vulnerable groups, states that want to ensure protections for older adults should continue to examine a waiver's impact on such groups. States are required to conduct periodic review of implementation of the waiver, and within six months of implementation must advise and hold a public forum." We believe this public forum should be held within six months of the implementation of the amended waiver and include an assessment of the amended waiver's impact on Maine's older residents.

It is our understanding that funding for the amended waiver should also not be a problem since the Bureau's own "Policy Option for Maine Individual and Small Group Markets" report noted "This program is funded by an assessment across the Maine full-insured and self-insured commercial markets, premiums paid by participating insurers to MGARA, and federal fund through Section 1332 waivers. Thus, it is not a financial burden upon the state."²

For these reasons, AARP Maine supports the amended waiver application. Please don't hesitate to contact me at lpaham@aarp.org or 207-400-1026 if you have any questions.

Lori Parham, Ph.D.
Sate Director, AARP Maine

² https://www.maine.gov/pfr/insurance/legal/ga_indiv_and_sm_grp_policy_option_report.pdf



April 12, 2021

Eric Cioppa
Superintendent
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Re: Maine Section 1332 Waiver Amendment

Dear Superintendent Cioppa:

The American Lung Association appreciates the opportunity to submit comments on Maine's Section 1332 Waiver Amendment Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the more than 36 million Americans living with lung diseases including over 250,000 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 American Lung Association believes everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people living with asthma, lung cancer and other lung diseases to access the coverage that they need. The Lung Association supports Maine's efforts to strengthen its marketplace by submitting this Section 1332 Waiver Amendment to include Maine's small group market in its existing reinsurance program for the individual market.

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% in its first year.¹ A recent analysis by Avalere of the seven states that have already created their own reinsurance programs through Section 1332 waivers found that these states reduced individual market premiums by an average of 19.9% in their first year.²

Maine's proposal will extend its reinsurance program to the small group market starting for the 2022 plan year and continuing for five years. This program is projected to reduce the average individual market premium by 6.6% and reduce the average small

group market premium by 4.2%. This would help patients with pre-existing conditions, including patients with lung disease, obtain affordable, comprehensive coverage.

The American Lung Association believes the Section 1332 Waiver Amendment will help stabilize Maine's marketplace and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,



Lance Boucher
Senior Division Director
American Lung Association

¹ 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.

² Avalere. *State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average*. March 2019. Retrieved from <https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average>.



Brittnee Greenleaf
34 State House Station
Augusta, ME 04333-0034
Brittnee.L.Greenleaf@maine.gov

Re: Comments on Proposed Section 1332 Waiver Amendment Application

Dear Ms. Greenleaf,

The following are comments submitted on behalf of Consumers for Affordable Health Care (“CAHC”) regarding the proposed Section 1332 waiver amendment application. CAHC is a nonprofit, nonpartisan organization with the mission to advocate for Maine people to be heard, respected, and well-served in a health system that provides coverage, access and quality, affordable care to all. CAHC serves as Maine’s Health Insurance Consumer Assistance Program, which provides toll-free access to certified application counselors, who help Mainers understand their health coverage options and how to apply and enroll in private health insurance.

We thank you for the opportunity to provide these comments on the proposed Section 1332 waiver amendment application. CAHC strongly supports the proposed application for a waiver to allow Maine to extend the MGARA reinsurance program to a pooled individual and small group market and transition to a retrospective claims cost-based reinsurance program. If approved, we believe the changes permitted under this waiver, particularly the extension of the MGARA reinsurance program to a pooled individual and small group market, will increase stability and improve affordability of health insurance for Maine people and small businesses.

Insurance functions as a means of spreading risk and costs across a pool of individuals, to minimize the risk and costs assumed by any one person. This makes it more affordable for someone to access health care, if and when they need to. Markets are most stable, and insurance is most successful in ensuring access to affordable coverage, when risk pools are as large and inclusive as possible.

Gorman Actuarial, Inc conducted an analysis for the Maine Bureau of Insurance on the impact of pooling individual and small group markets with a retrospective reinsurance program. In a report summarizing their findings, Gorman Actuarial states, “Generally, as markets get smaller, the enrollees who remain in the market are less healthy and require more health care resources, which drives up premiums.”¹ Smaller markets are also more susceptible to experiencing volatility from disruptions or changes to market conditions, compared to larger markets that can more easily balance fluctuations and absorb impacts from unexpected changes. Given the relatively small size of Maine’s existing individual and small group markets, combining the two markets into a single merged market may prove particularly beneficial. Additionally, people frequently move between private individual health coverage, employer-sponsored insurance, and

¹ Policy Option for Maine Individual and Small Group Markets, Gorman Actuarial, Inc. (2020). Available at: https://www1.maine.gov/pfr/insurance/legal/ga_indiv_and_sm_grp_policy_option_report.pdf

public coverage options, like Medicaid and Medicare. These transitions in coverage have recently been exacerbated, due to the economic downturn related to COVID-19. Merging the individual and small group markets would help to minimize the impact of enrollment churn and simplify transitions in coverage for individuals transitioning between individual and small group plans.

Findings from the 2019 Employer Health Benefits Survey released by the Kaiser Family Foundation show the average premiums nationally for employer sponsored health care have continued on an upward trend, with an average price tag of more than \$20,000 for family coverage in 2019. Nationally, this represents a 25% increase in premiums since 2014. Findings from the survey also indicate that, as the cost of employer sponsored coverage rises, the amounts paid by employees also increases. The national average employee contribution for family coverage in 2019 was over \$6,000, 8% higher than the previous year. Premiums for employer sponsored coverage are rising faster than the costs of workers' compensation or inflation, making the cost of employer-based coverage increasingly less affordable for employees, in addition to small business employers.² Premium rates for Maine's small businesses have increased on average by 57% since 2014.³ It is clear that the rapidly rising costs of small group health coverage is unsustainable, both for Maine's small businesses and their employees.

According to the proposed application, pooling the individual and small group markets and applying a retrospective reinsurance program is expected to lower individual market premium rates by an average of 6.6% and an average of 4.2% in the small group market. The Milliman analysis prepared on behalf of MGARA estimates only a 3% impact from the proposed changes on individual and small group market rates. However, an analysis conducted by Wakely Consulting Group comparing the Gorman and Milliman analyses, produced findings that more closely aligned with the Gorman report. The Wakely report states that the differences between the Gorman and Milliman findings are primarily attributed to an assumption of excessive conservatism in the methodology used by Milliman. However, while possible, Wakely explains that the minimized impact to individual plans estimated by Milliman would be a consequence of carriers actively deciding to incorporate excessive conservatism into rates, which can be avoided, rather than a result of a merged market:

Issuers often times include some probability that expected reinsurance payments will not be fully realized. The inclusion of a factor for non-payments results in a higher premium to cover that risk, leading to a smaller premium impact from reinsurance than there would otherwise be. However, since reinsurance funding in Maine is partially a function of how much reinsurance payments decrease premiums, incorporating conservatism into issuer rates or the reinsurance parameters can lead to a self-fulfilling prophecy in which conservatism yields smaller funding which yields more conservatism, etc. Wakely would define this equilibrium of smaller funding due to issuer uncertainty as excessively

² 2019 Employer Health Benefits Survey, Kaiser Family Foundation. Available at: <https://www.kff.org/reportsection/ehbs-2019-summary-of-findings/>

³ 2021 Rate presentation, Maine Bureau of Insurance. Available at: <https://www.maine.gov/pfr/insurance/2021%20Rate%20Presentation.pdf>.

conservative. While ultimately it is a possible outcome, **Wakely would view this result as a policy choice rather than an explicit outcome.**⁴ (*Emphasis added*)

We believe the benefit to the individual and small group markets demonstrated through the actuarial analyses meets the conditions for the implementation of a pooled market under Title 24-A M.R.S. §2792. It is also worth noting that any potential premium fluctuations for individual health plans due to changes in Maine’s reinsurance program will largely be mitigated by premium subsidies on the Marketplace. The majority of Mainers with individual health plans purchase their plans through the Marketplace. Income-eligible Marketplace enrollees qualify for financial support in the form of an Advanced Premium Tax Credit (“APTC”) to lower their monthly premium expense. The method used to calculate APTC amounts is based on the enrollee’s income level and the cost of the second lowest silver plan premium, which means that if premiums decrease for individual plans, APTC subsidies amounts will correspondingly decrease, and if that premium rates increase, APTC subsidy amounts will increase to offset the difference. Last year, 86% of people with Marketplace coverage in Maine qualified for APTC subsidies.⁵ However, expanded eligibility under the American Rescue Plan Act of 2021 has since increased the share of enrollees who are eligible for APTC.

The amount of funding received by reinsurance programs affects the degree to which the program positively impacts premium rates. An analysis conducted by Milliman on behalf of MGARA on the impacts of merging the individual and small group markets in conjunction with the implementation of a retroactive reinsurance program, explains that, “The ability to stabilize market premiums decreases as the attachment points increase.”

The American Rescue Plan Act of 2021 (ARPA) dramatically increased eligibility for APTC subsidies on a temporary basis for plan years 2021 and 2022. For these two years, Mainers will be eligible for substantially larger APTC subsidies and more people will qualify for APTC subsidies. The expanded subsidies under ARPA eliminate the so call “subsidy cliff” that prohibited people with income over 400% of the federal poverty level from qualifying for APTC subsidies. Under ARPA, there is no income limit for individuals to qualify for APTCs in 2021 and 2022. This temporary expansion of subsidies provides a unique opportunity for Maine to implement a pooled individual and small group market in 2022 with virtually no impact on Maine’s individual market or its enrollees, since people at all income levels will be eligible for APTCs. The increased federal pass-through funding available in 2022 under ARPA could also further amplify the expected savings in Maine’s small group market, compared to initial projections.

Again, we fully support this application. If the pooled market is delayed until 2023, however, we are concerned this will result in a missed opportunity, created by the American Rescue Plan Act, for Maine to increase market stability for individual and small group health plans and to improve affordability of coverage for Maine’s small businesses and employees. The proposed application

⁴ Comparative Analysis of the Estimated Impacts of a Merged Market and MGARA, Wakely Consulting Group, LLC (2020). Available at: https://www1.maine.gov/pfr/insurance/legal/notices/pdf/pooled_market_option_maine-wakely_review_actuarial_pass%20through_estimates.pdf

⁵ <https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

continues a \$4 per member per month assessment across all of Maine's fully-insured and self-insured commercial health insurance markets. The proposed application states that this assessment is expected to generate \$24.1 million in revenue in 2022, \$300,000 of which will be used to pay for the administration of the reinsurance program. If the merged market is delayed until 2023, it is unclear whether the MGARA reinsurance program will actually increase access to affordable private market coverage in 2022, given the expanded eligibility for APTCs under ARPA. If virtually all enrollees in the individual market can qualify for APTCs in 2022, and thus would not benefit from any reductions to base premium rates, it raises the question of whether reinsurance is still an effective use of the \$24.1 million derived from assessments, or whether other initiatives, such as providing state financial assistance directly to individuals, would be a more effective use of these funds in improving access to affordable private insurance in 2022.

As was pointed out during the first public hearing held on March 22, 2021, there is precedent for the need to adapt, including by carriers, to new and quick moving developments occurring throughout the rate setting timeline. We encourage the Bureau to revert to the original timeline proposed in the application to maximize the benefit for Maine's people, small businesses, and employees.

We would like to thank the Bureau of Insurance for their extensive and thoughtful work on this important matter and appreciate the opportunity to provide these comments. If you have any questions, please contact Kate Ende at kende@mainecahc.org or 207-480-2136.

Sincerely,

Kate Ende
Policy Director, Consumers for Affordable Health Care



February 4, 2022

Mr. Eric Cioppa, Superintendent
c/o Ms. Brittnee Greenleaf
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

Re: Gorman 1332 Waiver Actuarial and Economic Report and State of Maine Section 1332 Waiver Amendment Application

Dear Superintendent Cioppa:

On behalf of Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield, I would like to thank you for the opportunity to submit comments on the Gorman 1332 Waiver Actuarial and Economic Report dated December 9, 2021, and the proposed Section 1332 Waiver Amendment Application to be submitted by the State of Maine (“the Application”).

As noted in the comments submitted last year, Anthem does share the concerns expressed about the deterioration of Maine’s small group market. However, we do not believe that a merger of the markets, coupled with an expansion of the MGARA program to reinsure a merged market, is the way to address the issue. Not only will the relief to the small group market be a very modest, one-time reduction, but we are extremely concerned that the individual market will be harmed in the process, which could lead to further deterioration of that market as well.

When L.D. 2007 (P.L. 2019, c. 653) was introduced in 2020, we expressed significant reservations about the proposal to merge the individual and small group markets. At that time, we indicated that based on our analysis, we did not believe it would have the desired impact, but felt that it warranted further analysis, in order to truly understand the impact it might have on both the individual and small group markets. Those studies have now shown that it is not the right solution.

Five analyses of a proposed merger of the individual and small group markets have now been conducted:

- 1332 Waiver Actuarial and Economic Report Prepared for the Maine Bureau of Insurance, Gorman Actuarial, December 9, 2021 (the “December 2021 Gorman Report”);
- 1332 Waiver Actuarial and Economic Report Prepared for the Maine Bureau of Insurance, Gorman Actuarial, February 2021 (the “February 2021 Gorman Report”);
- Comparative Analysis of the Estimated Impacts of a Merged, Prepared for the Bureau of Insurance by Wakely, December 1, 2020;

- Individual market small group market merge analysis, Prepared for the Maine Guaranteed Access Reinsurance Association by Milliman, September 3, 2020 (the “Milliman Report”); and
- Policy Option [sic] for Maine Individual and Small Group Markets, Prepared for the Maine Bureau of Insurance by Gorman Actuarial, August 25, 2020 (“the 2020 Gorman Report”).

While the specific results of these analyses may vary, all point to the same result: that those insured in the Small Group Market will see extremely modest, one-time relief while those in the Individual market will not benefit at all; in fact, individual market members who do not receive subsidies in the form of Advanced Premium Tax Credits (APTCs) will actually see their rates increase by 6-8% as a result of the proposed amendment to Maine’s existing Section 1332 waiver and a merger of the individual and small group markets.

1. The Individual Market in Maine will suffer significant harm if the markets are merged.

The December 2021 Gorman analysis projects an 6% increase in individual market rates in 2023 when compared to the current policy (separate markets with the individual market reinsured by the MGARA program) and a staggering 8% in 2024 and beyond.¹ This increased cost will be borne particularly by the approximately 20,000 people, roughly one-third of the individual market, who do not receive premium assistance in the form of APTC subsidies.

The Gorman Report states that a merged market reinsured by the MGARA program “will be particularly beneficial to individuals not eligible for subsidized coverage.”² However, that comparison ignores the realities of the individual marketplace as it exists today. The individual market today is reinsured by the MGARA program. Expanding the MGARA program to a merged market will dilute the program, necessitating higher attachment points, thereby reducing its impact on the individual market. This will result in increased premiums for individuals who do not receive subsidies in the form of Advanced Premium Tax Credits—this will be to the detriment, rather than the benefit, of those individuals. In fact, the membership projections in the Gorman analysis show the reduction in Individual enrollment occurring exclusively in off exchange members and those without APTCs.³

According to the December 2021 Gorman analysis, membership in the Individual market will decrease by approximately 3% (over 1,700 members) between 2022 and 2025 when comparing membership under the 1332 waiver to membership in an individual market without MGARA. It is important to note, however, that analysis understates the loss of membership that would be

¹ Maine Section 1332 Waiver Application: Pooling Individual & Small Group Markets and Overlaying a Reinsurance Program, Gorman Actuarial, January 28, 2022, https://www.maine.gov/pfr/insurance/mgara/pdf/public_form_gorman_presentation_012822.pdf, slide 18, accessed February 3, 2022.

² 1332 Waiver Actuarial and Economic Report Prepared for the Maine Bureau of Insurance, Gorman Actuarial, December 9, 2021, p. 4

³ *Id.*, p. 31

experienced in the individual market. The Gorman analysis estimates that 2022 membership in an individual market without MGARA reinsurance would be 59,431. But actual membership in the individual market today with MGARA is 66,095.⁴ When comparing the current environment to the proposed section 1332 waiver, the Individual market will experience a significant decline of approximately 8,400 individuals—a decline of over 12.7% in just three years.

2. The benefit to the Small Group market is extremely modest and does not outweigh the harm to the Individual market.

The Gorman analysis indicates that if the proposed section 1332 waiver is implemented, premiums in the small group market will be reduced by approximately 6% in 2023, but that reduction will be reduced to 4% by 2025. The Gorman analysis estimates small group membership to be 47,972 in 2022. That membership is projected to decrease to 44,946 by 2025 under the current scenario and to 46,532 under the proposed section 1332 waiver—a net difference of less than 1,600 members. Although may mitigate the decline in the small group market to a slight extent, it does not represent a meaningful gain and comes at the expense of the individual market, which will see higher premiums and a more pronounced drop in enrollment.

In addition, it is worth noting that in the draft NBPP released in November 2021, CMS has proposed to reduce the de minimis ranges for the actuarial values for individual and small group plans. If this is implemented, this change could result in additional premium increases for small groups and individual enrollees who do not receive subsidies.

Furthermore, the dilution of the net savings from the MGARA program as the result of a merged market will reduce the amount of funding received under the section 1332 Waiver. Since the funding amount is calculated based on the difference between the premium rate of the second lowest cost silver plan offered on exchange with reinsurance and without reinsurance. Essentially the state will receive less funding to cover the reinsurance program and that funding will be spread across both the individual and small group members whose claims are eligible for reinsurance recovery, thereby reducing MGARA's impact.

3. The merged market has the potential to reduce competition in the small group market.

The Gorman Report also states that a merger of the market could increase the number of health insurance carriers participating in a merged market because there are carriers in the small group market that do not currently offer coverage in the individual market. The converse may also be true. Those carriers have long declined to participate in the individual market. They may choose not to actively market plans to individuals, effectively limiting themselves to the small group

⁴ Presentation to the Joint Standing Committee on Health Coverage, Insurance, and Financial Services, Meg Garratt-Reed Director, Office of the Health Insurance Marketplace, DHHS, January 18, 2022, <https://legislature.maine.gov/doc/7985>, slide 2, accessed February 3, 2022.

market or they may choose to exit the small group market entirely, resulting in a decrease in the number of carriers offering small group coverage in Maine and a reduction in choice.

4. Any determination of whether the market should be merged must compare the current scenario to that under the proposed section 1332 waiver.

While comparing individual rates without MGARA to the projected rates in a merged market reinsured by MGARA may be the appropriate baseline for determining the federal pass-through funding and/or budget neutrality under a 1332 waiver amendment application, it is not the appropriate baseline for determining whether a merger of the markets should be implemented.

Under the Made for Maine Health Coverage Act (L.D. 2007, enacted as P.L. 2019, c. 653), as originally enacted, a merger of the markets could only move forward if the Superintendent projected that “*both* average individual premium rates and average small group premium rates *would be the same or lower than they would have been absent the provision of this section.*”

The premise underlying the provisions of 24-A M.R.S. § 2792(5) as it was originally enacted was essentially “do no harm”— if the markets are merged, neither market should be worse off than it is today with separate markets. When it became apparent that this standard would not be met, L.D. 1725 was introduced (enacted as P.L. 2021, c. 361), including a provision to amend the law to change the baseline, essentially changing the rules after the fact.

Despite the statutory change, the Superintendent has the discretion to compare individual markets rates as they are today with MGARA reinsuring the individual market to individual rates in a merged market scenario. and we urge him to do so. Coverage in the individual market has been steadily declining. Maine cannot afford to take any actions that would have the effect of increasing individual market rates and decreasing individual market enrollment. As noted by Superintendent Cioppa in his testimony to the Health Coverage, Insurance and Financial Services Committee on L.D. 2007 “the overriding purpose of the bill is to make health insurance in Maine more affordable for *individuals, families, and small business*, and better designed to meet their needs.”

Absent a merger of the markets, MGARA would continue to reinsure the individual market. Therefore, the State must consider a comparison of individual and small group rates with MGARA reinsuring the individual market to the individual and small group rates in a merged market that is reinsured by MGARA.

When individuals are considering the impact of Made for Maine Health Coverage Act and a merger of the markets, they will be comparing their 2022 premium to their 2023 premium — not the premiums they would experience without MGARA, which are unknown to them.

It is easy for some to dismiss the impact on the individual market by stating that most individual market policyholders are “insulated” from rate increase because of the Advanced Premium Tax Credits under the Affordable Care Act. But membership in the Individual market has been

steadily decreasing. It is extremely important to remember that approximately 20,000 Mainers, or about one-third of those covered through the individual market, receive no subsidy and will have to bear the brunt of any increase.

5. There is not enough time to properly implement a merged market in time for 2023.

Carriers are less than one month from having to finalize their 2023 plan offerings in order to have sufficient time to build those plans in our systems, price those plans, and develop any needed changes to contract language. It is very time consuming and extremely burdensome for carriers to develop two sets of products and rates for two different market segments, one for the current scenario and one for a merged market environment. Give the timing constraints, if the State is interested in pursuing a merger of the markets, it should be for 2024 and not 2023.

6. Other options should be studied before the State moves forward with a merger of the markets.

There are other initiatives that could be explored to stabilize the small group market. One example would be to explore expanding the definition of small group from 50 to 75 or 100. These options are not without consequences or trade-offs. We certainly have concerns about some of them but because these options have not been studied, we cannot say whether we would support or oppose them. But all options must be studied and compared in order for the State to make a well-reasoned and informed decision.

Finally, the subsidization of the market in any form provides only temporary relief—absent steps to address the underlying cost of health care, premiums will continue to rise, and enrollment will continue to decline. The State must also consider solutions that will address the cost of care and reduce costs not only in the small group market, but across all markets. We would welcome the opportunity to work with the Bureau and other stakeholders to identify policy changes that would address rising health care costs.

Thank you 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 Government Relations Director

From: [Boles Welsh, Erin](#)
To: [Hooper, Mary M](#); [Yardley, Benjamin](#); [Greenleaf, Brittnee L](#)
Subject: Harvard Pilgrim Comments on Gorman 1332 Waiver Report
Date: Monday, February 7, 2022 6:10:15 PM

Marti,

Thank you for presenting the Bureau's 1332 waiver report produced by Gorman Actuarial. We are providing thoughts on the presented reports and comments related to plan designs, including Clear Choice questions, sales and operations impacted by a proposed merger of the individual and small group markets.

Over the past two years, as you know, Harvard Pilgrim Health Care has expressed concerns that merging the individual and small group markets will result in unintended consequences including further ceding of members to self-insured level funded products and concerns regarding premium impact on the individual market. We continue to be concerned that small group members will reach for products that allow flexibility in meeting their needs and averse to limitations imposed by standardized plans instead of remaining in the fully-insured market. The current analyses do not appear to evaluate small group member appetite for standardized plans or their potential interest in leaving the fully insured market for flexible self-insured level funded plans. As previously discussed, our experience with small group members is that they vary widely in needs, the small business market varies widely in scope as it is Maine expresses – a law firm with 49 members for instance has very different needs than an auto body shop of 5. It remains difficult to see standardized plans meeting needs this varied sector.

Report

The Gorman 1332 waiver report presentation included data showing the anticipated increase to individual premium rates. While it was noted verbally that a majority of the individual market in Maine receives income-based subsidies keeping them largely isolated from changes in premium, it is still important that those individuals who already bear the full cost of health insurance coverage be considered when making changes to the market and are sensitive to anticipated increases. Furthermore, we continue to be concerned that the baseline for decision making is premium impact absent a reinsurance program as this doesn't represent current consumer experience.

The Massachusetts market is contemplating unmerging their individual and small group markets after 15 years of operating combined. Each of these transitions causes disruptions in the marketplace and uncertainty to members. The current Gorman reports haven't discussed differences between these two markets and what leads to expected solutions here in Maine that haven't been realized long term in Massachusetts.

Plans

As we review plan designs for a merged market, we have additional questions. We hope for consideration of leeway in discontinuing plans during as a transitional period of a few years into a merged market while we learn from member experience in this market environment. Will there be consideration for a different filing date?

We would suggest consideration of additional plan designs to meet gaps in deductible levels including the following:
1. A deductible between the Clear Choice 3500 and (New) Clear Choice 5000 plan. 2. A deductible between the Clear Choice 2500 and 3500 plan. 3. A deductible between the Clear Choice 4500 (off-market place) and Clear Choice HSA 7000 plan (6300). We would also like to request two HSA deductibles (off-marketplace), a 4000 HSA & another plan between 4500-5900.

We hope carriers can offer new alternative plans off exchange as well as an increase in the number of alternative

plans to accommodate for small group needs.

Will Clear Choice plans for 2023 available for both on/off the Marketplace? Will the Clear Choice 3500 HSA and Clear Choice 4500 HSA be off-marketplace only?

Sales and Operations

We would like to know more details about how will SHOP operate in a merged market since it would be referencing a risk pool that includes individual members? Will Clear Choice apply to SHOP plans?

Currently in the Individual market, we send out letters to members when we file rates for the next year's plans. Will that letter process would continue in a merged market for the individual market and will a similar process be expected for Small Groups?

Thank you for the opportunity to provide comments on the Gorman 1332 waiver report for the Bureau as well as to compile additional questions regarding related plan design and operations.

Thank You,
Erin

Erin Boles Welsh
Government Affairs, Connecticut and Maine
Point32Health | 1 Wellness Way, Canton, MA 02021-1166 USA
tel: (617) 509 3540 cell: (781) 956-1788 fax: (617) 509 7531

**Please note change in email address:
Erin.Boles.Welsh@Point32Health.org**

www.point32health.org
www.harvardpilgrim.org
www.tuftshealthplan.com

Point32Health



SMR1.Point32Health.org made the following annotations

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Appendix G: **Tribal Consultation Communications**



Janet T. Mills
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

March 12, 2021

Via Email

Chief Clarissa Sabattis
Houlton Band of Maliseet Indians
csabattis@maliseets.com

Dear Chief Sabattis:

On behalf of the State of Maine's Bureau of Insurance, I am writing to inform you of a proposed amendment to the State's Section 1332 Waiver under the federal Affordable Care Act (ACA). Federal regulations require a state to consult with its federally recognized tribes regarding a proposed waiver.¹

Under Section 1332 of the ACA, a state may request a waiver ("1332 waiver") to pursue innovative strategies for providing its residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

The proposed 1332 waiver amendment does not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed 1332 waiver amendment does, however, seek to lower health insurance premiums for individual and small group health insurance coverage in Maine with the support of federal funding.

In 2018, Maine received federal approval for its current 1332 waiver in order to allow the Maine Guaranteed Access Reinsurance Association (MGARA) to operate a reinsurance program for the individual health insurance market in Maine with the support of federal pass-through funding beginning January 1, 2019. The goal of the reinsurance program was to bring increased certainty and stability to Maine's individual health insurance

¹ See Federal Code of Regulations, 31 CFR 33.112(a)(2) and 45 CFR 155.1312(a)(2).



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OFFICES LOCATED AT 76 NORTHERN AVENUE, GARDINER, MAINE 04345
www.maine.gov/insurance

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Fax (207) 624-8599

market through a positive impact on premium levels. Since the waiver became effective, average premium rates for the individual market have moderated each year: 1.1% in 2019, -0.5% in 2020, and -12.5% in 2021.

In recent years, the small group market in Maine has experienced significant declines in membership, due in part to high medical cost trends and associated premium increases. On its current trajectory, the small group market may continue to see membership decline, and only those that truly need health care services may stay enrolled in the market, which will lead to a continued escalation in premiums. Because of this trend, Maine has been considering ways to help stabilize and lower premiums for the small group market.

In 2020, the Maine Legislature enacted a law that allows the State's Superintendent of Insurance to pool the individual and small group health insurance markets into a single risk pool and to seek federal approval of an amendment to Maine's 1332 waiver that would allow extension of the MGARA reinsurance program to the pooled market and transition of the reinsurance program from a prospective model to a retrospective model. The change is contingent upon federal approval of the proposed waiver amendment.

Under the proposed 1332 waiver amendment, Maine would continue to receive federal pass-through funding to support the reinsurance program in the amount of the savings that would be generated from the resulting reduction in premium tax credits. Extending the MGARA reinsurance program to a pooled individual and small group health insurance market would bring increased certainty and stability to small group health insurance in Maine through a positive effect on premium levels. This proposed waiver amendment, if approved, would be effective as of January 1, 2022, for a period of five years.

More detailed information about the proposed 1332 waiver amendment, including a draft of the waiver amendment application, is available on the Bureau of Insurance website at the following link: <https://www.maine.gov/pfr/insurance/mgara/index.html>.

We would be happy to respond to any questions you may have about this proposed waiver amendment. If you would like to arrange a virtual meeting to discuss the proposal, please contact me at your earliest convenience. We would appreciate any written comments you may have by April 12, 2021, which may be sent to holly.doherty@maine.gov.

Thank you for your time.

Sincerely,



Holly Doherty
Attorney

From: [Doherty, Holly](#)
To: csabattis@maliseets.com
Subject: Tribal Consultation for Maine Bureau of Insurance Proposal
Date: Friday, March 12, 2021 1:44:00 PM
Attachments: [BOI Letter to Houlton Band of Maliseet Indians 03.12.21.pdf](#)

Chief Sabattis,

As you may recall, my colleague Tom Record contacted you in 2018 regarding the State's application to the federal government for a waiver under the Affordable Care Act to pursue innovative strategies for providing its residents with access to quality, affordable health insurance. That waiver was granted, and the State is now seeking an amendment to this waiver. The same waiver application process applies, which requires the State to consult with its federally-recognized tribes regarding the proposed waiver. **Attached please find a letter providing more detailed information about the proposal, including a link to related materials.**

Notably, the proposed waiver would not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed waiver does, however, seek to lower health insurance premiums for both individual and small group health insurance coverage sold in Maine with the support of federal funding.

We would be happy to answer any questions you have about this proposal. If a virtual meeting to discuss the proposal would be helpful, please let me know. We would appreciate any written comments you may have by **April 12th**.

Thank you for your time and consideration.

Sincerely,

Holly Doherty

Attorney, Consumer Health Care Division

Maine Bureau of Insurance

Phone: (207) 624-8463



Janet T. Mills
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

March 12, 2021

Via Email

Teresitia Hamel
Aroostook Band of Micmacs
thamel@micmac-nsn.gov

Dear Teresitia:

On behalf of the State of Maine's Bureau of Insurance, I am writing to inform you of a proposed amendment to the State's Section 1332 Waiver under the federal Affordable Care Act (ACA). Federal regulations require a state to consult with its federally recognized tribes regarding a proposed waiver.¹

Under Section 1332 of the ACA, a state may request a waiver ("1332 waiver") to pursue innovative strategies for providing its residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

The proposed 1332 waiver amendment does not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed 1332 waiver amendment does, however, seek to lower health insurance premiums for individual and small group health insurance coverage in Maine with the support of federal funding.

In 2018, Maine received federal approval for its current 1332 waiver in order to allow the Maine Guaranteed Access Reinsurance Association (MGARA) to operate a reinsurance program for the individual health insurance market in Maine with the support of federal pass-through funding beginning January 1, 2019. The goal of the reinsurance program was to bring increased certainty and stability to Maine's individual health insurance

¹ See Federal Code of Regulations, 31 CFR 33.112(a)(2) and 45 CFR 155.1312(a)(2).



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market through a positive impact on premium levels. Since the waiver became effective, average premium rates for the individual market have moderated each year: 1.1% in 2019, -0.5% in 2020, and -12.5% in 2021.

In recent years, the small group market in Maine has experienced significant declines in membership, due in part to high medical cost trends and associated premium increases. On its current trajectory, the small group market may continue to see membership decline, and only those that truly need health care services may stay enrolled in the market, which will lead to a continued escalation in premiums. Because of this trend, Maine has been considering ways to help stabilize and lower premiums for the small group market.

In 2020, the Maine Legislature enacted a law that allows the State's Superintendent of Insurance to pool the individual and small group health insurance markets into a single risk pool and to seek federal approval of an amendment to Maine's 1332 waiver that would allow extension of the MGARA reinsurance program to the pooled market and transition of the reinsurance program from a prospective model to a retrospective model. The change is contingent upon federal approval of the proposed waiver amendment.

Under the proposed 1332 waiver amendment, Maine would continue to receive federal pass-through funding to support the reinsurance program in the amount of the savings that would be generated from the resulting reduction in premium tax credits. Extending the MGARA reinsurance program to a pooled individual and small group health insurance market would bring increased certainty and stability to small group health insurance in Maine through a positive effect on premium levels. This proposed waiver amendment, if approved, would be effective as of January 1, 2022, for a period of five years.

More detailed information about the proposed 1332 waiver amendment, including a draft of the waiver amendment application, is available on the Bureau of Insurance website at the following link: <https://www.maine.gov/pfr/insurance/mgara/index.html>.

We would be happy to respond to any questions you may have about this proposed waiver amendment. If you would like to arrange a virtual meeting to discuss the proposal, please contact me at your earliest convenience. We would appreciate any written comments you may have by April 12, 2021, which may be sent to holly.doherty@maine.gov.

Thank you for your time.

Sincerely,



Holly Doherty
Attorney

From: [Doherty, Holly](#)
To: thamel@micmac-nsn.gov
Subject: Tribal Consultation for Maine Bureau of Insurance Proposal
Date: Friday, March 12, 2021 1:45:00 PM
Attachments: [BOI Letter to Aroostook Band of Micmacs 03.12.21.pdf](#)

Teresitia,

I recently contacted you regarding the State of Maine's proposed application to the federal government for a waiver under the Affordable Care Act to pursue innovative strategies for providing its residents with access to quality, affordable health insurance. In accordance with federal requirements for a state to consult with its federally-recognized tribes regarding a proposed waiver, **attached please find a letter providing more detailed information about the proposal, including a link to related materials.**

As I mentioned in my last email, the proposed waiver would not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed waiver does, however, seek to lower health insurance premiums for both individual and small group health insurance coverage sold in Maine with the support of federal funding.

We would be happy to answer any questions you have about this proposal. If a virtual meeting to discuss the proposal would be helpful, please let me know. We would appreciate any written comments you may have by **April 12th**.

Thank you for your time.

Sincerely,

Holly Doherty

Attorney, Consumer Health Care Division

Maine Bureau of Insurance

Phone: (207) 624-8463

From: [Doherty, Holly](mailto:thamel@micmac-nsn.gov)
To: thamel@micmac-nsn.gov
Subject: Tribal Contact for Maine Bureau of Insurance Proposal
Date: Friday, February 26, 2021 2:20:00 PM

Teresitia,

I'm hoping you are the appropriate contact for this question, or could direct me to the right person. I work for the State of Maine's Bureau of Insurance, and the State is working on an application to the federal government for a waiver under the Affordable Care Act to pursue innovative strategies for providing its residents with access to quality, affordable health insurance. The federal government's waiver application process requires the State to consult with its federally-recognized tribes regarding its proposed waiver. We therefore intend to submit a formal letter and more detailed information about the State's proposed waiver to the Aroostook Band of Micmacs. Is this something we could send to you, or is there another tribal representative we should send this to? If there is another representative we should contact, an email address would be most helpful so that we may send the necessary documents.

Notably, the proposed waiver would not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed waiver does, however, seek to lower health insurance premiums for individual and small group health insurance coverage sold in Maine with the support of federal funding.

I appreciate any assistance you can provide.

Thank you,

Holly Doherty

*Attorney, Consumer Health Care Division
Maine Bureau of Insurance
Phone: (207) 624-8463*



Janet T. Mills
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

March 12, 2021

Via Email

Representative Rena Newell
Passamaquoddy Tribe
rena.newell@legislature.maine.gov

Dear Representative Newell:

On behalf of the State of Maine's Bureau of Insurance, I am writing to inform you of a proposed amendment to the State's Section 1332 Waiver under the federal Affordable Care Act (ACA). Federal regulations require a state to consult with its federally recognized tribes regarding a proposed waiver.¹

Under Section 1332 of the ACA, a state may request a waiver ("1332 waiver") to pursue innovative strategies for providing its residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

The proposed 1332 waiver amendment does not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed 1332 waiver amendment does, however, seek to lower health insurance premiums for individual and small group health insurance coverage in Maine with the support of federal funding.

In 2018, Maine received federal approval for its current 1332 waiver in order to allow the Maine Guaranteed Access Reinsurance Association (MGARA) to operate a reinsurance program for the individual health insurance market in Maine with the support of federal pass-through funding beginning January 1, 2019. The goal of the reinsurance program was to bring increased certainty and stability to Maine's individual health insurance

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market through a positive impact on premium levels. Since the waiver became effective, average premium rates for the individual market have moderated each year: 1.1% in 2019, -0.5% in 2020, and -12.5% in 2021.

In recent years, the small group market in Maine has experienced significant declines in membership, due in part to high medical cost trends and associated premium increases. On its current trajectory, the small group market may continue to see membership decline, and only those that truly need health care services may stay enrolled in the market, which will lead to a continued escalation in premiums. Because of this trend, Maine has been considering ways to help stabilize and lower premiums for the small group market.

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Under the proposed 1332 waiver amendment, Maine would continue to receive federal pass-through funding to support the reinsurance program in the amount of the savings that would be generated from the resulting reduction in premium tax credits. Extending the MGARA reinsurance program to a pooled individual and small group health insurance market would bring increased certainty and stability to small group health insurance in Maine through a positive effect on premium levels. This proposed waiver amendment, if approved, would be effective as of January 1, 2022, for a period of five years.

More detailed information about the proposed 1332 waiver amendment, including a draft of the waiver amendment application, is available on the Bureau of Insurance website at the following link: <https://www.maine.gov/pfr/insurance/mgara/index.html>.

We would be happy to respond to any questions you may have about this proposed waiver amendment. If you would like to arrange a virtual meeting to discuss the proposal, please contact me at your earliest convenience. We would appreciate any written comments you may have by April 12, 2021, which may be sent to holly.doherty@maine.gov.

Thank you for your time.

Sincerely,



Holly Doherty
Attorney

From: [Doherty, Holly](#)
To: [Newell, Rena](#)
Subject: Tribal Consultation for Maine Bureau of Insurance Proposal
Date: Friday, March 12, 2021 1:45:00 PM
Attachments: [BOI Letter to Passamaquoddy Tribe 03.12.21.pdf](#)

Representative Newell,

I recently contacted you regarding the State of Maine's proposed application to the federal government for a waiver under the Affordable Care Act to pursue innovative strategies for providing its residents with access to quality, affordable health insurance. In accordance with federal requirements for a state to consult with its federally-recognized tribes regarding a proposed waiver, **attached please find a letter providing more detailed information about the proposal, including a link to related materials.**

As I mentioned in my last email, the proposed waiver would not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed waiver does, however, seek to lower health insurance premiums for both individual and small group health insurance coverage sold in Maine with the support of federal funding.

We would be happy to answer any questions you have about this proposal. If a virtual meeting to discuss the proposal would be helpful, please let me know. We would appreciate any written comments you may have by **April 12th**.

Thank you for your time.

Sincerely,

Holly Doherty

Attorney, Consumer Health Care Division

Maine Bureau of Insurance

Phone: (207) 624-8463

From: [Newell, Rena](#)
To: [Doherty, Holly](#)
Subject: Re: Tribal Consultation for Maine Bureau of Insurance Proposal
Date: Friday, March 12, 2021 5:00:48 PM

Good Afternoon Ms. Doherty,
Please excuse the delay in responding.
I will forward your email to our Indian Township Health Director and Pleasant Point Health Director for their input as well.
Thank you.
-Rep. Newell

From: Doherty, Holly <Holly.Doherty@maine.gov>
Sent: Friday, March 12, 2021 1:45:48 PM
To: Newell, Rena
Subject: Tribal Consultation for Maine Bureau of Insurance Proposal

This message originates from outside the Maine Legislature.

Representative Newell,

I recently contacted you regarding the State of Maine's proposed application to the federal government for a waiver under the Affordable Care Act to pursue innovative strategies for providing its residents with access to quality, affordable health insurance. In accordance with federal requirements for a state to consult with its federally-recognized tribes regarding a proposed waiver, **attached please find a letter providing more detailed information about the proposal, including a link to related materials.**

As I mentioned in my last email, the proposed waiver would not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed waiver does, however, seek to lower health insurance premiums for both individual and small group health insurance coverage sold in Maine with the support of federal funding.

We would be happy to answer any questions you have about this proposal. If a virtual meeting to discuss the proposal would be helpful, please let me know. We would appreciate any written comments you may have by **April 12th.**

Thank you for your time.

Sincerely,

Holly Doherty
Attorney, Consumer Health Care Division
Maine Bureau of Insurance

Phone: (207) 624-8463

From: [Doherty, Holly](#)
To: [Newell, Rena](#)
Subject: Tribal Contact for Maine Bureau of Insurance Proposal
Date: Friday, February 26, 2021 2:18:00 PM

Dear Representative Newell,

I am hoping you are the appropriate contact for this question, or could direct me to the right person. I work for the State of Maine's Bureau of Insurance, and we are working on an application to the federal government for a waiver under the Affordable Care Act to pursue innovative strategies for providing its residents with access to quality, affordable health insurance. The federal government's waiver application process requires the State to consult with its federally-recognized tribes regarding its proposed waiver. Accordingly, we intend to submit a formal letter and more detailed information about the State's proposed waiver to the Passamaquoddy Tribe. Is this something we could send to you, or is there another tribal representative we should send this to? If there is another representative we should contact, an email address would be most helpful so that we may send the necessary documents.

Notably, the proposed waiver would not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed waiver does, however, seek to lower health insurance premiums for individual and small group health insurance coverage sold in Maine with the support of federal funding.

I appreciate any assistance you can provide.

Thank you,

Holly Doherty

*Attorney, Consumer Health Care Division
Maine Bureau of Insurance
Phone: (207) 624-8463*



Janet T. Mills
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

March 12, 2021

Via Email

Mary Settles
Penobscot Nation
mary.settles@penobscotnation.org

Dear Mary:

On behalf of the State of Maine's Bureau of Insurance, I am writing to inform you of a proposed amendment to the State's Section 1332 Waiver under the federal Affordable Care Act (ACA). Federal regulations require a state to consult with its federally recognized tribes regarding a proposed waiver.¹

Under Section 1332 of the ACA, a state may request a waiver ("1332 waiver") to pursue innovative strategies for providing its residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

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More detailed information about the proposed 1332 waiver amendment, including a draft of the waiver amendment application, is available on the Bureau of Insurance website at the following link: <https://www.maine.gov/pfr/insurance/mgara/index.html>.

We would be happy to respond to any questions you may have about this proposed waiver amendment. If you would like to arrange a virtual meeting to discuss the proposal, please contact me at your earliest convenience. We would appreciate any written comments you may have by April 12, 2021, which may be sent to holly.doherty@maine.gov.

Thank you for your time.

Sincerely,



Holly Doherty
Attorney

From: [Doherty, Holly](#)
To: ["mary.settles@penobscotnation.org"](mailto:mary.settles@penobscotnation.org)
Subject: Tribal Consultation for Maine Bureau of Insurance Proposal
Date: Friday, March 12, 2021 1:45:00 PM
Attachments: [BOI Letter to Penobscot Nation 03.12.21.pdf](#)

Mary,

As you may recall, my colleague Tom Record contacted you in 2018 regarding the State of Maine's application to the federal government for a waiver under the Affordable Care Act to pursue innovative strategies for providing its residents with access to quality, affordable health insurance. That waiver was granted, and the State is now seeking an amendment to this waiver. The same waiver application process applies, which requires the State to consult with its federally-recognized tribes regarding the proposed waiver. **Attached please find a letter providing more detailed information about the proposal, including a link to related materials.**

Notably, the proposed waiver would not affect the provision of tribal health care services or the benefits of any health insurance policies that tribal members may be enrolled in. There is no impact to Indian Health Service, the Federal Health Program for American Indians and Alaska Natives. The proposed waiver does, however, seek to lower health insurance premiums for both individual and small group health insurance coverage sold in Maine with the support of federal funding.

We would be happy to answer any questions you have about this proposal. If a virtual meeting to discuss the proposal would be helpful, please let me know. We would appreciate any written comments you may have by **April 12th**.

Thank you for your time.

Sincerely,

Holly Doherty

Attorney, Consumer Health Care Division

Maine Bureau of Insurance

Phone: (207) 624-8463