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**STATE OF MAINE
128th LEGISLATURE**

Task Force on Health Care Coverage for All of Maine

November 2018

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**Sen. Rodney L. Whittemore, Chair
Rep. Heather B. Sanborn, Chair
Sen. Geoffrey M. Gratwick
Sen. Eric L. Brakey
Sen. Everett Brownie Carson
Rep. Robert A. Foley
Rep. Anne C. Perry
Rep. Paul Chace
Kristine Ossenfort
Joel Allumbaugh
Mark Hovey
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Executive Summary

The Task Force on Health Care Coverage for All of Maine was established by Joint Order S.P. 592 as amended by House Amendment “A.” The purpose expressed in the joint order was to ensure that all residents of the State have access to and coverage for affordable, quality health care and to study the design and implementation of options for a health care plan that provides coverage for all residents of the State.

Although the joint order asked the task force to study the design and implementation of options for different health care plans providing coverage for all residents of the State, the joint order also provided authority and discretion for the task force to consider a broad range of issues affecting the accessibility and affordability of health care coverage. The task force agreed to approach its work to first understand what isn’t working in the current health care system and then to work together to identify potential policy solutions.

The task force has 16 members: eight legislative members; and eight non-legislative members representing interests specifically identified in the joint order. Senator Rodney L. Whittemore was named Senate chair and Representative Heather B. Sanborn was named House chair. Pursuant to the joint order, the legislative members are bipartisan and seven of the eight members also serve on the Joint Standing Committee on Health and Human Services or the Joint Standing Committee on Insurance and Financial Services.

With authorization from the Legislative Council, the task force met eight times: once in 2017 on December 20; and seven times in 2018: January 22, March 2, April 2, May 23, September 12, October 2, and October 15. All of the meetings were held in the State House Complex in Augusta and open to the public. Live audio of each meeting was made available through the Legislature’s webpage. The task force also established a website which can be found at <http://legislature.maine.gov/task-force-on-health-care-coverage>. The website includes agendas, meeting materials and links to related resources.

This report fulfills the task force’s requirement to submit a final report for presentation to the First Regular Session of the 129th Legislature.

As a tool to help better understand the areas of agreement and identify possible areas of disagreement among the task force members, the chairs developed a survey. The chairs anticipated that the results of the survey and the expertise of task force members would be used to frame the task force’s work. After reviewing the survey, the task force recognized that there was some common ground among the members, particularly with regard to reducing the cost of health care services and prescription drugs. The survey responses were used by the task force as a framework for discussion.

To assist in completing its work and based on the survey responses, the task force formed three study groups organized around the following topics: Controlling Costs; the Structure of the Health Insurance Market; and Public Options. The study groups were directed to develop

potential policy recommendations related to each subject area for consideration by all members of the task force.

On November 7, 2017, a citizen-initiated ballot measure to expand Medicaid eligibility under the terms of the federal Affordable Care Act was approved by 59% of Maine voters. When the task force first convened on December 20, 2017, and in subsequent meetings, the task force did not directly focus on the issue of Medicaid expansion. As the work of the task force continued over the last ten months, the implementation of Medicaid expansion became contentious and is currently the subject of a pending case in Maine's Superior Court. While the task force discussed the issue, the task force did not debate or vote on Medicaid expansion. Although a majority of task force members believe strongly that Medicaid expansion should be implemented immediately, the task force instead focused its efforts on other areas of our complex health care system where structure, cost, access, and affordability could be improved for the benefit of all Mainers. As a result of those efforts, the task force arrived at the recommendations that follow.

The task force makes recommendations in three areas related to: 1) the task force and legislative oversight of health reform proposals; 2) suggested legislation for consideration in the 129th Legislature; and 3) continued study and monitoring of issues discussed by the task force's study groups.

1. Recommendations related to the task force and legislative oversight of health reform proposals

- Propose by letter to the Presiding Officers that the Legislature identify one joint standing committee to centralize oversight of health care reform efforts and that that committee consider any proposed legislation related to cost containment, to access and affordability of health care coverage and to the structure of the health care system*
- As recommended by the legislative members, propose by letter to the Presiding Officers that the Joint Standing Committee on Insurance and Financial Services be renamed the Joint Standing Committee on Health Care, Insurance and Financial Services and that its jurisdiction be expanded to oversee health care reform efforts and to consider proposed legislation related to cost containment, to access and affordability of health care coverage and to the structure of the health care system*
- Reestablish the task force in the 129th Legislature to allow the task force additional time to continue its work to develop, study and analyze options for health care reform*
- Pursue additional funding to provide consulting and actuarial support for the task force*

2. Recommendations related to suggested legislation for consideration by 129th Legislature

- Propose legislation in the 129th Legislature to address the transparency, accountability and oversight of pharmacy benefits managers {supported by 12 members of the task force}*

- Introduce concept draft legislation in the 129th Legislature to review the Maine Health Data Organization’s enabling statutes and consider statutory changes to MHDO’s structure, funding and capacity for the reporting and analysis of health care costs and quality {supported by 12 members of the task force}*

3. Recommendations related to continued study and monitoring of issues discussed by the task force’s study groups
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Through the work of the study groups, the task force recommends that the task force continue to monitor and study the following topics and potential policy proposals related to prescription drug pricing, to responding to changes in federal law and regulation and to the regulatory structure of Maine’s health insurance market.

Prescription Drug Pricing

- Monitor activity in Vermont and any other state to implement a state-sponsored wholesale importation program for certain high cost prescription drugs from Canada and explore opportunities for regional collaboration with Vermont and other New England states on wholesale importation program*
- Continue to study and analyze model legislation to establish a state commission authorized to set maximum rates paid for certain high cost prescription drugs*

Responding to Changes in Federal Law and Regulation

- Monitor the practice of “silver loading” of federal Affordable Care Act marketplace policies to mitigate the impact of the elimination of federal reimbursement to carriers for cost sharing reductions*
- Monitor federal activity related to the Section 1332 waiver process under the federal Affordable Care Act and consider engaging Congressional delegation to seek changes to streamline the waiver process*
- Monitor activity in states that have enacted a state-level individual mandate*
- Monitor how changes in federal rules for short-term health insurance policies impact Maine’s individual market*
- Monitor impact of reduction in federal funding for navigators and consider the possibility of providing State funding for navigators*

Regulatory Structure of Maine's Health Insurance Market

- Continue to study and analyze possible statutory changes, including changes related to Maine's reinsurance mechanism (MGARA), the segregation of the individual risk pool, the definition of small group and the determination/counting of full-time equivalent employees for insurance purposes*
- Monitor implementation of "right to shop" programs by health insurance carriers subject to requirements*
- Monitor implementation of Medicaid expansion*

I. INTRODUCTION

The Task Force on Health Care Coverage for All of Maine was established by Joint Order S.P. 592 as amended by House Amendment “A.” The purpose expressed in the joint order was to ensure that all residents of the State have access to and coverage for affordable, quality health care and to study the design and implementation of options for a health care plan that provides coverage for all residents of the State. A copy of Joint Order S.P. 592, as amended, is included as Appendix A.

Although the joint order asked the task force to study the design and implementation of options for different health care plans providing coverage for all residents of the State, the joint order also provided authority and discretion for the task force to consider a broad range of issues affecting the accessibility and affordability of health care coverage. The task force agreed to approach its work to first understand what isn’t working in the current health care system and then to work together to identify potential policy solutions.

The task force has 16 members: eight legislative members; and eight non-legislative members representing interests specifically identified in the joint order. Senator Rodney L. Whittmore was named Senate chair and Representative Heather B. Sanborn was named House chair. Pursuant to the joint order, the legislative members are bipartisan and seven of the eight members also serve on the Joint Standing Committee on Health and Human Services or the Joint Standing Committee on Insurance and Financial Services. The task force members are:

Sen. Rodney L. Whittmore, *Senate Chair and member of Insurance and Financial Services
Senate Chair Committee, appointed by the President of the Senate*

Rep. Heather B. Sanborn, *House Chair and member of Insurance and Financial Services
House Chair Committee, appointed by the Speaker of the House*

Sen. Geoffrey M. Gratwick *Senate member, appointed by the President of the Senate*

Sen. Eric L. Brakey *Senate member of Health and Human Services Committee,
appointed by the President of the Senate*

Sen. Everett Brownie Carson *Senate member of Insurance and Financial Services Committee,
appointed by the President of the Senate*

Rep. Robert A. Foley *House member of Insurance and Financial Services Committee,
appointed by the Speaker of the House*

Rep. Anne C. Perry *House member of Health and Human Services Committee,
appointed by the Speaker of the House*

Rep. Paul Chace *House member of Health and Human Services Committee,
appointed by the Speaker of the House*

Kristine Ossenfort	<i>Representing the interests of health insurance carriers, appointed by the President of the Senate</i>
Joel Allumbaugh	<i>Representing the interests of consumers, appointed by the President of the Senate</i>
Mark Hovey	<i>Representing the interests of employers with greater than 50 employees, appointed by the President of the Senate</i>
Jeffrey A. Austin	<i>Representing the interests of hospitals, appointed by the President of the Senate</i>
Daniel Kleban	<i>Representing the interests of employers with fewer than 50 employees, appointed by the Speaker of the House</i>
Kevin Lewis	<i>Representing the interest of health insurance carriers, appointed by the Speaker of the House</i>
Francis McGinty	<i>Representing the interests of health care providers, appointed by the Speaker of the House</i>
Trish Riley	<i>Representing the interests of consumers, appointed by the Speaker of the House</i>

The complete membership of the task force, including contact information, is included as Appendix B. As directed by the joint order, the President of the Senate and the Speaker of the House of Representatives invited the participation of the Commissioner of Health and Human Services and the Superintendent of Insurance or their designees, as members of the task force, but that invitation was declined. The Office of Policy and Legal Analysis provided staff support to the task force.

With authorization from the Legislative Council, the task force met eight times: once in 2017 on December 20; and seven times in 2018: January 22, March 2, April 2, May 23, September 12, October 2 and October 15. All of the meetings were held in the State House Complex in Augusta and open to the public. Live audio of each meeting was made available through the Legislature's webpage.

The task force also established a website which can be found at <http://legislature.maine.gov/task-force-on-health-care-coverage>. The website includes agendas, meeting materials and links to related resources.

This report fulfills the task force's requirement to submit a final report for presentation to the First Regular Session of the 129th Legislature.

II. TASK FORCE PROCESS

❖ Survey

As a tool to help better understand the areas of agreement and identify possible areas of disagreement among the task force members, the chairs developed a survey. The chairs anticipated that the results of the survey and the expertise of task force members would be used to frame the task force's work. Thirteen of the 16 members responded to the survey. A summary of the survey responses can be found in Appendix C.

After reviewing the survey, the task force recognized that there was some common ground among the members, particularly with regard to reducing the cost of health care services and prescription drugs. The survey responses were used by the study groups as a framework for discussion.

❖ Study Groups

The task force formed three study groups organized around the following topics: Controlling Costs; the Structure of the Health Insurance Market; and Public Options. The chairs considered preferences expressed by members and named the following members to each study group:

Controlling Costs Study Group: Sen. Brownie Carson, Rep. Paul Chace, Jeff Austin, Trish Riley, Mark Hovey

Public Options Study Group: Sen. Geoff Gratwick, Rep. Bob Foley, Dan Kleban, Kevin Lewis

Structure of the Health Insurance Market Study Group: Rep. Anne Perry, Sen. Eric Brakey, Joel Allumbaugh, Kristine Ossenfort, Frank McGinty

The study groups were directed to develop potential policy recommendations related to each subject area for consideration by all members of the task force. The study groups used the time between the task force's May and September meetings for discussion. The following summarizes the discussions of each study group.

Controlling Costs Study Group. The Controlling Costs Study Group met three times in person or by conference call: March 28, May 21 and September 20. The study group also circulated proposals for consideration and comment in writing. Rep. Sanborn, House chair of the task force, and Sen. Gratwick participated in some discussions.

The study group's goal was to develop both long-term and short-term approaches to controlling costs. The study group initially identified four areas of interest for further discussion:

1. Reduction of administrative costs in the billing/claim processes;
2. Reimbursement/rate reform – reasonable reimbursement to providers for services;
3. Reduction of prescription drug costs/growth rate; and
4. Incentives to change behavior to avoid medical care cost – prevention.

Between the May and September meetings of the study group, the members narrowed their focus to potential policy options to help control prescription drug costs. At the September 20th meeting, the study group developed its preliminary recommendations for consideration by the task force. Rep. Chace was not present at that meeting but circulated written comments expressing concerns about the potential legislative recommendations prior to the meeting.

The study group agreed to defer consideration of ways to reduce administrative costs and reporting burdens by standardizing billing for medical services to allow stakeholders additional time to develop recommendations. At previous meetings, the study group members discussed the possibilities for reducing administrative costs through standardization of the billing and claims process. This issue was the focus for a 1998 legislative study by The Task force to Study the Feasibility of a Single Claims Processing System for 3rd-Party Payors of Health Care Benefits. At that time, the task force declined to make recommendations for legislation and decided to defer to national efforts and private sector efforts to encourage electronic claims processing and simplify administrative claims processes. Many of the same issues raised years ago continue to exist today. Despite the use of the same form, government and commercial payers have different requirements for submitting claims. While Maine has enacted laws designed to standardize the billing and claims process, the group determined that it may be useful to gather more information and suggestions from providers and payers for additional measures to streamline the claims process.

Jeff Austin of the Maine Hospital Association reached out to the State Uniform Billing Committee (SUBC) and providers to gather more information and seek suggestions for potential ways to streamline the process. An issue that members expressed concerns with was the prior authorization process. One example described by Mr. Austin related to a recent proposed rule by DHHS for the MaineCare program; the proposed rule would require providers to call DHHS to determine if prior authorization is needed for lab services and then for providers to submit the necessary paperwork. Mr. Austin noted that hospitals alone provide approximately 250,000 lab services annually, frequently in the evening and on weekends when DHHS is not available for phone calls, and that the proposal raises many logistical concerns.

Because the next meeting of the SUBC is not scheduled until after the study group and task force are expected to complete their work, Mr. Austin suggested that the study group defer any specific recommendation at this time. Mr. Austin and the Maine Hospital Association will work with the Maine Medical Association and members of the SUBC to develop recommendations for proposed legislation and look for efficiencies in the process with all payers, public and commercial.

Public Options Study Group. The Public Options Study Group met seven times: March 23, March 30, May 8, July 25, August 15, August 22 and September 5. Rep. Sanborn, House chair of the task force, participated in some discussions.

The study group noted that significant time is needed to develop a concept for a new model or models for providing health care coverage to residents of Maine. The study group identified several important elements for inclusion in any new health care model. Moving forward, any new health care model must:

- Be simple and predictable;
- Be funded through contributions from all residents, including those receiving public benefits;
- Provide coverage for all residents – everybody in;
- Provide oversight through a centralized government trust or authority;
- Partner with existing carriers to provide coverage if possible and focus competition among carriers on service and consumer engagement in health and wellness;
- Provide an agreed-upon “basic health plan” or uniform benefits package with supplemental coverage and benefits available;
- Change the reimbursement/payment model for health care providers to eliminate/reduce cost-shifting;
- Provide reinsurance and risk adjustment for carriers;
- Include cost containment measures to bring down costs, including administrative costs and prescription drug costs; and
- Include a system for electronic sharing of individual health care data among carriers and providers – facilitate access to medical records/coverage information through a single ID card.

The study group acknowledged that any model would need careful actuarial analysis and study. The group also recognizes the difficult politics surrounding the enactment and implementation of such a model. Despite those challenges, the study group believes the system needs large scale and long-term reform.

Following the May task force meeting, the Public Options Study Group met four times by conference call. To facilitate public access, staff moderated the calls from the Insurance and Financial Services Committee Room so members of the public could attend the meeting or listen through the audio links on the Legislature’s website. The primary purpose of the calls was to discuss current and past health care reform efforts in several states and to discern what lessons could be learned as the study group considered potential recommendations for health care policy changes.

The following conference calls were held by the study group.

Wednesday, July 25th from 12:00 p.m. to 2:00 p.m. with Trish Riley, current task force member who was Director of the Governor’s Office of Health Policy and Finance when Dirigo Health was enacted. Ms. Riley provided her perspective on the Dirigo Health Program here in Maine.

Wednesday, August 15th from 9:00 a.m. to 11:00 a.m. with Dr. Deb Richter. Dr. Richter is a physician and board member of Vermont Health Care for All. She discussed universal health care efforts in Vermont.

Wednesday, August 22nd from 12:00 p.m. to 2:00 p.m. with Lyn Gullette, Co-Operate Colorado, and Ivan Miller, Colorado Foundation for Universal Health Care. They discussed universal health care efforts in Colorado.

Wednesday, September 5th from 9:30 a.m. to 11:30 a.m. with John Colmers, Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Medicine. Mr. Colmers discussed health policy efforts in Maryland, including global budgeting and rate setting.

Structure of the Health Insurance Market Study Group. The Structure of the Health Insurance Market Study Group met five times: March 26, April 23, May 21, July 24 and August 28. Sen. Gratwick also participated in some discussions.

The study group focused on the consideration of policy recommendations related to the individual and small group health insurance market. The members hoped to develop recommendations that would target certain populations experiencing problems related to health insurance coverage in the existing market, including:

- Individuals who have incomes below 100% of the federal poverty level who do not qualify for the APTC (advanced premium tax credit);
- Individuals who are “lightly subsidized” and particularly sensitive to health insurance premium increases;
- Individuals who have incomes above 400% of the federal poverty level who do not qualify for the APTC; and
- Those enrolled in the small group health insurance market.

Study group members noted that current federal law and uncertainty related to the action/inaction of the federal government are important factors in whether possible policy solutions can succeed at the state level to improve the affordability and stability of the health insurance market in Maine. Another significant factor not directly addressed by the study group is the underlying cost of health care, which drives the cost of health insurance; as a result, the efforts of the Controlling Costs Study Group and policy recommendations to control health care costs are very important.

The study group considered a number of possible policy options and identified the advantages and disadvantages of each policy option and the potential barriers to implementation. The study group also discussed the importance of having data to inform its policy recommendations and talked with the Maine Health Data Organization about whether its claims database could be more rigorously utilized to determine cost drivers, cost variations, trends and quality. The Maine Health Data Organization provided certain information related to health care claims costs requested by the study group.

III. STATEMENT ON MEDICAID EXPANSION

On November 7, 2017, a citizen-initiated ballot measure to expand Medicaid eligibility under the terms of the federal Affordable Care Act was approved by 59% of Maine voters. When the task

force first convened on December 20, 2017, and in subsequent meetings, the task force did not directly focus on the issue of Medicaid expansion. As the work of the task force continued over the last ten months, the implementation of Medicaid expansion became contentious and is currently the subject of a pending case in Maine's Superior Court. While the task force discussed the issue, the task force did not debate or vote on Medicaid expansion. Although a majority of task force members believe strongly that Medicaid expansion should be implemented immediately, the task force instead focused its efforts on other areas of our complex health care system where structure, cost, access, and affordability could be improved for the benefit of all Mainers. As a result of those efforts, the task force arrived at the recommendations that follow.

IV. RECOMMENDATIONS

The task force makes recommendations in three areas related to: 1) the task force and legislative oversight of health reform proposals; 2) suggested legislation for consideration in the 129th Legislature; and 3) continued study and monitoring of issues discussed by the task force's study groups.

☐ Recommendations related to the task force and legislative oversight of health reform proposals

- ☐ ***Propose by letter to the Presiding Officers that the Legislature identify one joint standing committee to centralize oversight of health care reform efforts and that that committee consider any proposed legislation related to cost containment, to access and affordability of health care coverage and to the structure of the health care system***

The task force recognizes that understanding Maine's complex health care system and issues related to the structure of that system and to health care affordability and access and developing proposals for health care reform will take a sustained effort over many years. While the work of the current task force is significant, the existence of any task force or other study committee is limited to two years and dissolves at the end of each legislative biennium. The task force believes that the sustained effort of one joint standing committee of the Legislature with the capacity to provide ongoing oversight of health care reform efforts is needed.

The task force believes this proposal would unify the consideration of legislative proposals related to the structure of the health care system and to health care access and affordability within a single committee that has the time and capacity to focus on our health care system in its entirety. The task force believes that this committee should also be responsible for continuing to study and monitor the innovations being introduced in other states and for working on a model for larger scale health care reform proposals. The task force also anticipates working closely with the committee should the task force continue in the 129th Legislature, and recommends that the Legislature reestablish the task force. See recommendation related to the reestablishing the task force below.

- ☐ ***As recommended by the legislative members, propose by letter to the Presiding Officers that the Joint Standing Committee on Insurance and Financial Services be renamed the Joint Standing Committee on Health Care, Insurance and Financial Services and that its***

jurisdiction be expanded to oversee health care reform efforts and to consider proposed legislation related to cost containment, to access and affordability of health care coverage and to the structure of the health care system

The legislative members of the task force propose that the Joint Standing Committee on Insurance and Financial Service be renamed the Health Care, Insurance and Financial Services Committee in the 129th Legislature and that the jurisdiction of the committee be expanded to oversee health care reform efforts and to consider proposed legislation related to cost containment, to access and affordability of health care coverage and to the structure of the health care system. The legislative members of the task force recommend that the committee coordinate its efforts with the Joint Standing Committee on Health and Human Services so that public spending through the MaineCare program is part of the broader conversation about health reform as well.

Those members of the task force who are not legislators do not take a position on this proposal as they do not believe it is appropriate for them to make recommendations related to which legislative committees should take on this role.

☐ Reestablish the task force in the 129th Legislature to allow the task force additional time and resources to continue its work to develop, study and analyze options for health care reform

The task force believes that more time and resources are needed to continue the discussions begun by the task force to develop proposals for providing health care coverage to residents of Maine. The task force acknowledges that development of a sustainable model for health care reform in Maine is a long-term and complex endeavor and work should continue through the 129th Legislature. The task force recommends that the Legislature reestablish the task force with similar membership including legislators from the relevant policy committees and stakeholders representing the interests outlined in the original joint study order.

The task force also recommends that any reestablished task force be given broad authority and discretion to consider a wide range of issues affecting the accessibility and affordability of health care coverage and the structure of Maine's health care system. The task force does not believe it necessary for the work of the reestablished task force to be limited to the design of specific models for health care reform.

☐ Pursue additional funding to provide consulting and actuarial support for the task force

The task force believes that it will require the expertise of consultants and actuaries to assist in the development, study and analysis of options for health care reform. Additional funding and resources will be needed for that analysis. The task force recommends that the task force, Legislature and other stakeholders pursue all avenues for additional funding, including federal and State funding and grant funding from public and private sources.

2. Recommendations related to suggested legislation for consideration by 129th Legislature

❑ *Propose legislation in the 129th Legislature to address the transparency, accountability and oversight of pharmacy benefits managers*

Twelve members¹ of the task force recommend that legislation be introduced in the 129th Legislature to address the transparency, accountability and oversight of pharmacy benefit managers (PBMs). The proposed legislation should consider laws enacted in other states and model legislation that has been developed on the topic. Under current Maine law, PBMs are required to register with the Bureau of Insurance, but are not licensed. Members of the task force suggested that there is a role for government to require more transparency and accountability for PBM business practices and that it would benefit all payers, including self-insured employers. Members also pointed out that the appropriate oversight entity for PBMs, whether it is the Bureau of Insurance or the Department of Health and Human Services, is an important consideration to be addressed in the proposed legislation. Three members of the task force disagreed with this recommendation: Rep. Paul Chace, Joel Allumbaugh and Kristine Ossenfort. These members believe it is premature to introduce legislation at this time. Additional comments can be found in Appendix G.

The task force discussed prior legislation enacted in Maine in 2003 to regulate PBMs, including a provision similar to the National Academy of State Health Policy model's provision stating that PBMs have a fiduciary duty to payers. The Maine law was repealed in 2011. Since 2011, members noted that the PBM industry has undergone significant changes. While Maine was at the forefront and originally one of the first states to enact legislation, 26 states now have laws addressing the regulation of PBMs. Given the current state of prescription drug prices and the expanding role of PBMs, the members agreed that this is an appropriate time to take legislative action to address accountability and transparency of PBMs.

Model legislation can be found in Appendix D. Additional information on this issue and the laws enacted in other states can be found at <https://nashp.org/pharmacy-benefit-manager/>.

❑ *Introduce concept draft legislation in the 129th Legislature to review the Maine Health Data Organization's enabling statutes and consider statutory changes to MHDO's structure, funding and capacity for the reporting and analysis of health care costs and quality*

Twelve members² of the task force recommend that concept draft legislation be introduced in the 129th Legislature to review the Maine Health Data Organization's enabling statutes and consider statutory changes to MHDO's structure, funding and capacity for the reporting and analysis of health care costs and quality. Three members of the task force disagreed with this recommendation: Rep. Paul Chace, Joel Allumbaugh and Jeff Austin. These members believe it

¹ Sen. Eric Brakey did not participate in the meetings when the task force recommendations were discussed or provide comments on the final draft report circulated to task force members.

² Ibid.

is premature to introduce legislation at this time. Additional comments can be found in Appendix G.

Maine has one of the most comprehensive all-claims, all-payor databases in the country through the MHDO. Because reporting and analysis of such data will be critical to the future of health care reform proposals, the task force recommends reviewing the MHDO's current structure, funding, and capacity to determine how best to ensure such data analysis is available to the public and to policymakers.

Members of the task force's Structure of the Health Insurance Market Study Group had discussions with the MHDO about its capacity to provide health care cost information. MHDO's claims database has the capacity to provide a great deal of information but has limited resources. Members were particularly interested in whether the claims database could be more rigorously and regularly analyzed to determine cost drivers, cost variations, trends and quality and to assist policymakers and others in developing health care reform proposals. In considering the concept draft legislation, legislators should determine whether the task of completing such reports and analyses should be done by an MHDO with increased resources and a revised structure and governance or whether it should be assigned to a different entity, utilizing MHDO data.

The task force believes that legislators should further consult with the MHDO, its board members and other stakeholders, before drafting any specific changes to the statute.

If additional reporting or analysis are proposed to be included in MHDO's statutory responsibilities, the task force stresses that additional funding for MHDO must be included from the State's General Fund. MHDO is currently funded through assessments on health care providers and health insurance carriers and those entities cannot absorb any increases in assessments without passing those increases directly onto health care consumers.

3. Recommendations related to continued study and monitoring of issues discussed by the task force's study groups

Through the work of the study groups, the task force recommends that the task force continue to monitor and study the following topics and potential policy proposals related to prescription drug pricing, to responding to changes in federal law and regulation and to the regulatory structure of Maine's health insurance market.

Prescription Drug Pricing

- ☐ *Monitor activity in Vermont and other states to implement a state-sponsored wholesale importation program for certain high cost prescription drugs from Canada and explore opportunities for regional collaboration with Vermont and other New England states on wholesale importation program***

The task force recommends that the task force continue to monitor and analyze activities in Vermont and other states to implement a wholesale importation program and to provide regular updates to the Legislature on those activities. The task force also agreed to recommend that the

Legislature explore opportunities for regional collaboration with Vermont and other New England states related to a wholesale importation program.

The Controlling Costs Study Group considered a proposal to establish a state-administered system to import and distribute certain prescription drugs from Canada; drugs purchasers, including pharmacies, drug distributors and health plans, would agree to purchase and reimburse drugs based on the imported price. If enacted, this proposal would require federal authorization. The National Academy for State Health Policy has developed model legislation. Vermont recently became the first state to enact legislation; the law directed the relevant state agencies to establish an importation program and request the necessary federal approvals.

Task force members expressed concerns about moving forward immediately with the model legislation. Vermont has to obtain the necessary federal approvals to authorize the program. In addition, there are a number of administrative and business challenges to be considered if wholesale importation is to be implemented. Members suggested that Maine may benefit from waiting and trying to learn from Vermont's experience and those in other states. Other members expressed concern about unintended consequences and whether costs would be shifted to other drugs. Although members noted that this approach may be more easily understood by consumers than other approaches, it was suggested that the group continue to monitor activities in Vermont and other states. Members suggested that the task force and the legislative committee overseeing prescription drug legislation could require staff to report regularly on Vermont's activities and that there may be opportunities for Maine and other states to collaborate with Vermont on an importation program.

Model legislation is included in Appendix E. Additional information on this issue can be found at <https://nashp.org/drug-importation/>.

☐ *Continue to study and analyze model legislation to establish a state commission authorized to set maximum rates paid for certain high cost prescription drugs*

The task force recommends that the task force continue to study and analyze model legislation to establish a state commission to set maximum rates paid for certain high cost prescription drugs.

The Controlling Costs Study Group considered model legislation developed by the National Academy for State Health Policy that would establish a state commission to review the cost of certain prescription drugs based on parameters set forth in the law and establish a maximum amount that payers, both public and private, would pay for those individual drugs. Similar legislation has been put forward in Maryland, but has not yet been enacted. Under such legislation, predetermined thresholds for prescription drug price increases trigger commission review and, if increases are not adequately justified, the commission could cap the reimbursement rate for those drugs for all payers. The commission would not set prices but would cap what payers pay for drugs.

The task force determined that additional costs and benefit analysis and refinement of the model should be done before recommending proposed legislation. The task force also agreed that identifying the source or sources of funding for a state commission would require further study.

Given the concerns, the task force agreed that it would be worthwhile to continue study and analysis of the model legislation and activities in other states that are considering similar legislation.

Model legislation is included in Appendix F. Additional information on this issue can be found at <https://nashp.org/rate-setting/>.

Responding to Changes in Federal Law and Regulation

- ❑ ***Monitor the practice of “silver loading” of federal Affordable Care Act marketplace policies to mitigate the impact of the elimination of federal reimbursement to carriers for cost sharing reductions***

The task force recommends that the task force monitor the practice of “silver loading” of federal Affordable Care Act (ACA) marketplace policies to mitigate the impact of the elimination of federal reimbursement to carriers for cost sharing reductions under the ACA.

The Structure of the Health Insurance Market Study Group discussed the impact of the elimination of federal reimbursement for cost-sharing reductions for enrollees in the federal marketplace that had incomes at or below 250% of the federal poverty level. Cost-sharing reductions are only available within silver-level health plans through the federal marketplace. For many enrollees, the impact of the change was mitigated by a practice called “silver loading.” Rather than simply raising the cost of all ACA health plans (“bronze,” “silver,” “gold,” and “platinum” plans), insurers added the cost sharing reduction-related premium rate increases due to the loss of federal reimbursement into just those silver-level plans where cost-sharing reductions are available. Because the ACA uses the premium for the second-lowest “silver” plan to determine the premium subsidies available to eligible individuals with annual incomes ranging from 100% to 400% of the federal poverty level, when premiums for silver plans increased, federal subsidies also changed in step. The study group recognizes that “silver loading” has had a mitigating effect on premium increases for consumers receiving federal subsidies and recommends continued monitoring of activities at the federal and state level that affect the member share of premiums for enrollees in the federal marketplace.

- ❑ ***Monitor activity in states that have enacted a state-level individual mandate***

The task force recommends that the task force monitor activity in states that have enacted a state-level individual mandate.

The Structure of the Health Insurance Market Study Group discussed the issue of incentivizing the purchase of health insurance coverage and whether to recommend a state-level individual mandate to replace the federal mandate following its repeal. One member noted that it would be unfair to recommend such a mandate without providing access to coverage through Medicaid expansion and sufficient financial assistance to purchase health insurance in the face of premium increases. Other members wondered whether a mandate would really help without adequate enforcement and affordable options for coverage and whether it could be successful at the state level. Members agreed it would be useful to monitor New Jersey, Vermont, the District of

Columbia and other states that have recently enacted a state mandate and noted that Massachusetts has had in place its individual mandate for nearly a decade. Members also discussed other policy options that could improve the stability of the individual market in the absence of a mandate. Members felt that financial incentives and financial assistance to purchase coverage could be more important than a mandate.

❑ *Monitor how changes in federal rules for short-term health insurance policies impact Maine's individual market*

The task force recommends that the task force monitor how changes in federal rules for short-term health insurance policies impact Maine's individual market.

The Structure of the Health Insurance Market Study Group discussed the recent changes to federal rules related to short-term health insurance policies and reviewed Maine's current law governing short-term policies. Federal regulations governing short-term health insurance policies were changed in early August and become effective for short-term policies sold on or after October 2, 2018. The federal regulations extend the maximum coverage period for short-term policies from three months to less than 12 months (or 364 days). The regulation also permits carriers who offer short-term policies to renew those policies for a total of 36 months. The prior federal rule prohibited renewals. Current Maine law mirrors the federal rule by defining a short-term policy as one with a term of less than 12 months. However, Maine law prohibits renewal of short-term policies and limits the maximum coverage under successive short-term policies to 24 months. The federal rule allows states to regulate short-term policies in a more restrictive manner, including prohibiting the sale of short-term policies altogether. It was also suggested that the task force could consider statutory changes to mirror the federal rules. The members agreed that it is important to monitor how the changes in federal rules may impact the sale of short-term policies in Maine health insurance market, the availability and affordability of health insurance coverage and the stability of the market for ACA-compliant individual health plans.

❑ *Monitor impact of reduction in federal funding for navigators and consider the possibility of providing State funding for navigators*

The task force recommends that the task force monitor impact of reduction in federal funding for navigators and consider the possibility of providing State funding for navigators. Navigators are an individual or organization trained and able to assist consumers with selecting health coverage options through the federal marketplace pursuant to the federal Affordable Care Act.

The Structure of the Health Insurance Market Study Group discussed the significant reduction in federal grant funding for navigators for the 2019 enrollment period. In terms of federal funding for navigator assistance in Maine, the total amount of funding allocated to Maine for the 2018-2019 program year is \$100,000; this is a significant reduction in total funding, as \$551,750 was awarded in 2017. Maine's two grantees in 2017 were: 1) The Fishing Partnership Health Plan, which was awarded \$100,000; and 2) Western Community Action Program, which was awarded \$451,750. On September 12th, CMS announced the 2018 grant awards. Maine has one grantee: Western Maine Community Action Program was awarded \$100,000. The members agreed to

suggest that the task force monitor the impact of the reduction in federal funding for navigators and consider the possibility of providing state funding for navigators to assist with future open enrollment periods.

Regulatory Structure of Maine's Health Insurance Market

- ❑ ***Continue to study and analyze possible statutory changes, including changes related to Maine's reinsurance mechanism (MGARA), the segregation of the individual risk pool, the definition of small group and the determination/counting of full-time equivalent employees for insurance purposes***

The task force recommends that the task force continue to study and analyze possible statutory changes to the individual and small group market.

While the Structure of the Health Insurance Market Study Group initially discussed developing a proposal to seek a waiver to restart operations of Maine's reinsurance mechanism (MGARA), that discussion became moot when a waiver request was submitted to and granted by the Federal government on July 30, 2018. MGARA's operations are expected to resume in January 2019. The members discussed the potential for changes that would have an impact on MGARA's operations, including the segregation of the risk pool within MGARA to limit reinsurance to unsubsidized policies or policies sold off the federal marketplace, changing the definition of "small group," merging the individual and small group markets, expanding eligibility for reinsurance to small group policies as well as individual policies and changing the way in which a full-time equivalent employee is determined for insurance purposes. The members decided to recommend that there be continued study, analysis and research done by MGARA and the Bureau of Insurance on these potential policy changes.

- ❑ ***Monitor implementation of "right to shop" programs by health insurance carriers subject to requirements***

The task force recommends that the task force monitor implementation of "right to shop" programs by health insurance carriers subject to requirements.

The Structure of the Health Insurance Market Study Group discussed whether the "right to shop" program should be expanded to include additional categories of health care services. Because the effective date for health insurers subject to the law to offer health plans with "right to shop" incentives is not until January 2019, the members believe it is premature to recommend changes but that the program should be monitored to determine if additional changes should be considered.

- ❑ ***Monitor implementation of Medicaid expansion***

The task force recommends that the task force monitor the implementation of Medicaid expansion and consider the impact of expansion on the health insurance market and the State's health care system

APPENDIX A

Authorizing Joint Order

Joint Study Order, To Establish the Task Force on Health Care Coverage for All of Maine

ORDERED, the House concurring, that, notwithstanding Joint Rule 353, the Task Force on Health Care Coverage for All of Maine, referred to in this order as "the task force," is established as follows.

1. Purpose. It is the intent of the Legislature to ensure that all residents of the State have access to and coverage for affordable, quality health care. It is the intent of the Legislature to study the design and implementation of options for a health care plan that provides coverage for all residents of the State; and be it further

2. Appointments; composition. The task force consists of members appointed as follows:

A. Four members of the Senate, appointed by the President of the Senate, including 2 members of the party holding the largest number of seats in the Senate and 2 members of the party holding the 2nd largest number of seats in the Senate, of whom at least one member is a member of the Joint Standing Committee on Insurance and Financial Services and at least one member is a member of the Joint Standing Committee on Health and Human Services;

B. Four members of the House of Representatives, appointed by the Speaker of the House of Representatives, including 2 members of the party holding the largest number of seats in the House of Representatives and 2 members of the party holding the 2nd largest number of seats in the House of Representatives, of whom at least 3 members are members of the Joint Standing Committee on Insurance and Financial Services or the Joint Standing Committee on Health and Human Services;

C. One member representing the interests of hospitals, appointed by the President of the Senate;

D. One member representing the interests of health care providers, appointed by the Speaker of the House of Representatives;

E. Two members representing the interests of health insurance carriers, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives;

F. Two members representing the interests of consumers, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives;

G. One member representing the interests of employers with fewer than 50 employees, appointed by the Speaker of the House of Representatives; and

H. One member representing the interests of the employers with 50 or more employees, appointed by the President of the Senate.

The President of the Senate and the Speaker of the House of Representatives shall invite to participate as members of the task force the Commissioner of Health and Human Services or the commissioner's designee and the Superintendent of Insurance or the superintendent's designee.

3. Chairs. The first-named Senator is the Senate chair of the task force, and the first-named member of the House of Representatives is the House chair of the task force. Notwithstanding Joint Rule 353, the chairs may appoint, as nonvoting members, individuals with expertise in health care policy, health care

financing or health care delivery. Any additional members appointed pursuant to this section are not entitled to compensation or reimbursement under section 6.

4. Appointments; convening. All appointments must be made no later than 15 days following passage of this order. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been made. When the appointment of all members has been completed, the chairs of the task force shall call and convene the first meeting of the task force. If 15 days or more after the passage of this order a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the task force to meet and conduct its business.

5. Duties; design options. The task force shall propose at least 3 design options, including implementation plans, for creating a system of health care that ensures all residents of the State have access to and coverage for affordable, quality health care. The design options must meet the principles and goals outlined in this order. The proposals designed under this order must contain the analysis and recommendations as provided for in this section.

A. The proposal must include the following design options:

(1) A design for a government-administered and publicly financed universal payer health benefits system that is decoupled from employment, that prohibits insurance coverage for the health services provided by the system and that allows for private insurance coverage of only supplemental health services;

(2) A design for a universal health benefits system with integrated delivery of health care and integrated payment systems for all individuals that is centrally administered by State Government or an entity under contract with State Government; and

(3) A design for a public health benefits option administered by State Government or an entity under contract with State Government that allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans.

Additional options may be designed by the task force, taking into consideration the parameters described in this section.

Each design option must include sufficient detail to allow the task force to report back to the Legislature to enable the Legislature to consider the adoption of one design and to determine an implementation plan for that design during the First Regular Session of the 129th Legislature, including the submission of any necessary waivers pursuant to federal law.

B. In creating the design options under paragraph A, the task force shall review and consider the following fundamental elements:

(1) The findings and reports from previous studies of health care reform in the State, including the December 2002 document titled "Feasibility of a Single-Payer Health Care Model for the State of Maine" produced by Mathematica Policy Research, Inc., and studies and reports provided to the Legislature;

(2) The State's current health care reform efforts;

(3) The health care reform efforts in other states, including any efforts in other states to develop state innovation waivers for universal health coverage plans as an alternative to the federal Patient Protection and Affordable Care Act;

(4) The federal Patient Protection and Affordable Care Act or any other successor federal legislation; the federal Employee Retirement Income Security Act of 1974, as amended; and the Medicare program, the Medicaid program and the State Children's Health Insurance Program under Titles XVIII, XIX and XXI, respectively, of the federal Social Security Act; and

(5) The health care systems adopted in other countries.

C. Each design option under paragraph A must maximize federal funds to support the system and must be composed of the following components:

(1) A payment system for health services that includes one or more packages of health services providing for the integration of physical and mental health services; budgets, payment methods and a process for determining payment amounts; and mechanisms for cost reduction and cost containment;

(2) Coordinated regional delivery systems;

(3) Health system planning and regulation and public health;

(4) Financing and estimated costs, including federal financing. Each design option must provide:

(a) An estimate of the total costs of the design option, including any additional costs for providing access to and coverage for health services to the uninsured and underinsured, any estimated costs necessary to build a new system and any estimated savings from implementing a single system;

(b) Financing proposals for sustainable revenue, including by maximization of federal revenues or by reductions from existing health care programs, services, state agencies or other sources necessary for funding the cost of the new system;

(c) A proposal to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services to waive provisions of Titles XVIII, XIX and XXI of the federal Social Security Act, if necessary, to align the federal programs with the proposals contained within the design option in order to maximize federal funds or to promote the simplification of administration, cost containment or promotion of health care reform initiatives; and

(d) A proposal to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services to waive provisions of the federal Patient Protection and Affordable Care Act, if necessary, to implement the proposals contained within the design option in order to maximize federal funds;

(5) A method to address compliance of the proposed design option with federal law. Unless specifically authorized by federal law, the proposed design option must provide coverage supplemental to coverage available under the Medicare program of the federal Social Security Act, Title XVIII and the federal TRICARE program, 10 United States Code, Chapter 55;

(6) A benefit package or packages of health services that meet the requirements of state and federal law and provide for the integration of physical and mental health care, including access to and coverage for primary care, preventive care and wellness services; specialty care; chronic care and

chronic disease management; acute episodic care; palliative and end-of-life care; hospital services; prescription drugs and durable medical equipment; maternity, newborn and pediatric care; laboratory services; mental health and substance use disorder services; and dental, vision and health care;

(7) A method for administering payment for health services, which may include administration by a government agency, under an open bidding process soliciting bids from insurance carriers or 3rd-party administrators, through a private nonprofit insurer or 3rd-party administrator, through private insurers or from a combination of methods;

(8) Enrollment processes;

(9) Integration of pharmacy best practices and cost control programs and other mechanisms to promote evidence-based prescribing, clinical efficacy and cost containment, such as a single statewide preferred drug list, prescriber education and utilization reviews;

(10) Appeals processes for decisions made by entities or agencies administering coverage for health services;

(11) Integration of the workers' compensation system;

(12) A recommendation for budgets and payment methods and a process for determining payment amounts. Payment methods for mental health services must be consistent with mental health parity. The design option must consider:

(a) Recommending a global health care budget when it is appropriate to ensure cost containment by a health care facility, a health care provider, a group of health care professionals or any combination of these entities. Any recommendation must include a process for developing a global health care budget, including circumstances under which an entity may seek an amendment of its budget;

(b) Payment methods to be used for each health care sector that are aligned with the goals of this section and provide for cost containment, provision of high-quality, evidence-based health services in a coordinated setting, patient self-management and healthy lifestyles; and

(c) What process or processes are appropriate for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts must be sufficient to provide reasonable access to health services, provide uniform payments to health care professionals and assist in creating financial stability for health care professionals. Payment amounts for mental health services must be consistent with mental health parity;

(13) Mechanisms for cost reduction and cost containment and for oversight to ensure accountability and transparency of all financial transactions;

(14) A regional health system that ensures that the delivery of health services to the residents of the State is coordinated in order to improve health outcomes, improve the efficiency of the health system and improve patients' experiences of health services; and

(15) An overall approach to funding that is broadly based to ensure financial stability.

D. The proposal must include a method to address compliance of the proposed design options under

paragraph A with federal law, if necessary, including the federal Patient Protection and Affordable Care Act or any other successor federal legislation; the federal Employee Retirement Income Security Act of 1974, as amended; and Titles XVIII, XIX and XXI of the federal Social Security Act.

E. The proposal must include an analysis of:

- (1) The impact of each design option on the State's current private and public insurance system;
- (2) The expected net fiscal impact of each design option;
- (3) The impact of each design option on the State's economy;
- (4) The benefits and drawbacks of alternative timing for the implementation of each design option, including the sequence and rationale for the phasing in of the major components; and
- (5) The benefits and drawbacks of each design option and of not changing the current system.

6. Compensation. The legislative members of the task force are entitled to receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses related to their attendance at authorized meetings of the task force. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the task force.

7. Quorum. A quorum is a majority of the voting members of the task force, including those members invited to participate who have accepted the invitation to participate.

8. Staffing. The Legislative Council shall provide staff support for the task force. To the extent needed when the Legislature is in session, the Legislative Council may contract for such staff support if sufficient funding is available.

9. Consultants; additional staff assistance. The task force may solicit the services of one or more outside consultants to assist the task force to the extent resources are available. Upon request, the Department of Health and Human Services, the Department of Professional and Financial Regulation, Bureau of Insurance and the University of Maine System shall provide any additional staffing assistance to the task force to ensure the task force and its consultant or consultants have the information necessary to create the design options required by this order.

10. Reports. The task force may submit an initial report, including suggested legislation, prior to January 1, 2018. No later than November 1, 2018, the task force shall submit a final report that includes its findings and recommendations, including suggested legislation, for introduction to the First Regular Session of the 129th Legislature.

11. Outside funding. The task force shall seek funding contributions to fully fund the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies. If sufficient contributions to fund the study have not been received within 30 days after the effective date of this order, no meetings are authorized and no expenses of any kind may be incurred or reimbursed.

APPENDIX B

Membership list, Task Force on Health Care Coverage for All of Maine

Task Force on Health Care Coverage for All of Maine

Appointment(s) by the President

Sen. Eric L. Brakey

146 Pleasant Street, Apt. 3
Auburn, ME 04210

Senators - 2 from party with largest number of seats, 2 from party froms second largest number of seats, at least one from IFS and one from HHS

Sen. Geoffrey M. Gratwick

1230 Kenduskeag Avenue
Bangor, ME 04401

Senators - 2 from party with largest number of seats, 2 from party froms second largest number of seats, at least one from IFS and one from HHS

Sen. Rodney L. Whittemore

PO Box 96
Skowhegan, ME 04976
207 474-6703

Senators - 2 from party with largest number of seats, 2 from party froms second largest number of seats, at least one from IFS and one from HHS

Ms. Kristine Ossenfort

25 Whaleboat Road
Portland, ME 04103
207 822-7260

Member representing interests of health insurance carriers

Sen. Everett Brownie Carson

PO Box 68
Harpwell, ME 04079

Senators - 2 from party with largest number of seats, 2 from party froms second largest number of seats, at least one from IFS and one from HHS

Joel Allumbaugh

128 Blodgett Road
Pittston, ME 04345
207 242-5007

Member representing interests of consumers

Jeffrey A. Austin

8 Parsons Farm Road
Brunswick, ME 04011
207 622-4794

Member representing the interests of hospitals

Mark Hovey

45 Harwood Circle
Belgrade, ME 04917
207 679-2261

Member representing interests of employers with greater than 50 employees

Appointment(s) by the Speaker

Rep. Paul Chace

31 Colonial Drive
Durham, ME 04222

Representatives - 2 from party with largest number of seats, 2 from party with 2nd largest number of seats at least one from IFS and one from HHS

Rep. Robert A. Foley

57 Shady Lane
Wells, ME 04090

Representatives - 2 from party with largest number of seats, 2 from party with 2nd largest number of seats at least one from IFS and one from HHS

Rep. Anne C. Perry

474 South Street
Calais, ME 04610

Representatives - 2 from party with largest number of seats, 2 from party with 2nd largest number of seats at least one from IFS and one from HHS

Rep. Heather B. Sanborn

82 Frost Hill Road
Portland, ME 04103

Representatives - 2 from party with largest number of seats, 2 from party with 2nd largest number of seats at least one from IFS and one from HHS

Daniel Kleban
Maine Beer Company
525 US Route 1
Freeport, ME 04032
207 221-5711

Member representing interests of employers with fewer than
50 employees

Kevin Lewis
Community Health Options
PO Box 1211
Lewiston, ME 04243
207 754-9516

Member representing interests of health insurance carriers

Francis McGinty
230 Clifton Street
Portland, ME 04103
207 653-4244

Member representing interests of health care providers

Patricia A. Riley
National Academy for Health Policy
50 Monument Square Suite 502
Portland, ME 04101
207 624-7442

Member representing interests of consumers

APPENDIX C

Summary of survey responses from task force members

Task Force on Health Care Coverage for All of Maine
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Summary of Survey Questions—13 respondents

Note from the chairs: We have developed this survey as a tool to help us better understand the areas of agreement and identify possible areas of disagreement among the task force members. We hope to use the results of the survey and the expertise of our task force members to frame our remaining work.

1. Do you agree that all Maine residents should be required to have health care coverage?

YES	NO
9	4

2. Do you agree that there should be a limit to what an individual pays for health care coverage based on a certain amount or percentage of income?*

YES	NO
9	2

**Does not equal 13 total responses as two respondents did not answer yes or no*

3. Do you agree that all health plans should be required to provide a certain level of minimum benefits? Please explain.

YES	NO
11	2

4. Do you agree that the affordability of health care coverage needs to be addressed? If so, what steps would you recommend?

YES	NO
13	0

5. Do you agree that access to health care coverage needs to be addressed? If so, what steps would you recommend?

YES	NO
12	1

6. Do you agree that administrative costs in the current health care system need to be addressed? If so, what steps would you recommend?

YES	NO
12	1

7. Do you agree that the cost and pricing of health care services need to be addressed? If so, what steps would you recommend?

YES	NO
12	1

8. Do you agree that the cost and pricing of prescription drugs need to be addressed? If so, what steps would you recommend?

YES	NO
13	0

9. Do you have any ideas for other state-level policy changes to improve the current health care system? Incremental or short-term improvements?

Comments:

- Restrict short term limited duration insurance to 3 months;
- Ensure association health plans pay for the externalities associated with creaming the best risk out of the individual market;
- Combine MHDO and HIN into a quasi-public-private entity that isn't hemmed in by its type of financing
- Link health maintenance and preventative measures with providing lower cost insurance. Real prevention--smoking cessation, weight loss and control (managing the obesity epidemic), nutrition and exercise programs for both healthy and at-risk people. Run a pilot for a study, and see what savings can be achieved.
- Public option
- Medicaid expansion
- Require all insurance sold in individual market to be in one risk pool
- Require all health care purchased with public dollars to jointly purchase and negotiate prices;
- Develop a public option or buy in to the aforementioned public payers plan
- I don't believe state level policy will be enough. It needs to be federal universal coverage
- Repeal of certificate of need laws or remove barriers to entry for new providers. Continued steps to improve transparency of pricing.
- I believe we'll have to do something to address health care pricing -- something like the Maryland model or other global budgeting solution
- Bring Private health insurers in the room and say we are going to take this away from you bit by bit with policy if you don't come back with a plan that works for all age levels at reasonable premiums
- Activate PL 90
- No, not without the kind of deliberation that this task force is doing.
- Give all state employees the option to switch their current healthcare plan for an HSA paired with a high-deductible plan. Allow them to invest the savings from switching to a high deductible into their HSA. Government is the largest single employer in Maine and putting

purchasing power directly into the hands of so many patients will force the industry to cater more to direct payers.

10. The task force is required to develop at least 3 proposals for providing coverage for all. Which model or models should the task force pursue? Please rank in order of highest to lowest priority.

2.82	a. A design for a government-administered and publicly financed universal payer health benefits system that is decoupled from employment, that prohibits insurance coverage for the health services provided by the system and that allows for private insurance coverage of only supplemental health services
2.83	b. A design for a universal health benefits system with integrated delivery of health care and integrated payment systems for all individuals that is centrally administered by State Government or an entity under contract with State Government;
3.92	c. A design for a public health benefits option administered by State Government or an entity under contract with State Government that allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans; or
3.67	d. A design for a private system consistent with state and federal law
2.57	e. Other (please describe)

APPENDIX D

Model legislation to address the transparency, accountability and oversight of pharmacy benefits managers



A MODEL ACT RELATING TO PHARMACY BENEFIT MANAGERS

1 *Whereas:* It is essential to understand the drivers and impacts of prescription drug costs, and
2 transparency is the first step toward that understanding and can lead to better cost containment and
3 greater consumer access to prescription drugs.

4 *Whereas:* Pharmacy benefit managers are companies that contract with health plans to administer the
5 health plan prescription drug benefit.

6 *Whereas:* Nearly all health plans require some level of cost sharing either via a fixed copayment or some
7 percentage of the cost of care. Pharmacy benefit managers may require patient drug cost sharing that
8 exceeds the pharmacy's actual cost of the medication.

9 *Whereas:* Pharmacy benefit manager business operations are not transparent.

10 *Whereas:* Some pharmacy benefit manager business practices appear to benefit the business at the cost
11 of the patient, the health plan, and the pharmacist.

12 *Therefore:* The legislature finds that there is a need to ensure the health and welfare of residents who
13 access prescription drugs managed by pharmacy benefit managers.

14 **General Description:**

15 The purpose of this act is to improve the business practice and transparency of pharmacy benefit
16 managers.

17 **Section 1. Definitions**

18 A. *Pharmacy Benefit Manager:* "Pharmacy Benefit Manager" means a person, business, or other
19 entity that, pursuant to a contract or under an employment relationship with a health carrier, a
20 self-insurance plan, or other third-party payer, either directly or through an intermediary,
21 manages the prescription drug coverage provided by the health carrier, self-insurance plan, or
22 other third-party payer including, but not limited to, the processing and payment of claims for

23 prescription drugs, the performance of drug utilization review, the processing of drug prior
24 authorization requests, the adjudication of appeals or grievances related to prescription drug
25 coverage, contracting with network pharmacies, and controlling the cost of covered prescription
26 drugs.

27 B. *Health Carrier*: “Health Carrier” means an entity subject to the insurance laws and regulations of
28 this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract,
29 or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the
30 cost of health care services, including a health insurance company, a health maintenance
31 organization, a hospital and health services corporation, or any other entity providing a plan of
32 health insurance, health benefits, or health care services.

33 C. *Health Benefit Plan*: “Health Benefit Plan” means a policy, contract, certificate or agreement
34 offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of
35 the costs of healthcare services.

36 D. *Covered Person*: “Covered Person” means a policyholder, subscriber, enrollee or other individual
37 participating in a health benefit plan. A covered person includes the authorized representative
38 of the covered person.

39 E. *Pharmacy*: “Pharmacy” means an established location, either physical or electronic that is
40 licensed by the State and that has entered into a network contract with a pharmacy benefit
41 manager and/or health carrier.

42 F. *Network Pharmacy*: “Network Pharmacy” means a retail or other licensed pharmacy provider
43 that contracts with a pharmacy benefit manager.

44 G. *Retail Pharmacy*: “Retail Pharmacy” means a chain pharmacy, a supermarket pharmacy, a mass
45 merchandiser pharmacy, an independent pharmacy, or a network of independent pharmacies
46 that is licensed as a pharmacy by the State of _____ and that dispenses medications to the
47 public.

48 H. *Mail Order Pharmacy*: “Mail Order Pharmacy” means a pharmacy whose primary business is to
49 receive prescriptions by mail, telefax or through electronic submissions and to dispense
50 medication to covered persons through the use of the United States mail or other common or
51 contract carrier services and that provides any consultation with patients electronically rather
52 than face to face.

53 I. *Aggregate Retained Rebate Percentage*: “Aggregate Retained Rebate Percentage” means the
54 percentage of all rebates received from a manufacturer or other entity to a Pharmacy Benefit
55 Manager for prescription drug utilization which is not passed on to Pharmacy Benefit Mangers’
56 health carrier clients. The percentage shall be calculated for each health carrier for rebates in

57 the prior calendar years as follows: a) the sum total dollar amount of rebates received from all
58 pharmaceutical manufacturers for all utilization of covered persons of a health carrier that was
59 not passed through to the health carrier; and b) divided by the sum total dollar amount of all
60 rebates received from all pharmaceutical manufacturers for covered persons of a health carrier.

61 J. *Rebates*: “Rebates” means all price concessions paid by a manufacturer to a Pharmacy Benefit
62 Manager or health carrier, including rebates, discounts, and other price concessions that are
63 based on actual or estimated utilization of a prescription drug. Rebates also include price
64 concessions based on the effectiveness a drug as in a value-based or performance-based
65 contract.

66 K. *Trade Secrets*: “Trade Secrets” has the meaning found in [state law citation].

67 L. *Cost Share/Cost Sharing*: “Cost Share/Cost Sharing” means the amount paid by a covered person
68 as required under the covered person’s health benefit plan.

69 **Section 2. Required Pharmacy Benefit Manager Licensure**

70 A. A Pharmacy Benefit Manager shall be licensed by [State Agency] before conducting business in
71 the State.

72 B. Licensure pursuant to this section is not transferable.

73 C. The license may be granted only when the [State Agency] is satisfied that the entity possesses
74 the necessary organization, background expertise, and financial integrity to supply the services
75 sought to be offered.

76 D. The [State Agency] may issue a license subject to restrictions or limitations upon the
77 authorization, including the type of services that may be supplied or the activities in which the
78 entity may be engaged.

79 E. All licenses are valid for a period of three years.

80 F. The [State Agency] shall develop an application for licensure that includes at least the following
81 information:

82 a. The name of the Pharmacy Benefit Manager;

83 b. The address and contact telephone number for the Pharmacy Benefit Manager;

84 c. The name and address of the Pharmacy Benefit Manager agent for service of process in
85 the State;

86 d. The name and address of each person beneficially interested in the Pharmacy Benefit
87 Manager; and

88 e. The name and address of each person with management or control over the Pharmacy
89 Benefit Manager.

90 G. The [State Agency] may suspend, revoke, or place on probation a Pharmacy Benefit Manager
91 license under any of the following circumstances:

- 92 a. The Pharmacy Benefit Manager has engaged in fraudulent activity that constitutes a
- 93 violation of state or federal law;
- 94 b. The [State Agency] received consumer complaints that justify an action under this
- 95 subdivision to protect the safety and interests of consumers;
- 96 c. The Pharmacy Benefit Manager fails to pay an application fee for the license; or
- 97 d. The Pharmacy Benefit Manager fails to comply with a requirement set forth in this
- 98 section.

99 H. If a Pharmacy Benefit Manager acts without registering, it will be subject to a fine of \$5,000 per
100 day for the period they are found to be in violation.

101 **Section 3. Pharmacy Benefit Manager Business Practices**

102 A. A Pharmacy Benefit Manager has a fiduciary duty to a health carrier client and shall discharge
103 that duty in accordance with the provisions of state and federal law.

104 B. A Pharmacy Benefit Manager shall perform its duties with care, skill, prudence, diligence, and
105 professionalism.

106 C. A Pharmacy Benefit Manager shall notify a health carrier client in writing of any activity, policy,
107 or practice of the Pharmacy Benefit Manager that directly or indirectly presents any conflict of
108 interest with the duties imposed in this section.

109 D. A Pharmacy Benefit Manager or health carrier shall not enter into a contract with a pharmacy or
110 pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to
111 a covered person regarding:

- 112 I. The cost of a prescription medication to the covered person; or
- 113 II. The availability of any therapeutically-equivalent alternative medications or alternative
114 methods of purchasing the prescription medication, including but not limited to, paying
115 a cash price that is less expensive to the customer than the cost of the prescription
116 under a covered person's health benefit plan.

117 E. A Pharmacy Benefit Manager shall not require pharmacy or other provider accreditation
118 standards or certification requirements inconsistent with, more stringent than, or in addition to
119 requirements of the [State] Pharmacy Board or other state or federal entity.

120 F. A health carrier or Pharmacy Benefit Manager may not require a covered person to make a
121 payment at the point of sale for a covered prescription medication in an amount greater than
122 the lesser of:
123 I. The applicable copayment for the prescription medication;
124 II. The allowable claim amount for the prescription medication;
125 III. The amount a covered person would pay for the prescription medication if the covered
126 person purchased the prescription medication without using a health benefit plan or
127 any other source of prescription medication benefits or discounts; or
128 IV. The amount the pharmacy will be reimbursed for the drug from Pharmacy Benefit
129 Manager or health carrier.

130 G. A health carrier or Pharmacy Benefit Manager is prohibited from penalizing, requiring, or
131 providing financial incentives, including variations in premiums, deductibles, copayments, or
132 coinsurance, to covered persons as incentives to use specific retail, mail order pharmacy, or
133 other network pharmacy provider in which a Pharmacy Benefit Manager has an ownership
134 interest or that has an ownership interest in a Pharmacy Benefit Manager.

135 **Section 4. Pharmacy Benefit Manager Transparency**

136 A. Beginning June 1, 2020, and annually thereafter, each licensed Pharmacy Benefit Manager shall
137 submit a transparency report containing data from the prior calendar year to the [State Agency].
138 The transparency report shall contain the following information:

139 I. The aggregate amount of all rebates that the Pharmacy Benefit Manager received from
140 all pharmaceutical manufacturers for all health carrier clients and for each health carrier
141 client;
142 II. The aggregate administrative fees that the Pharmacy Benefit Manager received from all
143 manufacturers for all health carrier clients and for each health carrier client;
144 III. The aggregate retained rebates that the Pharmacy Benefit Manager received from all
145 pharmaceutical manufacturers and did not pass through to health carriers;
146 IV. The aggregate retained rebate percentage as defined in Sec.(2)(I); and
147 V. The highest, lowest, and mean aggregate retained rebate percentage for all health
148 carrier clients and for each health carrier client.

149 B. A Pharmacy Benefit Manager r providing information under this section may designate that
150 material as a trade secret. Disclosure, however, may be ordered by a court of this State for good
151 cause shown or made in a court filing.

152 C. Within sixty (60) days of receipt, the [State Agency] shall publish the transparency report of each
153 Pharmacy Benefit Manager on the agency's website in a way that does not violate State trade
154 secrets law.

155 D. The state Attorney General may impose civil fines and penalties of not more than \$1,000 per
156 day per violation of this section.

157 **Section 5. Severability Clause**

158 If any provision of this act or the application of this act to any person or circumstance is held invalid, the
159 invalidity shall not affect other provisions or applications of this act which can be given effect without
160 the invalid provision or application, and to this end, the provisions of the act are declared severable.

161 **Except as otherwise provided, this Act is effective six months after enactment.**

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National Council of Insurance Legislators (NCOIL)

Pharmacy Benefits Manager Licensure and Regulation Model Act

Sponsored by Sen. Jason Rapert (AR)
Discussion Draft as of October 15, 2018

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Section 1. Title

This Act shall be known as and may be cited as the “[State] Pharmacy Benefits Manager Licensure and Regulation Act.”

Section 2. Purpose

(a) This Act establishes the standards and criteria for the regulation and licensure of pharmacy benefits managers providing claims processing services or other prescription drug or device services for health benefit plans.

(b) The purpose of this Act is to:

(1) Promote, preserve, and protect the public health, safety, and welfare through effective regulation and licensure of pharmacy benefits managers;

(2) Provide for powers and duties of the Insurance Commissioner, the State Insurance Department; and

(3) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

(a) "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

- (1) Receiving payments for pharmacist services;
- (2) Making payments to pharmacists or pharmacies for pharmacist services; or
- (3) Both subdivisions (a)(1) and (2) of this section.

(b) "Other prescription drug or device services" means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including without limitation:

- (1) Negotiating rebates, discounts, or other financial incentives and arrangements with drug companies;
- (2) Disbursing or distributing rebates;
- (3) Managing or participating in incentive programs or arrangements for pharmacist services;
- (4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
- (5) Developing formularies;
- (6) Designing prescription benefit programs; or
- (7) Advertising or promoting services.

(c) "Pharmacist" means an individual licensed as a pharmacist by the State Board of Pharmacy.

(d) "Pharmacist services" means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

(e) "Pharmacy" means the place licensed by the State Board of Pharmacy in which drugs, chemicals, medicines, prescriptions, and poisons are compounded, dispensed, or sold at retail.

(f) (1) "Pharmacy benefits manager" means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that provides claims processing services or other prescription drug or device services, or both, for health benefit plans.

(2) "Pharmacy benefits manager" does not include any:

(i) Healthcare facility licensed in [this State];

(ii) Healthcare professional licensed in [this State];

(iii) Consultant who only provides advice as to the selection or performance of a pharmacy benefits manager; or

(iv) Entity that provides claims processing services or other prescription drug or device services for the fee-for-service [State]Medicaid Program only in that capacity.

Section 4. License to do business – Annual statement – Assessment

(a) (1) A person or organization shall not establish or operate as a pharmacy benefits manager in this State for health benefit plans without obtaining a license from the Insurance Commissioner under this Act.

(2) The commissioner shall prescribe the application for a license to operate in this State as a pharmacy benefits manager and may charge application fees and renewal fees as established by rule.

(b) (1) The commissioner shall issue rules establishing the licensing, fees, application, financial standards, and reporting requirements of pharmacy benefits managers under this Act and not inconsistent herewith.

Section 5. Gag clauses prohibited

(a) In any participation contracts between pharmacy benefits managers and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted, or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny healthcare services or benefits, or information on financial incentives and structures used by the insurer.

(b) A pharmacy or pharmacist may provide to an insured information regarding the insured's total cost for pharmacist services for a prescription drug.

(c) A pharmacy or pharmacist shall not be proscribed by a pharmacy benefits manager from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available.

(d) A pharmacy benefits manager contract with a participating pharmacist or pharmacy shall not prohibit, restrict, or limit disclosure of information to the Insurance Commissioner, law enforcement, or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements under this Act.

Section 6. Enforcement

(a) The Insurance Commissioner shall enforce this Act.

(b) (1) The commissioner may examine or audit the books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine if the pharmacy benefits manager is in compliance with this Act.

(2) The information or data acquired during an examination under subdivision (b)(1) of this section is:

(A) Considered proprietary and confidential; and

(B) Not subject to the [Freedom of Information Act]¹ of this State

Section 7. Rules

(a) The Insurance Commissioner may adopt rules regulating pharmacy benefits managers that are not inconsistent with this Act.

(b) Rules adopted under this Act shall set penalties or fines, including without limitation monetary fines, suspension of licensure, and revocation of licensure for violations of this Act and rules adopted under this Act.

Section 8. Applicability

(a) This Act is applicable to a contract or health benefit plan issued, renewed, recredentialed, amended, or extended on and after _____.

(b) A contract existing on the date of licensure of the pharmacy benefits manager shall comply with the requirements of this Act as a condition of licensure for the pharmacy

¹ DRAFTING NOTE: State FOIAs have different names in different states, often called Open Records Acts, Public Records Act, Public Records Law, etc. and thus the specific title used in this subsection needs to be tailored accordingly.

benefits manager.

(c) This Act is not applicable to health benefit plans that are self-funded and specifically exempted from regulation by this State by The Employee Retirement Income Security Act of 1974 (ERISA).

Section 9. Severability Clause

If any provision of this act or the application of this act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are declared severable.

Section 10 Effective Date

This Act is effective immediately.

DRAFT

APPENDIX E

Model legislation related to importation of prescription drugs



1 **An Act to Permit the Wholesale Importation of Prescription Drugs into [State]**

2 *Whereas:* United States citizens pay some of the very highest prices for prescription drugs in the world
3 and the Canadian government estimated that U.S. consumers pay twice as much as Canadians for
4 patented prescription drugs and 20 percent more for generics.

5 *Whereas:* Under FDA discretion not to enforce the law, individual patients may import a 90 day supply of
6 prescription drugs from Canada that are less expensive than drugs licensed by the FDA in the United
7 States.

8 *Whereas:* Individual importation via the internet increases consumer health and safety risks because
9 many internet pharmacies are not licensed in Canada and it is difficult to verify the validity, reputation,
10 actual identity and pharmacy practices of ex-U.S., on-line pharmacies.

11 *Whereas:* The U.S. allows patients to go to other countries for surgeries and other high-risk medical
12 treatments without regulating that consumer purchasing activity and insurers sometimes facilitate and
13 pay for ex-US treatments.

14 *Whereas:* FDA estimates that currently 40 percent of finished prescription drug products are produced
15 outside the U.S. and 80 percent of raw product for U.S. pharmaceutical manufacturing comes from
16 outside the U.S.

17 *Whereas:* The FDA has just signed reciprocity agreements with EU regulators to accept the results of EU
18 inspections pharmaceutical manufacturing plants. The FDA has a Memorandum of Understanding for
19 regulatory cooperation around pharmaceuticals with the Canadian regulatory authorities since 1973.

20 *Whereas:* Canada has a rigorous regulatory system to license prescription drugs that is considered to be
21 on par with the U.S. licensing system.

22 *Whereas:* Title II of the federal Drug Quality and Security Act (P.L. 113 -54), Drug Supply Chain Security,
23 has resulted in improvements in drug security and safety through a system of pharmaceutical track and
24 trace that can be leveraged for safe importation.

25 *Whereas:* The Secretary of the U.S. Department of Health and Human Services may certify a prescription
26 drug reimportation program that is safe and saves consumers money.

27 *Whereas:* [State] can assure that wholesale importation of prescription drugs from Canada into our
28 State will be safe and cost-saving for [State] consumers.

29 *Therefore:* [State agency] is directed to implement a wholesale drug importation program for the
30 exclusive benefit of residents of the State of [name].

31 **General Description:**



1 This Act directs the [State agency] to work with relevant State stakeholders, as well as federal offices
2 and agencies, to develop and implement a prescription drug wholesale importation program that is safe
3 for [State] consumers and generates substantial savings for [State] consumers.

4 **Section 1. Definition**

5 Importation Program: A State-administered wholesale importation program where the State is the
6 licensed wholesaler, importing drugs from a licensed, regulated Canadian supplier, solely for distribution
7 to voluntarily participating, state-licensed, in-state, pharmacies and administering providers for the
8 exclusive purpose of dispensing to state residents with a valid prescription.

9 **Section 2. Directive to Develop the Wholesale Importation Program Design that Complies with the**
10 **Following Administrative Specifications**

11 The [State agency] is directed to design a wholesale prescription drug importation program in
12 consultation with relevant State stakeholders and federal offices and agencies that will meet relevant
13 requirements of 21 U.S.C. § 384, including safety and cost savings. In developing a prescription drug
14 importation program for federal certification, the [State agency] shall address the following issues:

- 15 1. That a State agency becomes a licensed wholesaler for the purpose of seeking federal
16 certification and approval to import safe prescription drugs that will provide savings to
17 [State] consumers/
- 18 2. That the program uses Canadian suppliers regulated under the appropriate Canadian and/or
19 provincial laws;
- 20 3. That the program has a process to sample the purity, chemical composition, and potency of
21 imported products;
- 22 4. That the program only imports those prescription pharmaceuticals expected to generate
23 substantial savings for [State] consumers;
- 24 5. That the program ensures imported products will not be distributed, dispensed, or sold
25 outside of [State] borders;
- 26 6. That the program ensures voluntary participant, state-licensed, pharmacies and
27 administering providers charge individual consumers and health plans the actual acquisition
28 cost of the imported, dispensed product;
- 29 7. That the program ensures health plan payment of the product component of pharmacy and
30 provider billing reimburses no more than the actual acquisition cost of the dispensed,
31 imported product;
- 32 8. That the program ensures participating health plans keep their formularies and claims
33 payment systems up to date with the prescription drugs provided through the wholesale
34 importation program;
- 35 9. That the program ensures participating health plans base patient cost sharing on no more
36 than the actual acquisition cost of the dispensed, imported product;
- 37 10. That the program require participating health plans to demonstrate to the [State agency]
38 how savings on imported drugs are reflected in premiums.



- 1 11. That profit margin of any participating wholesaler and/or distributor(s) of imported
2 pharmaceutical products is limited to a specified amount established by the [State agency];
- 3 12. That the program does not import generic products that would violate U.S. patent laws on
4 U.S. branded products;
- 5 13. That the program complies with the requirements of 21 U.S.C. §581-582, pertaining to the
6 track and trace requirements as enacted in Title II of the Drug Security and Quality Act (P.L.
7 113-54) to the extent practical and feasible before imported drugs come into possession of
8 the State wholesaler and complies fully after imported drugs are in the possession of the
9 State wholesaler;
- 10 14. That the program is adequately financed through a fee on each prescription or other
11 appropriate approach, but the size of the fee cannot jeopardize significant consumer
12 savings;
- 13 15. That the program includes an audit function to ensure that:
 - 14 (1) The [State agency] has a sound methodology by which to determine the most cost-
15 effective products to include in the importation program on an ongoing basis;
 - 16 (2) The [State agency] has processes in place to select Canadian suppliers of high quality,
17 high performance, and in full compliance with Canadian law and regulation [and at the
18 option of the Sponsor, state pharmacy or wholesaler laws];
 - 19 (3) Imported drugs under the State program are not shipped, sold, or dispensed outside the
20 State once in the possession of the State;
 - 21 (4) Imported products are pure, unadulterated, potent, and safe;
 - 22 (5) Participating pharmacies and administering providers are not charging more than actual
23 acquisition cost to any consumer or any participating health plan;
 - 24 (6) Participating health plan formularies and claims processing systems remain up to date
25 with all relevant aspects of the importation program;
 - 26 (7) Participating health plans base patient coinsurance and other cost sharing on the actual
27 acquisition cost of covered, imported drugs;
 - 28 (8) Participating health plans reimburse participating pharmacies and administering
29 providers actual acquisition cost for imported, dispensed product;
 - 30 (9) The program is adequately financed to support all administrative functions while
31 generating significant consumer savings;
 - 32 (10)The program does not put consumers at higher risk than if the program did not exist;
33 and
 - 34 (11)The program continues to provide [State] consumers with substantial savings on
35 prescription drugs.

36 **Section 3. Monitoring for Anti-Competitive Behavior**

37 The [State Agency] shall enlist the assistance of the Attorney General to identify the potential for
38 anticompetitive behavior in industries that would be affected by a program of importation.



1 **Section 4. Report Back to Authorizing Committee**

2 The [State agency] is directed to report back to Committee of jurisdiction by [6 months from date of
3 enactment] on the final State wholesale importation program design that takes into consideration at
4 least the items in Section 2 above.

5 **Section 5. Submission of Request for Federal Certification and Approval**

6 Upon the approval of the Committee, the [State agency] shall submit a formal request to the Secretary
7 of the U.S. Department of Health and Human Services for certification of the State’s wholesale drug
8 importation program. The [State agency] shall submit the request within two weeks of obtaining the
9 Committee’s approval.

10 **Section 6. Implementation/Additional Administrative Requirements**

11 Upon certification and approval by the Secretary of the US Department of Health and Human Services,
12 the [State agency] shall begin implementation of the wholesale importation program and have the
13 program operational within six months of the date of the Secretary’s certification. As part of the
14 implementation process the [State agency] shall, in accordance with State procurement and contracting
15 laws and rules as appropriate:

- 16 1. Become licensed as a wholesaler;
- 17 2. Contract with a state-licensed distributor or distributors;
- 18 3. Contract with a licensed, regulated, Canadian supplier or suppliers;
- 19 4. Engage health plans, employers, pharmacies, providers, and consumers;
- 20 5. Develop a registration process health plans, pharmacies, and administering providers willing to
21 participate;
- 22 6. Create a publicly available source for listing prices of imported products that will be available to
23 all participating entities and consumers;
- 24 7. Create an outreach and marketing plan to generate program awareness;
- 25 8. Create and staff a hotline to answer questions from any affected sector starting in the weeks
26 before the program becomes operational that can address the needs and questions of
27 consumers, employers, plans, pharmacies, and providers, among others;
- 28 9. Establish the audit function and a two year audit work plan cycle; and
- 29 10. Conduct any other activities determined to be important to successful implementation as
30 determined by the [State agency].

31 **Section 7. Ongoing Oversight of Program Administration**

32 The [State agency] shall report to this Committee biannually, commencing with either the first June or
33 December after implementation, whichever is the nearest date to the date that is six months after
34 program implementation. The report to the Committee shall include:

- 35 1. The drugs covered in the wholesale importation program;



- 1 2. The number of participating pharmacies, providers and health plans;
- 2 3. The number of prescriptions dispensed under the program in the period;
- 3 4. The estimated savings to consumers, health plans, and employers that resulted from the
- 4 program in the reporting period and to date;
- 5 5. In the first three reporting periods, information on the implementation of the audit plan and, on
- 6 an on-going basis, audit findings for the reporting period; and
- 7 6. Any other information of importance as determined by the [State agency].

Contact Us

States interested in this model legislation will have access to a legislator's guide and additional background materials as they become available. If you have questions about the model act or are interested in technical assistance please contact Jane Horvath (jhorvath@nashp.org).

APPENDIX F

Model legislation related to a state commission to establish rates for certain high-cost prescription drugs



1 **AN ACT TO ESTABLISH RATE SETTING OF PRESCRIPTION DRUGS IN [STATE]**

2 **Whereas** prescription medications are as important to the health and safety of State residents as
3 traditional public services or utilities such as transportation, gas, electric, telecommunications, and
4 water;

5 **Whereas** [State] has traditionally regulated the consumer price of utilities because of the monopoly
6 structure of the market;

7 **Whereas** the cost of many prescription drugs have become increasingly unaffordable for [State]
8 residents, [State] employers, and [State] and local governments because parts of the prescription drug
9 market are monopolies or oligopolies, and the costs to consumers in these parts of the market are not
10 managed;

11 **Whereas** Canada has a national drug price review board that seldom has to exert its express authority in
12 order for the industry to offer drugs to market at prices that are, on average, 30 percent less than U.S.
13 list prices;

14 **Whereas** the difference between the affordability of traditional utilities and the costs/affordability of
15 prescription drugs is due in part to the active role of our State government in directing how much
16 consumers pay for utilities and the corresponding inactive role of our State government in directing how
17 much consumers pay for drugs;

18 **Whereas** state and federal agencies have a long history of health care rate setting including for brand
19 pharmaceuticals and biologics, and generic drugs to control health care costs;

20 **Therefore**, be it resolved that [State] will create a Drug Cost Review Commission with authority to
21 protect State residents, state and local governments (including their contractors and vendors),
22 commercial health plans, providers, state-licensed pharmacies, and other health care system
23 stakeholders from excessive costs of certain prescription drugs.

24 **Overview**

25 This Act creates a new [State] Drug Cost Review Commission with five members and a full time staff to
26 receive and review statutorily-required information submissions from the makers of brand name and
27 generic prescription drug products, the price for which triggers reporting. The Commission will be
28 supported by an 11 stakeholder Advisory Board.

29 Manufacturer submissions, based on requirements established by the Commission, will be used to
30 determine the reasonableness of the costs created by a prescription drug product. The Commission will
31 have a public process for each drug under review. The Commission will accept analysis and data from
32 manufacturers, payors, consumers, as well as staff or Commission contractors to determine if the cost to



1 the system of appropriate utilization of a drug is commensurate with its benefit to the system and
2 whether the drug is affordable to State residents.

3 The Commission will review submissions that concern drug cost to make a determination as to whether
4 the cost of a drug under review is affordable. If the Commission finds that the cost in the State is not
5 affordable to State health care systems and State residents, the Commission is authorized to establish a
6 cost or payment rate for the drug to which all State programs, local governments, State-licensed
7 commercial health plans (including State marketplace plans), State-licensed pharmacies, wholesalers
8 and distributors must abide. These 'covered entities' are prohibited from paying more for the drugs than
9 the Commission-established rate and would be enforced by the Attorney General.

10 The Commission can contract-out the cost/affordability analysis or have in-house expertise.

11 The Commission will have an Advisory Board of experts and stakeholders.

12 The Commission's operations can be funded by a variety and combination of entity-appropriate fees
13 (see Section 8).

14 Section 1. Operations of the Commission

15 1) MEETINGS:

16 a) The Commission shall meet in public session at least every six weeks to review prescription drug
17 (biologic and pharmaceutical) product information submissions. Meetings can be cancelled or
18 postponed upon the decision of the Chair if there are no pending submissions.

19 b) Each public meeting will be announced two weeks in advance.

20 c) Materials for the meeting will be made public at least one week in advance.

21 d) Each public meeting will provide opportunity for comments from the public.

22 e) The Commission will provide the opportunity for written comments on pending decisions.

23 f) The Commission may allow expert testimony at the meetings and in Executive Session.

24 g) The Commission shall publicly deliberate on whether to subject a prescription drug product to a
25 full cost review.

26 h) The Commission shall publicly review a prescription drug product cost analysis and take a public
27 vote on whether to impose a cost or payment limit on payors for a prescription drug product.

28 i) The Commission may meet in Executive Session, so long as decisions are made in public.

29

30 2) PUBLIC ACCESS TO DATA: All submissions to the Commission pertaining to a drug price notices and
31 drug cost review are to be made publicly available with the exception of information determined to
32 be proprietary for different industries that may be submitting information. After public notice and
33 comment, the Commission will establish parameters for what is considered proprietary, and will give
34 particular attention to any pre-market submissions.



1 3) QUORUM: The Commission may make binding decisions in the presence of a simple majority of
2 Commissioners.

3 Section 2. Required Manufacturer Notice of Introductory Price 4 and Price Increases

5 1) FOR PATENTED PRODUCTS

6 a) A manufacturer shall notify the Commission if it is increasing the Wholesale Acquisition Cost
7 (WAC) of a patent-protected brand-name drug by more than 10 percent or by more than
8 \$10,000 during any 12-month period, or if it intends to introduce to market a brand-name drug
9 that has a WAC of \$30,000 per year or per course of treatment. The notice shall be provided in
10 writing at least 30 days prior to the planned effective date of the increase or launch and include
11 a justification as detailed in Paragraph 3 of this Section.

12 b) After consultation with stakeholders and experts, the Commission will establish a third
13 threshold that, when breached, triggers manufacturer reporting for brand prescription drugs,
14 including biologics and biosimilars. The third, distinct threshold will achieve reporting by
15 branded products that have launch prices or price increases below thresholds in (1)(a), but
16 impose costs on the State health care system that create significant challenges to affordability.

17 2) FOR GENERIC PRODUCTS AND OFF-PATENT SOLE SOURCE BRANDED PRODUCTS:

18 a) a manufacturer shall notify the Commission if it is increasing the WAC of a generic or off-patent
19 sole source branded product drug by more than 25 percent or by more than \$300 during any 12-
20 month period, or if it intends to introduce to market a generic drug that has a WAC of \$3,000 or
21 more annually. The notice shall be provided in writing at least 30 days prior to the planned
22 effective date of the increase or launch and include a justification as detailed in Paragraph 3 of
23 this Section.

24 b) After consultation with stakeholders and experts, the Commission will establish a third
25 threshold that when breached, triggers manufacturer reporting for generic and off-patent, sole
26 source branded prescription drugs. The third, distinct threshold will achieve reporting by
27 products that have price increases below thresholds in (2)(a), but impose costs on the State
28 health care system that create significant challenges to affordability.

29 3) JUSTIFICATION: Justification for the proposed launch price or price increases specified in (1) and (2)
30 of this section shall include all documents and research related to the manufacturer's selection of
31 the launch price or price increase, including but not limited to life cycle management, net average
32 price in the State (net of all price concessions but excluding in-kind concessions), market



1 competition and context, projected revenue, and if available, estimated value/cost-effectiveness of
2 the product.

3 Section 3. Criteria for Selection of Drugs for Review of Cost

- 4 1) PUBLIC COMMENT: The Commission will keep the public informed about manufacturer price
5 decision reporting under Section 2. The Commission will provide the public an opportunity to
6 request Commission review of the cost of any prescription drug that triggered reporting under
7 Section 2.
- 8 2) ROLE OF THE CHAIR: The Commission Chair will review the public comments and decide whether to
9 undertake a review of a particular drug that triggered reporting under Section 2. The Chair can
10 decide that the Commission will undertake a review in the absence of public comments.
- 11 3) ROLE OF COMMISSIONERS: The Commission members can request a vote on whether or not to
12 undertake a review if there is not consensus with the decision of the Chair.

13 Section 4. Determining Excess Costs to Payors and Consumers

- 14 1) IN GENERAL: Once a decision has been made to undertake a cost review pursuant to Section 3, the
15 Commission review will determine if appropriate utilization (utilization fully consistent with the FDA
16 label) of a prescription drug product has lead or will lead to excess costs for health care systems in
17 the State.
- 18 2) DEFINITION OF EXCESS COSTS: "Excess Costs" is defined as
 - 19 a) Costs of appropriate utilization of a prescription drug product that exceed the therapeutic
20 benefit relative to other therapeutic options/alternative treatments or
 - 21 b) Costs of appropriate utilization of a prescription drug product that are not sustainable to public
22 and private health care systems over a ten-year timeframe.
- 23 3) PHASE ONE DETERMINATIONS: Factors the Commission may consider in determining cost and
24 excess cost include the following:
 - 25 a) The price at which the prescription drug has been/will be sold in the State
 - 26 b) The average monetary price concession/discount/rebate the manufacturer provides to payors in
27 the State/or is expected to provide to payors in the State as reported by manufacturers and
28 health plans
 - 29 c) The price at which therapeutic alternates have been/will be sold in the State
 - 30 d) The average monetary price concession/discount/rebate the manufacturer provides to health
31 plan payors in the State or is expected to provide to payors in the State for therapeutic
32 alternates
 - 33 e) The relative clinical merits of the product under review compared to therapeutic alternates
 - 34 f) The cost to payors based on patient access consistent with FDA labeled indication(s)



- 1 g) The impact on patient access resulting from the cost of the product relative to insurance benefit
- 2 design
- 3 h) The current or expected value of manufacturer-supported, drug-specific, patient access
- 4 programs
- 5 i) The relative financial impacts to health, medical and other social services costs, as can be
- 6 quantified and compared to baseline effects of existing therapeutic alternatives
- 7 j) Other such factors as may be specified in regulation by the Commission.
- 8 4) PHASE TWO DETERMINATIONS: If, after considering the factors in (3), the Commission is unable to
- 9 determine if a prescription drug product will produce or has produced excess costs, then the
- 10 Commission may consider the following:
- 11 a) Manufacturer research and development costs, as shown on the company's federal tax filing for
- 12 the most recent tax year multiplied by the proportion of manufacturer in-State sales to U.S.
- 13 sales;
- 14 b) That portion of direct to consumer marketing costs eligible for favorable federal tax treatment
- 15 in the most recent tax year, which are specific to the prescription drug product under review
- 16 and that are multiplied by the ratio of total manufacturer in-State sales to total manufacturer
- 17 U.S. sales for the product under review;
- 18 c) Gross and net manufacturer revenues for the most recent tax year; and
- 19 d) Any additional factors which can be specified in regulations or that the Commission considers
- 20 relevant to the circumstances, as may be proposed by the manufacturer.

21 Section 5. Commission Determinations, Compliance and

22 Remedies

- 23 1) RATE SETTING: In the event the Commission finds that the spending on the prescription drug
- 24 product under review creates excess costs for payors and consumers, the Commission shall establish
- 25 the level of reimbursement that shall be billed and paid among payors and
- 26 pharmacies/administering providers, wholesalers/distributors and pharmacies/administering
- 27 providers, and pharmacies/administering providers and uninsured consumers or consumers in a
- 28 deductible period.
- 29 2) COMPLIANCE WITH RATE SETTING: Instances of failure to bill and pay at Commission-established
- 30 levels under Section 4 shall be referred to the Attorney General
- 31 a) Upon a finding of non-compliance with the Commission requirements, the Attorney General
- 32 may pursue remedies consistent with the State Fair Market Practice statutes, or in the case of
- 33 intentional profiteering, other appropriate criminal statutes.
- 34 b) It shall not be considered non-compliance if a health care stakeholder obtains price concessions
- 35 from a manufacturer that result in an insurer's net cost lower than the rate established by the
- 36 Commission.



- 1 c) The Attorney General shall provide guidance to stakeholders concerning activities that could be
2 considered non-compliant, in addition to payment transactions where drug costs exceed the
3 Commission established limit.
- 4 3) COMPLIANCE WITH REPORTING: Instances of manufacturer failure to report under Sections 2 or 4
5 shall be referred to the Attorney General for review. The Attorney General may pursue remedies
6 available based on State Fair Market Practice or Consumer Protection laws.

7 Section 6. Appeals

- 8 1) APPEALS: Individuals and entities affected by a decision of the Commission can request an appeal
9 within 30 days of the Commission decision. The full Commission will hear the appeal and make a
10 decision within 60 days.
- 11 2) JUDICIAL REVIEW: Decisions on appeal can be subject to judicial review.

12 Section 7. Financing

- 13 1) ESTABLISHING AN OPERATING BUDGET: The Commission Chair shall recommend to the legislature
14 financing options within six months of establishment of the Commission.
- 15 2) INTERIM FUNDING Commission will be funded for the first two years with such sums as are
16 necessary but not to exceed \$___ per year until the financing option selected from the
17 recommendations in Subsection 1 are enacted.

18 Section 8. Annual Reports

- 19 1) The Commission shall report annually to the public on general drug price trends, the number of
20 companies required to report because of drug pricing decisions, and the number of products that
21 were subject to Commission review and analysis – including the results of that analysis, as well as
22 the number and disposition of appeals and judicial reviews.

23 Section 9. The Drug Cost Review Commission Membership and 24 Staff Membership

- 25 1) COMMISSION COMPOSITION AND APPOINTMENTS:
- 26 a) The DCRC will have 5 members appointed as follows: 3 members appointed by the Governor, 1
27 member appointed by the Senate, and 1 member appointed by the Assembly.
- 28 b) Initial Appointees serve staggered terms of 3, 4 and 5 years, and subsequent appointees shall
29 serve 5 year terms. The Governor shall name the Chair, and the Chair shall designate the Co-
30 Chair. The Governor will appoint two alternate Commissioners to participate in deliberations in
31 the event a regular Commissioner must be recused.



- 1 c) Commissioners should have expertise in health care economics or clinical medicine.
- 2 2) ADVISORY BOARD COMPOSITION AND APPOINTMENTS:
- 3 a) The Governor will appoint an 11 member Board to advise the Commission on drug cost issues
- 4 and represent stakeholder views.
- 5 b) Initial Appointees serve staggered terms of 3, 4 and 5 years, and subsequent appointees shall
- 6 serve 2 year terms. The Governor shall name the Chair, and the Chair shall designate the Co-
- 7 Chair.
- 8 c) The Advisory Board members will be selected based on their knowledge of one or more of the
- 9 following: the pharmaceutical business model, practice of medicine/clinical knowledge and
- 10 training, patients' perspectives, health care cost trends and drivers, clinical and health services
- 11 research, and the state health care marketplace generally.
- 12 d) The Board must include at least 2 members representing patients and health care consumers, 2
- 13 members representing physicians and providers, 2 members each representing commercial
- 14 payors, government employee benefits, and large employer plans, 1 member representing
- 15 pharmaceutical manufacturers, 1 health services researchers, 1 clinical researcher, 1
- 16 pharmacologist, and 1 state budget office representative.
- 17 3) CONFLICT OF INTEREST:
- 18 a) In appointing the Commission or the Board, any conflicts of interest shall be considered and
- 19 disclosed. Members of the Commission and the Board shall be recused from relevant
- 20 Commission activities in the case where the member (or an immediate family member of such
- 21 member) has a real conflict of interest directly related to the drug product under review.
- 22 b) With regard to Commissioners, Board members, staff and contractors, the term 'conflict of
- 23 interest' means an association, including a financial or personal association, which has the
- 24 potential to bias or have the appearance of biasing an individual's decisions in matters related to
- 25 the Commission or the conduct of the Commission's activities.
- 26 c) A Commission member, staff or contractor with a real conflict of interest with regard to any
- 27 prescription drug under review will recuse themselves from the review. The term 'real conflict of
- 28 interest' means any instance where a member of the Commission (or a close relative), has
- 29 received or could receive either of the following:
- 30 (I) A direct financial benefit of any amount deriving from the result or findings of a study or
- 31 determination by or for the Commission or
- 32 (II) A financial benefit from individuals or companies that own or manufacture prescription
- 33 drug s, services, or items to be studied by the Commission that in the aggregate exceeds
- 34 \$5,000 per year. For purposes of the preceding sentence, a financial benefit includes
- 35 honoraria, fees, stock, or other financial benefit and the current value of the member's
- 36 (or close relative's) already existing stock holdings, in addition to any direct financial
- 37 benefit deriving from the results or findings of a study conducted under this section.
- 38 4) DISCLOSURE TIMING: In general, a conflict of interest shall be disclosed in the following manner:



- 1 a) By the Commission in the employment of Commission senior staff;
- 2 b) By the Governor, Senate or House/Assembly in appointing members to the Commission and
- 3 Advisory Board;
- 4 c) By the Commission, describing any recusals as part of any final decision resulting from a review
- 5 of a prescription drug product; and
- 6 d) By the fifth day after a conflict is identified or if sooner, in advance of any public meeting.
- 7 5) MANNER OF DISCLOSURE: Conflicts of interest will be publicly posted on the website of the
- 8 Commission. The information disclosed under the preceding sentence shall include the type, nature
- 9 and magnitude of the interests of the individual involved, except to the extent that the individual
- 10 recuses himself or herself from participating in the consideration of any activity with respect to the
- 11 study for which the potential conflict exists.
- 12 6) GENERAL PROHIBITIONS: The Commission, the Advisory Board, staff and third party contractors shall
- 13 be prohibited from accepting gifts, bequeaths or donations of services or property that raise the
- 14 specter of conflict of interest or have the appearance of injecting bias into the work of the
- 15 Commission.
- 16 7) APPOINTMENTS AND HIRING: The Commission shall be organized as follows:
- 17 a) The Governor shall appoint the Chair;
- 18 b) The Chair shall appoint the co-Chair;
- 19 c) The Chair shall hire an Executive Director and General Counsel;
- 20 d) The Executive Director, with the approval of the Commission, shall hire staff; and
- 21 e) Staff positions and salary shall, to the extent feasible, comport with state personnel rules and
- 22 requirements. Exceptions can be made for necessary positions that have no equivalent to state
- 23 government schedules in terms of expertise or function.
- 24 8) COMPENSATION:
- 25 a) Commissioners and Board Members will be paid a per diem and travel reimbursement
- 26 consistent with the State Administrative Procedures Act
- 27 b) Staff will be paid based on State Office of Personnel policies except as described in (6).

Contact Us

States interested in this model legislation will have access to a legislator's guide and additional background materials as they become available. If you have questions about the model act or are interested in technical assistance please contact Jennifer Reck (jreck@nashp.org).

APPENDIX G

Additional comments from task force members who are not in favor of certain recommendations

Joel Allumbaugh, who represents the interests of consumers on the task force, provided the following comments related to the task force recommendation proposing legislation in the 129th Legislature to address the transparency, accountability and oversight of pharmacy benefits managers:

Though I agree wholeheartedly with my fellow task force members that prescription drug prices are a significant and growing problem, I am uncomfortable recommending legislation to regulate PBM's. Self-insured employers have seen the PBM environment evolving in recent years. New entrants are trying to enter the PBM space, I expect largely due to the issues discussed by the task force such as lack of transparency and cost containment.

State level regulation of PBMs I fear will have the opposite effect intended. The large entrenched PBMs, largely where the problems exist, are the ones with the resources to navigate state specific rules, where the smaller new entrants disrupting the market are likely to lack the necessary resources and will simply be shut out of our market.

I don't come at this issue with the benefit of study and analysis and review of opposing positions which should accompany any discussion of legislative or regulatory action, however, my gut reaction is that this approach will do more harm than good and that the market is prime for competitive disruption which legislation could inhibit. Though state level PBM regulation would likely intend to benefit Maine employers, the result could be a reduction of choices for employers that results in higher versus lower prescription costs.

Kristine Ossenfort, who represents health insurance carriers on the task force, provided the following comments related to the task force recommendation proposing legislation in the 129th Legislature to address the transparency, accountability and oversight of pharmacy benefits managers:

It is premature to pursue adoption of a model act at this time, and that further study of the issue would be more appropriate. Furthermore, while the cost of prescription drugs is a significant concern it is worth noting that a legislative proposal to regulate PBMs does not address the underlying cost of prescription drugs.

Joel Allumbaugh, who represents the interests of consumers on the task force, provided the following comments related to the task force recommendation proposing legislation in the 129th Legislature to address the transparency, accountability and oversight of pharmacy benefits managers and to the task force recommendation proposing to introduce concept draft legislation in the 129th Legislature to review the Maine Health Data Organization's enabling statutes and consider statutory changes to MHDO's structure, funding and capacity for the reporting and analysis of health care costs and quality:

Information is a necessary component of decision making and the MHDO has a lot of information that could be useful both for groups like a health care task force and for the legislature in the future. We consulted with the MHDO and asked a series of questions and

received answers to all illustrating current capabilities of the organization. We did also discuss the MHDO statute and if changes might make sense and heard from MHDO that the statute did give broad authority as written.

A first step should simply be to request of the MHDO an annual report to the legislature. We or others could work to develop what that report should include such as what are the big cost drivers in health care in Maine and how are those changing over time. It might be as simple as a discussion with the MHDO to brainstorm what information would be most helpful, allow them to create a draft report, then the committee or task force can react to it to refine the request.

It seems sensible to first determine if we could achieve what the task force was envisioning with a simple ask and potentially not require additional material MHDO resources or legislative action. You could determine from that exercise if statutory changes might be needed or if additional resources are required for the MHDO, but that may not be the case at all.

Moving directly to a recommendation for a legislative action may have the effect of distracting the MHDO from other priorities resulting in less efficiency for both their current obligations and additional obligations imposed by a revised statute. I have at least some insight into the MHDO's priorities as a Board member, and I worry legislation may do more harm than good. We can potentially make a great deal of progress toward the objective simply by asking for an annual report that can then be refined over time by the legislature. I expect this is something the MHDO would be happy to provide that would be of great value to lawmakers.

Jeff Austin, who represents hospital interests on the task force, provided the following comments related to the task force recommendation proposing to introduce concept draft legislation in the 129th Legislature to review the Maine Health Data Organization's enabling statutes and consider statutory changes to MHDO's structure, funding and capacity for the reporting and analysis of health care costs and quality:

With respect to the recommendations, I am comfortable with all of the recommendations except that which deals with MHDO on page 9.

Essentially, I believe we haven't done the work necessary to justify a review of MHDOs statutes.

I believe it is our responsibility to first identify what we want from MHDO. Once we determine what we want from MHDO, we can determine what changes, if any, are necessary.

My recommendation is not to eliminate this section of the recommendations. I believe there is broad support for the notion that more could be done with the data at MHDO. My recommendation would be three-fold:

- First, that interested parties continue to meet to further explore this notion of MHDO doing more in the policymaking space and clearly articulate our goals;
- Second, that once developed, these goals should be shared with MHDO leadership and the MHDO board for their reaction;

- Third, that following receipt of feedback from MHDO, interested parties report back to the group on what changes are necessary, to accomplish our goals.

Once this is done, a bulleted list of items could be presented in concept draft legislation or could be sent to legislative staff for presentation in bill format.

I do not believe that we should support filing legislation first and doing the further research second. For that reason, I cannot support the recommendation as drafted.