

6/22/10 to St Select  
Comm.

from Trish Riley

**Criteria for Maine state government to seek and support grant, pilot and demonstration opportunities in the federal health reform law**

**For discussion by Steering Committee June 7, 2010**

1. Strong relationship to priority issues in the State Health Plan
2. Strong relationship to priorities of new administration and new legislature
3. Expands or improves related initiatives already underway in Maine
4. There is a level of support and resources available across stakeholders
5. Minimal state funding required (dollars and in-kind funding); recognize the new funding will require new state money to be appropriated.
6. Enhances State's ability to meet legal and financial obligations
7. Promotes collaboration among providers and harmonization of delivery systems in communities
8. Clear focus on broad populations and overall impact of the specific grant
9. Flexibility of application process: can the State delegate?
10. Sustainability after grant funding ends

Health Reform Estimated Impacts on the Medicaid Program 2010 - 2020

6/22/10 DHHS  
to Jt Select Comm.  
on Health Care  
Reform

This document contains the estimated impact of policy options available through the Patient Protection and Affordable Care Act on Maine's Medicaid Program. The information that follows:

- \* is based on policy decisions which have yet to be made
- \* is based on our understanding of PPACA today
- \* includes enrolment information consistent with the State Health Access Data Assistance Center
- \* represents only the General Fund Impact

Waitlist & New Population		FMAP	Estimated Members	General Fund
* PMPM based on FY09 expenditures less PNMI, Mental Health, Transportation & Community Support	2014	100.00%	29,210	1,314,275
* PMPM inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2%	2015	100.00%	29,651	1,356,321
* Estimated Members based on Non-Cat waitlist, SHADAC uninsured, shifting Dirigo members, adjusted for young adults leaving foster care	2016	100.00%	30,079	1,399,721
* Enhanced FMAP	2017	95.00%	30,493	10,814,169
	2018	94.00%	30,895	13,248,426
	2019	93.00%	31,284	15,874,395
	2020	90.00%	31,661	22,979,867
				<b>66,987,174</b>

Current Non-Cat Population		FMAP	Estimated Members	General Fund
* PMPM based on FY09 expenditures less PNMI, Mental Health, Transportation & Community Support	2014	81.90%	14,233	(14,624,800)
* PMPM inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2%	2015	85.52%	13,792	(17,549,760)
* Estimated Members based on annual budget of \$80.3M divided by PMPY	2016	89.14%	13,364	(20,474,720)
* Enhanced FMAP used based on recognition as an Expansion State	2017	88.76%	12,950	(20,167,680)
	2018	90.98%	12,548	(21,961,440)
	2019	93.00%	12,159	(23,593,600)
	2020	90.00%	11,782	(21,169,600)
				<b>(139,541,600)</b>

CHIP		FMAP	Estimated Members	General Fund
* General Fund based on FY09 filed CMS 64 & CMS 21-B	2014	98.49%	15,528	(12,931,894)
* Cost inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2%	2015	98.49%	15,528	(13,345,715)
* Estimated Members based on April 2010 Enrollment	2016	98.49%	15,528	(13,772,778)
* FMAP Increase of 23 percentage points for CHIP	2017	98.49%	15,528	(14,213,507)
	2018	98.49%	15,528	(14,668,339)
	2019	98.49%	15,528	(15,137,726)
	2020	98.49%	15,528	(15,622,133)
				<b>(99,692,091)</b>

Convert Parents over 133% FPL into the Exchange		FMAP	Estimated Members	General Fund
* PMPM based on FY09 expenditures	2014	62.65%	14,629	(10,651,388)
* PMPM inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2%	2015	62.65%	14,629	(10,992,233)
* FMAP based on FFIS estimated for FFY12	2016	62.65%	14,629	(11,343,984)
* Additional savings of \$5,000,000 annually to Dirigo Health.	2017	62.65%	14,629	(11,706,992)
* In 2011, States can choose to convert eligibles over 133% FPL into the exchange or basic health plan by FY14	2018	62.65%	14,629	(12,081,615)
	2019	62.65%	14,629	(12,468,227)
	2020	62.65%	14,629	(12,867,210)
				<b>(82,111,650)</b>

Foster Care Kids Stay until 26		FMAP	Estimated Members	General Fund
* PMPM based on FY09 expenditures	2014	62.65%	751	1,582,516
* PMPM inflated annually based on Bureau of Labor Statistics Medical Care CPI 2008 - 3.2%	2015	62.65%	751	1,633,141
* Estimated Members based on eligibles aged 18 to 25 (Foster care and Adoption), adjusted for pregnancy, death, & incarceration rates and income	2016	62.65%	751	1,685,415
* FMAP based on FFIS estimated for FFY12	2017	62.65%	751	1,739,338
	2018	62.65%	751	1,795,011
	2019	62.65%	751	1,852,435
	2020	62.65%	751	1,911,709
				<b>12,199,564</b>

Rebates		General Fund
* The Act, increased the prescription drug rebates on brand drugs from 15.1% to 23.1% after 12/31/09.	2010	3,500,000 ?
* For generic drugs this increase is 11-13%.	2011	3,500,000 ?
* The increase in these rebates go solely to the Federal Government.	2012	3,500,000 ?
* GHS calculates the loss on rebates to be approximately 10% or \$3.5M of GF annually.	2013	3,500,000 ?
* The loss of rebates begins retroactively 1/1/2010. (\$3.5M)	2014-2020	24,500,000 ?
* A budget request will be submitted for the FY11 Emergency Budget and FY12 & FY13 Biennial Budget.		<b>38,500,000</b>

Health Reform Estimated Impacts on the Medicaid Program 2010 - 2020 = (\$203,658,604)

Net Impact by Year		General Fund
Aggregates:		
* Cost of Waitlist & New Population	2010	3,500,000 ?
* Savings from Enhanced FMAP on Non-Cat Population	2011	3,500,000 ?
* Savings from Enhanced FMAP on CHIP beginning 2011	2012	3,500,000 ?
* Savings from Converting Parents over 133% FPL	2013	3,500,000 ?
* Cost of Foster Care Kids Stay until 25	2014	(31,811,291) ?
* Cost of loss of Rebates (retroactive) is still being refined	2015	(35,398,246) ?
	2016	(39,006,346) ?
	2017	(30,034,672) ?
	2018	(30,167,958) ?
	2019	(29,972,723) ?
	2020	(21,267,367) ?
		<b>(203,658,604)</b>

- Notes:
- \* States that demonstrate deficits may eliminate coverage for Parent Expansion populations over 133% FPL (2011-2013)
  - \* State employee health plan will generate savings from retiree health insurance

**High Level Overview Managed Care**

Driver:  
 e Map Mapping

Maine and PPACA		
Map Code	Description	Key Dates
L03	Payments to primary care physicians increased	1/1/2013

**Current State:**  
 The State of Maine is already embarking on a Managed Care initiative and this direction is supported by various provisions of healthcare reform.  
 1. RFI issued 12/21/09 to 92 parties - 22 responses received by 2/1/10  
 2. Initial approach includes three phases: 1) TANF/CHIP (Legislation gave approval to move to managed care on 7/1/10), 2) Disabled, 3) Dual Eligibles  
 3. Legislature mandated a stakeholder meeting - scheduled for 6/29/10

**Key Take-Aways:**  
 1. Legislation directed transition to managed care and start-up implementation costs are partially funded  
 2. Comprehensive stakeholder involvement is crucial in the RFP development to avoid any unintended consequences or mis-aligned incentives  
 3. Re-definition of staff roles/responsibilities may be required as a vendor is procured

People Impact:	Readiness	Impact
1. Define internal vs. external responsibilities based upon model chosen	High	High
2. Re-definition of roles to focus more on vendor management (including training, skill set re-alignment)	Medium	X Medium
3. Possible re-organization across Offices/Programs (for example, a central QA department vs. QA team members in each Office)	X Low	Low

Process Impact:	Readiness	Impact
1. Cyclical calendar-based process (data collection, rate-setting, contracting, negotiations with plans, waiver application, reporting to CMS)	High	High
2. Transition process for phased roll-out	Medium	Medium
3. Vendor monitoring process	X Low	Low

Technology Impact:	Readiness	Impact
1. Capitation payment system development and maintenance - interface with current systems and vendors	High	High
2. Data collection and warehouse capabilities in order to have access to granular data - robust reporting	X Medium	Medium
3. Leverage other technology improvement efforts such as HIT, HIE, ICD-10	Low	Low

Finance Impact:	Readiness	Impact
1. Start-up costs for implementation are not fully funded	High	High
2. Change in cash flow budgeting from reimbursement-based to capitation pre-payment	X Medium	X Medium
Cost-neutral impact of primary care physician payment rate at 100% of Medicare mandate until 2015 (due to 100% FMAP for any additional costs in 2013)	Low	Low

Risk and Regulation Impact:	Readiness	Impact
1. Contract risk management	High	High
2. Risk of mis-aligned incentives, undesirable results, unintended consequences due to RFP development/wording	X Medium	Medium
3. Provider and public relations	Low	Low
4. Consumer access (potential reduced number of providers due to MCO cost/quality requirements)		

Next Steps	DHHS Owner
RFP Development	Paul Saucier and Tony Marple

Legislative Summary

Name	Summary	Effective Date	Section
Payments to primary care physicians	Mandates that for calendar years 2013 and 2014 payment for primary care services provided by primary care physicians be at a rate not less than 100 percent of the Medicare payment rate that applies to such services and physicians. Payments by Medicaid managed care plans must be consistent with the mandated minimum payment rates. States will receive a 100 percent FMAP for the additional costs in increasing the payment rates	1/1/2013	R-1202: Payments to primary care physicians (Page R-24)
Medicaid Global Payment System Demonstration Project	Establishes a Medicaid Global Payment System Demonstration Project in up to 5 states to evaluate use of a global capitated payment model for large safety net hospitals and networks. The Secretary will report on the results and recommendations of the project.	1/1/2010	2705: Medicaid Global Payment System Demonstration Project (Page 206)
Physician Feedback Program - Comparative Resource Use Reporting & Episode Grouping	Effective beginning with 2012, the Secretary shall provide reports to physicians that compare patterns of resource use of the individual physician to such patterns of other physicians caring for similar patients with similar conditions. An episode grouper will be developed to combine separate but clinically related items and services into an episode of care for an individual, to support this reporting.	1/1/2012 (Not later than Jan 1, 2012)	3003: Improvements to the Physician Feedback Program (Page 248 - 250)
Bundled Payments - Pilot Program	Creates the National Pilot Program on Bundling - a pilot program to develop and evaluate the bundling payments for an episode of care centered around a hospitalization. Payments would cover: inpatient hospital services, physician services, outpatient hospital services and post-acute care services for an episode of care that begins three days prior to a hospitalization and concludes 30 days after discharge. The objectives of the bundled payments are to improve the coordination, quality and efficiency of health care services delivered to the beneficiary for that episode of care. If the pilot is deemed to achieve the goals of improving (or not reducing) quality, and reducing spending, the Secretary shall develop a plan to expand the program. Pilot established by January 1, 2013. Expansion, if warranted, January 1, 2016.	1/1/2013 (January 1, 2013)	3023 as amended by 10308: Developing a pilot program for bundling payments for integrated care (Page 823 amends 281)
Grants Established by Primary Care Extension for developing State Hubs and Local Primary Care Agencies.	Establishes the Primary Care Extension Program through AHRQ to provide support and education about preventive medicine, health promotion, disease management, mental and behavioral health services, and evidence-based therapies and techniques through Health Extension Agents. Grants are awarded to States for the establishment of State Hubs and Local Primary Care Extension Agencies.  \$120M is appropriated for each of FY2011 and FY2012.	10/1/2010 (FY 2011)	5405: Primary care extension program (Page 531)
Research on Optimizing the Delivery of Public Health Services	The Secretary will provide funding for public health services research such as evidence-based practices relating to prevention, comparing community-based public health interventions and identifying effective delivery strategies. Additionally, it shall submit an annual report to Congress with the findings	Not Specified	4301: Research on Optimizing the Delivery of Public Health Services (Page 460)

**High-Level Overview Medicaid & CHIP**

Driver:  
Value Map Mapping

PPACA and CHIPRA		
Map Code	Description	Key Dates
E02	State option to create a "State Basic Plan" for those at 133% - 200% FPL	Not specified
L01	Minimum eligibility set to 133% FPL	1/1/2014
L02	Disproportionate Share payment reductions	10/1/2013
L04	CHIP expansion & eligibility maintained until 2019	Not specified
L06	Medicaid LTC & community based care programs & pilots created	10/1/2010
M02	Increased fraud and abuse detection, prevention programs	1/1/2011
O04	ACOs that meet quality standards can share in savings	1/1/2012
P02	Episode-based payment pilots (Medicare & Medicaid)	1/1/2012
P05	No Federal match for Medicaid payments for hospital acquired infections	7/1/2011

Current State:
1. Already covering at 200% FPL for children and parents
2. Childless adults are covered at 100% FPL
3. Using IMD portion of DSH for funding of the two state hospitals

Key Take-Aways:
1. Savings possibilities exist within expanded eligibility requirements, due to enhanced match
2. Pursuit of any demonstration projects will involve significant up-front staff, technology and funding resources

People Impact:	Readiness	Impact
1. Eligibility staff - expanded case load due to expanded eligibility	High	High
2. Community outreach	X Medium	Medium
3. Resource needs for grant applications	Low	X Low

Process Impact:	Readiness	Impact
1. Income calculation process - new CMS guidelines using MAGI	High	High
2. Monitoring of providers who are terminated from Medicare or another state's Medicaid programs	Medium	X Medium
3. Extension of vendor management for contracting with RACs	Low	Low
4. Refinement of data collection, reporting, and payment processes to properly identify hospital acquired conditions		

Technology Impact:	Readiness	Impact
1. System capabilities - data storage and interface testing for expanded enrollment volume	High	High
2. Cutover period for different eligibility groups based upon date of enrollment	Medium	Medium
3. Addition of rules to capture "present at admission" type data for claim payment decision making (until ICD-10 implementation)	X Low	X Low

Finance Impact:	Readiness	Impact
1. Revenue enhancement potential from eligibility expansion due to enhanced match. Similarly, CHIP program revenue enhancement due to increased match.	High	X High
2. No enhanced match for additional administration costs (funded based on 50%/50% match)	Medium	Medium
3. Possible loss of state hospital funding if IMD portion of DSH payments are reduced	X Low	Low

Risk and Regulation Impact:	Readiness	Impact
1. Should the decision be made to contract eligibility from groups at 200% FPL to 133%, increase in uncovered individuals.	High	High
2. Potential inability to provide CMS with requested information - resources, reporting, system constraints	X Medium	X Medium
	Low	Low

Next Steps	DHHS Owner
Identify significance of "woodwork" effect (i.e. potential influx of clients who would not have received care in the absence of enhanced programs). Follow development of legislation.	Tony Marple

Legislative Summary

Name	Summary	Effective Date	Section
State Basic Health Programs	States may establish a "state basic health program" for individuals between 133% and 200% of FPL. The state may contract with health plans or networks of providers to offer coverage, and must cover the essential health benefits. Cost sharing under the program may not exceed certain limits. States must coordinate the state basic plan with other state health programs (including Medicaid and CHIP), and may enter into regional compacts with other states to contract for plans.	Not Specified	1331: State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid (Page 81 - 85)
Option to extend Medicaid coverage to individuals above 133% FPL	States may opt to provide Medicaid coverage to individuals with incomes above 133% FPL (at regular state matching rates)	1/1/2014	2001: Medicaid coverage for the lowest income populations. (Page 160)
Medicaid DSH Payment Adjustments	Reduces States' Medicaid Disproportionate Share (DSH) funding by \$18.1 billion between FY 2014 and 2020. Requires the Secretary to develop a methodology to distribute the DSH reductions that imposes the largest reductions on states with the lowest numbers of uninsured. Low DSH states have smaller reductions.	10/1/2013	2551 as amended by R-1202: Disproportionate share hospital payments (Page R-25 amends 19)
Extension of Funding for CHIP through Fiscal Year 2015 and other CHIP-Related Provisions	Extends the CHIP program appropriations through FY2015	Not Specified	10203: Extension of funding for CHIP through fiscal year 2015 and other CHIP-related provisions (Page 809)
Fraud, Waste & Abuse: RAC Program Extension to Medicaid, and Medicare Parts C & D	Requires States to establish contracts with one or more Recovery Audit Contractors (RACs), which shall identify underpayments and overpayments and recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers	1/1/2011 (Not later than December 31, 2010)	6411: Expansion of the Recovery Audit Contractor (RAC) program to Medicaid, and Medicare Part C & D (Page 655)
Fraud, Waste & Abuse: Termination Of Provider Participation Under Medicaid If Terminated Under Medicare Or Other State Plan	Require states to terminate individuals or entities (providers) from their Medicaid programs if they were terminated from Medicare or another state's Medicaid program.	1/1/2011	6501: Termination of provider participation under Medicaid if terminated under Medicare or other State plan (Page 658)
Medicaid FMAP Elimination for payment for Health Care-Acquired Conditions	Prohibits federal payments to states for Medicaid services related to healthcare acquired conditions.	7/1/2011	2702: Payment Adjustment for Health Care-Acquired Conditions (Page 200)
Physician Feedback Program - Comparative Resource Use Reporting & Episode Grouper	Effective beginning with 2012, the Secretary shall provide reports to physicians that compare patterns of resource use of the individual physician to such patterns of other physicians caring for similar patients with similar conditions. An episode grouper will be developed to combine separate but clinically related items and services into an episode of care for an individual, to support this reporting.	1/1/2012 (Not later than Jan 1, 2012)	3003: Improvements to the Physician Feedback Program (Page 248 - 250)

Bundled Payments - Pilot Program	Creates the National Pilot Program on Bundling - a pilot program to develop and evaluate the bundling payments for an episode of care centered around a hospitalization. Payments would cover: inpatient hospital services, physician services, outpatient hospital services and post-acute care services for an episode of care that begins three days prior to a hospitalization and concludes 30 days after discharge. The objectives of the bundled payments are to improve the coordination, quality and efficiency of health care services delivered to the beneficiary for that episode of care. If the pilot is deemed to achieve the goals of improving (or not reducing) quality, and reducing spending, the Secretary shall develop a plan to expand the program. Pilot established by January 1, 2013. Expansion, if warranted, January 1, 2016.	1/1/2013 (January 1, 2013)	3023 as amended by 10308: Developing a pilot program for bundling payments for integrated care (Page 823 amends 281)
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Research on Optimizing the Delivery of Public Health Services	The Secretary will provide funding for public health services research such as evidence-based practices relating to prevention, comparing community-based public health interventions and identifying effective delivery strategies. Additionally, it shall submit an annual report to Congress with the findings	Not Specified	4301: Research on Optimizing the Delivery of Public Health Services (Page 460)

Demonstration Projects	Summary	Effective Date	Section
Medicaid/CHIP Pediatric Accountable Care Organization Demonstration Project	Establishes a Pediatric Accountable Care Organization Demonstration project in Medicaid and CHIP to allow pediatric accountable care organizations to share in cost savings. Authorizes funding.	1/1/2012	2706: Pediatric Accountable Care Organization Demonstration Project (Page 207)
Medicaid bundled payment demonstration project	Establishes a demonstration project in up to 8 states to evaluate bundled payments for care of Medicaid beneficiaries that involve hospitalization and concurrent physician services (acute & post-acute care)	1/1/2012	2704: Demonstration project to evaluate integrated care around a hospitalization (Page 205-206)
Removal of barriers to providing home and community-based services	Gives States the option to 1) provide home and community-based services to individuals eligible for services using a waiver and 2) create an eligibility category to provide full Medicaid benefits for specific, targeted populations requiring home and community-based care through use of a state plan amendment. In general States are expected to allocate resources such that they are responsive to beneficiary needs, maximize independence, and coordinate care with all providers.	10/1/2010 (first day of the first quarter of the fiscal year when the act is enacted)	2402: Removal of barriers to providing home and community-based services (Page 183)
Medicaid Global Payment System Demonstration Project	Establishes a Medicaid Global Payment System Demonstration Project in up to 5 states to evaluate use of a global capitated payment model for large safety net hospitals and networks. The Secretary will report on the results and recommendations of the project.	1/1/2010	2705: Medicaid Global Payment System Demonstration Project (Page 206)

**High Level Overview ICD-10**

Driver:  
 e Map Mapping

PPACA		
Map Code	Description	Key Dates
C01	HIPAA 5010/NCPDP	1/1/2012
R01	ICD-10 requirements	10/1/2013

**Current State:**

International Classification of Disease (ICD) Code set is used to classify diagnosis and procedures and is a basis for all US based codification which drives provider contracting, medical authorization – and ultimately claims processing. ICD-10 replaces ICD-9 (a 5-digit coding system) with a 7 place alphanumeric system and allows for moving from 20K codes to 150K codes.

1. PAPD approved.
2. RFP development in process.
3. TriZetto has been selected as the software vendor for MaineCare. Further assessment will be needed to identify other impacted systems.

**Key Take-Aways:**

1. HIPAA 5010/NCPDP is mandated by 1/1/2012 and ICD-10 is mandated by 10/1/2013.
2. Planning is underway for the adoption of these requirements.
3. Tight timeline from testing to implementation.
4. Dependency on MIHMS go-live and stability.

**People Impact:**

1. Workforce re-assignment for clinical coders
2. Internal training - reporting/rating/quality/coding
3. External provider training and monitoring

Readiness	Impact
High	High
Medium	X Medium
X Low	Low

**Process Impact:**

1. Local Codes are being phased out - need to develop mapping
2. Other internal processes and reporting (prior authorizations, clinical/medical policy changes) will need to be updated
3. Fraud monitoring for ICD-10 compliance

Readiness	Impact
High	High
Medium	X Medium
X Low	Low

**Technology Impact:**

1. Upgrade application in December 2010 - vendor is developing new release currently
2. Create custom interfaces in new application
3. Compressed testing timeline between date of release from vendor and go-live date
4. Dual processing - establish plan for ICD-9/ICD-10 overlap period

Readiness	Impact
High	X High
Medium	Medium
Low	Low

**Finance Impact:**

1. Neutrality of rates for new ICD-10 codesets
2. Cost of system upgrades for ICD-10 compliance

Readiness	Impact
High	High
X Medium	X Medium
Low	Low

**Risk and Regulation Impact:**

1. Definition of compliance - risk of losing federal share of funding
2. Compressed system testing timeline
3. Provider non-compliance with ICD-10 adoption
4. Crosswalk implications

Readiness	Impact
High	X High
Medium	Medium
X Low	Low

**Next Steps** RFP development.

**DHHS Owner**

Planning - Tony Marple; Implementation - Geoff Green

**Legislative Summary**

Name	Summary	Effective Date	Section
Development of Standards for Financial and Administrative Transactions - ICD-10 and related Crosswalks (CMS to post)	The ICD-9-CM Coordination and Maintenance Committee will be directed to convene a meeting of relevant stakeholders (including health plans, health care providers, and clinicians) by Jan 1, 2011 to obtain input and feedback on the ICD-9 to ICD-10 crosswalk and to make recommendations about appropriate revisions to that crosswalk. Any changes to the crosswalk would be published on the CMS website with all historical details, and would be treated as an approved/adopted code set. Future revisions should follow a similar process.	1/1/2011 (Not later than January 1, 2011)	10109 as appended to 1104(b): Development of standards for financial and administrative transactions (Page 797)
Development of Standards for Financial and Administrative Transactions - ICD-10 and related Crosswalks (CMS to post)	<p>ICD-9 TO ICD-10 CROSSWALK.—The Secretary shall task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting, not later than January 1, 2011, to receive input from appropriate stakeholders (including health plans, health care providers, and clinicians) regarding the crosswalk between ICD-9 and ICD-10 that is posted on the CMS website and make recommendations about appropriate revisions to such crosswalk.</p> <p>(2) Crosswalk Revisions—For purposes of the crosswalk described in paragraph (1), the Secretary shall make appropriate revisions and post any such revised crosswalk on the CMS website.</p> <p>(3) For purposes of paragraph (2), any revised crosswalk shall be treated as a code set for which a standard has been adopted by the Secretary.</p> <p>(4) Subsequent crosswalks—For subsequent revisions of the ICD that are adopted by the Secretary as a standard code set, the Secretary shall, after consultation with the appropriate stakeholders, post on the CMS website a crosswalk between the previous and subsequent version of the ICD not later than the date of implementation of such subsequent revision</p>	1/1/2011 (Not later than January 1, 2011)	1104(b) as appended by 10109: Development of standards for financial and administrative transactions (Page 797)



MAINE ASSOCIATION  
OF  
HEALTH PLANS

Dependent Care Coverage Expansion

Materials from selected member health plans (CIGNA HealthCare of Maine, Inc.; Harvard Pilgrim Health Care; Aetna; and UnitedHealth Group) presented by Katherine Pelletreau.

June 22, 2010

## **CIGNA Announces Plan to Accelerate Extension of Coverage to Young Adults on June 1**

PHILADELPHIA, April 26, 2010 - CIGNA (NYSE:CI), one of the nation's largest health service companies, said today it will be extending health insurance coverage to young adults, up to age 26, to help prevent a potential coverage gap for these individuals that may occur prior to provisions of the new health care reform law taking effect.

CIGNA's new policy, which is effective June 1, will keep as dependents young adults who would otherwise not be eligible for coverage on their parent's insurance policies because of their residency, college enrollment and/or financial support.

"CIGNA believes all Americans must have access to quality, affordable health care," said Tom Richards, senior vice president, U. S. product. "By extending health insurance coverage for our current young adult customers up to age 26, we can help ensure continuous access to care."

The recent health care reform legislation extends the dependent coverage age of young adults to up to age 26. However, that specific provision of the law is not effective until September 23, 2010, potentially leaving many young adults, especially those graduating from college this spring, with a gap in coverage. The policy change means CIGNA will work to ensure that young adults will have continued coverage more than three months prior to the provision taking effect.

CIGNA's new policy will automatically apply for its fully-insured business. Employers and other plan sponsors with other funding arrangements, including self-funded plans, are responsible for establishing requirements for their benefit plans. These employers will have the option of also adopting the extended coverage.

### **About CIGNA**

CIGNA (NYSE:CI), a global health service company, is dedicated to helping people improve their health, well being and sense of security. CIGNA Corporation's operating subsidiaries provide an integrated suite of medical, dental, behavioral health, pharmacy and vision care benefits, as well as group life, accident and disability insurance, to approximately 46 million people throughout the United States and around the world. To learn more about CIGNA, visit [www.cigna.com](http://www.cigna.com). To sign up for email alerts or an RSS feed of company news, log on to <http://newsroom.cigna.com/rss/>. Also, follow us on Twitter: @cigna and visit CIGNA's YouTube channel at <http://www.youtube.com/cignatv>



[June 17th, Health Care Reform Presentation](#)

## Dependent Coverage

### Extended to Age 26

[Can you tell me more about the extension of dependent coverage to age 26?](#)

[If an employee covered by an ASO plan has a child who had reached the cut-off age previously and is now being covered by COBRA, will the employee be able to add that child back onto their plan until they reach the age of 26?](#)

[How soon will employers be required to cover dependents to age 26?](#)

[Does the coverage requirement extend to an adult dependent's spouse or children?](#)

[If a child is married, will he or she be covered under this extension of dependent coverage?](#)

[How does the PPA define dependent?](#)

[Will dependent coverage to age 26 extend to other types of coverage beyond medical, such as dental?](#)

[Is it true that the dependent will no longer have to be a full-time student to be considered a covered dependent when the law actually takes effect?](#)

[Can CIGNA charge more for dependents over a certain age if not in school, as long as it does not exceed the cost of the employer premium?](#)

[If a child has already graduated from college but is still under 26, can he or she be covered?](#)

### Early Adoption (Announced by CIGNA on April 26, 2009)

[How is CIGNA accelerating the Patient Protection and Affordable Care Act provision?](#)

[Does CIGNA's early adoption of the dependent care coverage extension apply to former Great-West customers?](#)

[Will CIGNA's early adoption of the dependent care coverage extension affect current stop-loss rates?](#)

### Extended to Age 26

#### **Can you tell me more about the extension of dependent coverage to age 26?**

A plan is not required to provide dependent coverage. For plans that do provide dependent coverage, the dependent age is extended to children (married or unmarried) up to age 26 for plan years beginning after 9.23.10. Until 2014, grandfathered plans do not have to provide the extended coverage to an adult child who has access to other employer-provided coverage.

The term dependent is still to be defined in regulation, but the law at least clarifies that it does not extend to children of adult children.

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#### **How soon will employers be required to cover dependents to age 26?**

For group plans that are grandfathered (i.e., in effect on 3.23.10), the requirement applies on the first day of the plan year beginning on or after 9.23.10, but only with respect to adult children who are not eligible for coverage under another employer-sponsored health plan.

For plan years beginning on and after 1.1.14, the provision applies to grandfathered plans with respect to all adult children.

For non-grandfathered plans, the provision is effective on the first day of the plan year beginning on and after 9.23.10.

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#### **Does the coverage requirement extend to an adult dependent's spouse or children?**

No.

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**How does the PPA define dependent?**

It doesn't. The Act requires the Secretary of Health and Human Services to define dependent in regulations. However, the reconciliation legislation amending the tax code made clear that a child means an individual who is a son, daughter, stepson, stepdaughter or eligible foster child of the taxpayer, and extends the general exclusion for reimbursements for medical care expenses under an employer-provided health plan to any child of an employee who at the end of the taxable year has not reached the age of 27.

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**Is it true that the dependent will no longer have to be a full-time student to be considered a covered dependent when the law actually takes effect?**

Correct.

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**If a child has already graduated from college but is still under 26, can he or she be covered?**

Yes, if the child is embraced by definition of dependent in regulations to be provided by the Secretary of Health and Human Services.

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**If an employee covered by an ASO plan has a child who had reached the cut-off age previously and is now being covered by COBRA, will the employee be able to add that child back onto their plan until they reach the age of 26?**

Yes, if the child is embraced by definition of dependent in regulations to be provided by the Secretary of Health and Human Services.

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**If a child is married, will he or she be covered under this extension of dependent coverage?**

Yes, provided the child is embraced by definition of dependent in regulations to be promulgated by the Secretary of Health and Human Services. The PPACA removed the requirement that the adult child be unmarried, but dependents of the dependent covered will not be eligible.

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**Will dependent coverage to age 26 extend to other types of coverage beyond medical, such as dental?**

Extended Dependent Coverage applies to all health insurance plans including, but not limited to, medical, behavioral and pharmacy benefits. The PPACA does not apply to employer-sponsored dental, vision and group life insurance plans; whether bundled together with medical or standalone.

Although we are awaiting final regulations, it appears that most dental plans will not be subject to this requirement. However, should CIGNA customers wish to extend this benefit to their dental plan, making it consistent with changes required in their health plan, they are instructed to contact their CIGNA Representative to discuss their options.

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**Can CIGNA charge more for dependents over a certain age if not in school, as long as it does not exceed the cost of the employer premium?**

The PPACA provides no guidance. This is a question that may be addressed in regulations.

Early Adoption (Announced by CIGNA on April 26, 2009)

**How is CIGNA accelerating the Patient Protection and Affordable Care Act provision?**

We are proactively extending health coverage for adult dependent children currently enrolled in CIGNA health plans who may experience a gap in coverage until a new health reform provision is implemented this September. This new regulation requires plans to extend dependent care coverage to age 26 on the first plan anniversary after September, 23, 2010. **We will expedite this mandate and extend dependent coverage up to age 26 effective June 1, 2010** at a time when some enrollees will graduate, losing their student status, and more than three months in advance of the provision taking effect.

**We will work with all of our group and individual customers to implement early adoption of the "dependents to age 26 provision" as follows:**

- Fully insured groups and individuals who are paying premiums to CIGNA to provide insurance coverage will automatically fall under this extended dependent coverage policy.

- Employers and other plan sponsors that are self-insured are responsible for establishing the eligibility requirements for their plans. CIGNA administers these plans according to the provisions the employer establishes. These self-insured employers, inclusive of ASO and Shared Returns plans, will have the option, and are encouraged, to pursue early adoption of this extended coverage.

By extending health insurance coverage for these young adults, we can help ensure continuous access to care while they embark on a bright, healthy future post-graduation.

Although we are awaiting final regulations, it appears that most dental plans will **not** be subject to this requirement. However, should CIGNA customers wish to extend this benefit to their dental plan, making it consistent with changes required in their health plan, they are instructed to contact their CIGNA Representative to discuss their options.

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**Does CIGNA's early adoption of the dependent care coverage extension apply to former Great-West customers?**

Yes, for guaranteed cost insured plans. Shared Returns (experience rated) insured and self-insured (ASO) clients can voluntarily opt in to the early adoption program.

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**Will CIGNA's early adoption of the dependent care coverage extension affect current stop-loss rates?**

Not immediately. Current stop-loss rates will stand until renewal.

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NOTICE FOR EXTERNAL USERS: This document is for general informational purposes only. While we have attempted to provide current, accurate and clearly expressed information, this information is provided "as is" and CIGNA makes no representations or warranties regarding its accuracy or completeness. The information provided should not be construed as legal or tax advice or as a recommendation of any kind. External users should seek professional advice from their own attorneys and tax and benefit plan advisers with respect to their individual circumstances and needs.

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## **Harvard Pilgrim expands dependent eligibility effective June 1**

Effective June 1, 2010, Harvard Pilgrim will adopt the federal health care reform provision to allow dependents to continue their coverage up until age 26. While the federal legislation provision does not take effect until September 23, 2010, Harvard Pilgrim is adopting the extension early to help prevent potential coverage gaps for dependents and minimize confusion as the new federal provision goes into effect.

The extension will be effective as follows:

- June 1, 2010: Dependents already covered on a fully insured plan can remain enrolled until age 26.
- Beginning September 23, 2010: Dependents under age 26 not currently enrolled will have the opportunity to enroll on the employer group renewal date. For example, for customers renewing on January 1, 2011, non-covered dependents under age 26 can enroll effective January 1, 2011.

We will continue to send written notification when a child dependent's eligibility ends so that any continuation of coverage options may be arranged.

Please note that the early adoption of the dependent reform provision does not apply to self-insured employers. Harvard Pilgrim will work directly with our self-insured employers to implement their coverage decisions.

For more information, visit [www.harvardpilgrim.org](http://www.harvardpilgrim.org) and click on "Dependent eligibility extension" in the News and Updates section of the Broker home page.



May 2010

«Contact Name»

«Company Name»

«Company Address»

«Company State», «Company Zip»

**RE: Harvard Pilgrim expands dependent eligibility effective June 1, 2010**

Dear «Contact Name»

This letter is to inform you that, effective June 1, 2010, Harvard Pilgrim will adopt the federal health care reform provision to allow dependents to continue their coverage up until age 26. While the federal legislation provision does not take effect until September 23, 2010, Harvard Pilgrim is adopting the extension early to help prevent potential coverage gaps for dependents and minimize confusion as the new federal provision goes into effect.

Harvard Pilgrim will no longer send Child Dependent Verification Affidavits to subscribers with child dependents enrolled in plans offered through Maine fully insured employer groups who did not elect to follow Maine Legislative Directive 841.

Although Harvard Pilgrim will no longer send Child Dependent Verification Affidavits, we will continue to send written notification when a child dependent's eligibility ends so that any continuation of coverage options may be arranged.

- June 1, 2010: Dependents already covered on a fully insured plan can remain enrolled until age 26.
- Beginning September 23, 2010: Dependents under age 26 not currently enrolled will have the opportunity to enroll on the employer group renewal date. For example, if you are a customer renewing on January 1, 2011, your non-covered dependents under age 26 can enroll effective January 1, 2011.

Please note the early adoption of the dependent reform provision does not apply to self-insured employers. Harvard Pilgrim will work directly with our self-insured employers to implement their coverage decisions.

If you have questions about this process, please contact your Harvard Pilgrim Account Services Coordinator at (800) 637-4751. Thank you for your business.

Sincerely,

A handwritten signature in cursive script that reads "Vincent Capozzi".

Vincent Capozzi  
Senior Vice President, Sales and Customer Service

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## News Releases

### **Aetna Announces Plan to Extend Coverage for Young Adults Before Reform Law Takes Effect**

Decision will allow young adults to avoid gaps in health care coverage, stay on parents' plan

HARTFORD, Conn., April 21, 2010 — Aetna (NYSE: [AET](#)) today released the following statement regarding its decision to work with customers to extend dependent coverage to young adults.

"We understand that young adults are concerned about potential gaps in health care coverage. We are working with our customers to allow young adults to remain on their parents' plan until the dependent coverage requirements of the Patient Protection and Affordable Care Act go into effect later this year. We believe this is in the best interests of our members and is in keeping with the spirit of the health

reform law.”

## **About Aetna**

Aetna is one of the nation’s leading diversified health care benefits companies, serving approximately 36.1 million people with information and resources to help them make better informed decisions about their health care. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and health care management services for Medicaid plans. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates. For more information, see [www.aetna.com](http://www.aetna.com).

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## **Plans and Services**

From: "Tully Abdo, Susan C" <TullyAbdoSC@aetna.com>  
Subject: **ok, now try...**  
Date: June 16, 2010 1:54:56 PM EDT  
To: "meahp@maine.rr.com" <meahp@maine.rr.com>

[http://www.aetna.com/news/newsReleases/2010/0421\\_Young\\_Adults.html](http://www.aetna.com/news/newsReleases/2010/0421_Young_Adults.html)

#### **Q&A: Dependent Coverage**

*Does dependent requirement apply to all markets? Does it apply to grandfathered plans?*

*Does dependent mandate apply to child only coverage?*

*When are full-time students under age 26 eligible to be enrolled on their parents plan? Does this impact current plans or just new plans?*

*Do you have to offer dependent coverage?*

*Does dependent mandate apply to married children?*

*Does mandate require that the dependents are living in the household?*

*Can covered dependents be employed full time?*

*Can you create a new family tier of "Family plus Adult child"? What if you are a small employer?*

- For plan years starting six months after enactment (09/23/2010), all plans providing dependent coverage are required to make that coverage available to adult children—both married and unmarried—up to age 26. This provision applies to both new and grandfathered plans.
- Aspects of this provision will need to be clarified during the regulatory process. The Secretary is charged with creating regulations to define the dependents to which coverage will be made available (e.g., it is not clear if the dependents need to reside in the household).
- The administration has provided the following answers to consumer questions on their website, [HealthReform.gov](http://HealthReform.gov): "Six months from now [September 2010], insurers will be required to permit children to stay on family policies until age 26. This applies to all plans in the individual market, new employer plans, and existing employer plans, unless your adult child has an offer of coverage through his or her employer. This requirement will take effect the next time your plan comes up for renewal. Adult children who are on their parents' plan now but who lose that coverage when they graduate from college will have the option of rejoining their parents' policy in the new plan year beginning 6 months from now. Those whose parents work at self-insured companies will also be eligible if they do not have an offer of employer-sponsored insurance. Both married and unmarried dependents qualify for this dependent coverage. Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have an offer of coverage through their employer."

> [Field Communication Request form](#)

> [News & Field Communications Archive](#)

June 1, 2010 – June 4, 2010

## Update #3 on Expansion of Dependent Eligibility: Dental, Vision and Group

*The following message is a follow-up to the field communication originally distributed [May 21, 2010](#).*

#### Message Highlights

- > Health Care Reform mandates changes in dependent eligibility in Medical and Pharmacy plans.
- > Aetna will allow plan sponsors to change dependent

#### All Market Segments – FYI

Health Care Reform does not require stand-alone Dental, Vision or Group Insurance plans to extend coverage of dependents to age 26 as it does for medical and pharmacy plans. Aetna's approach for Dental, Vision and Group products will allow plan sponsors the ability to simplify their administration.

## Background

On April 21, 2010, Aetna issued a public statement about expanding dependent eligibility beginning June 1, 2010 in advance of the date required in the Health Care Reform law. The law will require health plans to cover dependents up to age 26, effective on renewal after September 23, 2010 which is 6 months after the Health Care Reform bill was signed into law (or on 1/1/2011 for Individual renewals). We now have defined the terms under which we accelerate the expansion of dependent eligibility, prior to the law's required effective date:

- **Individual and Small Group:** Beginning 6/1/2010, Aetna will continue coverage up to age 26, for all child dependents that are currently covered on a parent's Medical plan, or beyond if the plan's current Dependent Eligibility Rules are higher than age 26. This change will apply to all fully insured Individual and Small Group plans.
- **National Accounts, Key, Select and Self-funded plans:** Beginning 6/1/2010, Self-funded, National Account, Key or Select plan sponsors may elect to continue coverage up to age 26 for all child dependents who are currently covered on a parent's Medical plan. Aetna will work with these customers to determine appropriate rates and cost impact. All customers electing to accelerate adoption before 9/23/10 must follow normal business practices related to plan changes and/or revision activity.

## National, Key, and Select Accounts and Small Group Market Segments

*Please note that each request will have to be evaluated on a case-by-case basis, as some state regulations or system limitations may affect implementation.*

- **Dental:** For the National, Key, and Select segments, our plan sponsors will have the choice of whether to extend Dental coverage of dependents to age 26, and we will price accordingly. For Small Group, we will mirror the Medical dependent age policy for all plan sponsors. System updates will be completed by June 15, 2010, with a June 1, 2010, effective date. Any claims received between June 1 and June 15 will be reprocessed as needed. This policy liberalization will not be extended to Individual Dental, including Individual Dental bundled with Medical. See the [attached chart](#) for details by segment.
- **Stand-alone Vision:** Our stand-alone Aetna Vision Preferred product has only been launched for the National Accounts segment. Our plan sponsors will have the choice of whether to extend vision coverage of dependents to age 26 and to suspend age-outs to 26 for dependents currently covered under a parent's stand-alone Vision plan, and we will price accordingly.

- **Dental Riders and Embedded Vision** (where Dental and Vision benefits are components of the Medical plan) will be subject to the Medical Dependent Age Policy. They will also be included in early implementation that was communicated previously for Medical (suspending age-outs for dependents under age 26) by default (via the automated approach for Small Group or at the customer's election for National, Key and Select segments.)
  
- **Group:** For the National, Key, and Select segments, our plan sponsors will have the choice of whether to suspend age-outs to 26 for dependents currently covered under a parent's Life Insurance or Accidental Death and Personal Loss plan, if permitted by existing state law, and we will price accordingly.
  - We are not changing dependent eligibility for Small group life products, so it will remain age 19 for non-students and age 23 for students at this time. Disability coverage is not applicable to dependents; therefore, there is no impact on Disability products.
  
- **Behavioral Health:** We have very little stand-alone Behavioral Health business, but large plan sponsors will have the choice of whether to suspend age-out to 26 for dependents currently covered under a parent's stand-alone Behavioral Health plan.

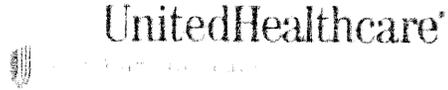
The [attached chart](#) summarizes our stand-alone **Dental and Group** position for each segment.

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This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna



# NEWS RELEASE



Contact: Daryl Richard  
UnitedHealthcare  
(860) 702-5795  
[daryl\\_richard@uhc.com](mailto:daryl_richard@uhc.com)

*For immediate release*

## **UNITEDHEALTHCARE TO FILL TEMPORARY GAP IN HEALTH COVERAGE FACING 2010 COLLEGE GRADS UNDER HEALTH REFORM LEGISLATION**

*First company to offer extension of existing coverage for graduating students  
ahead of dependent care provision's September 23 effective date*

**Minneapolis, Minn. (April 19, 2010)** – UnitedHealthcare, a UnitedHealth Group (NYSE: UNH) company, will extend the health coverage that graduating college students currently have under their parents' plans until the new health reform provision requiring dependent coverage up to age 26 is fully implemented.

As part of the Patient Protection and Affordable Care Act, young adults will be able to stay on their parents' employer-offered or individual family health plans up until age 26. However, this extension does not begin to take effect for employer-sponsored plans until September 23, 2010.

UnitedHealthcare is acting to eliminate this coverage gap that some graduating students may face when losing their parents' UnitedHealthcare health plan coverage upon graduation, and will work with its employer customers to implement the extension.

"We want students to graduate into a secure future, not the ranks of the uninsured, so we are working with employers to make sure these young adults have health coverage available to them ahead of the new requirements," said Gail Boudreaux, President of UnitedHealthcare. "Accelerating the dependent coverage extension timeline for our graduating student enrollees is another tangible step we are taking to help translate the new, complex health reform directives into workable reality."

This extension of coverage applies to college students who currently are covered under their parents' fully-insured health plan offered through UnitedHealthcare. Individual family health plans through UnitedHealthcare's Golden Rule business already allow all dependents to stay on the plan until age 26 and enrollees do not need to take any action.

### **About UnitedHealthcare**

UnitedHealthcare provides a full spectrum of consumer-oriented health benefits plans and services to individuals, public sector employers and businesses of all sizes, including more than half of the Fortune 100 companies. The company organizes access to quality, affordable health care services on behalf of approximately 25 million individual consumers, contracting directly with more than 600,000 physicians and care professionals and 5,000 hospitals to offer them broad, convenient access to services nationwide. UnitedHealthcare is one the businesses of UnitedHealth Group (NYSE: UNH), a diversified Fortune 50 health and well-being company.



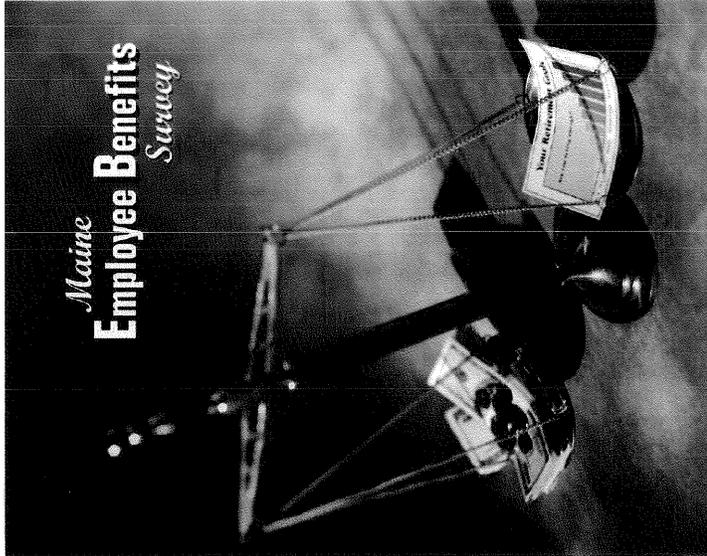
**Impacts of Health Reform Legislation on Maine  
Employers: Baseline Data**  
for  
**Joint Select Committee on Health Care Reform  
Opportunities and Implementation**

John Dorrer, Director  
Center for Workforce Research and  
Information  
Maine Department of Labor

**MAINE**  
**DEPARTMENT OF**  
**LABOR**  
*Center for Workforce  
Research and Information*

# The Structure of Maine Employment: Number of Companies, Number of Employees and Wage & Salaries Average Annual 2008

Categories	Companies		Employees		
	Less than 10 Employees and less than \$25K	23,467	48,781	Less than 10 Employees Total	37,308
Less than 10 Employees and more than \$25K	13,841	41,597			
Less than 25 Employees and less than \$50K	36,946	143,591	Less Than 25 Employees Total	42,322	164,616
Less than 25 Employees and more than \$50K	5,376	21,025			
More than 25 Employees and less than 50 Employees	1,839	63,872			
More than 50 Employees	1,778	384,289			
All Employees	45,939	612,777			



Released February 2006

The **Maine Employee Benefits Survey** report examines the range and frequency of employee benefits offered by Maine employers who were surveyed in the spring of 2004. The survey was conducted to fill data gaps identified at the state and national levels, as well as to provide immediate information to businesses, workers, and others. The results may help us reexamine the balance between wages and benefits and perhaps heighten an awareness of them as a vital component of compensation packages. In total, it offers an analysis that can mutually benefit all.

## Employers Offering Insurance Benefits to FULL-TIME Employees

Insurance Benefits	Less than 20 Employees	20 to 49 Employees	50 to 99 Employees	100 to 249 Employees	250 or More Employees
Health Insurance to Employer	61.9%	89.3%	93.2%	98.5%	99.3%
<i>Percent Paid by Employer</i>	79.3%	75.8%	74.5%	72.6%	76.4%
Health Insurance to Dependents*	53.8%	85.6%	91.7%	96.3%	95.1%
<i>Percent Paid by Employer</i>	42.3%	36.3%	49.8%	49.8%	64.7%
Have Premiums Increased	75.6%	80.6%	82.1%	80.9%	83.6%
<i>Increased by What Percent</i>	18.0%	15.4%	13.7%	14.4%	12.2%
Offer Dental Insurance	30.9%	56.3%	71.6%	86.9%	95.1%
Offer Eye care Plan	16.3%	32.4%	47.2%	37.5%	44.0%
Offer Short-Term Disability	25.1%	51.1%	69.3%	78.8%	89.4%
Offer Long-Term Disability	23.1%	44.5%	65.3%	70.1%	88.0%
Offer "Cafeteria Style" Benefits	17.4%	38.6%	42.0%	48.5%	55.6%
Offer Prescription Drug Plan	44.8%	73.9%	82.3%	87.5%	91.5%
Offer Life Insurance	32.9%	65.8%	81.3%	95.6%	99.3%
Domestic Partners considered Dependents	19.7%	22.1%	26.4%	36.3%	41.8%

\*Dependent Health Insurance is a subset of employers offering Health Insurance

## Employers Offering Insurance Benefits to FULL-TIME Employees

Insurance Benefits	Natural Resources & Mining	Construction	Manufacturing	Trade, Transportation, & Utilities	Information	Financial Activities	Professional & Business Services	Educational & Health Services	Leisure & Hospitality	Other Services
Health	66.7%	65.8%	88.7%	82.3%	89.8%	91.3%	79.9%	90.2%	61.5%	68.2%
<i>% Paid by Employer</i>	85.7%	72%	74.2%	69.8%	81.3%	84.4%	78.3%	82.1%	69.2%	75.3%
Health, Dependent*	57.6%	65.4%	88.7%	78.3%	91.5%	82.8%	71.7%	82.2%	59.8%	75.0%
<i>% Paid by Employer</i>	37.9%	39.2%	60.5%	50.2%	61.7%	50.8%	42.8%	34.8%	43.7%	40.9%
Premiums Increased	63.0%	79.0%	84.3%	79.7%	90.9%	81.1%	84.2%	76.7%	68.3%	83.0%
<i>Increased %</i>	19.7%	15.4%	15.5%	16.2%	14.3%	13.6%	16.8%	13.2%	16.9%	16.0%
Dental	23.1%	27.4%	66.0%	59.2%	79.6%	63.1%	55.2%	72.0%	33.7%	42.4%
Eye Care Plan	20.5%	20.5%	43.3%	26.2%	53.1%	36.9%	29.1%	29.1%	20.2%	25.8%
Short-Term Disability	30.8%	29.1%	69.5%	56.3%	73.5%	55.3%	49.3%	61.2%	13.5%	33.3%
Long-Term Disability	33.3%	21.4%	53.2%	46.4%	77.6%	71.8%	49.3%	57.5%	12.5%	31.8%
"Cafeteria Style" Benefits	17.9%	14.7%	38.3%	37.5%	42.9%	48.5%	33.8%	39.7%	14.4%	24.2%
Prescription Drug Plan	43.6%	55.6%	78.6%	71.7%	75.5%	80.6%	64.2%	71.5%	38.8%	54.5%
Life Insurance	35.9%	39.3%	78.7%	64.1%	77.6%	72.8%	58.2%	72.4%	32.7%	54.5%
Domestic Partners considered Dependents	12.8%	16.4%	17.7%	22.3%	46.9%	35.0%	21.8%	39.2%	21.6%	18.2%

\*Dependent Health Insurance is a subset of employers offering Health Insurance

## Employers Offering Insurance Benefits to Part-Time Employees

Insurance Benefit	Less than 20 Employees	20 to 49 Employees	50 to 99 Employees	100 to 249 Employees	250 or More Employees
Health Insurance to Employees	16.5%	23.3%	39.1%	55.3%	77.5%
<i>Percent Paid by Employer</i>	72.3%	72.0%	69.7%	61.1%	66.4%
Health Insurance to Dependents*	22.1%	30.9%	54.7%	69.1%	80.0%
<i>Percent Paid by Employer</i>	34.8%	29.8%	35.6%	41.7%	54.7%
Have Premiums Increased	50.0%	44.9%	64.4%	75.7%	78.0%
<i>Increased by what Percent</i>	16.9%	15.7%	13.0%	12.6%	10.6%
Offer Dental Insurance	12.4%	17.4%	33.8%	43.0%	61.3%
Offer Eye care Plan	6.5%	10.1%	23.7%	19.7%	21.8%
Offer Short-Term Disability	9.3%	16.9%	25.9%	39.3%	52.3%
Offer Long-Term Disability	7.5%	15.9%	25.9%	31.4%	50.5%
Offer "Cafeteria Style" Benefits	6.7%	13.5%	20.1%	32.5%	45.0%
Offer Prescription Drug Plan	7.8%	14.4%	14.7%	22.1%	33.0%
Offer Life Insurance	10.4%	18.8%	30.9%	53.3%	62.4%
Domestic Partners considered Dependents	11.3%	14.6%	20.4%	28.3%	44.0%

\*Dependent Health Insurance is a subset of employers offering Health Insurance



STATE OF MAINE  
DEPARTMENT OF ECONOMIC  
AND COMMUNITY DEVELOPMENT



JOHN ELIAS BALDACCI  
GOVERNOR

THAXTER R. TRAFTON  
COMMISSIONER

TO: Joseph Brannigan, Senate Chair  
Sharon Anglin Treat, House Chair  
Joint Select Committee on Health Care Reform Opportunities  
and Implementation

FROM: George Gervais, Office of the Commissioner, DECD

DATE: Tuesday, June 22, 2010

SUBJECT: Federal Healthcare Reform Outreach Efforts - DECD

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**DECD has made the following outreach efforts as a result of the Federal Health Care Reform Small Business Tax Credit:**

1. DECD convened a meeting to discuss and plan a common and consistent message to be distributed statewide with intentions of raising awareness of the new Small Business Tax Credit available through the Federal Healthcare Legislation. Participating in this initial meeting:
  - o Brian Hodges, Deputy Commissioner, DECD
  - o George Gervais, DECD, Office of the Commissioner
  - o Mark Ouellette, Director, DECD Office of Business Development
  - o Laura Fortman, Commissioner, DOL
  - o Adam Fisher, DOL, Office of the Commissioner
  - o Dana Connors, President, Maine State Chamber of Commerce
2. A Flyer designed to both communicate an outline of the tax credit details and drive the reader to the more detailed and up to date information on the Maine Bureau of Insurance website was designed by DECD and vetted through Trish Riley and Phil Saucier from the Office of Health Policy and Finance.
3. Phil Saucier from the Office of Health Policy and Finance was invited to speak at the monthly Economic Development Team Meeting in May. Mr. Saucier discussed elements of the Federal Health Care Reform that had an impact on small business.

4. Also at the May ED Team Meeting the Tax Credit Communication piece was discussed and distributed to all in attendance with an agreement to use it as a consistent message for statewide distribution through their organizations. Represented at this Team Meeting:

- a. Finance Authority of Maine (FAME)
- b. Small Business Administration (SBA)
- c. Small Business Development Centers (SBDC)
- d. Maine Technology Institute (MTI)
- e. Maine International Trade Center (MITC)
- f. All DECD Senior Staff
- g. Maine Manufacturers Extension Partnership (MEP)

5. The communication piece has been made, or is in the process of being made available on the following organizations websites:

- a. Maine DECD [www.businessinmaine.com](http://www.businessinmaine.com)
- b. Maine State Chamber of Commerce [www.mainechamber.org](http://www.mainechamber.org)
- c. Maine Dept. of Labor website [www.maine.gov/labor](http://www.maine.gov/labor)

6. Secured a commitment from the Maine State Chamber of Commerce to distribute to local chamber of commerce organizations statewide.

7. The communication piece will be distributed at the Maine State Chamber Federal Healthcare Reform event. This event, which has been widely publicized, is being held on June 30, 2010 at the Augusta Civic Center from 8:30am -12:00pm

8. DECD Office of Business Development has armed regional Business Development Specialists with information and a directive to communicate the message throughout their region as they meet with business owners.

9. DECD has featured the information in our monthly Connections e-newsletter

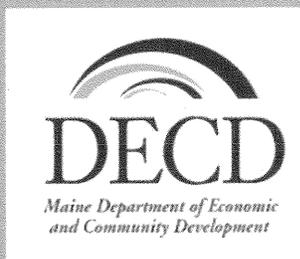
# Wondering If Your Small Business Qualifies For The New Federal Health Care Tax Credits?



## FOR COMPLETE INFORMATION:

The Maine Bureau of Insurance website offers updated information - including Frequently Asked Questions - as well as links to the most up to date IRS public information. To access this information Click [http://maine.gov/pfr/insurance/federal\\_health\\_care\\_reform/index.htm](http://maine.gov/pfr/insurance/federal_health_care_reform/index.htm)

Then click on the Small Business Tax Credit link.



Read on to find out if this tax credit will benefit a company like yours...

## Your Company May Benefit By Offering Health Insurance To Employees

We want to remind small business owners about one of the first provisions of the recently passed federal health care reform legislation. This provision is the small business health care tax credit.

This tax credit provision encourages small business owners to either offer employees health insurance coverage for the first time or encourages them to maintain health insurance coverage if they already do so. The U.S. Congress has specifically targeted small business and tax exempt organizations that primarily employ low and moderate income workers.

Here are some quick facts regarding the small business health care tax credit:

- The new federal health care reform law provides a Small Business Tax Credit to eligible small businesses for contributing toward the workers' health insurance premiums.
- The credit applies to all amounts paid or incurred in taxable years beginning after December 31, 2009.
- To receive the credit an eligible small business must have a group health plan and pay at least 50% of the premium.
- A small business qualifies if they have fewer than 25 full-time equivalent (FTE) employees (they could have more than 25 part time as long as the combined FTE does not exceed 25).
- Companies with average annual wages less than \$50,000 per employee qualify (average annual wage = total wages divided by total FTE)

**3 SIMPLE STEPS...** The following three simple steps will help you determine if your small business would qualify for the Small Business Health Care Tax Credit:

**Step 1:** Determine the total number of your employees – (not counting owners or family members) – by adding the number of full time employees to the number of full-time equivalent of part time employees. If this number is less than 25 then go to step two.

**Step 2:** Calculate the average annual wages of employees by dividing the total annual wages paid to employees by the final number of employees arrived at in step two. If this number is less than \$50,000 then go to step three.

**Step 3:** If you pay at least half of the insurance premiums for your employees at the single coverage rate then you may be able to claim the Small Business Health Care Tax Credit.

Here is a simple example of how the tax credit would benefit a company with 10 full time employees:

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 -- Employees: 10  
 -- Total wages: \$250,000  
 -- Average Wage: \$250,000/10 = \$25,000

In this example the maximum 2010 tax credit for an employer that is not tax-exempt would be \$8,750 (35% credit). In 2014 the maximum tax credit would be \$12,500 (50% credit).

Your Employees And Your Company May Benefit.