117th MAINE LEGISLATURE

SECOND REGULAR SESSION-1996

Legislative Document **No. 1753**

H.P. 1277 House of Representatives, February 6, 1996

An Act to Control Health Care Costs and Improve Access to Health Care.

Reported by Representative FITZPATRICK for the Maine Health Care Reform Commission pursuant to Public Law 1993, chapter 707, Part AA, section 5.

Reference to the Joint Standing Committee on Banking and Insurance suggested and printing ordered under Joint Rule 20.

Joseph W. Mayo

JOSEPH W. MAYO, Clerk

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

PART A

Sec. A-1. 5 MRSA §12004-G, sub-§21-B is enacted to read:

21-B. Insurance	Maine Community Purchasing Alliance Board of Directors	Expenses Only	24 MRSA §3403

Sec. A-2. 24 MRSA c. 29 is enacted to read:

CHAPTER 29

MAINE COMMUNITY PURCHASING ALLIANCE

GENERAL PROVISIONS

§3401. Definitions

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

1. Agent. "Agent" means an agent or broker licensed to do business in this State under Title 24-A, chapter 17.

2. Alliance. "Alliance" means the Maine Community Purchasing Alliance established in section 3403.

3. Alliance member. "Alliance member" means a participating employer, an enrolled employee or an enrolled individual. A dependent of a participating consumer covered under the participating consumer's health benefit plan is not an alliance member.

4. Board. "Board" means the alliance board authorized pursuant to section 3403.

5. Bureau. "Bureau" means the Bureau of Insurance.

6. Carrier. "Carrier" means an insurer, health maintenance organization or nonprofit hospital or medical service organization licensed to do business in this State.

7. Enrolled employee. "Enrolled employee" means an employee or association member of a participating employer whose health care coverage is purchased through the alliance.

8. Enrolled individual. "Enrolled individual" means a person purchasing health care coverage through the alliance, without contribution from a participating employer.

9. Enrollee. "Enrollee" means an enrolled employee, an enrolled individual or a dependent of an enrolled employee or enrolled individual.

10. Health benefit plan. "Health benefit plan" means any of the health benefit plans authorized by the alliance for purchase by alliance members.

11. Participating carrier. "Participating carrier" means an eligible carrier under section 3406 that contracts with the alliance.

12. Participating consumer. "Participating consumer" means an enrolled individual or an enrolled employee.

13. Participating employer. "Participating employer" means an employer, or an association meeting the requirements set forth in Title 24-A, section 2805-A, that meets the eligibility requirements established pursuant to section 3405 and that purchases health care coverage through the alliance on behalf of its employees or association members.

14. Superintendent. "Superintendent" means the Superintendent of the Bureau of Insurance.

§3402. Jurisdiction of bureau

Nothing in this chapter is intended to conflict with or limit the duties and powers granted to the superintendent under the laws of this State. The board and alliance established under this chapter shall report to the bureau any suspected or alleged violations of this chapter. Violations of this chapter are subject to the full range of regulatory actions, processes and remedies available to the superintendent in dealing with other entities that the superintendent may regulate.

§3403. Maine Community Purchasing Alliance established

The Maine Community Purchasing Alliance is established as a nonprofit, nonrisk-bearing corporation licensed pursuant to this chapter to purchase health care coverage on behalf of its alliance members. The alliance may not be considered a state agency or instrumentality of the State for any purpose. The State may not borrow or otherwise appropriate funds from the alliance.

1. Alliance board of directors. The alliance operates under the supervision of a board of directors that consists of 11 voting members and 2 nonvoting members.

A. Ten of the voting board members must be designated as follows. Five must represent participating consumers. The remaining 5 must represent participating employers. One employer member must represent a self-employed business. One employer member must represent a public employer. One employer member must represent a business with fewer than 100 employees. One employer member must represent a business with 100 to 999 employees. One employer member must represent a business with 1,000 or more employees.

(1) Initially the Governor shall appoint the 10 voting board members who must represent participating consumers and employers, subject to review by the joint standing committee of the Legislature having jurisdiction over insurance matters and confirmation by the Legislature. For the purpose of the initial appointment, a person represents a consumer or group of employers if that person is eligible to participate as a consumer or as a member of that group of employers.

(2) After the initial term, the 10 board members designated pursuant to this paragraph must be elected by alliance members. The board shall establish procedures in its bylaws governing the election of board members and maintaining the distribution of consumer and employer representatives. For the purpose of this section, except for the initial appointment, a person represents a consumer if that person is elected by participating consumers. For the purpose of this section, except for the initial appointment, a person represents a group of employers if that person is elected by participating employers from that employer group. To be eligible to vote, a participating employer must contribute a minimum of 50% of the premium cost toward the purchase of health care coverage for its employees. The board may set a higher minimum employer contribution as a voting eligibility requirement for participating employers.

B. The 10 board members shall choose the 11th voting board member. The appointed members shall choose the 11th member prior to the adoption of the board's bylaws.

C. The Commissioner of Human Services is an ex officio nonvoting member of the board.

D. The executive director of the alliance is an ex officio nonvoting member of the board.

E. A person may not be a board member if that person or a member of that person's household is currently employed as or by, is a consultant for, is a member of the board of directors of or is affiliated with an agent or representative of a carrier, agent, health care provider or other entity having an interest in board decisions distinct from the interest of alliance members. Prior to appointment or election to the board, potential board members shall disclose to those appointing or electing any other personal financial interest the potential board member has in an entity having an interest in board decisions distinct from the interest of the alliance members. Board members may not accept gifts or any other financial gain from any carrier, agent, health care provider or other entity having an interest in board decisions distinct from the interest of alliance members. This paragraph does not preclude a board member from purchasing coverage from a carrier.

F. All board members must be knowledgeable about health care financing and delivery systems.

2. Bylaws. The board shall adopt bylaws that govern the operation of the alliance. The bylaws must include procedures for the election of board members consistent with the terms set forth in this section.

3. Terms of office. The terms of the voting board members are staggered. For the initially appointed members of the board, the terms of office are as follows: Three members serve one-year terms; 3 members serve 2-year terms; and 4 members serve 3-year terms. Of the initial appointees, no 3 consumer representatives may have the same term length. The 10 appointed members shall determine the initial term of the 11th voting member. After the initial appointment of members, voting board members serve 3-year terms. Board members may serve a maximum of 2 consecutive terms.

4. Officers. The Governor shall appoint the first chair of the board. Subsequently, the members of the board shall elect the chair. A member chosen as chair serves as chair for a length of time equal to that member's term.

5. Meetings. The board shall meet at times and places as it determines necessary to operate the alliance in accordance with this section. To the extent that it does not interfere with the alliance's effectiveness at performing its purchasing functions, including, but not limited to, planning negotiation

strategy, negotiating with carriers and settling personnel matters, the board shall conduct meetings open to alliance members.

6. Standard of performance. The board shall discharge its duties with the care, skill, prudence and diligence as that of prudent directors acting in a similar enterprise and with a similar purpose.

7. Personal liability. The members of the board and officers or employees of the alliance are not liable personally, either jointly or severally, for any debt or obligation created or incurred by the alliance.

8. Powers and duties. The board has the powers and duties regarding operation of the alliance set forth in section 3404.

9. Compensation. Board members are entitled to compensation for expenses only.

§3404. Powers and duties of the board

The board has the following powers and duties.

1. Contracts with carriers. The board may enter into contracts with eligible carriers to provide health care coverage to enrollees.

2. Contracts with independent contractors. The board may contract with qualified, independent contractors for services necessary to carry out the powers and duties of the alliance. Unless permission is granted specifically by the board, an independent contractor hired by the alliance may not release, publish or otherwise use any information to which the independent contractor has access under its contract. Except with the express written approval of the board, an entity may not act, directly or through an affiliated person, both as a participating carrier and an independent contractor under contract to the alliance.

3. Contracts generally. The board may enter into all other contracts necessary to carry out the powers and duties of this chapter.

4. Legal action. The board may sue or be sued, including taking any action necessary for securing legal remedies for, on behalf of or against the alliance, alliance members, any board member or other parties subject to this chapter.

5. Executive director; staff. The board shall appoint an executive director to serve as the chief operating officer of the alliance and to perform those duties delegated to the executive director by the board. The executive director serves at the pleasure of the board. The executive director may employ other staff as needed to administer the alliance, subject to the personnel policies established by the board.

6. Premium assessment. The board may assess alliance members a reasonable assessment for costs incurred or anticipated in connection with the operation of the alliance.

7. Advisory committees. The board may appoint advisory committees that may include persons with expertise in health benefits management and representatives of participating carriers, consumer groups and health care providers necessary to carry out the purposes of this chapter.

8. Reports and record. The board shall prepare an annual report on the operations of the alliance that must include annual internal and independent audits and an accounting of all outside revenue received by the board. The board shall submit the annual report to the Governor, the joint standing committee of the Legislature having jurisdiction over insurance matters and the State Auditor no later than January 15th of each year.

9. Grants. The board may receive and accept grants, funds or anything of value from any public or private agency and receive and accept contributions from any legitimate source of money, property, labor or any other thing of value. However, the board may not accept grants from any carrier, agent or health care provider or other person or entity that might have a financial interest in the decisions of the board.

10. Risk selection. The board may not use health status as a condition of participation in the alliance.

11. Other powers. The board may carry out all other powers and responsibilities granted or imposed by this chapter.

§3405. Operation of the alliance

The board shall establish and implement standards and procedures for the operation of the alliance, including but not limited to the following.

1. Eligibility of carriers. The board shall establish conditions and procedures for determining the eligibility of carriers, including, but not limited to, those conditions set forth in section 3406. The board shall ensure that the

conditions and procedures established under this subsection are consistent with the cooperative purchasing required under Title 5, section 288.

2. Report cards. The board shall develop a uniform format for report cards to be prepared and provided by participating carriers. The report cards must include data necessary for evaluation of the performance of participating carriers and their provider networks by consumers, providers, employers and the board, including, but not limited to, information on consumer satisfaction, service utilization and the cost of the health benefit plan over time. In formulating the report card format, the board shall use standards based on, and consistent with, existing state and national health care data collection initiatives and shall take into account the feasibility and cost-effectiveness of those standards. The board shall also develop standards and procedures for reviewing and auditing the report cards before publication and distribution to current and potential alliance members.

3. Eligibility of employers and participating consumers. The board shall establish conditions for enrollment and participation, including payment of premiums. For employers, including the self-employed, these conditions must include, but are not limited to, assurances that, for each employer, all employees or an entire class or classes of employees are enrolled in the alliance. The board shall also set a minimum employer contribution for employer participation.

4. Enrollment procedures. The board shall establish standard enrollment procedures, including, but not limited to, ongoing enrollment for those joining the alliance, procedures that allow participating consumers to change participating carriers for good cause and annual open enrollment for participating consumers that desire to change health benefit plans or participating carriers without good cause. The board shall provide that each participating consumer may enroll in any health benefit plan offered by any participating carrier, so long as the carrier provides coverage where that participating consumer lives. The board shall establish rules for reenrollment within 90 days if coverage was terminated involuntarily. The board shall define "involuntary termination" to include loss of coverage resulting from job loss, divorce and other causes, and to exclude termination for nonpayment and other causes, as it considers appropriate. For other than involuntary termination, the board may deny reenrollment for a period of up to 12 months.

5. Quality performance reports. The board shall develop uniform standards for the collection of data to be provided by participating carriers. The board shall collect data necessary

for evaluating the performance of participating carriers and their provider networks. The board may develop methods of quality analysis for analyzing the data for use within quality performance reports. The board may use the reports for determining the qualifications of plans. The board shall use standards based on and consistent with existing state and national health care data collection initiatives and shall take into account the feasibility and cost-effectiveness of those standards. To the extent feasible, the board shall use the quality performance reports to work with participating carriers and their provider networks to improve the quality and cost-effectiveness of the care provided. The board may consult a quality improvement foundation designated by an independent state health data organization to assist it in the evaluation of the quality and appropriateness of care for participating providers. At its discretion, the board may publish all or part of the quality performance reports.

6. Collection of premium; payment of rates. The board shall establish procedures for the collection of premiums from participating employers, from enrolled employees, as necessary, and from enrolled individuals. To the extent feasible, the board shall allow participating consumers to pay through a voluntary automatic payment system. The board shall pay contracted rates to participating carriers on a monthly basis or as otherwise provided by mutual agreement.

7. Administrative and accounting procedures. The board shall establish administrative and accounting procedures for operating the alliance and for providing services to alliance members.

8. Risk pools. The board shall develop standards for classifying groups of participating consumers into risk pools. The risk pools may include one or more risk pools for enrolled employees and their dependents and a risk pool for enrolled individuals and their dependents. No later than January 1, 2000, the board shall determine whether to merge the risk pools. Each year after the year 2000 that the risk pools remain separate, the board shall reassess the value of maintaining separate risk pools.

9. Risk adjustment. The board may establish a procedure for adjusting payments within each risk pool to participating carriers if the board finds that some carriers have a significantly disproportionate share of high-risk or low-risk enrollees.

10. Ombudsman services. The board shall establish procedures for assisting enrollees in resolving problems associated with enrollment, coverage and other disputes arising

between the carrier and the enrollee that are not otherwise resolved by available grievance procedures.

11. Marketing; marketing materials. The board shall develop standards for reviewing and approving marketing materials offered to alliance members by participating carriers. The board shall establish procedures for distributing marketing information to alliance members and potential alliance members.

12. Health benefit plans. Subject to the insurance laws of this State, the board shall establish no more than 10 health benefit plans that may be sold within the alliance. At least one health benefit plan must offer coverage equivalent to the state employee health plan as defined under Title 5, sections 285 and 288. At least one health benefit plan must be a fee-for-service policy. For at least one fee-for-service health benefit plan, there must be an actuarially equivalent managed care health benefit plan. The alliance may establish supplemental benefit plans that may be offered through the alliance. The supplemental plans may cover services not covered in the health benefit plans.

13. Underserved areas. The board shall develop standards for designating underserved and rural populations and shall develop standards for determining when a carrier has made all best efforts to extend its service area to and improve access for those populations. When applicable, all best efforts include good faith negotiation with providers serving underserved and rural populations.

14. Agents. The board may establish relationships with agents to facilitate the purchase of health care coverage through the alliance. The board may offer training and information programs to educate agents on alliance operations and products.

15. Cooperative purchasing committee. Consistent with Title 5, section 288, the board shall establish policies and procedures for participating in the cooperative purchasing committee and for coordinating and facilitating the cooperative purchasing of health care coverage with the State Employee Health Commission.

§3406. Eligible carriers

1. Qualifications. To be eligible as a participating carrier, a carrier must be able to demonstrate the following operating characteristics to the board's satisfaction.

A. The carrier must be licensed by the bureau as authorized to operate in this State.

B. The carrier must have the ability to provide alliance enrollees with adequate capacity and reasonable access to covered services in any part of the State where that carrier is authorized to do business.

C. The carrier must have established grievance procedures, including the ability to respond to enrollees' calls, questions and complaints.

D. If the carrier does not have a license to operate in all parts of this State, the carrier must have demonstrated that it has made all best efforts to extend its service area to, and improve access for, rural and underserved populations designated by the board.

E. The carrier must have the ability, to the satisfaction of the board, to provide the data necessary for reviewing the quality and appropriateness of the care provided.

2. Selection of carriers. In evaluating which eligible carriers may participate in the alliance, the board shall consider, in addition to other factors it considers relevant, the following factors:

A. Pricing and competitiveness of each bid from a carrier;

B. The effect of contracting with additional carriers on the administrative costs of the alliance and on alliance members, the efficiency of the alliance and the competitiveness of the premiums that will be paid to participating carriers; and

C. Evidence of quality of care and consumer satisfaction.

3. Participation. A participating carrier shall:

A. Offer one or more standardized health benefit plans authorized by the board pursuant to section 3405, subsection 12;

B. Provide for collection and reporting to the alliance of information on the effectiveness and outcomes of the health benefit plan in providing selected services;

C. Accept and renew each health benefit plan with respect to each participating consumer, except in the following cases:

(1) Nonpayment of the required premiums;

(2) Willful or deliberate fraud or material misrepresentation by the alliance member; or

(3) Election by the participating carrier to terminate its contract with the alliance. The carrier shall provide to the alliance, the bureau and to affected participating consumers, notice of the carrier's decision to terminate its contract with the alliance at least 180 days prior to the nonrenewal of any health benefit plan;

D. Comply with all rules regarding rating, underwriting, claims handling, sales, solicitation, licensing, fair marketing, unfair trade practices and other provisions in this chapter and chapter 24-A, established by the alliance or adopted by the bureau;

E. Consistent with the standards set forth in paragraph C, enroll and disenroll participating consumers and dependents as directed by the alliance or its designee;

F. Agree not to offer lower premium prices to nonmembers of the alliance for the actuarial equivalent of any health benefit plan that the carrier sells to participating consumers; and

G. Comply with any other requirement established by the board pursuant to this chapter or pursuant to the contract between the alliance and the participating carrier.

4. Failure to maintain compliance. The board may suspend or revoke the eligibility of any carrier that fails to maintain compliance with the requirements listed in this section.

§3407. Agent commissions

Commissions paid to an agent for coverage purchased through the alliance must be collected by the agent directly from the purchaser of the agent's services and may not be considered part of the premium collected by the alliance. An agent may not be paid a commission calculated as a percentage of actual premium cost. The agent may be paid a commission calculated as a percentage of average premium cost for the relevant enrollment period. The board shall determine an average premium cost for the relevant enrollment period.

§3408. Effective date

This chapter takes effect January 1, 1997.

Sec. A-3. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	1996-97
MAINE COMMUNITY PURCHASING ALLIANCE	
Maine Community Purchasing Alliance	
All Other	$1,500,000
Provides start-up funds for establishing and marketing Maine Community Purchasing Alliance, a nonstate agency.	

PART B

Sec. B-1. 5 MRSA §285, first ¶, as amended by PL 1989, c. 776, §1, is further amended to read:

A--~~group~~ The state employee health plan, as defined in subsection 2, is available to state employees, subject to the following provisions.

Sec. B-2. 5 MRSA §285, sub-§1, as amended by PL 1993, c. 410, Pt. L, §§9 to 11, is further amended by amending the first paragraph to read:

1. Eligibility; generally. The following persons are eligible for a-~~group~~ the state employee health plan:

Sec. B-3. 5 MRSA §285, sub-§1-A, ¶¶A to C, as amended by PL 1989, c. 776, §1, are further amended to read:

A. If retiring on a disability retirement, have participated in the ~~group~~ state employee health plan immediately prior to retirement;

B. If not retiring on a disability retirement, have participated, as an employee, in the ~~group~~ state employee health plan for at least one year immediately prior to retirement; or

C. If eligibility is based upon subsection 1, paragraph G, subparagraph (3), have participated in the ~~group~~ state employee health plan for at least one year immediately prior to ceasing to be a member of the Legislature.

Sec. B-4. 5 MRSA §285, sub-§2, as amended by PL 1991, c. 780, Pt. Y, §23, is further amended to read:

2. State employee health plan; coverage. ~~Each--state employee--to--whom--this--section--applies--is--eligible--for--a--group health--plan--as--provided--in--Title--24-A,--sections--2802--to--2812, including--major--medical--benefits--or--through--a--self-funded alternative.--The--provisions--of--the--group--insurance--policy--or policies--or--the--self-funded--alternative~~ The state employee health plan is a group health plan, including major medical benefits, as provided in Title 24-A, chapter 35 or through a self-funded alternative, the provisions of which plan must be determined, insofar as the provisions are not inconsistent with terms and conditions contained in collective bargaining agreements negotiated pursuant to Title 26, chapter 9-B, by the State Employee Health Commission as provided in section 285-A. The master policy or policies for the ~~group--health--plan~~ state employee health plan must be held by the Commissioner of Administrative and Financial Services.

Sec. B-5. 5 MRSA §285, sub-§2-A is enacted to read:

2-A. Carrier. For the purposes of this chapter, "carrier" means an insurance company, health maintenance organization, nonprofit hospital or medical services organization, 3rd-party administrator or other entity licensed by the Bureau of Insurance that is necessary to administer or provide the state employee health plan.

Sec. B-6. 5 MRSA §285, sub-§3, as amended by PL 1987, c. 731, §3, is further amended to read:

3. Enrollment. Any employee eligible under ~~this--section~~ subsection 1 or 1-A may join the state employee health plan within the first 60 days of employment or during a declared open enrollment period. The filing of necessary applications ~~shall--be~~ is the responsibility of the employer. Effective dates under this section ~~shall--be~~ are determined at the discretion of the commission.

Sec. B-7. 5 MRSA §285, sub-§5, as amended by PL 1995, c. 368, Pt. G, §1, is further amended to read:

5. Purchase of policies. ~~The--commission--shall--purchase,--by competitive--bidding,--from--one--or--more--insurance--companies, nonprofit---organizations,---3rd-party---administrators---or---any organization--necessary--to--administer--and--provide--a--health--plan,--a policy--or--policies--or--contract,--to--provide--the--benefits--specified by--this--section.--The--purchase--of--policies--by--the--commission--must be--accomplished--by--use--of--a--written--contract--that~~ In compliance

with section 288, the commission shall contract with one or more carriers to administer or provide the benefits specified in the state employee health plan. The contract or contracts must be in writing and fully executed within 90 calendar days of notification of bid acceptance from the commission to the ~~insurer~~ carrier. In extenuating circumstances, the Commissioner of Administrative and Financial Services may grant a waiver to that 90-day limit. ~~Notwithstanding this subsection, with the consent of the policyholder and of the insurer and at the sole discretion of the commission, existing policies of insurance covering at least 1,000 of the employees defined as eligible by this section may be amended to provide the benefits specified by this section and assigned to the Commissioner of Administrative and Financial Services for the benefit of all those eligible under this section. The company or companies or nonprofit organizations must be licensed under the laws of the State, when applicable.~~ The ~~policy~~ contract provisions are subject to and as provided for by the insurance laws of this State, when applicable. Notwithstanding any other provisions of law, the term of a contract executed with a successful bidder may not exceed 3 years.

Sec. B-8. 5 MRSA §285, sub-§6, as amended by PL 1991, c. 780, Pt. Y, §24, is further amended to read:

6. Master policy and certificates. The ~~insurance company, companies or nonprofit organizations~~ carrier or carriers selected pursuant to subsection 5 or the Commissioner of Administrative and Financial Services shall furnish the usual master policy and certificates. Each covered participant must receive a certificate setting forth the benefits to which the participant is entitled, to whom payable, and to whom claims must be submitted, and summarizing the provisions of the policy principally affecting the participant.

Sec. B-9. 5 MRSA §285, sub-§7, as amended by PL 1995, c. 368, Pt. G, §2, is further amended to read:

7. Payment by State. Except as otherwise provided in this subsection, the State, through the commission, shall pay 100% of ~~only the employee's share of this health plan, except for~~ the premiums for the employee's coverage, not to exceed the cost of the lowest-cost state employee health plan. For Legislators, ~~for whom~~ the State also shall pay 50% of the health plan premium for dependent coverage. For any person appointed to a position after November 1, 1981, who is employed less than full time, the State shall pay a share of the employee's share reduced pro rata to reflect the reduced number of work hours.

For persons who were first employed before July 1, 1991, the State shall pay 100% of only the retiree's share of the premiums

for the lowest cost state employee health plan for persons who were previously eligible for this health plan pursuant to subsection 1, paragraph A and who have subsequently become eligible pursuant to subsection 1, paragraph G.

For persons who were first employed by the State after July 1, 1991, the State shall pay a pro rata share portion of only the retiree's share of the premiums, as described in this section, for the lowest cost state employee health plan for persons who were previously eligible for this health plan pursuant to subsection 1, paragraph A and who have subsequently become eligible pursuant to subsection 1, paragraph G based on the total number of years of participation in the group health plan prior to retirement as follows:

Years of Participation	State Portion
10 or more years	100% group health plan premium
9 but less than 10 years	90% group health plan premium
8 but less than 9 years	80% group health plan premium
7 but less than 8 years	70% group health plan premium
6 but less than 7 years	60% group health plan premium
5 but less than 6 years	50% group health plan premium
Less than 5 years	No contribution

Sec. B-10. 5 MRSA §285, sub-§8-B is enacted to read:

8-B. Choice of carriers. Any person eligible under subsection 1 or 1-A may select the carrier from which the State shall purchase the state employee health plan on the eligible person's behalf. The eligible person shall choose a carrier that provides coverage where that person lives or works. The commission shall provide the eligible person with adequate information to make a choice between carriers. That information must include, but is not limited to, the cost of coverage with that carrier and a list of the health care providers available with that carrier if the person's choice of health care provider is restricted. If the eligible person fails to choose a carrier, the commission shall purchase the state employee health plan from the carrier offering the lowest price and providing coverage where that person lives. The eligible person may choose a carrier charging more than the lowest-cost state employee health plan, in which case that person shall pay the difference between the cost and the State's contribution.

Sec. B-11. 5 MRSA §285-A, sub-§1, as amended by PL 1991, c. 780, Pt. Y, §25, is further amended to read:

1. Establishment. The State Employee Health Commission, in this subchapter referred to as the "commission," is established to serve as trustee of the ~~group~~ state employee health plan in this subchapter and to advise the Executive Director of Health Insurance and the Director of the Bureau of Human Resources on health insurance issues and the Director of the Bureau of Human Resources on issues concerning employee health and wellness and the State Employee Assistance Program.

Sec. B-12. 5 MRSA §288 is enacted to read:

§288. Cooperative health benefits purchasing

The State Employee Health Commission, established in section 285-A and referred to in this section as the "commission," shall join with the Maine Community Purchasing Alliance, established in Title 24, chapter 29 and referred to in this section as the "alliance," to negotiate and purchase collectively health benefits on behalf of persons eligible under section 285 and alliance members. The commission and the alliance shall develop policies for their cooperative purchasing as follows.

1. Joint policies. The commission and the alliance collectively shall establish procedures for joint decision making and dispute resolution as required by this section.

2. Cooperative purchasing committee. The cooperative purchasing committee, referred to in this section as the "committee," is established and consists of 2 commission members and 2 alliance board members and other members as allowed pursuant to subsection 7. The commission shall appoint one employee representative and one management representative to the committee. The alliance shall appoint one consumer representative and one employer representative to the committee. The committee has the following functions.

A. Under the direction of the commission and the alliance, the committee shall develop and issue joint requests for proposals for the state employee health plan and for the health benefit plans offered by the alliance.

B. The committee shall review bids and negotiate with carriers. The committee may only consider a bid that, at a minimum, offers coverage to alliance members under the equivalent of the state employee health plan and one other health benefit plan offered in the alliance, as described in

Title 24, section 3405, subsection 12. The committee shall ensure that differences in prices offered the alliance board and prices offered the commission are based upon actuarially significant differences in the composition of the state employee health plan membership and the alliance membership.

The committee may perform its functions in closed session.

3. Joint purchasing. When the committee has reached agreement that it has obtained a bid or bids satisfactory to both the alliance and the commission, the commission and the alliance shall vote separately on whether to accept the bids. Any disagreement between the alliance and the commission must be resolved according to their dispute resolution policies established under subsection 1.

4. Negotiation; competitive bidding. The commission may conduct the development of the request for proposals, the bid review and award and the negotiations in closed session. The commission shall otherwise comply with competitive bidding requirements unless, upon a finding that compliance with competitive bidding requirements will undermine the joint purchasing activities of the alliance and the commission and that satisfactory alternative safeguards are in place, the Commissioner of Administrative and Financial Services waives one or more competitive bidding requirements.

5. Term of contract. The term of the contract for the purchase of the state employee health plan and the health benefit plans offered through the alliance must be one year unless otherwise agreed to by the alliance board, the commission and the carrier.

6. State employee health plan. For the purposes of this section, the state employee health plan need not include coverage for vision or dental services or other health services not typically purchased as part of a health benefit plan.

7. Other cooperative members. With the agreement of the commission and the alliance, the Department of Human Services may purchase coverage for Medicaid beneficiaries through the committee according to the requirements set forth in this section. If the Department of Human Services purchases coverage pursuant to this subsection, the department may appoint one member to the committee.

Sec. B-13. Effective date. This Part takes effect January 1, 1997.

PART C

Sec. C-1. 24 MRSA §2349, sub-§2, ¶B, as enacted by PL 1989, c. 867, §1 and affected by §10, is repealed and the following enacted in its place:

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within 3 months before the date the person enrolls or is eligible to enroll in the succeeding contract.

A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within a time period specified under this section.

Sec. C-2. 24-A MRSA §707, sub-§3, as amended by PL 1995, c. 375, Pt. C, §4, is further amended to read:

3. An insurer other than a casualty insurer may transact employee benefit excess insurance only if that insurer is authorized to insure the class of risk assumed by the underlying benefit plan. Employee benefit excess insurance, even if written by a life or health insurer, is not subject to chapters 29 and 31 to 37, except to the extent that particular provisions are made expressly applicable by rule or law. ~~The~~ No later than July 1, 1997, the superintendent ~~may~~ shall by rule set standards distinguishing excess insurance from basic insurance. In developing these standards the superintendent may consider the analysis supporting the recommendations of the National Association of Insurance Commissioners.

Sec. C-3. 24-A MRSA §1549 is enacted to read:

§1549. Disclosure by agents and brokers

Every agent or broker representing one or more carriers for the purpose of selling health plans shall do all of the following.

1. Disclosure. When providing information to a potential purchaser of a health plan and prior to filing an application for a particular health plan, the agent or broker shall:

A. For a potential purchaser of an individual health plan as defined under section 2736-C or a potential purchaser of a small group health plan as defined in section 2808-B, advise the potential purchaser of the carrier's obligation to sell any of the individual and small group health plans it offers and provide the purchaser, upon request, with the actual rates that would be charged for a given benefit plan design;

B. Notify the potential purchaser of all alternative health plans offered by the agent's carrier or the broker that the potential purchaser would be eligible to purchase;

C. Notify a potential purchaser of health plans offered through the Maine Community Purchasing Alliance established under Title 24, chapter 29 that the potential purchaser would be eligible to purchase;

D. Refrain from offering a specific recommendation as to which health plan the potential purchaser should choose;

E. Notify the potential purchaser that, upon request, the agent will provide rate information on any benefit plan offered by a carrier for whom the agent or broker sells health benefit plans or any health benefit plan offered by the Maine Community Purchasing Alliance;

F. Notify the potential purchaser that, upon request, the agent will provide the potential purchaser with a summary brochure, as required in section 6652, for each health benefit plan design offered by a carrier the agent represents; and

G. Notify the potential purchaser of the commission or fee paid to the agent or broker. A carrier may not vary compensation or commissions to agents or brokers based, directly or indirectly, on the anticipated or actual claims experience or health status associated with parties to which each health plan is sold.

2. Acknowledgment. Upon filing an application for a particular health benefit plan, the agent shall obtain a signed

statement from the purchaser acknowledging that the purchaser has received the disclosures required by this section.

3. Carrier. For the purposes of this section, "carrier" means an insurer, health maintenance organization, nonprofit hospital or medical service organization authorized in this State.

4. Health plan. For the purposes of this section, "health plan" means a plan operated by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan.

Sec. C-4. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 1995, c. 177, §1, is further amended to read:

D. A carrier may vary the premium rate due to age, smoking status, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State ~~after~~ between July 15, 1995 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4-A) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1997 and July 14, 1998, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5-A) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued

or renewed in this State on or after July 15, 1998, the premium rate may not deviate above or below the community rate filed by the carrier.

Sec. C-5. 24-A MRSA §2804-A is enacted to read:

§2804-A. Duties of the employer

The superintendent shall adopt rules requiring that every employer, as defined in Title 26, section 1043, provide access to and information about health care benefits for that employer's employees in accordance with the following provisions. At a minimum, the rules must require an employer to offer each employee access to health care benefits.

1. Health care benefits. For the purposes of this section, "access to health care benefits" means:

A. Access to health care benefits of at least the actuarial equivalent of a standard plan, as defined in section 2808-B, offered through an insurer, a health maintenance organization or a nonprofit hospital or medical service organization authorized to do business in this State; or

B. Access to health care benefits through a health benefits plan qualified under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988).

2. Payment for benefits. The employer shall offer payroll deduction for an employee's payment for health care benefits. The employer may financially contribute toward the purchase of the employee's health benefit plan.

Sec. C-6. 24-A MRSA §2808, sub-§1-A is enacted to read:

1-A. Purchase of health care coverage by Maine Community Purchasing Alliance. Nothing in this section may be construed to prevent the purchase of health care coverage by the Maine Community Purchasing Alliance established in Title 24, chapter 29 on behalf of its members.

Sec. C-7. 24-A MRSA §2808-B, sub-§1, ¶D, as enacted by PL 1991, c. 861, §2, is amended to read:

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that during at least 50% of its working days in the preceding calendar quarter employed fewer than ~~25~~ 100 eligible employees, the majority of whom are employed within

the State. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer. In the calculation of carrier percentage participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation.

Sec. C-8. 24-A MRSA §2808-B, sub-§1, ¶H, as enacted by PL 1991, c. 861, §2, is amended to read:

H. "Subgroup" means an employer with fewer than ~~25~~ 100 employees within an association or a multiple employer trust or any similar subdivision of a larger group covered by a single group health policy or contract.

Sec. C-9. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 1995, c. 177, §2, is further amended to read:

D. A carrier may vary the premium rate due to age, smoking status, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State ~~after~~ between July 15, 1995 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4-A) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1997 and July 14, 1998, the premium rate may not deviate above or

below the community rate filed by the carrier by more than 10%.

(5-A) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1998, the premium rate may not deviate above or below the community rate filed by the carrier.

Sec. C-10. 24-A MRSA §2849-B, sub-§2, ¶B, as amended by PL 1993, c. 666, Pt. D, §4, is repealed and the following enacted in its place:

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within 3 months before the date the person enrolls or is eligible to enroll in the succeeding contract.

A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within a time period specified under this section; and

Sec. C-11. Effective date. This Part takes effect January 1, 1997.

PART D

Sec. D-1. 24-A MRSA c. 83 is enacted to read:

CHAPTER 83

THE HEALTH PLAN QUALITY IMPROVEMENT ACT

§6651. Definitions

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

1. Bureau. "Bureau" means the Bureau of Insurance.

2. Carrier. "Carrier" means an insurance company licensed in accordance with this Title, a health maintenance organization licensed pursuant to chapter 56, a preferred provider organization licensed pursuant to chapter 32, a physician-hospital organization, a nonprofit hospital or medical service organization organized pursuant to Title 24, an administrator licensed pursuant to chapter 18, a utilization review entity licensed pursuant to chapter 34 or any other entity that provides or administers health care coverage. This definition does not include employers exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988).

3. Direct service ratio. "Direct service ratio" means the ratio of benefits returned to policyholders or contract holders, not including refunds or credits, to premiums collected.

4. Emergency medical condition. "Emergency medical condition" means:

A. A medical condition manifesting itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or the unborn child in serious jeopardy;

(2) Serious impairment to bodily function; or

(3) Serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman who is having contractions:

(1) That there is inadequate time to effect a safe transfer from one hospital to another hospital before delivery; or

(2) That the transfer from one hospital to another hospital may pose a threat to the health or safety of the woman or the unborn child.

5. Emergency services. "Emergency services" means those covered services provided after the sudden onset of an emergency medical condition.

6. Enrollee. "Enrollee" means an enrolled employee, an enrolled individual or a dependent of an enrolled employee or enrolled individual.

7. Health plan. "Health plan" means a plan operated or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan.

8. Managed care plan. "Managed care plan" means a plan operated or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan through:

A. Arrangements with selected providers to furnish health care services;

B. Explicit standards for the selection of participating providers;

C. Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan; or

D. Arrangements that share risks with providers.

9. Participating provider. "Participating provider" means a licensed or certified provider of health care services, including mental health services, or a health care supplier that has entered into an agreement with a carrier to provide those services or supplies to a patient enrolled in a managed care plan.

10. Superintendent. "Superintendent" means the Superintendent of Insurance.

§6652. Reporting requirements

To operate in this State, a carrier must comply with the following requirements.

1. Description of plan. A carrier shall prepare for each health plan that it offers a brochure to provide to prospective enrollees, and to members of the public and nonparticipating providers upon request, that contains information on the terms and conditions of the health plan to enable those persons to make informed decisions regarding their choice of plan. A carrier shall provide this information annually to current enrollees,

participating providers and the superintendent. This information must be presented in a format acceptable to the superintendent. All written and oral descriptions of the health plan must be truthful and must use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of health plans under this subsection must be standardized so that enrollees may compare the attributes of the health plans. After a carrier has provided the required information, the annual information requirement under this subsection may be satisfied by the provision of any amendments to the materials on an annual basis. Specific items that must be included in a description are as follows:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type; and

(4) Health care services that are or may be provided only by referral;

B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may lead the enrollee to be denied coverage or not be provided a particular service;

C. Financial arrangements or contractual provisions with hospitals, review companies, physicians and any other providers of health care services that could potentially limit the services offered, restrict referral or treatment options or negatively affect the providers' fiduciary responsibility to the providers' patients, including, but not limited to, financial incentives not to provide medical services or other services;

D. An explanation of how health plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other

noncovered or out-of-plan services and limits on preexisting conditions and waiting periods;

E. The terms under which the health plan may be renewed by the plan members or enrollees, including any reservation by the health plan of any right to increase premiums;

F. A statement as to when benefits cease in the event of nonpayment of the prepaid or periodic premium and the effect of nonpayment upon the enrollees who are hospitalized or undergoing treatment for an ongoing condition;

G. A description of the enrollees' right to appropriate and accessible care in a timely fashion, an effective and timely grievance process, timely determinations of coverage issues, confidentiality of medical records, written copies of coverage decisions that are not explicit in the health plan agreement and 2nd opinions when used in grievance procedures as outlined in section 6657. The description must also include the enrollees' right not to be discriminated against based on health status and the right to refuse treatment without jeopardizing future treatment; and

H. The relative value of the health plan based on an actuarial index of benefit factors developed by the bureau. The benefit factors must use standard assumptions for all plans and measure the cost differences associated with benefit levels and the expected impact of the benefit level on utilization.

2. Schedule of revenue costs and expenses. A carrier, for each health plan that it offers, shall provide the following information annually to the superintendent in accordance with definitions of terms in this subsection set by the superintendent:

A. A schedule of revenues and expenses, including direct service ratios;

B. Health plan revenue;

C. Health plan administrative costs; and

D. Health plan costs of medical services.

As necessary, the superintendent may require the carrier to furnish supporting detail for the information required in this subsection.

3. Plan complaint, adverse decisions and prior authorization statistics. A carrier shall provide annually to

the superintendent information for each health plan that it offers on plan complaints, adverse decisions and prior authorization statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received to the total number of enrollees, reported by type of complaint and category of enrollee;

B. The ratio of the number of adverse decisions issued to the number of complaints received, reported by category;

C. The ratio of the number of prior authorizations denied to the number of prior authorizations requested, reported by category;

D. The ratio of the number of successful enrollee appeals to the total number of appeals filed;

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and

F. Enrollee satisfaction statistics, including complaints received, provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints.

4. Acceptable methods of providing information. A carrier may meet any of the reporting requirements set forth in this section by providing information in conformity with the requirements of the federal Health Maintenance Organization Act of 1973, 42 United States Code, Sections 280c and 300e to 300e-17 (1988), or any other applicable state or federal law or any accrediting organization recognized by the superintendent, as long as the superintendent finds that the information is substantially similar to the information required by this section and is presented in a format that provides a meaningful comparison between health plans. When the superintendent determines that it is feasible and appropriate, the information required by this section must be provided by geographic region, age, gender and employer or group. With respect to geographical breakdown, the information must be provided in a manner that permits comparisons between urban and rural areas.

The superintendent shall compile information relevant to a meaningful comparison of health plans from the information reported according to this section into an annual report and shall make the report available to the public and other interested persons. The report must be presented in a format that provides a meaningful comparison between health plans. The report must also include a description of the data reported as well as a disclaimer regarding any limitations on the use of the data.

§6653. Plan requirements

A health plan in this State must meet the following requirements.

1. Provider participation; credentials. For managed care plans the participation of providers and the granting of credentials is governed by this subsection.

A. A managed care plan must establish credentials for participating providers and allow all providers within the managed care plan's geographic service area to apply for these credentials, if those providers provide services covered by the managed care plan.

B. The credential-granting process begins upon application of a provider to a managed care plan, except that if a managed care plan demonstrates that the plan's provider panel is full, the managed care plan need not undertake the credential-granting process. To qualify for this exception, the managed care plan must demonstrate, to the superintendent's satisfaction, that it satisfies all of the access standards set forth in this chapter.

C. If a managed care plan is accepting applications and a provider is denied participation, that provider's application must be reviewed by a credential-granting committee that contains appropriate representation of the applicant's specialty.

D. The granting of credentials must be based on standards of quality and performance, which may include economic profiling, with input from providers granted credentials by the managed care plan. A description of these standards must be made available to applicants and enrollees. Economic profiling of a provider must reflect variation in case mix, patient age and other factors outside the control of the provider that influence the cost of care. Providers may review and must be given an opportunity to contest these economic profiles.

E. A managed care plan may not discriminate against enrollees based on health status by excluding a provider based solely on the fact that the provider's practice contains a substantial number of patients with chronic or disabling medical conditions.

F. All decisions regarding the granting of credentials must be in writing. The applicant must be provided with all reasons for the denial of an application or nonrenewal of a contract.

G. A managed care plan may not include any clause in a provider's contract that allows the managed care plan to terminate the contract without cause. Nothing in this subsection prohibits a managed care plan from terminating a provider's contract on the grounds of excess capacity when the managed care plan demonstrates, to the superintendent's satisfaction, that the managed care plan complies with the access standards set out in this chapter.

H. A managed care plan may not terminate or restrict in any way a provider's contract because the provider advocates for medically appropriate care.

(1) For the purposes of this paragraph, "to advocate for medically appropriate care" means to appeal a managed care plan's decision to deny payment for a service pursuant to a reasonable grievance or appeal procedure or to protest a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by reputable providers practicing in the same or similar locality under similar circumstances, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients.

(2) Nothing in this paragraph may be construed to prohibit a managed care plan from making a determination not to pay for a particular medical treatment or service or to prohibit a plan from enforcing reasonable peer review or utilization review protocols or determining whether a provider has complied with those protocols.

I. There must be an appeal process available for all adverse decisions. The bureau shall determine whether the process provided by a managed care plan is consistent with due process, using as a standard the due process provisions contained in the federal Health Care Quality Improvement Act

of 1986, 42 United States Code, Sections 11101 to 11152 (1988).

2. Confidentiality. A carrier shall establish procedures to ensure that all applicable federal and state laws designed to protect the confidentiality of provider and individual medical records are followed.

3. Grievance procedures. All health plans must have a grievance procedure as set out in section 6657.

§6654. Utilization review

If a health plan in this State requires prior authorization or other review requirements, including any requirements that may lead a patient to be denied coverage or not be provided a particular service, that health plan must comply with chapter 34 and any applicable rules in conducting utilization reviews. In addition, the health plan must comply with the following requirements.

1. Requirements for medical review or utilization review practices. A carrier must appoint a medical director who is responsible for all clinical decisions by any health plan that it offers and must provide assurances that the medical review or utilization review practices it uses, and the medical review or utilization review practices of payers or reviewers with whom it contracts, comply with the following requirements.

A. Screening criteria, weighting elements and computer algorithms utilized in the review process and their method of development must be released, upon request, to providers and the public. Such criteria must be based on sound scientific principles to the greatest extent possible.

B. Any person who recommends denial of coverage or payment, or determines that a service should not be provided, based on medical necessity standards, must have relevant training and expertise that are, at a minimum, comparable to those of the treating provider.

2. Same-day telephone responses. Health plan personnel must respond to telephone inquiries about medical necessity, including approval of a continued stay in a health care facility, on the same day the inquiry is made.

3. Prior authorization of nonemergency services. A carrier shall ensure that provider requests for prior authorization of a nonemergency service are answered within 2 business days. If the information submitted is insufficient to make a decision, the

carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

4. Medical information release consent forms. When prior authorization is a condition to coverage of a service, a carrier shall ensure that an enrollee signs a medical information release consent form upon enrollment.

§6655. Quality of care

A carrier shall ensure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community.

1. Internal quality assurance program. A health plan must have an ongoing quality assurance program for the health care services provided or reimbursed by the health plan.

2. Written standards. The standards of quality of care must be described in a written document, which must be available for examination by the superintendent or by the Department of Human Services.

§6656. Enrollee choice of provider

1. Choice of provider. A managed care plan must allow enrollees to choose their own participating providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A managed care plan must allow enrollees to change providers without good cause at least once annually and to change providers with good cause as necessary. In the event an enrollee fails to choose a participating provider, the managed care plan may assign the enrollee a participating provider, as long as the participating provider is located in the same area in which the enrollee resides.

2. Chronic disease or condition. When the enrollee has a chronic disabling disease or condition and it is in the enrollee's best interest to continue an existing provider-patient relationship with a nonparticipating provider or establish a new

provider-patient relationship with a nonparticipating provider, that provider must be permitted to enroll as a participating provider, even if it is only to continue caring for that particular patient. The provider must meet the standards of quality set by the managed care plan and accept the managed care plan's standard contractual requirements and fee schedules and financial arrangements.

§6657. Grievance procedure

1. Statement of reasons for denial. An enrollee or a provider who has had a claim denied or is otherwise aggrieved by any decision of a carrier must be provided a written statement of reasons for the decision, which must be clearly documented in the health plan's permanent records of the grievance, whether such record is automated or manual. The written statement must include a general description of the reason the service was denied or a description of the grievance, an explanation of both the enrollee's and the provider's appeal rights and instructions for both the enrollee and the provider to appeal pursuant to the grievance process described in subsection 2.

2. Grievance process. A health plan must have a grievance process that meets the requirements established by the superintendent. The grievance process may not be construed as mandatory for the enrollee or the provider and exhaustion of the grievance process or administrative remedies may not be construed to be a prerequisite to civil court action against the health plan.

3. Appeal process. An enrollee or a provider, upon assignment of an enrollee, who has had a claim denied as not medically necessary must be provided an opportunity for a due process appeal to an independent medical consultant or peer review group. The independent medical consultant or peer review group must be agreed upon by the appealing party and the carrier and may not be affiliated with the organization that performed the initial review. This subsection applies only to claims for services for life-threatening conditions or conditions likely to lead to permanent impairment.

4. Independent 2nd opinion. In any appeal where a professional opinion regarding a health condition is a material issue in the dispute, the appealing party is entitled to an independent 2nd opinion paid for by the health plan.

§6658. Cost containment

A carrier that offers a managed care plan shall work with its participating providers to establish evidence-based and cost-effective practice guidelines.

§6659. Enforcement by enrollees or participating providers

Enrollees and participating providers have the right to bring a private action at law or equity to enforce any of the standards, rights or requirements of this chapter in a court of law and to be awarded costs and legal fees, if successful.

§6660. Construction

Nothing in this chapter may be construed to:

1. Purchase services with own funds. Prohibit an individual from purchasing any health care services with that individual's own funds, whether these services are covered within the individual's benefit package or from another health care provider or plan, except as otherwise provided by federal or state law;

2. Additional benefits. Prohibit any plan sponsor from providing additional coverage for benefits, rights or protections not set out in this chapter; or

3. Provider participation. Require a carrier to admit to a managed care plan a provider willing to abide by the terms and conditions of the managed care plan.

§6661. Liability

1. Indemnification. A contract between a carrier and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with any claim or action brought against the health plan based on the carrier's own fault.

2. Immunity from liability. A participating provider is immune from civil liability for a health plan's negligent decision that causes an enrollee's injury when the participating provider has informed the enrollee or, in the event the enrollee is incapacitated, the enrollee's legal representative, of the provider's disagreement with the decision, the medical consequences of acting according to the decision and the enrollee's opportunity to appeal the decision pursuant to rules adopted by the superintendent. The provider's disclosure to the enrollee must be in terms understandable to a reasonable person.

The health plan is civilly liable to an enrollee for its negligent decisions that cause an enrollee's injury. Nothing in this subsection may be construed to immunize the provider from civil liability arising from the provider's own negligence.

§6662. Adoption of rules

The superintendent shall adopt rules and establish standards of compliance and penalties for noncompliance for carriers to carry out the purposes of this chapter.

Sec. D-2. Effective date. This Part takes effect January 1, 1997.

PART E

Sec. E-1. 22 MRSA §3174-G, sub-§1, as enacted by PL 1989, c. 502, Pt. A, §72, is amended to read:

1. Delivery of services. The department shall provide for the delivery of federally approved Medicaid services to qualified pregnant women up to 60 days following delivery ~~and infants up to one year of age~~ when the woman's ~~or child's~~ family income is below 185% of the nonfarm income official poverty line ~~and children under 5 years of age and;~~ to qualified elderly and disabled persons, when the ~~child's or~~ person's family income is below 100% of the nonfarm income official poverty line; and to children under 19 years of age when the child's family income is below 250% of the nonfarm income official poverty line. The official poverty line ~~shall~~ must be that applicable to a family of the size involved, as defined by the Federal Office of Management and Budget and revised annually in accordance with the United States Omnibus Budget Reconciliation Act of 1981, Section 673, Subsection 2. These services shall be effective October 1, 1988.

Sec. E-2. 22 MRSA §3192 is enacted to read:

§3192. Healthy Children's Trust Fund

The Healthy Children's Trust Fund is established to finance the Medicaid services provided to children under 19 years of age pursuant to section 3174-G, subsection 1. The Healthy Children's Trust Fund does not lapse, but carries forward from one fiscal year to the next. The commissioner shall oversee and administer the Healthy Children's Trust Fund.

Sec. E-3. Allocation of Healthy Children's Trust Fund. The following funds are allocated from the Healthy Children's Trust Fund to carry out the purposes of this Part.

	1996-97
HUMAN SERVICES, DEPARTMENT OF	
Medical Services - Bureau of	
All Other	$8,000,000
Provides funds for expanding delivery of Medicaid services to children whose family income is below 250% of the nonfarm income federal poverty line.	

PART F

Sec. F-1. 24 MRSA §2311 is repealed and the following enacted in its place:

§2311. Taxation

Title 36, chapter 357 applies to every corporation subject to this chapter. Payment of the tax imposed by this section up to $1,500,000 for fiscal year 1996-97 must be credited to the General Fund, and all tax imposed by this section in excess of $1,500,000 for fiscal year 1996-97 must be credited to the Healthy Children's Trust Fund. Payment of the tax imposed by this section up to $1,200,000 for fiscal year 1997-98 must be credited to the General Fund, and all tax imposed by this section in excess of $1,200,000 for fiscal year 1997-98 must be credited to the Healthy Children's Trust Fund. Payment of the tax imposed by this section for fiscal year 1998-99 and all subsequent fiscal years must be credited to the Healthy Children's Trust Fund.

Sec. F-2. 24-A MRSA §4240 is enacted to read:

§4240. Taxation

Title 36, chapter 357 applies to every health maintenance organization subject to this chapter, except that a taxable corporation shall pay the amount calculated in Title 36, chapter 357, less the corporate income tax paid pursuant to Title 36, chapter 817.

Payment of the tax imposed by this section must be credited to the Healthy Children's Trust Fund.

Sec. F-3. 36 MRSA §2513, first ¶, as amended by PL 1985, c. 783, §11, is further amended to read:

Every insurance company ~~or~~, association ~~which~~ , nonprofit hospital or medical services organization or health maintenance organization that does business or collects premiums or assessments including annuity considerations in the State, except those mentioned in section 2517, including surety companies and companies engaged in the business of credit insurance or title insurance, shall, for the privilege of doing business in this State, and in addition to any other taxes imposed for such privilege pay a tax upon all gross direct premiums or subscription income as measured in Title 24, section 2332, including annuity considerations, whether in cash or otherwise, on contracts written on risks located or resident in the State for insurance of life, annuity, fire, casualty and other risks at the rate of 2% a year. Nothing in this section may be interpreted to impose a tax upon the Maine Community Purchasing Alliance established in Title 24, chapter 29.

Sec. F-4. PL 1939, c. 149, §10 is repealed.

Sec. F-5. P&SL 1939, c. 24, §15 is repealed.

Sec. F-6. Effective date. This Part takes effect July 1, 1996.

PART G

Sec. G-1. 22 MRSA §253, as amended by PL 1981, c. 470, Pt. A, §§55 and 56, is repealed and the following enacted in its place:

§253. Comprehensive health planning

The department shall adopt before January 15, 1997 and review every year after 1997 a state health plan in accordance with the United States Public Health Services Act, 42 United States Code, Sections 201 to 300aaa-13 (1988). This plan must identify the health care, facility and human resource needs in the State, the resources available to meet those needs and priorities and recommendations for addressing those needs on a statewide basis.

1. Data; supporting information. In developing and reviewing the state health plan, the department shall use the best and most recent data describing the current supply and distribution of health care, facility and human resources. The department shall consult with the Department of Mental Health and Mental Retardation and a broadly representative health planning council as provided for in the United States Public Health Services Act, 42 United States Code, Sections 201 to 300aaa-13 (1988).

2. Plan components. The state health plan must include:

A. A statement of principles used in the allocation of resources and in establishing priorities for health services;

B. Identification of the current supply and distribution of health care resources, including, but not limited to, hospital, nursing home and other inpatient services; home health and mental health services; treatment services for alcohol and substance abuse; emergency care; ambulatory care services including primary care resources; human resources; major medical equipment; and health screening and early intervention;

C. A determination of the appropriate supply and distribution of resources and services identified in paragraph B and mechanisms that encourage the appropriate integration of these services on a local or regional basis. In making this determination, the council shall consider the following factors: the needs of the population on a statewide basis; the needs of particular geographic areas of the State; the use of facilities in this State by out-of-state residents; the use of out-of-state facilities by residents of this State; the needs of populations with special health care needs; the desirability of providing high-quality services in an economical and efficient manner, including the appropriate use of mid-level practitioners; and the cost impact of these requirements on health care expenditures; and

D. A component that addresses health promotion and disease prevention prepared by the Bureau of Health in a format established by the department.

3. Public hearings. Prior to adopting the state health plan and in reviewing the state health plan, the department shall conduct public hearings, in different regions of the State, on the proposed state health plan. Interested persons must be given the opportunity to submit oral and written testimony. Not less than 30 days before each hearing, the department shall publish in a newspaper of general circulation in the region the time and place of the hearing, the place where interested persons may review the plan in advance of the hearing and the place to which and period during which written comment may be directed to the department.

4. Funds. The department is authorized to accept and expend federal funds allotted or otherwise made available under the United States Public Health Services Act, 42 United States

Code, Sections 201 to 300aaa-13 (1988), to states for the purposes of the Act in accordance with the Act and any amendments of the Act, and the applicable laws, rules, regulations or fiscal policies or practices of this State.

Sec. G-2. 22 MRSA §303, sub-§21, as amended by PL 1985, c. 418, §3, is further amended to read:

21. State health plan. "State health plan" means the plan prepared annually by the ~~State Health Coordinating Council after consideration of the preliminary state health plan prepared by the Office of Health Planning and Development, within the Bureau of Medical Services~~ department pursuant to section 253.

PART H

Sec. H-1. 22 MRSA §256-A is enacted to read:

§256-A. Health work force forum

The department shall convene at least once annually a health work force forum to discuss health work force issues. The forum must include representatives of health professionals, licensing boards and health education programs. The forum shall:

1. Inventory. Develop an inventory of present health work force and educational programs; and

2. Research. Develop research and analytical methods for understanding population-based health care needs on an ongoing basis.

Through the forum, the department shall serve as a clearinghouse for information relating to health work force issues. The department shall use the information gathered through the forum to inform its health policy and planning decisions authorized under this Title.

PART I

Sec. I-1. 5 MRSA §1812-G is enacted to read:

§1812-G. Reimbursement for health benefits

1. Maine Community Purchasing Alliance. Except as provided in subsection 2, a state agency contracting with an independent contractor may not reimburse the independent contractor for administrative costs associated with health benefits for the independent contractor or the independent contractor's employees, unless the health benefits are purchased through the Maine

Community Purchasing Alliance, established in Title 24, chapter 29.

2. Requirement waived. According to rules adopted by the State Purchasing Agent, the Director of the Bureau of General Services may waive the requirement under subsection 1 if:

A. Revenues derived from the independent contractor's contract or contracts with the State do not comprise a substantial portion of the independent contractor's total revenues; or

B. If the independent contractor's place of business is not in this State and the independent contractor purchases health benefits outside this State.

STATEMENT OF FACT

This bill makes the following changes to the health care laws.

1. It establishes the Maine Community Purchasing Alliance, a purchasing alliance through which employers and individuals may unite their bargaining power for purchasing health care coverage. The alliance is a nonstate agency governed by a board of consumers and employers. The alliance may establish no more than 10 health benefit plans that may be offered within the alliance and may negotiate with carriers wishing to sell one or more of those plans to alliance members. The alliance performs other consumer services including collecting and paying premiums, publishing report cards on the quality of services provided by the participating carriers and helping to resolve disputes between enrollees and their carriers. The alliance receives an initial General Fund appropriation and then will be funded by assessments on premiums sold through the alliance.

2. It amends the laws governing the manner in which the State purchases health care coverage on behalf of its employees and Medicaid recipients to allow a state employee to choose between approved carriers in purchasing a health plan and require the State Employee Health Commission to negotiate jointly for the purchase of health care coverage with the Maine Community Purchasing Alliance and explicitly exempts the State Employee Health Commission from the requirement to negotiate publicly. The Department of Human Services is required to consider whether or not to purchase Medicaid services through the cooperative committee.

3. It amends the laws governing community rating, guaranteed issue and continuity of coverage in order to protect the Maine Community Purchasing Alliance from adverse selection. It extends continuity coverage for persons receiving unemployment compensation by making continuity coextensive with eligibility for unemployment compensation. It also requires the Bureau of Insurance to set standards for distinguishing excess insurance from basic insurance, imposes mandatory disclosure requirements on agents and brokers and requires a business to offer health care coverage.

4. It requires health plans operating in the State to comply with certain disclosure requirements, provider credentialling restrictions, utilization review protections and other patient or provider protections.

5. It extends Medicaid coverage to children under the age of 19 whose family income is below 250% of the nonfarm income poverty line. This Medicaid expansion is funded through the Healthy Children's Trust Fund, an account funded by eliminating the tax-exempt status of nonprofit hospital and medical service organizations and health maintenance organizatons.

6. It eliminates the tax exemption for nonprofit hospital and medical service organizations licensed to do business pursuant to the Maine Revised Statutes, Title 24, chapter 19. The taxes collected from nonprofit hospital and medical service organizations are used to fund an expansion of Medicaid and to provide start-up funds for the Maine Community Purchasing Alliance.

7. It amends the law governing preparation of the state health plan by the Department of Human Services.

8. It requires the Department of Human Services to convene a forum on health work force resources.

9. It allows state agencies to reimburse independent contractors for health benefits purchased for the independent contractor's employees only if the health benefits are purchased through the Maine Community Purchasing Alliance. The State Purchasing Agent must adopt rules pursuant to which the Director of the Bureau of General Services may waive this requirement if the independent contractor does only an insubstantial amount of state business or the independent contractor's place of business is not in this State and the independent contractor does not purchase health benefits in this State.