L.D. 392

DATE: 6-4-01 (Filing No. H-670)

MAJORITY

BANKING AND INSURANCE

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
120TH LEGISLATURE
FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 315, L.D. 392, Bill, "An Act to Implement the Recommendations of the Joint Select Committee to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for All Maine Citizens"

Amend the bill by striking out the title and substituting the following:

'**An Act to Establish the Community Health Access Program**'

Further amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

'**Sec. 1. 22 MRSA §3192** is enacted to read:

§3192. Community Health Access Program

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Benefit design" means the health care benefits package provided through the Community Health Access Program.

B. "Community board" means the local governing board of a community health plan corporation.

C. "Community health plan corporation excess insurance" means insurance that protects a plan offered by a community health plan corporation against higher than expected

obligations at retention levels that do not have the effect of making the plan an insured plan. The issuance of community health access program excess insurance does not constitute the business of reinsurance.

D. "Complementary health care provider" means a health care professional, including, but not limited to, a massage therapist, naturopath, chiropractor, physical therapist or acupuncturist, who provides care or treatment to a person that complements the care or treatment provided by a primary care physician and is credentialed by a community board.

E. "Health quality measures" means statistical data that provides information on the quality of health care outcomes for individuals and groups with similar health problems.

F. "Medical data collection system" means the computerized, systematic collection of individual medical data, including the cost of medical care, that when analyzed provides information on the quality and costs of health care outcomes.

G. "Micro-employer" means an employer that has an average of 4 or fewer employees eligible for health care benefits in the 12 months preceding its enrollment in a plan offered by a community health plan corporation.

H. "Out-of-area medical services" means medical care services provided outside of the geographic region of a community health plan corporation.

I. "Program" means the Community Health Access Program established in this section.

2. Program established. The Community Health Access Program is established within the department to provide comprehensive health care services through local nonprofit community health plan corporations governed by community boards. The program's primary goal is to provide access to health care services to persons without health care insurance or who are underinsured for health care services. The purpose of the program is to demonstrate the economic and health care benefits of a locally managed, comprehensive health care delivery model. The program's emphasis is on preventive care, healthy lifestyle choices, primary health care and an integrated delivery of health care services supported by a medical data collection system.

3. Service areas. The department may establish 2 service areas for local plans developed by community health plan corporations in different geographic regions of the State. A

service area established by the department must be an area that serves residents who seek regular primary health care services in conjunction with support from a hospital located in the same geographic region.

4. Eligible population. This subsection governs eligibility.

A. The following persons may enroll in plans developed by community health plan corporations:

(1) Micro-employers and their employees;

(2) Medicaid recipients;

(3) Self-insured employers and their employees to the extent allowed under the federal Employee Retirement Income Security Act;

(4) Self-employed persons; and

(5) Individuals without health care insurance.

B. Individuals eligible for group health care benefits through an individual's employment or spouse's employment may not enroll.

5. Community boards. A local community health plan corporation established pursuant to this section is governed by a community board composed of community members. The board membership must include representation of primary and complementary health care providers, mental health care providers, micro-employers and individuals enrolled in a plan offered by the community health plan corporation. The community boards shall establish bylaws and operating procedures.

6. Authorized powers. A local community health plan corporation may:

A. Develop a comprehensive health care benefit package that may include, but is not limited to, primary and tertiary health care services, mental health services, complementary health care services, preventive health care services, healthy lifestyle services and pharmaceutical services;

B. Develop medical data collection systems that will provide the program with the information necessary to support medical management strategies and will determine the costs and quality outcomes for the services provided;

C. Establish a fee structure sufficient to cover the actuarially determined costs of the comprehensive health care benefit package offered;

D. Develop a sliding fee schedule based on income to ensure that the fees are affordable for individuals covered by a plan offered by the community health plan corporation. The corporations are further authorized to establish mandatory minimum contributions by employers;

E. Collect fees from enrolled individuals and employers;

F. Solicit and accept funds from private and public sources to subsidize the corporation;

G. Develop community preventive care education and wellness programs. A corporation may coordinate its community preventive care education and wellness programs with schools, employers and other community institutions;

H. Enter into agreements with the department to provide care for individuals covered by the department's Medical Assistance Program in its geographic region and to develop methods to share access to medical information necessary for the program's medical data collection system; and

I. Enter into agreements with 3rd parties to provide needed services, including, but not limited to, administration, claims processing, customer services, stop-loss insurance, education, out-of-area medical services and other related services and products.

7. Community health plan corporation excess insurance. In order to ensure adequate financial resources to pay for medical services allowed in the benefit plans developed by community health plan corporations, a local community health plan corporation is required to enter into agreements with insurers licensed in this State to obtain community health plan corporation excess insurance and to provide coverage for those portions of the health care benefits package that expose the corporations to financial risks beyond the resources of the corporation. The department may develop rules to provide further options for community health plan corporations to maintain financial solvency. Participation in the Medicaid program satisfies the requirement of this subsection. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter II-A and must be reviewed before final approval by the joint standing committee of the legislature having jurisdiction over health insurance matters.

8. Cost-sharing agreements. A local community health plan corporation may enter into agreements with private health insurance carriers or the Medicaid program in accordance with the following.

A. A local community health plan corporation may enter into agreements with private health care insurers to cover individual medical costs associated with all or a portion of the costs resulting from the benefit plan or benefit plans offered by the community health plan corporation.

B. A local community health plan corporation may enter into agreements with the department to access Medicaid coverage for all or a portion of the individual medical costs resulting from the benefit plan or benefit plans offered by the local community health plan corporation.

C. No later than January 1, 2002, the department shall seek a waiver from the Federal Government as necessary to permit funding under the Medicaid program to be used for coverage of Medicaid-eligible individuals enrolled in a plan offered by a community health plan corporation. The department may adopt rules required to implement the waiver in accordance with this paragraph. Rules adopted pursuant to this paragraph are major substantive rules as defined in Title 5, chapter 375, subchapter II-A and must be reviewed before final approval by the joint standing committee of the Legislature having jurisdiction over health insurance matters.

9. Medical and cost data. If Medicaid-eligible individuals are enrolled in the program, the department shall provide medical and cost data to each local community health plan corporation at the community health plan corporation's request in a format usable by the community health plan corporation's medical data collection system for the analysis of health care costs and health care outcomes.

10. Dissolution or sale. Upon the dissolution, sale or other distribution of assets of a local community health plan corporation, the community board may convey or transfer the assets of the corporation only to one or more domestic corporations engaged in charitable or benevolent activities substantially similar to those of the community health plan corporation.

11. Annual reports. A local community health plan corporation established pursuant to this section shall submit a written report to the commissioner on or before January 21st annually. The report must address the financial feasibility, fee

structure and benefit design of the plan offered by the community health plan corporation; the health quality measures, health care costs and quality of health care outcomes under the plan; and the number of persons enrolled in the plan. The commissioner may require more frequent reports and additional information. Annually, before March 15th of each year, the department must submit a report summarizing the plan's demonstrated effectiveness to the joint standing committees of the Legislature having jurisdiction over banking and insurance matters and health and human services matters.

12. Not subject to Title 24 or Title 24-A. A local community health plan corporation established pursuant to this section is not subject to any provisions of Title 24 or Title 24-A.

13. Confidentiality. All information in the medical data collection system maintained by a local community health plan corporation established under this section is confidential and may not be disclosed except as permitted by sections 1711-C and 1828.

14. Rules. The department shall adopt rules establishing minimum standards for financial solvency, benefit design, enrollee protections, disclosure requirements, conditions for limiting enrollment and procedures for dissolution of a community health plan corporation. The department may also adopt any rules necessary to carry out the purposes of this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter II-A and must be reviewed before final approval by the joint standing committee of the Legislature having jurisdiction over health insurance matters.

Sec. 2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	2001-02	2002-03
HUMAN SERVICES, DEPARTMENT OF		
Bureau of Medical Services		
Positions	(1.000)	(1.000)
Personal Services	$20,516	$56,098
All Other	2,500	3,250
TOTAL	$23,016	$59,348

Provides funds for one Social

Services Program Manager position and related operating costs associated with establishing and administering the Community Health Access Program.		
Bureau of Medical Services		
All Other	$100,000	$50,000
Provides funds to contract for actuarial services associated with preparing and submitting the federal waiver and operating the program.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$123,016	$109,348

Sec. 3. Allocation. The following funds are allocated from the Federal Expenditures Fund to carry out the purposes of this Act.

	2001-02	2002-03
HUMAN SERVICES, DEPARTMENT OF		
Bureau of Medical Services		
Positions	(0.000)	(1.000)
Personal Services	$20,516	$56,098
All Other	2,500	3,250
TOTAL	$23,016	$59,348
Allocates funds for one Financial Analyst position and related operating costs associated with establishing and administering the Community Health Access Program.		
Bureau of Medical Services		
All Other	$100,000	$50,000
Allocates federal matching funds to contract for		

actuarial services associated with preparing and submitting the federal waiver and operating the program.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$123,016	$109,348

Further amend the bill by inserting at the end before the summary the following:

FISCAL NOTE

	2001-02	2002-03
APPROPRIATIONS/ALLOCATIONS		
General Fund	$123,016	$109,348
Other Funds	123,016	109,348
REVENUES		
Other Funds	$123,016	$109,348

This bill provides General Fund appropriations totalling $123,016 and $109,348 in fiscal years 2001-02 and 2002-03, respectively, for the Department of Human Services to establish the Community Health Access Program to provide comprehensive health care services through local nonprofit community health plan corporations governed by community boards.

This bill includes General Fund appropriations of $100,000 and $50,000 in fiscal years 2001-02 and 2002-03, respectively, and matching Federal Expenditures Fund allocations of $100,000 and $50,000 in those same years for the Bureau of Medical Services associated with contracting for services to prepare and submit the federal waiver and to operate the program.

This bill includes General Fund appropriations of $23,016 in fiscal year 2001-02 and $59,348 in fiscal year 2002-03 for the Bureau of Medical Services within the Department of Human Services for one Social Services Program Manager position and related operating costs associated with establishing and administering the program.

This bill also includes Federal Expenditures Fund allocations of $23,016 and $59,348 in fiscal years 2001-02 and

2002-03, respectively, for the Bureau of Medical Services for one Financial Analyst position and related operating costs associated with establishing and administering the program.'

SUMMARY

This amendment is the majority report of the Joint Standing Committee on Banking and Insurance and establishes the Community Health Access Program within the Department of Human Services. The amendment allows the department to determine service areas throughout the State for the provision of comprehensive health care services through local community-based health plans. The community-based health plans are managed by nonprofit community health care corporations and governed by local boards. The program is primarily designed for individuals without health insurance and micro-employers with 4 employees or less.

The amendment removes the provisions of the bill that amend the laws governing private purchasing alliances and direct the Department of Human Services to apply for a Medicaid waiver to develop a Medicaid buy-in program because those provisions are included in other legislation.

The amendment also adds an appropriation, an allocation and a fiscal note to the bill.