120th MAINE LEGISLATURE

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Legislative Document **No. 392**

H.P. 315 House of Representatives, January 30, 2001

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.

Reported by Representative O'NEIL for the Joint Select Committee to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for All Maine Citizens pursuant to Joint Order 1999, H.P. 1857

Reference to the Joint Standing Committee on Banking and Insurance suggested and printing ordered under Joint Rule 218.

Millicent M. MacFarland

MILLICENT M. MacFARLAND, Clerk

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

Sec. 1. 24 MRSA c. 19, sub-c. V is enacted to read:

SUBCHAPTER V

COMMUNITY HEALTH ACCESS PROGRAM

§2381. 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 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 of Human Services 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 of Human Services may establish 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 of Human Services 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 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 of Human Services 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 to corporations 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 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.

8. Continuity. Enrollment in a local plan offered by a community health plan corporation authorized under this section is not considered prior coverage for the purposes of Title 24-A, section 2849-B, subsection 2, paragraph A.

9. 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 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 community health plan corporation may enter into agreements with the Department of Human Services 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 community health plan corporation.

C. No later than January 1, 2002, the Department of Human Services 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.

10. Medical and cost data. The department shall provide medical and cost data to each 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.

11. Dissolution or sale. Upon the dissolution, sale or other distribution of assets of a 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.

12. Annual reports. A local community health plan corporation established pursuant to this section shall submit a written report to the Commissioner of Human Services 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 of Human Services 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.

13. Not subject to Title 24-A. A local plan developed by a community health plan corporation established pursuant to this section or a community health plan corporation organized pursuant to this section is not subject to any other provisions of this Title or Title 24-A.

14. Rules. The Department of Human Services 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.

Sec. 2. 24-A MRSA §1951, sub-§2, as amended by PL 1997, c. 616, §1, is further amended to read:

2. Private purchasing alliance. "Private purchasing alliance" or "alliance" means a corporation licensed pursuant to

this section established under Title 13-A or Title 13-B to provide health insurance to its members through ~~multiple unaffiliated~~ one or more participating carriers.

Sec. 3. 24-A MRSA §1954, sub-§2, as amended by PL 1997, c. 370, Pt. A, §§1 and 2, is further amended to read:

2. Enrollee choice. Ensure that enrollees have a choice among a reasonable number of competing carriers and types of health benefit plans ~~in accordance with the following:~~

~~A. In every portion of the alliance's service area, the alliance must offer at least 3 different carriers. When 3 participating carriers are not reasonably available in some or all of the alliance's service area, the superintendent may waive this requirement in accordance with standards and procedures established by rule pursuant to this chapter.~~

Sec. 4. Department of Human Services to apply for waiver. By January 1, 2002, the Department of Human Services shall apply to the Federal Government for a waiver to permit funding under the Medicaid program to allow individuals and small employers to purchase coverage under the Medicaid program. The waiver must provide for a sliding scale fee based upon income and must be revenue-neutral. The waiver must provide that any savings be used to increase coverage for individuals and small employers. The department may adopt rules required to implement the waiver program in accordance with this section. Rules adopted pursuant to this section are major substantive rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

SUMMARY

This bill implements 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. The bill does the following.

1. It establishes the Community Health Access Program within the Department of Human Services. The bill 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 plans are managed by nonprofit community health plan corporations and governed by local boards. The program is primarily designed for individuals without health insurance and micro-employers with 4 or fewer employees.

2. It eliminates the requirement that a voluntary private purchasing alliance offer at least 3 different carriers through the alliance.

3. It directs the Department of Human Services to apply for a waiver from the Federal Government to establish a Medicaid "buy-in" program for individuals without health insurance coverage and small employers as a benefit to their employees.