121st MAINE LEGISLATURE

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Legislative Document **No. 1174**

H.P. 871 House of Representatives, March 5, 2003

An Act Relating to Options for Health Insurance Coverage

(EMERGENCY)

Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative O'NEIL of Saco.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the State seeks to protect all its residents from significant financial hardship due to major illness or accident; and

Whereas, the State's current health insurance market is in crisis and premiums are unaffordable for too many state residents; and

Whereas, this legislation intends to pool the insurance risk for catastrophic medical services across a broad population; and

Whereas, this legislation seeks to promote the development of affordable, noncatastrophic health insurance options for small and large employers as well as individuals; and

Whereas, this legislation aims to reduce cost shifting created by charity and bad debt and direct these savings toward reducing health insurance premium expenses; and

Whereas, this legislation recognizes that appropriate and quality-oriented management of medical services is necessary to ensure program sustainability; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

Sec. 1. 24-A MRSA c. 54 is enacted to read:

CHAPTER 54

MAINE CATASTROPHIC HEALTH PROTECTION PLAN

§3901. Short title

This chapter may be known and cited as "the Maine Catastrophic Health Protection Plan."

§3902. Maine Catastrophic Health Protection Plan

The Maine Catastrophic Health Protection Plan, referred to in this chapter as "the plan," is established to provide

catastrophic health insurance protection to eligible state residents. The plan shall operate in accordance with the requirements of this section.

1. Organization. The plan is established as an independent, nonprofit insurance company and is authorized to conduct all activities described in this chapter, either directly or through subcontractual arrangements with other appropriate entities. The plan is also authorized to identify and purchase reinsurance coverage.

2. Board of directors. The plan is governed by a board of directors, referred to in this chapter as "the board."

A. The board consists of 9 members appointed as follows:

(1) Three members appointed by the Governor;

(2) Three members appointed by the President of the Senate; and

(3) Three members appointed by the Speaker of the House of Representatives.

For each set of initially selected directors, one-year, 2-year and 3-year terms of office must be randomly assigned. After the initial terms are completed, directors are appointed for 3-year terms. An individual may not serve more than 3 consecutive terms.

3. Executive director. The board shall hire an executive director to administer and oversee the plan. The executive director serves at the direction of the board.

4. Eligibility. All eligible state residents, except those covered by Medicare or MaineCare, must be annually enrolled in the plan as of July 1st. To be eligible, a person must have established legal residence in this State for the entire calendar year preceding the date of the person's enrollment. Eligible residents filing personal tax returns as a single person with no dependents must be considered single subscribers in the plan; those residents filing all other personal tax returns must be considered family subscribers in the plan.

5. Benefit coverage. The plan covers medical expenses, generally defined to be those hospital, professional, diagnostic, therapeutic, pharmacy and similar services associated with acute medical care, after satisfaction of an annual deductible established in subsection 6.

6. Annual deductible. The costs of services, which must be calculated based on a rate consistent with current, average reimbursement levels in this State, associated with the defined benefit coverage must be recorded toward the annual deductible amount. A minimum and maximum calendar year deductible amount for the first year of operation must be established by the plan for single subscribers and family subscribers. Between these limits, the plan shall establish an administratively manageable set of tiers that represent, on average, 30% of the individual's or family's adjusted gross income as reported to the Treasurer of State for the calendar year immediately preceding the date of the enrollee's eligibility. Subsequent to the first year of operation, these minimum and maximum deductible amounts must increase at a rate equal to the Consumer Price Index in the State for the previous calendar year. The accrual of deductible amounts restarts each January 1st. These deductible amounts can not be changed without the approval of the Governor.

7. Lifetime maximum. The board shall establish a single subscriber and family subscriber lifetime maximum, an amount above which the enrollee is no longer required to satisfy an annual deductible prior to receiving coverage.

8. Community rating. Notwithstanding the requirements of sections 2736-C and 2808-B relating to community rating for individual and small group health plans, a prospective and actuarially determined community rate must be calculated annually. A single subscriber premium and a family subscriber premium that are actuarially based on this community rate must be established by the board.

9. Premium payments. All eligible residents are required to participate in the plan. Single subscriber or family subscriber premium payments may be voluntarily paid on behalf of an enrollee by an employer. This subsection does not require any self-insured employer plan to participate in premium payments. Compliance by a self-insured employer plan is entirely voluntary. In the event that there is no employer contribution for an enrollee, single subscriber or family subscriber premiums must be collected directly from the enrollee by the State.

10. Claims payments. Upon satisfaction of the deductible, the plan shall reimburse at a rate consistent with current average reimbursement levels in the State. If a health plan or self-insured employer has incurred, for an enrollee, medical costs eligible for reimbursement that are in excess of the deductible, the plan shall reimburse the health plan or self-insured employer, and this payment must be considered full and complete. Adjustments to this payment amount must be made to reflect the expected efficiency and effectiveness of the health

plan or self-insured employer to manage services provided before and after the deductible amount is reached. For an enrollee without other health insurance coverage who has incurred medical costs eligible for reimbursement that are in excess of the deductible, the plan shall reimburse providers directly for any amount in excess of the deductible, provided that the reimbursed amount represents full and complete payment for the service. In the alternative, the plan shall reimburse the enrollee, who is responsible for paying the provider.

11. Medical management. The board shall establish and administer appropriate medical and utilization management programs that ensure the delivery of cost-effective, high-quality services. These programs include, but are not limited to, the identification of clinical centers of excellence. Health plans and self-insured employers shall advise the plan of persons with medical conditions that are likely to reach deductible levels and shall cooperate with the medical management protocols established under this subsection.

12. Coordination with bureau. The board shall coordinate with the bureau to develop an operation plan to implement this chapter.

13. Planning activities. The board shall prepare a comprehensive plan for implementation of this chapter. Organizational, operational and financing arrangements include, but are not limited to: specifying eligibility criteria, establishing benefit coverage levels, establishing single and family deductible amounts, tiers and lifetime maximums, establishing levels and procedures related to a lifetime maximum, calculating community-rated premium levels, establishing a reasonable cost structure consistent with current, average reimbursement levels, describing premium collection and claims processing arrangements, identifying and complying with or modifying insurance requirements, ensuring that reduced bad debt and charity expenses are recognized and establishing medical management and payment adjustment programs. The board shall submit its comprehensive plan to the Governor and the Legislature by December 31, 2004.

14. Availability of coverage. The plan shall begin offering coverage on July 1, 2005.

Sec. 2. Appropriations and allocations. The following appropriations and allocations are made.

Maine Catastrophic Health Protection Plan

Initiative: Provides funds for the administration of the Maine Catastrophic Health Protection Plan.

General Fund	**2003-04**
All Other	$400,000
General Fund Total	$400,000

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved.

SUMMARY

This bill establishes the Maine Catastrophic Health Protection Plan as a nonprofit insurance company. The plan provides catastrophic health insurance coverage to all state residents. The plan is governed by a 9-member board of directors. The bill requires that the plan begin offering coverage on July 1, 2005. The bill also appropriates $400,000 for planning activities and requires the board of directors to submit a comprehensive plan to the Governor and the Legislature by December 31, 2004.