121st MAINE LEGISLATURE

FIRST REGULAR SESSION-2003

Legislative Document **No. 1611**

H.P. 1187 House of Representatives, May 12, 2003

An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs

Reference to the Joint Select Committee on Health Care Reform suggested and ordered printed.

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative O'NEIL of Saco. (GOVERNOR'S BILL)
Cosponsored by Senator TREAT of Kennebec and
Representatives: Speaker COLWELL of Gardiner, DAVIS of Falmouth, MILLS of Cornville, RICHARDSON of Brunswick, Senators: President DAGGETT of Kennebec, GAGNON of Kennebec, MAYO of Sagadahoc, TURNER of Cumberland.

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

PART A

Sec. A-1. 5 MRSA §285, sub-§1, ¶I, as amended by PL 2001, c. 667, Pt. E, §2, is further amended to read:

I. Any licensed foster parent caring for a child or children in the foster parent's residence whose care is reimbursed through the Department of Human Services for the period during which the child or children are in that foster parent's care; and

Sec. A-2. 5 MRSA §285, sub-§1, ¶J, as enacted by PL 2001, c. 667, Pt. E, §3, is amended to read:

J. Legislative employees that are recipients of retirement allowances from the Maine State Retirement System based upon creditable service as teachers, as defined by section 17001, subsection 42.; and

Sec. A-3. 5 MRSA §285, sub-§1, ¶K is enacted to read:

K. Any employee of Dirigo Health, as established in Title 24-A, chapter 87.

Sec. A-4. 5 MRSA §1547, sub-§3, as enacted by PL 1999, c. 731, Pt. RRR, §1, is amended to read:

3. Component units. Component units of the State include, but are not limited to, the following organizations: the Loring Development Authority of Maine; the Finance Authority of Maine; the Maine Educational Loan Authority; the Maine Municipal Bond Bank; the Maine Health and Higher Education Facilities Authority; the Maine Governmental Facilities Authority; the Maine Maritime Academy; the Maine State Housing Authority; the University of Maine System; the Maine ~~Technical~~ Community College System; Dirigo Health; and the Maine State Retirement System. The State Controller may identify additional component units in accordance with standards established by a governmental accounting standards board.

Sec. A-5. 5 MRSA §12004-G, sub-§14-D is enacted to read:

14-D. Health Care	Board of Directors of Dirigo Health	$100 per diem and expenses	24-A MRSA §6907

Sec. A-6. 5 MRSA §12004-I, sub-§31-A is enacted to read:

	31-A.	Maine	Expenses	24-A MRSA
Health Care		Quality Forum Advisory Council	Only	§6952

Sec. A-7. 22 MRSA §3174-G, sub-§1, as amended by PL 2001, c. 450, Pt. A, §§1 and 2, is amended to read:

1. Delivery of services. The department shall provide for the delivery of federally approved Medicaid services to the following persons:

A. A qualified woman during her pregnancy and up to 60 days following delivery when the woman's family income is equal to or below 200% of the nonfarm income official poverty line;

B. An infant under one year of age when the infant's family income is equal to or below ~~185%~~ 200% of the nonfarm income official poverty line;

C. A qualified elderly or disabled person when the person's family income is equal to or below 100% of the nonfarm income official poverty line;

D. A child one year of age or older and under 19 years of age when the child's family income is equal to or below ~~150%~~ 200% of the nonfarm income official poverty line;

E. The parent or caretaker relative of a child described in paragraph B or D when the child's family income is equal to or below ~~150%~~ 200% of the nonfarm income official poverty line, subject to adjustment by the commissioner under this paragraph. Medicaid services provided under this paragraph must be provided within the limits of the program budget. Funds appropriated for services under this paragraph must include an annual inflationary adjustment equivalent to the rate of inflation in the Medicaid program. On a quarterly basis, the commissioner shall determine the fiscal status of program expenditures under this paragraph. If the commissioner determines that expenditures will exceed the funds available to provide Medicaid coverage pursuant to this paragraph, the commissioner must adjust the income eligibility limit for new applicants to the extent necessary to operate the program within the program budget. If, after an adjustment has occurred pursuant to this paragraph, expenditures fall below the program budget, the commissioner must raise the income eligibility limit to the extent necessary to provide services to as many eligible persons as

possible within the fiscal constraints of the program budget, as long as the income limit does not exceed ~~150%~~ 200% of the nonfarm income official poverty line; and

F. A person 20 to 64 years of age who is not otherwise covered under paragraphs A to E when the person's family income is below or equal to ~~100%~~ 125% of the nonfarm income official poverty line~~, provided that the commissioner shall adjust the maximum eligibility level in accordance with the requirements of the paragraph~~.

~~(1) If, on October 1, 2003 and annually thereafter, expenditures for the population described in this paragraph are reasonably anticipated to fall below the program budget, the commissioner shall raise the maximum eligibility level to the extent necessary to provide coverage to as many persons with income below 125% of the nonfarm income official poverty line as possible within the fiscal constraints of the Maine Health Access Fund described in section 260.~~

~~(2) If the maximum eligibility level is raised above 100% of the poverty level pursuant to this paragraph and subsequently the commissioner reasonably anticipates the cost of the program to exceed the budget of the population described in this paragraph, the commissioner shall lower the maximum eligibility level to the extent necessary to provide coverage to as many persons as possible within the program budget.~~

~~(3) The commissioner shall give at least 30 days' notice of the proposed change in maximum eligibility level to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters.~~

~~(4) The department must begin offering coverage 3 months after obtaining approval of a waiver of coverage from the United States Department of Health and Human Services or on October 1, 2002, whichever is later.~~

For the purposes of this subsection, the "nonfarm income official poverty line" is that applicable to a family of the size involved, as defined by the federal Department of Health and Human Services and updated annually in the Federal Register under authority of 42 United States Code, Section 9902(2). For purposes of this subsection, "program budget" means the amounts

available from both federal and state sources to provide federally approved Medicaid services.

Sec. A-8. 22 MRSA §3174-DD is enacted to read:

§3174-DD. Dirigo Health Plan

The department may contract with one or more health insurance carriers to purchase Dirigo Health Insurance for MaineCare members who seek to enroll through their employers pursuant to Title 24-A, chapter 87. The insurance received by the MaineCare member must be the same as the insurance offered to other employees in the MaineCare member's group, except that only nominal cost-sharing, as permitted by 42 United States Code, Section 1396(o) (2003) may be required of MaineCare members. The department shall continue to provide MaineCare members services covered by MaineCare that are not covered by the member's Dirigo Health Insurance.

Sec. A-9. 24-A MRSA c. 87 is enacted to read:

CHAPTER 87

DIRIGO HEALTH

SUBCHAPTER 1

GENERAL PROVISIONS

§6901. Short title

This chapter may be known and cited as "the Dirigo Health Act."

§6902. Declaration of necessity

Dirigo Health is established to arrange for the provision of comprehensive, affordable health care coverage to small employers, including the self-employed, their employees and dependents, as well as individuals on a voluntary basis. Dirigo Health is also responsible for monitoring and improving the quality of health care in this State.

§6903. Dirigo Health

Dirigo Health is established as a body corporate and politic and a public instrumentality of the State, and the exercise by Dirigo Health of the powers conferred by this chapter must be deemed and held to be the performance of essential governmental functions.

§6904. Liberal construction of chapter

This chapter, being necessary for the welfare of the State and its inhabitants, must be liberally construed. In the event of any conflict between this chapter and any other law, this chapter prevails, but the power and authority granted under this chapter must be considered to be in addition to and not in derogation of power and authority granted by any other law.

§6905. Tax exemptions

The ownership of all property by Dirigo Health and the issuance of bonds and notes under this chapter are deemed to constitute essential public and governmental purposes, and the property and the bonds and notes so issued, their transfer and the income from those bonds and notes, including any profits made on the sale of the bonds or notes, are at all times exempt from taxation within the State.

§6906. Definitions

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

1. Board. "Board" means the Board of Directors of Dirigo Health, as established in section 6907.

2. Dependent. "Dependent" means a spouse or unmarried child under 19 years of age who resides with a plan enrollee or a child who is a student under 23 years of age and who is financially dependent upon a plan enrollee or a person of any age who is the child of a plan enrollee and who is disabled and dependent upon that plan enrollee.

3. Dirigo Health Insurance. "Dirigo Health Insurance" means the health insurance product established by Dirigo Health that is offered by a private health insurance carrier or carriers.

4. Eligible business. "Eligible business" means a business that employs at least 2 but not more than 50 eligible employees, the majority of whom are employed in the State.

After one year of operation of Dirigo Health, the board may, by rule, define "eligible business" to include larger public or private employers.

5. Eligible employee. "Eligible employee" means an employee of an eligible business who works at least 15 hours per week for that eligible business.

6. Eligible individual. "Eligible individual" means:

A. A self-employed individual who:

(1) Works and resides in the State; and

(2) Is organized as a sole proprietorship or in any other legally recognized manner in which a self-employed individual may organize, a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income;

B. An unemployed individual who resides in this State; or

C. An individual employed in an eligible business that does not offer health insurance.

7. Employer. "Employer" means the owner or responsible agent of a business authorized to sign contracts on behalf of the business.

8. Executive director. "Executive director" means the Executive Director of Dirigo Health.

9. Health insurance carrier. "Health insurance carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance;

B. A health maintenance organization licensed pursuant to chapter 56;

C. A preferred provider arrangement administrator registered pursuant to chapter 32; or

D. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24.

10. Health plan in Medicaid. "Health plan in Medicaid" means a health insurance carrier that meets the requirements of 42 Code of Federal Regulations, Part 438 (2002) and has a contract with the Department of Human Services to provide MaineCare-covered services to individuals enrolled in MaineCare.

11. Participating employer. "Participating employer" means an eligible business whose employees are plan enrollees in Dirigo Health Insurance.

12. Plan enrollee. "Plan enrollee" means an eligible individual or eligible employee who enrolls in Dirigo Health Insurance through Dirigo Health. "Plan enrollee" includes an eligible employee who is eligible to enroll in MaineCare.

13. Provider. "Provider" means any person, organization, corporation or association that provides health care services and products and is authorized to provide those services and products under the laws of this State.

14. Reinsurance or reinsurer. "Reinsurance" and "reinsurer" have the same meanings as in section 741.

15. Resident. "Resident" means a person who is legally domiciled in this State and has been for at least 60 days and has a Maine driver's license, is registered to vote in this State or meets other criteria established by Dirigo Health.

16. Subsidy. "Subsidy" means a subsidy as described in section 6918.

17. Third-party administrator. "Third-party administrator" means any person who, on behalf of any person who establishes a health insurance plan covering residents, receives or collects charges, contributions or premiums for or settles claims on residents in connection with any type of health benefit provided in or as an alternative to insurance as defined by section 704, other than any person listed in section 1901, subsection 1, paragraphs A to O.

18. Unemployed individual. "Unemployed individual" means an individual who does not work more than 15 hours a week for any single employer.

§6907. Board of Directors of Dirigo Health

1. Establishment; appointments. The Board of Directors of Dirigo Health is established and comprises 5 voting members and 3 ex officio, nonvoting members.

A. The 5 voting members of the board must be appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate.

B. Ex officio, nonvoting members of the board must include:

(1) The Commissioner of Professional and Financial Regulation or the commissioner's designee;

(2) The director of the Governor's Office of Health Policy and Finance or the director of a successor agency; and

(3) The Commissioner of Administrative and Financial Services or the commissioner's designee.

2. Qualifications of voting members. Voting members of the board:

A. Must have knowledge and experience in one or more of the following areas:

(1) Health care purchasing;

(2) Health insurance;

(3) MaineCare;

(4) Health policy and law;

(5) State management and budget; or

(6) Health care financing; and

B. May not be:

(1) A representative or employee of an insurance carrier;

(2) A representative or employee of a health care provider; or

(3) Affiliated with a health or health-related organization regulated by State Government.

3. Terms of office. Voting members serve 3-year terms. Voting members may serve up to 2 consecutive terms. Of the initial appointees, one serves an initial term of one year, 2 serve initial terms of 2 years and 2 serve initial terms of 3 years. The Governor shall fill any vacancy for an unexpired term in accordance with subsections 1 and 2. Members reaching the end of their terms may serve until replacements are named.

4. Chair. The Governor shall appoint one of the voting members as the chair of the board.

5. Quorum. Three voting members of the board constitute a quorum.

6. Affirmative vote. An affirmative vote of 3 members is required for any action taken by the board.

7. Compensation. A member of the board must be compensated according to the provisions of Title 5, section 12004-G, subsection 14-D; a member must receive compensation whenever that member fulfills any board duties in accordance with board bylaws.

8. Meetings. The board shall meet at least 4 times a year at regular intervals. It may also meet at other times at the call of the chair or the executive director.

§6908. Limitation on liability

A member of the board or an employee of Dirigo Health is not subject to any personal liability for having acted within the course and scope of membership or employment to carry out any power or duty under this chapter. Dirigo Health shall indemnify any member of the board and any employee of Dirigo Health against expenses actually and necessarily incurred by that member or employee in connection with the defense of any action or proceeding in which that member or employee is made a party by reason of past or present authority with Dirigo Health.

§6909. Prohibited interests of officers, directors and employees

Officers, directors or employees of Dirigo Health or their spouses or dependent children may not receive any direct personal benefit from the activities of Dirigo Health in assisting any private entity, except that they may participate in Dirigo Health Insurance on the same terms as others may under this chapter. This section does not prohibit corporations or other entities with which officers or directors are associated by reason of ownership or employment from participating in activities of Dirigo Health or receiving services offered by Dirigo Health as long as the ownership or employment is made known to the board and, if applicable, the officers or directors abstain from voting on matters relating to that participation.

§6910. Donations to State

The State, through the Governor, may accept donations, bequests, devises, grants or other interests of any nature on behalf of Dirigo Health and transfer those funds, property or other interests to Dirigo Health.

§6911. Confidential records

Except as provided in subsections 1 and 2, information obtained by Dirigo Health under this chapter is a public record as provided by Title 1, chapter 13, subchapter 1.

1. Financial information. Any personally identifiable financial information, supporting data or tax return of any person obtained by Dirigo Health under this chapter is confidential and not open to public inspection.

2. Health information. Health information obtained by Dirigo Health under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information covered by chapter 24 or Title 22, section 1711-C is confidential and not open to public inspection.

§6912. Powers and duties of Dirigo Health

1. Powers. Subject to any limitations contained in this chapter or in any other law, Dirigo Health may:

A. Take any legal actions necessary or proper to recover or collect assessments due Dirigo Health or that are necessary for the proper administration of Dirigo Health;

B. Make and alter bylaws, not inconsistent with this chapter or with the laws of this State, for the administration and regulation of the activities of Dirigo Health;

C. Borrow money or otherwise obtain credit in its own name;

D. Have and exercise all powers necessary or convenient to effect the purposes for which Dirigo Health is organized, or to further the activities in which Dirigo Health may lawfully be engaged, including the establishment of Dirigo Health Insurance;

E. Engage in legislative liaison activities, including gathering information regarding legislation, analyzing the effect of legislation, communicating with Legislators and attending and giving testimony at legislative sessions, public hearings or committee hearings;

F. Take any legal actions necessary to avoid the payment of improper claims against Dirigo Health or the coverage provided by or through Dirigo Health, to recover any amounts erroneously or improperly paid by Dirigo Health, to recover any amounts paid by Dirigo Health as a result of mistake of fact or law and to recover other amounts due Dirigo Health;

G. Enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out the purposes of this chapter;

H. Conduct studies and analyses related to the provision of health care, health care costs and quality, and matters Dirigo Health considers appropriate;

I. Establish and administer a revolving loan fund to assist providers in the purchase of hardware and software necessary to implement the provisions of section 2436, subsection 2-A. Dirigo Health shall solicit matching contributions to the fund from each health insurer licensed to do business in this State;

J. Apply for and receive funds or grants from public and private sources; and

K. In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried out by one or more nonprofit organizations exempt from taxation under the United States Internal Revenue Code and organized, created or operated under the laws of this State.

2. Duties. Dirigo Health shall:

A. Establish administrative and accounting procedures for the operation of Dirigo Health;

B. Collect the recovery payments provided in section 6920;

C. Develop the specifications for Dirigo Health Insurance in accordance with the provisions in section 6916;

D. Develop and implement a program to publicize the existence of Dirigo Health and Dirigo Health Insurance, the eligibility requirements and the enrollment procedures for Dirigo Health Insurance and to maintain public awareness of Dirigo Health and Dirigo Health Insurance;

E. Arrange the provision of Dirigo Health Insurance benefit coverage to eligible individuals and eligible employees through contracts with one or more qualified bidders; and

F. Establish and operate the Maine Quality Forum in accordance with the provisions of section 6951.

3. Audit. Dirigo Health must be audited by the State Auditor at least every 3 years. A copy of the audit must be provided to the superintendent and to the joint standing committees of the Legislature having jurisdiction over health insurance matters and health and human services matters.

4. Rulemaking. Dirigo Health may adopt, amend and repeal rules as necessary for the proper administration and enforcement of this chapter, pursuant to the Maine Administrative Procedure Act. Unless otherwise specified, rules adopted pursuant to this chapter are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

5. Technical assistance from state agencies. Agencies of State Government shall provide technical assistance and expertise to Dirigo Health.

6. Coordination with federal, state and local health care systems. Dirigo Health shall institute a system to coordinate the activities of Dirigo Health with the health care programs of the Federal Government and state and municipal governments.

7. Advisory committees. Dirigo Health may appoint advisory committees to advise and assist Dirigo Health. Members of an advisory committee serve without compensation but may be reimbursed by Dirigo Health for necessary expenses while on official business of the committee.

§6913. Specific powers and duties of board

1. Powers of board. The board may request and the governor if requested shall provide staffing assistance for Dirigo Health in the initial phases its operation.

2. Duties of board. The board of directors shall:

A. Appoint the executive director and fix the executive director's duties and compensation;

B. Provide general oversight and supervision of the activities of Dirigo Health and its executive director;

C. Determine the comprehensive services and benefits to be included in Dirigo Health Insurance pursuant to Title 22, section 3174-DD; and

D. Beginning September 1, 2004, and annually thereafter, report to the Governor and the joint standing committee of the Legislature having jurisdiction over health insurance matters and the joint standing committee of the Legislature

having jurisdiction over human services matters on the impact of Dirigo Health on the small group and individual health insurance markets in this State. The board shall also report on membership in Dirigo Health, the administrative expenses of Dirigo Health, the extent of coverage, the effect on premiums, the number of covered lives, the number of Dirigo Health Insurance policies issued or renewed and Dirigo Health Insurance premiums earned and claims incurred by health insurance carriers offering Dirigo Health Insurance.

§6914. Executive director

The executive director shall:

1. Serve as liaison. Serve as the liaison between the board of directors and Dirigo Health and serve as secretary and treasurer to the board;

2. Manage programs and services. Manage Dirigo Health's programs and services, including the Maine Quality Forum established under section 6951;

3. Employ or contract for personnel or service. Employ or contract on behalf of Dirigo Health for professional and nonprofessional personnel or service;

4. Approve accounts. Approve all accounts for salaries, per diems, allowable expenses of Dirigo Health or of any employee or consultant and expenses incidental to the operation of Dirigo Health; and

5. Perform other duties. Perform other duties prescribed by the board to carry out the functions of this chapter.

§6915. Status of employees

1. State civil service exemption. Employees of Dirigo Health are unclassified major policy-influencing employees under the state civil service provisions of Title 5, Part 2 and chapter 372.

2. State retirement and employee health insurance. Employees of Dirigo Health are deemed state employees for the purposes of the state retirement provisions of Title 5, Part 20 and the state employee health insurance program under Title 5, chapter 13, subchapter 2.

§6916. Dirigo Health Insurance

1. Dirigo Health Insurance. Dirigo Health shall arrange for the provision of health benefits coverage through Dirigo Health Insurance. Dirigo Health Insurance must comply with all relevant requirements of this Title. Dirigo Health Insurance may be offered by health insurance carriers that apply to the board and meet qualifications described in this section and any additional qualifications set by the board. If health insurance carriers do not apply to offer and deliver Dirigo Health Insurance, the board shall have Dirigo Health provide access to health insurance by establishing a nonprofit health plan or through an existing public plan. To qualify as a carrier of Dirigo Health Insurance, a health insurance carrier must:

A. Provide the comprehensive health services and benefits as determined by the board, including a standard benefit package and any supplemental benefits the board wishes to make available; and

B. Ensure that:

(1) Providers participating in Dirigo Health Insurance do not charge plan enrollees or 3rd parties for covered health care services in excess of the amount reimbursed to that provider by Dirigo Health Insurance; and

(2) Providers participating in Dirigo Health Insurance do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status.

Health insurance carriers that seek to qualify to provide Dirigo Health Insurance must also qualify as health plans in MaineCare.

2. Contracting authority. Dirigo Health has contracting authority and powers to administer Dirigo Health Insurance as set out in this subsection.

A. Dirigo Health may contract with health insurance carriers licensed to sell health insurance in this State or other private or public 3rd-party administrators to provide Dirigo Health Insurance. In addition:

(1) Dirigo Health shall issue requests for proposals from health insurance carriers;

(2) Dirigo Health may include quality control, disease management and cost-containment provisions in the contracts with participating health insurance carriers

or may arrange for the provision of such services through contracts with other entities;

(3) Dirigo Health shall require participating health insurance carriers to offer a benefit plan identical to Dirigo Health Insurance, for which no Dirigo Health subsidies are available, in the general small group market;

(4) Dirigo Health shall make payments to participating health insurance carriers under a Dirigo Health Insurance contract to provide Dirigo Health Insurance benefits to plan enrollees not enrolled in MaineCare; and

(5) Dirigo Health may set allowable rates for administration and underwriting gains for contracting health insurance carriers.

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by Dirigo Health Insurance for their employees and dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(a) Dirigo Health Insurance for enrolled employees and dependents;

(b) Dirigo Health's quality assurance, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers for plan enrollees and their dependents who are enrolled in MaineCare.

(4) Dirigo Health shall require participating employers to certify that at least 75% of their employees are enrolled in Dirigo Health Insurance, are enrolled in the MaineCare program or receive health care benefits through another creditable health plan.

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6918 accordingly. Dirigo Health shall return any payments made by plan enrollees also enrolled in MaineCare to those enrollees.

(6) Dirigo Health shall require participating employers to pass on any subsidy in section 6918 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(7) Dirigo Health may establish other criteria for participation.

(8) Dirigo Health may limit the number of participating employers.

C. Dirigo Health may permit eligible individuals to purchase Dirigo Health Insurance for themselves and their dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health may collect payments from eligible individuals participating in Dirigo Health Insurance to cover the cost of:

(a) Enrollment in Dirigo Health Insurance for dependents;

(b) Dirigo Health's quality assurance, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall reduce the payment amounts for individuals eligible for a subsidy under section 6918 accordingly.

(4) Dirigo Health may require that eligible individuals certify that all their dependents are enrolled in Dirigo Health Insurance or are covered by another creditable plan.

(5) Dirigo Health may require an eligible individual who is currently employed by an eligible employer that does not offer health insurance to certify that the current employer did not provide access to an employer-sponsored benefits plan in the 12-month period immediately preceding the eligible individual's application.

(6) Dirigo Health may limit the number of plan enrollees.

(7) Dirigo Health may establish other criteria for participation.

3. Enrollment in Dirigo Health Insurance. Dirigo Health shall perform, at a minimum, the following functions to facilitate enrollment in Dirigo Health Insurance.

A. Dirigo Health shall publicize the availability of Dirigo Health Insurance to businesses, self-employed individuals and others eligible to enroll in Dirigo Health Insurance.

B. Dirigo Health shall screen all eligible individuals and employees for eligibility for subsidies under section 6918 and eligibility for MaineCare. To facilitate the screening and referral process, Dirigo Health shall provide a single application form for Dirigo Health and MaineCare. The application materials must inform applicants of subsidies available through Dirigo Health and of the additional coverage available through MaineCare. It must allow an applicant to choose on the application form to apply or not to apply for MaineCare or for a subsidy. It must allow an applicant to provide household financial information necessary to determine eligibility for MaineCare or a subsidy. Except when the applicant has declined to apply for MaineCare or a subsidy, an application must be treated as an application for Dirigo Health, for a subsidy and for MaineCare. MaineCare must make the final determination of eligibility for MaineCare.

4. Quality improvement, disease management and cost containment. Dirigo Health shall promote quality improvement, disease management and cost-containment programs as part of its administration of Dirigo Health Insurance.

§6917. Coordination with MaineCare

The Department of Human Services is the state agency responsible for the financing and administration of MaineCare. It shall pay for MaineCare benefits for MaineCare-eligible individuals, including those enrolled in health plans in MaineCare that are providing coverage under Dirigo Health Insurance.

§6918. Subsidies

Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health Insurance paid by individuals or employees whose income is under 300% of the federal poverty level and who are not eligible for MaineCare. Dirigo Health may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than 50 employees, whose income is under 300% of the federal poverty level and who are not eligible for MaineCare.

1. Administration. Dirigo Health shall, by rule, establish procedures to administer this section.

2. Individuals eligible for subsidy. Individuals eligible for a subsidy must:

A. Have an income under 300% of the federal poverty level, be a resident of the State, be ineligible for MaineCare coverage and be enrolled in Dirigo Health Insurance; or

B. Be enrolled in a health plan of an employer with more than 50 employees. The health plan may not be self-funded and must meet any other criteria established by Dirigo Health. The individual must meet other eligibility criteria established by Dirigo Health.

3. Limitation of subsidies. Dirigo Health may limit the availability of subsidies to reflect limitations of available funds.

4. Limitation on amount subsidized. Dirigo Health may limit the amount subsidized of the payment made by individual plan enrollees under section 6916, subsection 2, paragraph C to 40% of the payment to more closely parallel the subsidy received by employees. In no case may the subsidy granted to eligible individuals in accordance with subsection 2, paragraph A exceed the maximum subsidy level available to other eligible individuals.

5. Notification of subsidy. Dirigo Health shall notify applicants in writing of their eligibility and approved level of subsidy.

§6919. Intragovernmental transfer

Starting July 1, 2004, Dirigo Health shall transfer to a special dedicated, nonlapsing revenue account administered by the agency of State Government that administers MaineCare for the purpose of providing a state match for federal Medicaid dollars. Dirigo Health shall annually set the amount of contribution. The transfer may not include money collected as a recovery in section 6920.

§6920. Recovery against insurers

1. Recovery. For the purpose of providing the funds necessary to carry out the powers and duties of Dirigo Health, the board shall assess, starting April 1, 2004, health insurance carriers, reinsurance carriers and 3rd-party administrators, not including carriers and 3rd-party administrators with respect to Medicare supplemental insurance, long-term care insurance and disease-specific insurance, at such a time and for such amounts as the board finds necessary. Recovery payments must be made quarterly and are due not less than 30 days after written notice to the member insurers and must accrue interest at 12% per annum on and after the due date.

2. Maximum recovery payments. Each health insurance carrier must be assessed an amount not to exceed 4.1% of annual health insurance premiums of persons insured or reinsured by the insurer. An insurer may not be assessed on policies or contracts insuring federal or state employees.

3. Determination of recovery payment. The board shall make reasonable efforts to ensure that premium revenue associated with each covered person is counted only once with respect to any recovery payment. For that purpose, the board shall require each health insurance carrier that obtains excess or stop loss insurance to include in its gross premium revenue that revenue associated with all individuals whose coverage is insured, in whole or in part, through excess or stop loss coverage. The board shall allow a health insurance carrier to exclude from its gross premium revenue that revenue associated with covered persons who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its recovery payment under this subsection. The board may verify each insurer's recovery payment based on annual statements and other reports determined to be necessary by the board. The board may use any reasonable method

of estimating the number of covered persons of an insurer if the specific number is unknown.

4. Failure to pay recovery payment. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any insurer or reinsurer that fails to pay a recovery payment. As an alternative, the superintendent may levy a penalty on any insurer or reinsurer that fails to pay a recovery payment when due. In addition, the superintendent may use any power granted to the superintendent by this Title to collect any unpaid recovery payments.

5. Excess payments. Dirigo Health may return unused payments in accordance with a formula established by the board.

SUBCHAPTER 2

MAINE QUALITY FORUM

§6951. Maine Quality Forum

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within Dirigo Health. The forum is governed by the board with advice from an advisory council pursuant to section 6952. The forum must be funded, at least in part, through the recovery against insurers established in section 6920 and may seek and receive grants and contracts to advance its work.

§6952. Advisory council appointment; composition

The Maine Quality Forum Advisory Council, referred to in this subchapter as "the advisory council," is a 15-member body established by Title 5, section 12004-I, subsection 31-A. The Governor shall appoint the following members with the approval of the joint standing committee of the Legislature having jurisdiction over health affairs:

1. Providers. Five members representing providers, including one allopathic physician, one osteopathic physician, one registered nurse, one representative of hospitals and one mental health provider;

2. Consumers. Four members representing consumers, including one employee who receives health care through a commercially insured product, one representative of organized labor, one representative of a consumer health advocacy group and one representative of the uninsured or MaineCare recipients;

3. Employers. Four members representing employers, including one representative from the state employee health insurance program, one representative of a large private employer with more than 1,000 full-time equivalent employees, one medium-sized employer with 50 to 1,000 full-time employees and one representative of a small business with 50 or fewer employees; and

4. Health plans. Two members representing health plans, including one representative of a private health plan and one representative from MaineCare.

Prior to making appointments to the forum, the Governor shall seek nominations from a statewide medical association, a statewide osteopathic association, a statewide hospital association, a statewide nurses association, a statewide health purchasing collaborative, a statewide health management coalition, organized labor, a statewide organization representing consumers advocating for affordable health care, a national association of retired persons, a statewide citizen action organization, a statewide organization advocating equal justice, a statewide organization representing local chambers of commerce, a statewide organization representing businesses for social responsibility, a statewide small business alliance, a national federation of independent businesses, a statewide association of health plans and others as appropriate.

§6953. Term

Members of the advisory council serve 5-year terms and may serve no more than 2 consecutive terms. The terms of the initial members appointed to the advisory council must be staggered.

§6954. Compensation

Members of the advisory council are entitled to compensation according to Title 5, chapter 379.

§6955. Quorum

A quorum is a majority of the members of the advisory council.

§6956. Chair and officers

The advisory council shall annually choose one of its members to serve as chair for a one-year term. The advisory council may select other officers and designate their duties.

§6957. Meetings

The advisory council shall meet at least 4 times a year at regular intervals. It may also meet at other times at the call of the chair or the executive director.

§6958. Operation

The forum shall conduct its work in an open, transparent manner and make an annual report to the public and recommendations for inclusion in the State Health Plan under Title 2, chapter 5.

§6959. Forum duties

The forum shall, at a minimum:

1. Disseminate research. Collect and disseminate research regarding evidence-based medicine and patient safety to promote the rapid deployment of best practices;

2. Provider performance. Adopt a set of measures to compare health care provider performance, working collaboratively with other organizations, including representatives of providers, to collect health care data, analyze performance and disseminate comparative performance information in formats useable to consumers, providers, purchasers and policy makers;

3. Consumer education. Conduct consumer education campaigns to assist health care consumers make informed decisions and engage in healthy lifestyles; and

4. Technology assessments. Conduct technology assessment reviews to guide the diffusion of new technologies in this State and to make recommendations to the State Health Plan under Title 2, chapter 5 and the certificate of need program under Title 22.

§6960. Staff support and other assistance

Dirigo Health shall provide staff support and other assistance needed to carry out the forum's duties. Dirigo Health is authorized to contract with the Maine Health Information Center, the Maine Health Data Organization and other entities to assist the forum in the performance of its responsibilities.

Sec. A-10. Effective date. That section of this Part that amends the Maine Revised Statutes, Title 22, section 3174-G, subsection 1 takes effect July 1, 2004.

PART B

Sec. B-1. 2 MRSA c. 5 is enacted to read:

CHAPTER 5

STATE HEALTH PLAN

§101. State Health Plan

1. Governor. The Governor or the Governor's designee shall:

A. Issue the biennial State Health Plan, referred to in this chapter as "the plan." The first plan must be issued by May 2004;

B. Make an annual report to the public assessing the progress toward meeting goals of the plan and provide any needed updates to the plan;

C. Issue yearly a state health expenditure budget report. That expenditure report must serve as the basis for establishing priorities within the plan; and

D. Set a cap, called the capital investment fund, for resources allocated annually under the certificate of need program under Title 22. The first capital investment fund limit must be established by May 2004 for state fiscal year 2004-05.

2. Plan. The plan must:

A. Establish a capital investment fund limit for each year of the biennial plan;

B. Identify and prioritize capital investment needs of the health care system in this State;

C. Assess the quality and availability of health care services across the State;

D. Establish and address health care cost, quality and access goals for the State;

E. Address strategies to:

(1) Ensure access to affordable, sustainable health care;

(2) Maintain a rational, affordable system of preventive health and health care services and facilities;

(3) Stimulate an adequate, qualified workforce to operate the system at the highest quality standards;

(4) Establish priorities annually among the goals;

(5) Develop specific benchmarks and indicators to measure and to assess the availability, quality, effectiveness and efficiency of the health care system in this State and report on progress toward meeting those benchmarks; and

(6) Set forth specific goals and strategies to address the major cost drivers in the health care system and the major threats to public health and safety. These should include both medical care and public health goals. Specifically, these should include, but are not limited to, strategies to reduce the high rates of lung disease, diabetes, cancer and heart disease in this State;

F. Explicitly identify levers to stimulate change such as purchasing strategies, consumer information, pay for performance and state licensing and rules; and

G. Be developed to assist purchasers and providers to make resource decisions that improve the public's health and build an affordable, quality health care system.

§102. Advisory Council on Health Systems Development

1. Appointment; composition. The Advisory Council on Health Systems Development, established by Title 5, section 12004-I, subsection 31-B and referred to in this section as "the council," consists of the following 11 members appointed by the Governor with approval of the joint standing committee of the Legislature having jurisdiction over health matters:

A. Two experts in health care delivery;

B. One expert in long-term care;

C. One expert in mental health;

D. One expert in public health care financing;

E. One expert in private health care financing;

F. One expert in health care quality;

G. One expert in public health;

H. Two consumer representatives; and

I. One representative of the Department of Human Services, Bureau of Health program that works collaboratively with other organizations to improve the health of the citizens of this State.

Prior to appointment, the Governor shall solicit nominations from the public.

2. Term. Members serve 5-year terms and may serve no more than 2 consecutive terms. The terms of the initial members appointed to the council must be staggered.

3. Compensation. Members of the council are entitled to compensation according to Title 5, chapter 379.

4. Quorum. A quorum is a majority of the members of the council.

5. Chair. The council shall annually choose one of its members to serve as chair for a one-year term.

6. Meetings. The council shall meet at least 4 times a year at regular intervals. It may also meet at other times at the call of the chair or the Governor or the Governor's designee.

7. Duties. The council shall assist the Governor or the Governor's designee in developing the plan by:

A. Synthesizing current research and studies available in this State and collecting and coordinating existing data;

B. Advising on the development of the plan; and

C. Holding at least one public hearing on the plan.

8. Staff support. The Governor's office shall provide staff support to the council. The Department of Human Services, Bureau of Health and other agencies of State Government as necessary and appropriate shall provide additional staff support. The Maine Health Data Organization, the Maine Health Information Center and the Department of Human Services, Bureau of Health or its successor shall cooperate with the council. The work of the Maine Quality Forum established in Title 24-A,

section 6951 and the health performance council administered by the Maine Development Foundation must also inform the plan developed by the council.

§103. Data

The council shall solicit data and information from both the public and private sectors to help inform the council's work.

1. Bureau of Health to forward data. The Department of Human Services, Bureau of Health, in consultation with the Maine Center for Public Health Practice established pursuant to Title 22, section 3-D, the program in the Bureau of Health that works collaboratively to improve the health of the citizens of this State and a statewide public health association, shall forward to the council each year data documenting key public health needs, organized by region of the State.

2. Public purchasers to present report. Public purchasers using state or municipal funds to purchase health care services or health insurance shall, beginning January 1, 2004, present to the council a consolidated state health expenditure report outlining all funds expended in the most recently completed state fiscal year for hospital inpatient and outpatient care, physician services, prescription drugs, long-term care, mental health, other services and administration, organized by agency.

3. Council to develop document. The council, through a health management coalition in this State and other groups, shall encourage private purchasers established under Titles 13, 13-B and 13-C to develop a document similar to that described in subsection 2 for the council's consideration.

§104. Uses of plan

1. Guide decisions. The State in awarding certificates of need and the Maine Health and Higher Education Facilities Authority in its health care lending shall use the plan as a guide in making their decisions.

2. Certificate of need. A certificate of need or public financing that affects health care costs may not be provided unless it meets goals and budgets explicitly outlined in the plan.

Sec. B-2. 5 MRSA §12004-I, sub-§31-B is enacted to read:

31-B. Health Care	Advisory Council on Health Systems	Expenses Only	2 MRSA §102

Development

Sec. B-3. 22 MRSA §253, as amended by PL 2001, c. 354, §3, is repealed.

Sec. B-4. 22 MRSA §1709, as enacted by PL 1965, c. 231, §3, is repealed.

PART C

Sec. C-1. 5 MRSA §12004-I, sub-§38, as amended by PL 1997, c. 689, Pt. A, §1 and affected by Pt. C, §2, is repealed.

Sec. C-2. 22 MRSA §328, sub-§3-A is enacted to read:

3-A. Capital investment fund. "Capital investment fund" means that fund described in Title 2, section 101, subsection 1, paragraph D.

Sec. C-3. 22 MRSA §328, sub-§8, as enacted by PL 2001, c. 664, §2, is amended to read:

8. Health care facility. "Health care facility" means a hospital, psychiatric hospital, nursing facility, kidney disease treatment center including a freestanding hemodialysis facility, rehabilitation facility, ambulatory surgical facility, independent radiological service center, independent cardiac catheterization center ~~or~~, cancer treatment center or office of a private physician or physicians, whether in individual or group practice. "Health care facility" does not include the office of ~~a private physician or physicians or~~ a dentist or dentists, whether in individual or group practice.

Sec. C-4. 22 MRSA §328, sub-§27 is enacted to read:

27. State Health Plan. "State Health Plan" means the plan developed in accordance with Title 2, chapter 5.

Sec. C-5. 22 MRSA §335, sub-§1, as enacted by PL 2001, c. 664, §2, is repealed and the following enacted in its place:

1. Basis for decision. Based solely on a review of the record maintained under subsection 6, the commissioner shall approve an application for a certificate of need if the commissioner determines that:

A. The project meets the conditions set forth in subsection 7;

B. The project is consistent with the State Health Plan;

C. The project ensures the realization of high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers;

D. The project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine; and

E. The project can be funded within the capital investment fund.

Sec. C-6. 22 MRSA §335, sub-§1-A is enacted to read:

1-A. Review cycle. The commissioner shall review applications in 2 competitive review cycles each state fiscal year, one for large projects and one for small projects.

Sec. C-7. 22 MRSA §335, sub-§5, as enacted by PL 2001, c. 664, §2, is amended to read:

5. Record. The record created by the department in the course of its review of an application must contain the following:

A. The application and all other materials submitted by the applicant for the purpose of ~~being--made~~ making those documents part of the record;

B. All information generated by or for the department in the course of gathering material to assist the commissioner in determining whether the conditions for granting an application for a certificate of need have or have not been met. This information may include, without limitation, the report of consultants, including reports by panels of experts assembled by the department to advise it on the application, memoranda of meetings or conversations with any person interested in commenting on the application, letters, memoranda and documents from other interested agencies of State Government and memoranda describing officially noticed facts;

C. Stenographic or electronic recordings of any public hearing held by the commissioner or the staff of the department at the direction of the commissioner regarding the application;

D. Stenographic or electronic recording of any public informational meeting held by the department pursuant to section 337, subsection 5;

E. Any documents submitted by any person for the purpose of ~~being--made~~ making those documents part of the record regarding any application for a certificate of need or for the purpose of influencing the outcome of any analyses or decisions regarding an application for certificate of need, except documents that have been submitted anonymously. Such source-identified documents automatically become part of the record upon receipt by the department; ~~and~~

F. Preliminary and final analyses of the record prepared by the staff~~.~~; and

G. Written assessments by the Director of the Bureau of Health and the Superintendent of Insurance assessing the impact of the application on the health care system or cost of health insurance in the State.

Sec. C-8. 22 MRSA §335, sub-§7, ¶¶C and D, as enacted by PL 2001, c. 664, §2, are amended to read:

C. There is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

(1) Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

(2) Whether the project will have a positive impact on the health status indicators of the population to be served;

(3) Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and

(4) Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project; ~~and~~

D. The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

(1) The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project

and the competing demands in the local service area and statewide for available resources for health care;

(2) The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and

(3) The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available.; and

Sec. C-9. 22 MRSA §335, sub-§7, ¶E is enacted to read:

E. The project meets the criteria set forth in subsection 1.

Sec. C-10. 22 MRSA §338, sub-§1, ¶¶A and B, as enacted by PL 2001, c. 664, §2, are amended to read:

A. New medical technologies and the impact of those technologies on the health care delivery system in the State; and

B. Unmet need for health care services in the State.; and

Sec. C-11. 22 MRSA §338, sub-§1, ¶C is enacted to read:

C. The quality of health care.

Sec. C-12. 22 MRSA §1718 is enacted to read:

§1718. Consumer information

The department shall adopt rules that are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A establishing reasonable guidelines for policies to be adopted and implemented by hospitals with respect to the provision of notice to the public of the average charges and average payment accepted from payors other than Medicare and MaineCare for the most common inpatient procedures and services offered and the most common outpatient procedures and services offered, average daily room and board charges and average payment accepted for medical or surgical beds and the average charges and payment accepted for basic emergency department visits.

Sec. C-13. 22 MRSA §1890 is enacted to read:

§1890. Plan for Hospitals for Maine's Future.

1. Plan. The Governor annually shall issue the Plan for Hospitals for Maine's Future, referred to in this section as "the

plan." The plan must include a report describing the manner in which statewide hospital expenditures will be allocated in the coming state fiscal year. The Governor shall issue the first such report no later than March 1, 2004.

2. Purpose. The purpose of the plan is to promote the effective, efficient and rational expenditure of limited financial resources in a manner that preserves access to critical, primary and preventive services for rural and vulnerable residents of this State. To achieve this goal, otherwise competing entities must collaborate to develop a coordinated plan to restructure the hospital system of this State to provide the highest quality care in the most efficient manner. The plan must inform the certificate of need process and the development of the State Health Plan in Title 2, section 101.

3. Statewide hospital expenditures. The level of statewide hospital expenditures to be allocated by the plan must equal that portion of personal health care expenditures in this State attributable to inpatient and outpatient hospital care in the most recent 12-month period for which auditable data are available, adjusted forward to the plan year by the Consumer Price Index for each intervening time period. For purposes of developing the first plan, 1999 hospital expenditures must be used as a basis for calculating the target level of statewide hospital expenditures. The expenditure level for the most recent year for which audited hospital data are available must be used, adjusted forward to state fiscal year 2005 by the appropriate values for the Hospital Cost Index developed by the federal Centers for Medicare and Medicaid Services. This adjusted expenditure level is equal to the amount to be allocated under the plan.

4. Working group. The Governor shall annually convene a working group to develop a proposed plan pursuant to this subsection.

A. The working group comprises representatives of a statewide hospital association, a statewide medical association, a statewide osteopathic association and representatives of the Governor's Office of Health Policy and Finance or its successor. The Governor shall designate the chair of the working group. The State Government shall actively participate in the development of the proposed plan. The Governor shall convene the first working group no later than November 1, 2003.

B. The members of the working group shall develop a proposed plan for the hospital system in this State that satisfies the following criteria:

(1) The proposed plan promotes the realization of high-quality outcomes for patient care and enhanced patient safety;

(2) The proposed plan promotes the efficient use of the hospital resources of this State in delivering care to the residents of this State, ensuring that rural residents of this State have appropriate access to critical care services as well as primary and preventive care, within a reasonable geographic distance; and

(3) The proposed plan promotes cost-effectiveness.

C. The working group shall present the Governor with a final proposal for design modifications to the hospital system in this State no later than February 1, 2004.

5. Intent to displace competition. It is the intent of the Legislature that, to the extent necessary for the purpose of permitting collaboration to formulate a proposed plan allocating costs and services, such collaboration must displace competition in affected health care markets; and further, that such collaboration and the resulting plan are subject to the active supervision of the Governor and the Attorney General, or their designees.

6. Evaluation of proposed plan. The Governor shall evaluate the plan proposed by the working group pursuant to subsection 4 in accordance with the evaluation criteria set forth in this subsection.

A. In evaluating the proposed plan, the Governor shall assess the extent to which the proposed plan offers one or more of the following benefits:

(1) Enhancement of the quality of hospital or related care provided to the citizens of this State;

(2) Preservation of critical care, primary and preventive health care services in geographical proximity to the communities traditionally served by those facilities;

(3) Gains in the cost-efficiency of services provided by hospitals in this State;

(4) Improvements in the utilization of hospital resources and equipment;

(5) Avoidance of duplication of hospital resources; and

(6) Continuation or establishment of needed educational programs for health care professionals and providers.

B. In evaluating the proposed plan, the Governor shall assess the extent to which the proposed plan presents one or more of the following disadvantages:

(1) The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents or other health care payors to negotiate optimal payment and service arrangements with hospitals, physicians, allied health care professionals or other health care providers;

(2) The extent of any reduction in competition among hospitals, physicians, allied health professionals, other health care providers or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed plan;

(3) The extent of any likely adverse impact on patients or clients in the quality, availability and price of health care services;

(4) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed plan; and

(5) The extent of any likely adverse impact on the access of persons in in-state educational programs for health professions to existing or future clinical training programs.

C. The Governor shall consult with the Attorney General regarding the evaluation of any potential reduction in competition resulting from the proposed plan.

7. Administrative procedures. Prior to approval of the proposed plan, the Governor or the Governor's designee shall conduct an adjudicatory proceeding in conformity with the Maine Administrative Procedure Act.

8. Implementation. If, after evaluating the proposed plan and consulting with the Attorney General pursuant to subsection 6, the Governor determines that the proposed plan satisfies the criteria set forth in subsection 4 and, further, that the benefits posed by the proposed plan outweigh the disadvantages, the proposed plan must be approved for implementation. The approved plan does not require additional review under the Maine Certificate of Need Act of 2002.

Sec. C-14. 22 MRSA §2061, sub-§2, as amended by PL 1993, c. 390, §24, is further amended to read:

2. Review. Each project for a health care facility has been reviewed and approved to the extent required by the agency of the State that serves as the Designated Planning Agency of the State or by the Department of Human Services in accordance with the provisions of the Maine Certificate of Need Act of ~~1978~~ 2002, as amended, ~~or, in the case of a project for a hospital, has been reviewed and approved by the Maine Health Care Finance Commission to the extent required by chapter 107~~ and meets the intent of the State Health Plan in Title 2, chapter 5 for controlling health care and health insurance costs in the State;

Sec. C-15. 22 MRSA §8702, sub-§4, as amended by PL 2001, c. 596, Pt. B, §21 and affected by §25, is further amended to read:

4. Health care facility. "Health care facility" means a public or private, proprietary or not-for-profit entity or institution providing health services, including, but not limited to, a radiological facility licensed under chapter 160, a health care facility licensed under chapter 405 or certified under chapter 405-D, an independent radiological service center, a federally qualified health center ~~or~~, rural health clinic or rehabilitation agency certified or otherwise approved by the Division of Licensing and Certification within the Department of Human Services, a home health care provider licensed under chapter 419, a residential care facility licensed under chapter 1664, a hospice provider licensed under chapter 1681, ~~a community rehabilitation program licensed under Title 20-A, chapter 701~~ a retail store drug outlet licensed under Title 32, chapter 117, a state institution as defined under Title 34-B, chapter 1 and a mental health facility licensed under Title 34-B, chapter 1.

Sec. C-16. 22 MRSA §8702, sub-§4-A is enacted to read:

4-A. Health care practitioner. "Health care practitioner" means a person licensed by this State to provide or otherwise lawfully providing health care or a partnership or corporation made up of such persons or an officer, employee, agent or contractor of such a person acting in the course and scope of

employment, agency or contract related to or supportive of the provision of health care to individuals.

Sec. C-17. 22 MRSA §8702, sub-§8, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

8. Payor. "Payor" means a 3rd-party payor or 3rd-party administrator.

Sec. C-18. 22 MRSA §8702, sub-§9-A is enacted to read:

9-A. Quality data. "Quality data" means data submitted by health care providers from which health care service indicators may be developed and reported to the public.

Sec. C-19. 22 MRSA §8702, sub-§11, as amended by PL 2001, c. 677, §2, is further amended to read:

11. Third-party payor. "Third-party payor" means a health insurer, nonprofit hospital, medical services organization or managed care organization licensed in the State or the plan established in chapter 854. "Third-party payor" does not include carriers licensed to issue limited benefit health policies or accident, specified disease, vision, disability, long-term care, or nursing home care ~~or Medicare supplement~~ policies.

Sec. C-20. 22 MRSA §8703, sub-§1, as amended by PL 2001, c. 457, §4, is further amended to read:

1. Objective. The ~~purpose~~ purposes of the organization ~~is~~ are to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens and, either independently or in conjunction with another state entity, to issue periodic reports. This database must be publicly accessible while protecting patient confidentiality and respecting providers of care. The organization shall collect, process ~~and~~, analyze and report clinical ~~and~~, financial and quality data as defined in this chapter.

Sec. C-21. 22 MRSA §8704, sub-§1, ¶A, as amended by PL 2001, c. 457, §7, is further amended to read:

A. The board shall develop and implement data collection policies and procedures for the collection, processing, storage and analysis of clinical, financial and restructuring data in accordance with this subsection for the following purposes:

(1) To use, build and improve upon and coordinate existing data sources and measurement efforts through the integration of data systems and standardization of concepts;

(2) To coordinate the development of a linked public and private sector information system;

(3) To emphasize data that is useful, relevant and is not duplicative of existing data;

(4) To minimize the burden on those providing data;

(5) To preserve the reliability, accuracy and integrity of collected data while ensuring that the data is available in the public domain; ~~and~~

~~(6) To collect information from providers who were required to file data with the Maine Health Care Finance Commission. The organization may collect information from additional providers only when a linked information system for the electronic transmission, collection and storage of data is reasonably available to providers.~~

(7) To develop annually, either independently or in conjunction with another state entity, meaningful, easy-to-understand reports of quality data for distribution on a publicly accessible Internet site or, through the creation of a list of interested parties or through a specific request by a member of the public, via mail or electronic mail;

(8) To periodically produce, either independently or in conjunction with another state entity, at least annually, the reports described in section 8712 on a publicly accessible Internet site or, through the creation of a list of interested parties or through a specific request by a member of the public, via mail or electronic mail; and

(9) To publish at least once per year in the major in-state newspapers the availability of the quality data and price reports described in section 8712.

Sec. C-22. 22 MRSA §8704, sub-§7, as amended by PL 2001, c. 457, §9, is further amended to read:

7. Annual report. The board shall prepare and submit an annual report on the operation of the organization and the Maine

Health Data Processing Center, including any activity contracted for by the organization, and on health care trends to the Governor and the joint standing committee of the Legislature having jurisdiction over health and human services matters no later than February 1st of each year. The report must include an annual accounting of all revenue received and expenditures incurred in the previous year and all revenue and expenditures planned for the next year. The report must include a list of persons or entities that requested data from the organization in the preceding year with a brief summary of the stated purpose of the request.

Sec. C-23. 22 MRSA §8707, sub-§2, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

2. Notice and comment period. The rules must establish criteria for determining whether information is confidential clinical data, confidential commercial data or privileged medical information and adopt procedures to give affected health care providers, facilities and payors notice and opportunity to comment in response to requests for information that may be considered confidential or privileged.

Sec. C-24. 22 MRSA §8708, sub-§6-B is enacted to read:

6-B. Quality data. Pursuant to rules adopted by the board for form, medium, content and period for filing, providers shall file with the organization quality data. Quality data must include data that help consumers make informed choices regarding their health care services. In developing the rules, the board shall collaborate with other agencies, professional associations and entities working in the field of health care data.

Sec. C-25. 22 MRSA §8711, sub-§3 is enacted to read:

3. Most commonly performed services and procedures. The organization shall develop an annual report of the 10 services and procedures most often provided by osteopathic and allopathic physicians in the private office setting in this State. The organization shall make this report available to all physician practices in the State. The first report must be produced and published by July 1, 2004.

Sec. C-26. 22 MRSA §8712 is enacted to read:

§8712. Reports for consumer use

1. Price reports. The organization, with direction from the board, shall develop clearly labeled and easy-to-understand price reports for consumer use. At a minimum, the organization

shall develop these reports on the 15 most common services provided by health care facilities and health care practitioners, excluding emergency services. The board shall specify the data elements to be included in the price reports, including, but not limited to, average paid price per service per facility and total number of services per facility, organized by payor type such as Medicare, Medicaid, aggregated commercial insurers, aggregated 3rd-party administrators and self-pay or uninsured.

2. Comparison report of diagnosis-related groups and outpatient procedures. At a minimum, the organization shall develop a report that compares the 15 most common diagnosis-related groups and the 15 most common outpatient procedures for all hospitals and the 15 most common procedures for nonhospital health care facilities in the State to similar data for medical care rendered in other states, when such data are available.

PART D

Sec. D-1. 24 MRSA §2321, sub-§4, ¶B, as enacted by PL 1997, c. 344, §6, is amended to read:

B. The nonprofit hospital and medical service organization must demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratios of benefits incurred to premiums earned for said products average no less than ~~80%~~ 87.5% for the previous 12-month period.

Sec. D-2. 24 MRSA §2327, as amended by PL 1985, c. 648, §2, is further amended to read:

§2327. Group rates

No group health care contract may be issued by a nonprofit hospital or medical service organization in this State until a copy of the group manual rates to be used in calculating the rates for these contracts has been filed for informational purposes with the superintendent. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care contracts must be filed in accordance with section 2321 and rates for small group health plans as defined by Title 24-A, section 2808-B must be filed in accordance with that section.

Sec. D-3. 24 MRSA §2332-E, as enacted by PL 1993, c. 477, Pt. D, §5 and affected by Pt. F, §1, is amended to read:

§2332-E. Standardized claim forms

~~On or after December 1, 1993, all~~ All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form for professional services approved by the Federal Government in electronic format. ~~On or after December 1, 1993, all~~ All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. A nonprofit hospital or medical service organization or nonprofit health care plan may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically.

Sec. D-4. 24-A MRSA §423-D is enacted to read:

§423-D. Annual report

The superintendent shall adopt routine technical rules as defined in Title 5, chapter 375, subchapter 2-A regarding specifications for an annual report to be filed by each authorized insurer on or before March 1st of each year, or within any reasonable extension of time that the superintendent for good cause may have granted on or before March 1st. The annual reports must provide the public with general, understandable and comparable financial information relative to the operations of authorized insurers. Such information must include, but is not limited to, medical claims expense, administrative expense and underwriting gain for each line segment of the market in this State in which the insurer participates. The superintendent shall develop standardized definitions of each reported measure.

Sec. D-5. 24-A MRSA §1952, as enacted by PL 1995, c. 673, Pt. A, §3, is amended to read:

§1952. Licensure

A person or entity may not market, sell, offer or arrange for a package of one or more health benefit plans underwritten by 2 or more carriers without first being licensed by the superintendent. The superintendent shall specify by rule standards and procedures for the issuance and renewal of licenses

for private purchasing alliances. A rule may require an application fee of not more than $400 and an annual license fee of not more than $100. A license may not be issued until the rulemaking required by this chapter has been undertaken and all required rules are in effect. Dirigo Health, as established in chapter 87, is exempt from the licensure requirements of this section as an instrumentality of the State.

Sec. D-6. 24-A MRSA §2436, sub-§2-A, as enacted by PL 2001, c. 569, §1, is amended to read:

2-A. For purposes of this section, ~~an~~ "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer ~~on~~ in the insurer's standard ~~claim form~~ electronic data format using the most current published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. This subsection applies only to a policy or certificate of a health plan as defined in section 4301-A, subsection 7.

Sec. D-7. 24-A MRSA §2736-C, sub-§2, ¶B-1 is enacted to read:

B-1. In no instance may a rate reflect the cost to the individual health carrier of the recovery amount applied in accordance with section 6920.

Sec. D-8. 24-A MRSA §2808-B, sub-§§2-A to 2-C are enacted to read:

2-A. Rate filings. A carrier offering small group health plans shall file with the superintendent every rate, rating formula and classification of risks and every modification of any formula or classification that it proposes to use. Every filing must state the effective date of the filing. Every filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent.

2-B. Rate review and hearings. Except as provided in subsection 2-C, rate filings are subject to this subsection.

A. The effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in paragraph E, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the

carrier satisfactorily responds to any reasonable discovery requests.

B. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums.

C. When a filing is not accompanied by the information upon which the carrier supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the carrier to furnish the information upon which it supports the filing. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to paragraph D.

D. If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this section must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

E. Any filing of rates, rating formulas and modifications that satisfies the criteria set forth in this paragraph is subject to the provisions of paragraph F:

(1) The rate increase for any group or subgroup does not exceed the index of inflation multiplied by 1.5, excluding any approved rate differential based on age. For the purposes of this subsection, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the superintendent that includes this State for the most recent 12-month period immediately preceding the date of the filing for which data are available; and

(2) The carrier demonstrates in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratio of benefits incurred to premiums earned averages no less than 87.5% for the previous 12-month period.

F. Any rate hearing conducted with respect to filings that meet the criteria in paragraph E is subject to this paragraph.

(1) Any person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(2) If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(3) In any hearing conducted under this subsection, the bureau and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate and not unfairly discriminatory remains with the carrier.

2-C. Optional guaranteed loss ratio. At the carrier's option, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is deemed credible if the anticipated number of member months for which the rates will be in effect is at least 1,000 or if it meets credibility standards adopted by the superintendent by rule. The rate filing must state the anticipated number of

member months for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of member months is likely to be less than 1,000 and the block does not satisfy any alternative credibility standards adopted by rule, the filing is subject to subsection 2-B.

B. Within 7 months after the end of the period for which rates are in effect, the carrier shall file a report with the superintendent showing aggregate earned premiums and incurred claims for the period the rates were in effect. Incurred claims must include claims paid to a date 6 months after the end of the period for which rates were in effect and an estimate of unpaid claims. The report must state how the unpaid claims estimate was determined.

C. If incurred claims were less than 80% of earned premiums, the carrier shall refund a percentage of the premium to an entity or person that paid the premium. The percentage must be the same for all groups and subgroups and must be calculated as the ratio of excess premiums to aggregate earned premiums. Excess premiums must be calculated by dividing the aggregate incurred claims by 0.8 and subtracting the result from aggregate earned premiums. The total of all refunds must equal the excess premiums.

D. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large.

E. The superintendent may adopt rules setting forth appropriate methodologies regarding reports, refunds and credibility standards pursuant to this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. D-9. 24-A MRSA §2839, as amended by PL 1985, c. 648, §11, is further amended to read:

§2839. Rates filed

No policy of group health insurance may be delivered in this State until a copy of the group manual rates to be used in calculating the premium for these policies has been filed for informational purposes with the superintendent. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care insurance contracts must be filed in accordance with section 2736 and rates for small group health

plans as defined by section 2808-B must be filed in accordance with that section.

Sec. D-10. 24-A MRSA §2839-B is enacted to read:

§2839-B. Large group rates

1. Application. This section applies to group health insurance offered in the large group market as defined in section 2850-B, except insurance covering only accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance.

2. Annual filing. Every carrier offering group health insurance specified in subsection 1 shall annually file with the superintendent on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board. The filing must also certify that the carrier has not reflected cost to the group health carrier of the recovery amount applied in accordance with section 6920. The filing also must state the number of policyholders and dependents, as of the close of the preceding calendar year, enrolled in large group health insurance plans offered by the carrier. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3.

3. Documentation. Every carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrates that its rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board.

Sec. D-11. 24-A MRSA §4207, sub-§5, as repealed and replaced by PL 1993, c. 645, Pt. A, §6, is amended to read:

5. A schedule or an amendment to a schedule of charge for enrollee health coverage for health care services may not be used by any health maintenance organization unless it complies with section 2736, 2808-B or 2839, whichever is applicable.

Sec. D-12. Effective date. That section of this Part that amends the Maine Revised Statutes, Title 24-A, section 2436, subsection 2-A takes effect January 1, 2005.

PART E

Sec. E-1. 32 MRSA §2599-C is enacted to read:

§2599-C. Consumer information

Each osteopathic physician in private practice shall post a readable public notice of the average charges and average payment accepted from payors other than Medicare and MaineCare for the most common services and procedures provided in physicians' offices in this State, as specified by the Maine Health Data Organization in accordance with Title 22, section 8711. This notice must be posted in a public area of the physician's office.

Sec. E-2. 32 MRSA §3299-B is enacted to read:

§3299-B. Consumer information.

A physician in private practice shall post a readable public notice of the average charges and average payment accepted from payors other than Medicare and MaineCare for the most common services and procedures provided in physicians' offices in this State, as specified by the Maine Health Data Organization in accordance with Title 22, section 8711. This notice must be posted in a public area of the physician's office.

PART F

Sec. F-1. Voluntary limits to control growth of insurance and health care costs.

1. Purpose. The cost of health care and health care coverage in this State is growing at a rate that is unaffordable or unsustainable for many residents of the State. There is a pressing need to mitigate the rate of increases in these costs in order to avert increases in loss of health care coverage and to protect access to health care services. The purpose of this section is to encourage health care providers and health insurance carriers to voluntarily restrain the rate of increases in costs.

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

A. "Health care provider" means any person, entity or facility providing health care services in this State.

B. "Health insurance provider" means any nonprofit health or medical services organization as defined in the Maine Revised Statutes, Title 24, any person engaged in the provision of health insurance and any person engaged in the provision of reinsurance for health insurers.

3. Voluntary limits on costs. The following constraints are called for:

A. Each health care provider in this State is asked to voluntarily restrain increases in the charges imposed and the average payments assessed or accepted by that health care provider for the health care services provided by that health care provider to no more than 3% for a period of one year following the effective date of this section; and

B. Each health care insurer licensed in this State is asked to voluntarily limit the pricing of products sold in this State to that level that supports no more than a 3% underwriting gain for a period of one year following the effective date of this section.

4. Compliance. The State shall monitor compliance with the voluntary effort described in subsection 3. If, on a statewide basis, average charges or average payments for health care providers and average underwriting gain for insurance providers exceed 3% for the one-year period following the effective date of this section, the Governor's office shall develop plans for implementation of provider rate-setting systems, global budgeting systems and more stringent insurance rate regulation.

PART G

Sec. G-1. Medicare and veterans' health care. The Governor shall engage in active negotiations with the Federal Government to increase access to federally sponsored health services for veterans in this State and to increase the rates of Medicare reimbursement for the State's health care providers.

SUMMARY

Part A of the bill establishes Dirigo Health as an independent agency of State Government. It seeks to make affordable health insurance available to small businesses and individuals, provide additional assistance to employees and individuals with earnings below 300% of the federal poverty

guidelines and establishes the Maine Quality Forum to improve the quality of care in this State.

Part B requires the Governor to issue a biennial State Health Plan and establishes an advisory council to assist in the development of the plan.

Part C ties the administration of the certificate of need process to the State Health Plan and the capital investment fund. It further seeks to strengthen the public database administered by the Maine Health Data Organization.

Part D requires insurers in the small group market to submit to the Superintendent of Insurance the same rate information that insurers in other markets are required to provide.

Part E requires certain health care providers to provide consumer information.

Part F establishes voluntary constraints on health care cost increases.

Part G requires the Governor to work to improve access to care for veterans and to improve Medicare reimbursements for Maine providers.