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H.P. 693 House of Representatives, March 12, 2009

An Act To Continue Access to Dirigo Choice Health Insurance by Reducing Administrative Costs and Replacing the Savings Offset Payment

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

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative TREAT of Hallowell.
Cosponsored by Senator BOWMAN of York and
Representatives: BEAUDOIN of Biddeford, GOODE of Bangor, LEGG of Kennebunk, PERRY of Calais, Speaker PINGREE of North Haven.

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

Sec. 1. 24-A MRSA §2736-C, sub-§2, ¶F, as amended by PL 2007, c. 629, Pt. M, §4, is further amended to read:

F. A carrier that adjusts its rate shall account for the savings offset payment or any recovery in that offset payment in its experience consistent with this section and former section 6913, but the carrier may not adjust its rate to reflect any savings offset payment or health access surcharge amount paid by the carrier pursuant to former section 6913 or section 6913-A.

Sec. 2. 24-A MRSA §2808-B, sub-§2-B, ¶D, as amended by PL 2007, c. 629, Pt. M, §8, is further amended to read:

D. A carrier that adjusts its rate shall account for the savings offset payment or any recovery of that savings offset payment in its experience consistent with this section and former section 6913, but the carrier may not adjust its rate to reflect any savings offset payment or health access surcharge amount paid by the carrier pursuant to former section 6913 or section 6913-A.

Sec. 3. 24-A MRSA §2839-B, sub-§2, as amended by PL 2007, c. 629, Pt. M, §11, is further amended to read:

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 included in its experience any savings offset payments or recovery of those savings offset payments consistent with former section 6913. The filing must certify that the carrier has not included in its rates any savings offset payments or health access surcharges paid in accordance with former section 6913 and section 6913-A. The filing also must state the number of policyholders, certificate holders 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.

Sec. 4. 24-A MRSA §6913, as amended by PL 2007, c. 1, Pt. X, §§1 and 2 and affected by §3, is repealed.

Sec. 5. 24-A MRSA §6913-A is enacted to read:

§6913-A. Health access surcharge

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

A. "Paid claims" means all payments made by health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers for health and medical

services provided under policies issued pursuant to the laws of this State that insure residents of this State or, in the case of 3rd-party administrators, for health care for residents of this State, except that "paid claims" does not include:

(1) Claims-related expenses and general administrative expenses;

(2) Payments made to qualifying providers under a "pay for performance" or other incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals;

(3) Claims paid by carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, except that claims paid for dental services covered under a medical policy are included;

(4) Claims paid for services rendered to nonresidents of this State;

(5) Claims paid under retiree health benefit plans that are separate from and not included within benefit plans for existing employees;

(6) Claims paid by an employee benefit excess insurance carrier that have been counted by a 3rd-party administrator for determining its health access surcharge;

(7) Claims paid for services rendered to persons covered under a benefit plan for federal employees; and

(8) Claims paid for services rendered outside of this State to a person who is a resident of this State.

In those instances in which a health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator is contractually entitled to withhold certain amounts from payments due to providers of health and medical services in order to help ensure that the providers can fulfill any financial obligations they may have under a managed care risk arrangement, the full amounts due the providers before application of such withholds must be reflected in the calculation of paid claims.

B. "Claims-related expenses" includes:

(1) Payments for utilization review, care management, disease management, risk assessment and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals, usually either by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping such covered individuals to maintain or improve their health; and

(2) Payments that are made to or by organized groups of providers of health and medical services in accordance with managed care risk arrangements or network access agreements. The payments are unrelated to the provision of services to specific covered individuals.

C. "Health and medical services" includes, but is not limited to, any services included in the furnishing of medical care, dental care to the extent covered under a medical insurance policy, pharmaceutical benefits or hospitalization, including but not limited to services provided in a hospital or other medical facility; ancillary services, including but not limited to ambulatory services; physician and other practitioner services, including but not limited to services provided by a physician's assistant, nurse practitioner or midwife; and behavioral health services, including but not limited to mental health and substance abuse services.

2. Health access surcharge on paid claims required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. All health insurance carriers, employee benefit excess insurance carriers and 3rd-party administrators, not including carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, shall pay a health access surcharge of 2.14% on all paid claims. The following provisions govern the health access surcharge.

A. A health insurance and employee benefit excess insurance carrier is not required to pay a surcharge on policies or contracts insuring federal employees.

B. The surcharge applies to paid claims beginning October 1, 2009.

C. Surcharge payments must be made monthly to Dirigo Health beginning November 2009 and are due not less than 15 days after the end of the month and must accrue interest at 12% per annum on or after the due date, except that surcharge payments for 3rd-party administrators for groups of 500 or fewer members may be made annually not less than 60 days after the close of the plan year.

D. Surcharge payments received by Dirigo Health must be pooled with other revenues of the agency in the Dirigo Health Enterprise Fund established in section 6915.

3. Failure to pay health access surcharge payments. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any health insurance carrier or employee benefit excess insurance carrier or the license of any 3rd-party administrator to operate in this State that fails to pay a health access surcharge. In addition, the superintendent may assess civil penalties in accordance with section 12-A against any health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator that fails to pay a health access surcharge, may take any other enforcement action authorized under section 12-A to collect any unpaid health access surcharge payments and may collect the costs of enforcement including attorney's fees from those who fail to pay a health access surcharge.

4. Rulemaking. The board may adopt any rules necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 6. 24-A MRSA §6915, as amended by PL 2005, c. 386, Pt. D, §3, is further amended to read:

§6915. Dirigo Health Enterprise Fund

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, any ~~savings offset~~ payments made pursuant to former section 6913 and section 6913-A and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. 7. Savings offset payments calculated prior to effective date. Notwithstanding that section of this Act that repeals the Maine Revised Statutes, Title 24-A, section 6913, the savings offset payments that have been calculated, assessed and become due as required under former Title 24-A, section 6913 prior to October 1, 2009 must be paid at an accelerated rate. Payments must be made monthly and are due not later than 15 days after the end of the month and must accrue interest at 12% per annum on or after the due date.

SUMMARY

This bill repeals the savings offset payment used to fund subsidies for the Dirigo Health Program and eliminates the administrative costs associated with the annual adjudicatory hearings. In place of the savings offset payment, the bill establishes a health access surcharge of 2.14% on all paid claims to be paid monthly as a source of funding for Dirigo Health Program subsidies. The bill changes the payment date for savings offset payments that have been previously assessed but not yet paid before the effective date of the bill. The bill also prohibits insurance carriers from including the costs of the health access surcharge used to support the Dirigo Health Program in health insurance premium rates.