124th MAINE LEGISLATURE

FIRST REGULAR SESSION-2009

Legislative Document **No. 1264**

H.P. 883 House of Representatives, March 31, 2009

An Act To Stabilize Funding and Enable DirigoChoice To Reach More Uninsured

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. (GOVERNOR'S BILL)
Cosponsored by Senator BOWMAN of York and
Representative: Speaker PINGREE of North Haven, Senator: President MITCHELL of Kennebec.

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

Sec. 1. 24-A MRSA §6908, sub-§2, ¶B, as amended by PL 2007, c. 629, Pt. L, §1, is further amended to read:

B. Collect the savings offset payments provided in former section 6913 and the ~~health~~ access ~~surcharge~~ payment provided in section ~~6913-A~~ 6917;

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 X, §§1 and 2 and affected by §3, is repealed.

Sec. 3. 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, any access payments made pursuant to section 6917 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. 4. 24-A MRSA §6917 is enacted to read:

§6917. Access payment

1. Access payments required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. All health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers shall pay an access payment of 2.14% on all paid claims, except claims under accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance. The following provisions govern access payments.

A. A health insurance carrier or employee benefit excess insurance carrier may not be required to pay an access payment on policies or contracts insuring federal employees.

B. Access payments apply to claims paid beginning on or after the effective date of this section.

C. Access payments must be made monthly to Dirigo Health and are due 15 days after the end of each month and must accrue interest at 12% per annum on or after the due date, except that access 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. Access payments received by Dirigo Health must be pooled with other revenues of the agency in the Dirigo Health Enterprise Fund established in section 6915.

2. Failure to pay access 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 an access payment. 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 an access payment or may take any other enforcement action authorized under section 12-A to collect any unpaid access payments and may collect the cost of enforcement including attorney's fees from those who fail to pay an access payment.

3. Definitions. As used in this section, the following terms have the following meanings.

A. "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 and that are unrelated to the provision of services to specific covered individuals.

B. "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.

C. "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 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 access payment;

(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.

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. 5. 24-A MRSA §6951, first ¶, as amended by PL 2007, c. 629, Pt. L, §5, is further amended to read:

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 the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded, at least in part, through the savings offset payments made pursuant to former section 6913 and the ~~health~~ access ~~surcharge~~ payment pursuant to section ~~6913-A~~ 6917. Except as provided in section 6907, subsection 2, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties.

Sec. 6. Changes to Dirigo Health. The Board of Trustees of Dirigo Health, or "the board," shall:

1. Develop products, procedures. Develop more affordable products and procedures that can reach uninsured and underinsured residents of the State to reduce uncompensated care;

2. Maximize federal initiatives. Use subsidies to maximize federal initiatives, including Medicaid and any national health reform;

3. Asset tests. Determine the impact of asset tests on determining eligibility;

4. Voucher program. Consider offering a voucher-based program to provide health insurance benefits based upon the experience in the Dirigo voucher program established in section 6; and

5. Redesign. Redesign the DirigoChoice product or products.

The board shall report to the Joint Standing Committee on Insurance and Financial Services regarding changes that will be made to the Dirigo Health Program consistent with this section by January 1, 2010.

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 and required under former Title 24-A, section 6913 for claims paid prior to the effective date of this Act are due and payable in the same manner and subject to the same procedures set forth in former Title 24-A, section 6913.

SUMMARY

This bill requires the Board of Trustees of Dirigo Health to reach more uninsured and underinsured individuals through a more affordable product and to report to the Joint Standing Committee on Insurance and Financial Services regarding changes to the Dirigo Health Program by January 1, 2010. The bill replaces the savings offset payment, currently assessed at a variable rate up to 4% of paid claims determined each year depending on savings, with a fixed 2.14% access payment on paid claims paid monthly.