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OF THE

STATE OF MAINE

AS PASSED BY THE

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IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED,
TITLE 3, SECTION 163-A, SUBSECTION 4.

Penmor Lithographers
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2005

§93-C. Liability insurance

1. Procurement of coverage. An ambulance service may not be required to procure liability insurance coverage that exceeds the liability limits specified in Title 14, sections 8104-D and 8105 while acting as an emergency medical service as defined in Title 14, section 8102, subsection 1-A.

2. Coverage required by insurer. An insurer providing insurance to an ambulance service may not require coverage that exceeds the liability limits specified in subsection 1.

See title page for effective date.

CHAPTER 399

H.P. 629 - L.D. 910

An Act To Include Regional Transportation Systems under the Maine Tort Claims Act

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

Sec. 1. 14 MRSA §8102, sub-§3, as amended by PL 1997, c. 234, §1, is further amended to read:

3. Political subdivision. "Political subdivision" means any city, town, plantation, county, administrative entity or instrumentality created pursuant to Title 30-A, chapters 115 and 119, incorporated fire fighting unit that is organized under Title 13-B and is officially recognized by any authority created by statute, quasi-municipal corporation and special purpose district, including, but not limited to, any water district, sanitary district, hospital district, school district of any type, any volunteer fire association as defined in Title 30-A, section 3151, a transit district as defined in Title 30-A, section 3501, subsection 1, a regional transportation corporation as defined in Title 30-A, section 3501, subsection 2, and any emergency medical service.

See title page for effective date.

CHAPTER 400

S.P. 555 - L.D. 1577

An Act To Modify Savings Offset Payments and To Clarify Certain Other Provisions of the Dirigo Health Act

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

PART A

Sec. A-1. 24-A MRSA §2735-A, sub-§§1-A and 3 are enacted to read:

1-A. Notice of rate filings or rate increase on existing policies renewed in calendar year 2006. Notwithstanding subsection 1, for existing policies renewed in calendar year 2006, an insurer offering individual health plans as defined in section 2736-C for plan years beginning in 2006 must provide written notice by first class mail of a rate filing to all affected policyholders at least 30 days before the effective date of any proposed increase in premium rates or any proposed rating formula or classification of risks or modification of any formula or classification of risks. The notice must also inform policyholders of their right to request a hearing pursuant to section 229 or a special rate hearing pursuant to section 2736, subsection 4 or Title 24, section 2321, subsection 5. The notice must show the proposed rate and state that the rate is subject to regulatory approval. An increase in premium rates may not be implemented until 30 days after the notice is provided.

This subsection is repealed January 1, 2007.

3. Notice of rate increase on new business for calendar year 2006. Notwithstanding subsection 2, for new business quoted in calendar year 2006 by an insurer offering individual health plans as defined in section 2736-C, the insurer must disclose any rate increase that the insurer anticipates implementing within the following 30 days. If the quote is in writing, the disclosure must also be in writing. If the increase is pending approval at the time of notice, the disclosure must include the proposed rate and state that it is subject to regulatory approval. If disclosure required by this subsection is not provided, an increase may not be implemented until at least 30 days after the date the quote is provided.

This subsection is repealed January 1, 2007.

Sec. A-2. 24-A MRSA §2839-A, sub-§§1-A and 3 are enacted to read:

1-A. Notice of rate increase on existing policies renewed in calendar year 2006. Notwithstanding subsection 1, for existing policies renewed in calendar year 2006, an insurer offering group health insurance for 2006 plan years, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, must provide written notice by first class mail of a rate increase to all affected policyholders or others who are directly billed for group coverage at least 30 days before the

effective date of any increase in premium rates. An increase in premium rates may not be implemented until 30 days after the notice is provided.

This subsection is repealed January 1, 2007.

3. Notice of rate increase on new business for calendar year 2006. Notwithstanding subsection 2, for new business quoted in calendar year 2006 by an insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, quotes a rate for new business, the insurer must disclose any rate increase that the insurer anticipates implementing within the following 30 days. If the quote is in writing, the disclosure must also be in writing. If such disclosure is not provided, an increase may not be implemented until at least 30 days after the date the quote is provided.

This subsection is repealed January 1, 2007.

Sec. A-3. 24-A MRSA §6903, sub-§4, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

Sec. A-4. 24-A MRSA §6903, sub-§4-A is enacted to read:

4-A. Dirigo Health Program. "Dirigo Health Program" means the program of services provided by Dirigo Health that includes comprehensive health benefits coverage, subsidies, wellness programs and quality improvement initiatives.

Sec. A-5. 24-A MRSA §6908, sub-§12 is enacted to read:

12. Report; jurisdiction. Dirigo Health shall report twice annually, once in January and once during the last month of the regular legislative session, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on the Dirigo Health Program and budget. Minutes of meetings of the Board of Directors of Dirigo Health must be provided to each member of the joint standing committees of the Legislature having jurisdiction over insurance and financial services matters, health and human services matters and appropriations and financial affairs.

Sec. A-6. 24-A MRSA §6911, as enacted by PL 2003, c. 469, Pt. A, §8 and amended by c. 689, Pt. B, §6, is further amended to read:

§6911. Coordination with MaineCare

The Department of Health and 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 the Dirigo Health ~~Insurance~~ Program. An individual participating in the Dirigo Health Program who applies for and is determined eligible for MaineCare is enrolled directly in MaineCare.

Sec. A-7. 24-A MRSA §6912, first ¶, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health ~~Insurance~~ Program coverage paid by eligible 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~~.

Sec. A-8. 24-A MRSA §6912, sub-§2, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

2. Eligibility for subsidy. ~~Individuals~~ To be eligible for a subsidy an individual or employee must:

A. ~~Have~~ Be enrolled in the Dirigo Health Program, have an income under 300% of the federal poverty level~~,~~ and 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 and have an income under 300% of the federal poverty level. The health plan must meet any criteria established by Dirigo Health. The individual must meet other eligibility criteria established by Dirigo Health.

Sec. A-9. 24-A MRSA §6912, sub-§6, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

6. Report. Within 30 days after any subsidies are established pursuant to this section, the board shall report on the amount of the subsidies, the funding required for the subsidies and the estimated number of Dirigo Health Program enrollees eligible for the subsidies and submit the report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

Sec. A-10. 24-A MRSA §6913, sub-§1, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed and the following enacted in its place:

1. Determination of cost savings. The following are the procedures for determining cost savings.

A. After an opportunity for a hearing conducted pursuant to Title 5, chapter 375, subchapter 4, the board shall determine annually not later than April 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

B. Within 30 days of the board's determination pursuant to paragraph A, the board shall file with the superintendent its determination as well as the supporting information for that determination. The filing constitutes a public record.

C. Following a public hearing held in accordance with the Maine Administrative Procedure Act and no later than 6 weeks following the receipt of the board's determination, the superintendent shall issue an order approving, in whole or in part, or disapproving the filing made under paragraph B. The board is designated a party to the hearing. The superintendent shall approve the filing upon a determination that the aggregate measurable cost savings filed by the board are reasonably supported by the evidence in the record.

Sec. A-11. 24-A MRSA §6913, sub-§§2 and 3, as enacted by PL 2003, c. 469, Pt. A, §8, are repealed and the following enacted in their place:

2. Determination of savings offset amount. The board shall determine annually a savings offset amount to be paid by 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. The board shall determine the savings offset amount in accordance with the following:

A. Not later than April of each year, the board shall prospectively determine the savings offset amount to be applied during each 12-month calendar year period;

B. To determine the savings offset amount, the board shall use the criteria and reports described in subsections 7 and 8;

C. The savings offset amount must reflect and may not exceed aggregate measurable cost savings, as determined by the board pursuant to subsection 1; and

D. The savings offset amount calculation is limited to the amount of funds necessary to provide subsidies pursuant to section 6912 and to support the Maine Quality Forum established in section 6951 and may not include general administrative expenses of Dirigo Health, except for general administrative expenses of the Maine Quality Forum.

The savings offset amount determined by the board in accordance with this subsection is the determining factor for inclusion of savings offset payments in premiums through rate setting review by the bureau.

3. Savings offset payments required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. Except for the carriers and 3rd-party administrators that are specifically excluded in subsection 2, each health insurance carrier, 3rd-party administrator and employee benefit excess insurance carrier shall pay a savings offset payment. The following provisions govern savings offset payments.

A. The board shall calculate savings offset payments as a percentage of paid claims, as defined by the board pursuant to subsection 10. The board shall make reasonable efforts to ensure that paid claims are counted only once with respect to any savings offset payment. The board may verify each health insurance carrier's, 3rd-party administrator's and employee benefit excess insurance carrier's savings offset payment based on annual statements and other reports the board determines to be necessary.

B. Maximum savings offset payments are as follows:

(1) For health insurance carriers, the savings offset payment may not exceed 4.0% of annual paid claims for health care on policies issued pursuant to the laws of this State that insure residents of this State;

(2) For 3rd-party administrators, the savings offset payment may not exceed 4.0% of annual paid claims for health care for residents of this State; and

(3) For employee benefit excess insurance carriers, the savings offset payment may not exceed 4.0% of annual paid claims on employee benefit excess insurance policies, as defined in section 707, subsection 1, para-

graph C-1, issued pursuant to the laws of this State that insure residents of this State.

C. A health insurance and employee benefit excess insurance carrier may not be required to pay a savings offset payment on policies or contracts insuring federal employees.

D. Savings offset payments apply to claims paid for plan years beginning on or after January 1, 2006.

E. Savings offset payments may not begin until 12 months after Dirigo Health begins providing health insurance coverage;

F. Savings offset payments must be made quarterly and are due not less than 60 days after the close of the quarter and with a minimum of 30 days' written notice by Dirigo Health to health insurance carriers, employee benefit excess insurance carriers and 3rd-party administrators and must accrue interest at 12% per annum on or after the due date, except that:

(1) For plan years beginning between January 1, 2006 and March 31, 2006, both days inclusive, savings offset payments must be made monthly for January 2006, February 2006 and March 2006 and are due not less than 60 days after the close of each of those calendar months; and

(2) Savings offset 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.

G. Savings offset payments received by Dirigo Health must be pooled with other revenues of the agency in the Dirigo Health Fund established in section 6915; and

H. Annual savings offset payments received must be reconciled by Dirigo Health. Any unused payments must reduce the next savings offset payment charged to health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers according to a formula developed by the board.

Sec. A-12. 24-A MRSA §6913, sub-§§4 and 6, as enacted by PL 2003, c. 469, Pt. A, §8, are repealed.

Sec. A-13. 24-A MRSA §6913, sub-§10 is enacted to read:

10. Definition of paid claims; rulemaking. The board shall adopt rules regarding the definition of paid claims for the purposes of calculating savings offset payments for health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers due on or after January 1, 2007. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-14. 24-A MRSA §6914, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

§6914. Intragovernmental transfer

Starting July 1, 2004, Dirigo Health shall transfer funds, as necessary, 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 savings payment offset pursuant to section 6913.~~

PART B

Sec. B-1. Savings offset payments working group. The Superintendent of Insurance shall convene a working group to advise the Board of Directors of Dirigo Health, referred to in this section as "the board," as provided in this section.

1. Membership. The working group must include 5 members representing the interests of insurers, self-insured entities and 3rd-party administrators and 5 members representing the interests of Dirigo Health.

2. Convening of working group; schedule. The Superintendent of Insurance shall convene the first meeting of the working group. In order to complete its work in a timely fashion, the working group may make its recommendations in accordance with time frames discussed with the Joint Standing Committee on Insurance and Financial Services.

3. Duties. The working group shall make recommendations to advise the board on the following issues:

A. The definition of "subsidy" within the Dirigo Health Program;

B. The definition of "paid claims" for the purpose of using paid claims as the base for savings offset payment assessments on health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers;

C. The process for implementing and invoicing savings offset payment assessments based on the recommended definition of paid claims;

D. The board's proposed methodology for calculating aggregate measurable cost savings. This

recommendation must be made no later than September 20, 2005; and

E. A funding strategy to cover Dirigo Health's administrative expenses. This recommendation must be made no later than December 31, 2005.

4. Technical assistance; facilitator. The Department of Professional and Financial Regulation, Bureau of Insurance shall provide technical assistance to the working group upon request. Meetings of the working group must be moderated by an independent facilitator selected by the Superintendent of Insurance.

5. Monthly reports; notice of meetings. The working group shall provide monthly reports to the Joint Standing Committee on Insurance and Financial Services and shall notify committee members of each meeting of the working group. The monthly reports must include any recommendations the working group has made to the board pursuant to subsection 3.

6. Termination of working group. The working group terminates December 31, 2005.

Sec. B-2. Provisions governing first year of savings offset payments.

1. Definition of paid claims; first assessment year. The Board of Directors of Dirigo Health shall adopt rules regarding the definition of paid claims under section 1 of this Part for the calculation of savings offset payments for the first 12-month calendar year period of savings offset payments, referred to in this section as "the first assessment year," due from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers pursuant to the Maine Revised Statutes, Title 24-A, section 6913. In adopting these rules, the board shall take into account the recommendations of the working group established under section 1 with respect to the definition of paid claims and the methodology for calculating and invoicing savings offset payment assessments based on paid claims. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. For savings offset payments after the first assessment year, the board shall define paid claims through major substantive rulemaking in accordance with Title 24-A, section 6913, subsection 10.

2. Timeline. Notwithstanding any deadlines specified in the Maine Revised Statutes, Title 24-A, section 6913, the Board of Directors of Dirigo Health shall comply with the following deadlines for the first assessment year:

A. No later than the effective date of this Act, the board shall file with the Superintendent of Insurance its determination as to the aggregate measurable cost savings in this State, including any reduction or avoidance of bad debt and charity care cost to health care providers as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004 as well as the supporting information for that determination. The filing constitutes a public record; and

B. Following a public hearing held in accordance with the Maine Administrative Procedure Act and no later than 6 weeks following the effective date of this Act, the Superintendent of Insurance shall issue an order approving, in whole or in part, or disapproving the filing made under paragraph A. The board is designated a party to the hearing. The superintendent shall approve the filing upon a determination that the aggregate measurable cost savings filed by the board are reasonably supported by the evidence in the record.

Sec. B-3. Funding Dirigo Health administrative expenses. General administrative expenses of Dirigo Health, excluding administrative expenses directly associated with the Maine Quality Forum established in the Maine Revised Statutes, Title 24-A, section 6951, may be covered by the remaining balance of the $53,000,000 in funds transferred from the unappropriated surplus of the General Fund to the Dirigo Health Fund pursuant to Public Law 2003, chapter 469, Part H, section 1 and may not be covered by savings offset payments in accordance with the Maine Revised Statutes, Title 24-A, section 6913, subsection 2. Following receipt and review of the recommendations of the working group, established in section 1, regarding a funding strategy for Dirigo Health's administrative expenses and no later than February 15, 2006, the Board of Directors of Dirigo Health shall submit its recommendations, including any suggested legislation, for funding administrative expenses to the Joint Standing Committee on Insurance and Financial Services. Following receipt and review of the board's recommendation, the committee may report out a bill related to funding Dirigo Health's administrative expenses to the Second Regular Session of the 122nd Legislature.

PART C

Sec. C-1. 22 MRSA §3174-V, sub-§2, as amended by PL 2003, c. 469, Pt. A, §7, is further amended to read:

2. Contracted services. When a federally qualified health center otherwise meeting the requirements of subsection 1 contracts with a managed care plan or the Dirigo Health ~~Insurance~~ Program for the provision of MaineCare services, the department shall

reimburse that center the difference between the payment received by the center from the managed care plan or the Dirigo Health ~~Insurance~~ Program and 100% of the reasonable cost, reduced by the total copayments for which members are responsible, incurred in providing services within the scope of service approved by the federal Health Resources and Services Administration or the commissioner. Any such managed care contract must provide payments for the services of a center that are not less than the level and amount of payment that the managed care plan or the Dirigo Health ~~Insurance~~ Program would make for services provided by an entity not defined as a federally qualified health center.

Sec. C-2. 22 MRSA §3174-DD, as enacted by PL 2003, c. 469, Pt. A, §6, is amended to read:

§3174-DD. Dirigo Health coverage

The department may contract with one or more health insurance carriers to purchase Dirigo Health ~~Insurance~~ Program coverage for MaineCare members who seek to enroll through their employers pursuant to Title 24-A, section 6910, subsection 4, paragraph B. A MaineCare member who enrolls in ~~a~~ the Dirigo Health ~~Insurance plan~~ Program as a member of an employer group receives full MaineCare benefits through the Dirigo Health ~~Insurance~~ Program. The benefits are delivered through the employer-based health plan, subject to nominal cost sharing as permitted by 42 United States Code, Section 1396o(2003) and additional coverage provided under contract by the department.

Sec. C-3. 24-A MRSA §6903, sub-§§12 and 13, as enacted by PL 2003, c. 469, Pt. A, §8, are amended to read:

12. Participating employer. "Participating employer" means an eligible business that contracts with Dirigo Health pursuant to section 6910, subsection 4, paragraph B and that has employees enrolled in the Dirigo Health ~~Insurance~~ Program.

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

Sec. C-4. 24-A MRSA §6906, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

§6906. Prohibited interests of board members and employees

Board members and employees of Dirigo Health and their spouses and 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 the Dirigo Health ~~Insurance~~ Program on the same terms as others may under this chapter. This section does not prohibit corporations or other entities with which board members 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 board members abstain from voting on matters relating to that participation.

Sec. C-5. 24-A MRSA §6908, sub-§1, ¶C, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

C. 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 the Dirigo Health ~~Insurance~~ Program;

Sec. C-6. 24-A MRSA §6908, sub-§2, ¶¶C to F, as enacted by PL 2003, c. 469, Pt. A, §8, are amended to read:

C. Determine the comprehensive services and benefits to be included in the Dirigo Health ~~Insurance~~ Program and develop the specifications for the Dirigo Health ~~Insurance~~ Program in accordance with the provisions in section 6910. Within 30 days of its determination of the benefit package to be offered through the Dirigo Health ~~Insurance~~ Program, the board shall report on the benefit package, including the estimated premium and applicable coinsurance, deductibles, copayments and out-of-pocket maximums, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters;

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

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

F. Develop a high-risk pool for plan enrollees in the Dirigo Health ~~Insurance~~ Program in accordance with the provisions of section 6971; and

Sec. C-7. 24-A MRSA §6908, sub-§6, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

6. Annual report. Beginning September 1, 2004, and annually thereafter, the board shall report on the impact of Dirigo Health on the small group and individual health insurance markets in this State and any reduction in the number of uninsured individuals in the 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~~ Program policies issued or renewed and Dirigo Health ~~Insurance~~ Program premiums earned and claims incurred by health insurance carriers offering coverage under the Dirigo Health ~~Insurance~~ Program. The board shall submit the report to the Governor, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

Sec. C-8. 24-A MRSA §6910, as corrected by RR 2003, c. 1, §22, is amended to read:

§6910. Dirigo Health Program

1. Dirigo Health Program. Dirigo Health shall arrange for the provision of health benefits coverage through the Dirigo Health ~~Insurance~~ Program not later than October 1, 2004. The Dirigo Health ~~Insurance~~ Program must comply with all relevant requirements of this Title. Dirigo Health ~~Insurance~~ Program coverage 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.

2. Legislative approval of nonprofit health care plan or expansion of public plan. If health insurance carriers do not apply to offer and deliver Dirigo Health ~~Insurance~~ Program coverage, the board may have Dirigo Health provide access to health insurance by proposing the establishment of a nonprofit health care plan organized under Title 13-B and authorized pursuant to Title 24, chapter 19 or by proposing the expansion of an existing public plan. If the board proposes the establishment of a nonprofit health care plan or the expansion of an existing public plan, the board shall submit its proposal, including, but not limited to, a funding mechanism to capitalize a nonprofit health care plan and any recommended legislation to the joint standing committee of the Legislature having jurisdiction over health insurance matters. Dirigo Health may not provide access to health insurance by establishing a nonprofit health care plan or through an existing public plan without specific legislative approval.

3. Carrier participation requirements. To qualify as a carrier of Dirigo Health ~~Insurance~~ Program coverage, a health insurance carrier must:

A. Provide the comprehensive health services and benefits as determined by the board, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under Title 24 and this Title and any supplemental benefits the board wishes to make available; and

B. Ensure that:

(1) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not charge plan enrollees or 3rd parties for covered health care services in excess of the amount allowed by the carrier the provider has contracted with, except for applicable copayments, deductibles or coinsurance or as provided in section 4204, subsection 6;

(2) Providers contracting with a carrier contracted to provide coverage to plan enrollees 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. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(3) Providers contracting with a carrier contracted to provide coverage to plan enrollees are reimbursed at the negotiated reimbursement rates between the carrier and its provider network.

Health insurance carriers that seek to qualify to provide Dirigo Health ~~Insurance~~ Program coverage must also qualify as health plans in Medicaid.

4. 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 third-party administrators to provide Dirigo Health ~~Insurance~~ Program coverage. In addition:

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

(2) Dirigo Health may include quality improvement, disease prevention, 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 the Dirigo Health ~~Insurance~~ Program, 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~~ Program contract to provide Dirigo Health ~~Insurance~~ Program benefits to plan enrollees not enrolled in MaineCare;

(5) Dirigo Health may set allowable rates for administration and underwriting gains for the Dirigo Health ~~Insurance~~ Program;

(6) Dirigo Health may administer continuation benefits for eligible individuals from employers with 20 or more employees who have purchased health insurance coverage through Dirigo Health for the duration of their eligibility periods for continuation benefits pursuant to the federal Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, Title X, Private Health Insurance Coverage, Sections 10001 to 10003; and

(7) Dirigo Health may administer or contract to administer the United States Internal Revenue Code of 1986, Section 125 plans for employers and employees participating in Dirigo Health, including medical expense reimbursement accounts and dependent care reimbursement accounts.

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by the Dirigo Health ~~Insurance~~ Program 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) The Dirigo Health ~~Insurance~~ Program for enrolled employees and dependents in contribution amounts determined by the board;

(b) Dirigo Health's quality assurance, disease prevention, 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 or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

(4) Dirigo Health shall require participating employers to certify that at least 75% of their employees that work 30 hours or more per week and who do not have other creditable coverage are enrolled in the Dirigo Health ~~Insurance~~ Program and that the employer group otherwise meets the minimum participation requirements specified by section 2808-B, subsection 4, paragraph A.

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6912 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 6912 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~~ Program coverage 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 the Dirigo Health ~~Insurance~~ Program to cover the cost of:

(a) Enrollment in the Dirigo Health ~~Insurance~~ Program for eligible individuals and dependents;

(b) Dirigo Health's quality assurance, disease prevention, 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 6912 accordingly.

(4) Dirigo Health may require that eligible individuals certify that all their dependents are enrolled in the Dirigo Health ~~Insurance~~ Program 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.

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

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

B. Dirigo Health shall screen all eligible individuals and employees for eligibility for subsidies under section 6912 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.

C. Except as provided in this paragraph, the effective date of coverage for a new enrollee in the Dirigo Health ~~Insurance~~ Program is the first day of the month following receipt of the fully completed application for that enrollee by the carrier contracting with Dirigo Health or the first day of the next month if the fully completed application is received by the carrier within 10 calendar days of the end of the month. If a new enrollee in the Dirigo Health ~~Insurance~~ Program had prior coverage through an individual or small group policy, coverage under the Dirigo Health ~~Insurance~~ Program must take effect the day following termination of that enrollee's prior coverage.

6. Quality improvement, disease management and cost containment. Dirigo Health shall promote quality improvement, disease prevention, disease management and cost-containment programs as part of its administration of the Dirigo Health ~~Insurance~~ Program.

Sec. C-9. 24-A MRSA §6913, sub-§8, ¶A, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

A. On a quarterly basis beginning with the first quarter after the Dirigo Health ~~Insurance~~ Program begins offering coverage, the board shall collect and report on the following:

(1) The total enrollment in the Dirigo Health ~~Insurance~~ Program, including the

number of enrollees previously underinsured or uninsured, the number of enrollees previously insured, the number of individual enrollees and the number of enrollees enrolled through small employers;

(2) The total number of enrollees covered in health plans through large employers and self-insured employers;

(3) The number of employers, both small employers and large employers, who have ceased offering health insurance or contributing to the cost of health insurance for employees or who have begun offering coverage on a self-insured basis;

(4) The number of employers, both small employers and large employers, who have begun to offer health insurance or contribute to the cost of health insurance premiums for their employees;

(5) The number of new participating employers in the Dirigo Health ~~Insurance~~ Program;

(6) The number of employers ceasing to offer coverage through the Dirigo Health ~~Insurance~~ Program;

(7) The duration of employers participating in the Dirigo Health ~~Insurance~~ Program; and

(8) A comparison of actual enrollees in the Dirigo Health ~~Insurance~~ Program to the projected enrollees.

Sec. C-10. 24-A MRSA §6971, sub-§§2 and 3, as enacted by PL 2003, c. 469, Pt. A, §8, are amended to read:

2. Disease management. Dirigo Health shall develop appropriate disease management protocols, develop procedures for implementing those protocols and determine the manner in which disease management must be provided to plan enrollees in the high-risk pool. Dirigo Health may include disease management in its contract with participating carriers for the Dirigo Health ~~Insurance~~ Program pursuant to section 6910, contract separately with another entity for disease management services or provide disease management services directly through Dirigo Health.

3. Report. Dirigo Health shall submit a report, no later than January 1, 2006, outlining the disease management protocols, procedures and delivery mechanisms used to provide services to plan enrollees. The report must also include the number of plan enrollees in the high-risk pool, the types of diagnoses managed within the high-risk pool, the claims experience within the high-risk pool and the number and type of claims exceeding $100,000 for enrollees in the high-risk pool and for all enrollees in the Dirigo Health ~~Insurance~~ Program. The report must be submitted to the joint standing committee of the Legislature having jurisdiction over health insurance matters. The committee may make recommendations on the operation of the high-risk pool and may report out legislation to the Second Regular Session of the 122nd Legislature relating to the high-risk pool.

PART D

Sec. D-1. Appropriations and allocations. The following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Bureau of Insurance 0092

Initiative: Allocates funds for the costs of reviewing and analyzing the Board of Directors of Dirigo Health's filing of its determination as to the aggregate measurable cost savings from the operation of Dirigo Health and related MaineCare expansions.

OTHER SPECIAL REVENUE FUNDS	**2005-06**	**2006-07**
All Other	$50,000	$50,000
OTHER SPECIAL REVENUE FUNDS TOTAL	$50,000	$50,000

See title page for effective date.

CHAPTER 401

H.P. 924 - L.D. 1325

An Act To Ensure Continuity of Care Related to Implementation of the Federal Medicare Drug Benefit

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

PART A

Sec. A-1. 22 MRSA §254, as amended by PL 2005, c. 12, Pt. KKK, §§1 to 3, is repealed.

Sec. A-2. 22 MRSA §254-D is enacted to read:

§254-D. Elderly low-cost drug program

The Department of Health and Human Services may conduct the elderly low-cost drug program to provide low-cost prescription and nonprescription