CHAPTER 87

DIRIGO HEALTH

SUBCHAPTER 1

GENERAL PROVISIONS

§6901. Short title

This chapter may be known and cited as "the Dirigo Health Act." [PL 2003, c. 469, Pt. A, §8 (NEW).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW).

§6902. Dirigo Health established; declaration of necessity

Dirigo Health is established as an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis. Dirigo Health is also responsible for monitoring and improving the quality of health care in this State. 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. [PL 2003, c. 469, Pt. A, §8 (NEW).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW).

§6903. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [PL 2003, c. 469, Pt. A, §8 (NEW).]

1. Board. "Board" means the Board of Trustees of Dirigo Health, as established in section 6904. [PL 2007, c. 447, §3 (AMD).]

2. Child. "Child" means a natural child, stepchild, adopted child or child placed for adoption with a plan enrollee.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

3. Dependent. "Dependent" means a spouse, an unmarried child under 19 years of age, a child who is a student under 23 years of age and is financially dependent upon a plan enrollee or a person of any age who is the child of a plan enrollee and is disabled and dependent upon that plan enrollee. "Dependent" may include a domestic partner consistent with sections 2741-A, 2832-A and 4249 and Title 24, section 2319-A.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

4. Dirigo Health Insurance.
[PL 2005, c. 400, Pt. A, §3 (RP).]

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.
[PL 2005, c. 400, Pt. A, §4 (NEW).]

5. 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, including a municipality that has 50 or fewer employees.

After one year of operation of Dirigo Health, the board may, by rule, define "eligible business" to include larger public or private employers.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

6. Eligible employee. "Eligible employee" means an employee of an eligible business who works at least 20 hours per week for that eligible business. "Eligible employee" does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

7. 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; [PL 2003, c. 469, Pt. A, §8 (NEW).]

B. An unemployed individual who resides in this State; or [PL 2003, c. 469, Pt. A, §8 (NEW).]

C. An individual employed in an eligible business that does not offer health insurance. [PL 2003, c. 469, Pt. A, §8 (NEW).]
[PL 2003, c. 469, Pt. A, §8 (NEW).]

8. Employer. "Employer" means the owner or responsible agent of a business authorized to sign contracts on behalf of the business.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

9. Executive director. "Executive director" means the Executive Director of Dirigo Health.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

10. Health insurance carrier. "Health insurance carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance; [PL 2003, c. 469, Pt. A, §8 (NEW).]

B. A health maintenance organization licensed pursuant to chapter 56; [PL 2003, c. 469, Pt. A, §8 (NEW).]

C. A preferred provider arrangement administrator registered pursuant to chapter 32; [PL 2003, c. 469, Pt. A, §8 (NEW).]

D. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; or [PL 2003, c. 469, Pt. A, §8 (NEW).]

E. An employee benefit excess insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance pursuant to section 707, subsection 1, paragraph C-1. [PL 2003, c. 469, Pt. A, §8 (NEW).]
[PL 2003, c. 469, Pt. A, §8 (NEW).]

11. 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 Health and Human Services to provide MaineCare-covered services to individuals enrolled in MaineCare.
[PL 2003, c. 469, Pt. A, §8 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

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 Program.
[PL 2005, c. 400, Pt. C, §3 (AMD).]

13. Plan enrollee. "Plan enrollee" means an eligible individual or eligible employee who enrolls in the Dirigo Health Program through Dirigo Health. "Plan enrollee" includes an eligible employee who is eligible to enroll in MaineCare.
[PL 2005, c. 400, Pt. C, §3 (AMD).]

13-A. Practitioner-specific quality data. "Practitioner-specific quality data" means material in electronic or paper format that provides information about the professional performance of a health care practitioner licensed to provide health care in the State. "Practitioner-specific quality data" includes, but is not limited to, records, reports, working papers, drafts, analyses, e-mail, interoffice and intraoffice memoranda and other data collected, used, produced or maintained by the Maine Quality Forum, established in section 6951, for the purposes of measuring a health care practitioner's professional performance against consensus best practices and local and national patterns of health care.
[PL 2005, c. 615, §1 (NEW).]

13-B. Primary care. "Primary care" means regular check-ups, wellness and general health care provided by a provider with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.
[PL 2019, c. 244, §1 (NEW).]

14. 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.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

15. Reinsurance or reinsurer. "Reinsurance" and "reinsurer" have the same meanings as in section 741.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

16. Resident. "Resident" has the same meaning as in section 2736-C, subsection 1, paragraph C-2.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

17. Subsidy. "Subsidy" means a subsidy as described in section 6912.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

18. 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:

A. Any person listed in section 1901, subsection 1, paragraphs A to C and paragraphs E to O; or [PL 2003, c. 469, Pt. A, §8 (NEW).]

B. Any person who provides those services in connection with a group health plan sponsored by an agricultural cooperative association located outside of this State that provides heath insurance coverage to members and employees of agricultural cooperative associations located within this State. [PL 2003, c. 469, Pt. A, §8 (NEW).]

[PL 2003, c. 469, Pt. A, §8 (NEW).]

19. Unemployed individual. "Unemployed individual" means an individual who does not work more than 20 hours a week for any single employer.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2003, c. 689, §B6 (REV). PL 2005, c. 400, §§A3,4,C3 (AMD). PL 2005, c. 615, §1 (AMD). PL 2007, c. 447, §3 (AMD). PL 2019, c. 244, §1 (AMD).

§6904. Board of Trustees of Dirigo Health

Dirigo Health operates under the supervision of the Board of Trustees of Dirigo Health established in accordance with this section. [PL 2007, c. 447, §4 (AMD).]

1. Appointments. The board consists of 9 voting members and 3 ex officio, nonvoting members as follows.

A. The 9 voting members of the board are 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 in accordance with this paragraph.

(1) Five members qualified in accordance with subsection 2-A, paragraph A are appointed by the Governor.

(2) One member qualified in accordance with subsection 2-A, paragraph A is appointed by the Governor and must be selected from candidates nominated by the President of the Senate.

(3) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from candidates nominated by the Speaker of the House.

(4) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from the candidates nominated by the Senate Minority Leader.

(5) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from candidates nominated by the House Minority Leader. [PL 2007, c. 447, §4 (AMD).]

B. The 3 ex officio, nonvoting members of the board are:

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

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

(4) The Treasurer of State or the treasurer's designee. [PL 2011, c. 90, Pt. J, §22 (AMD).]
[PL 2011, c. 90, Pt. J, §22 (AMD).]

2. Qualifications of voting members.
[PL 2007, c. 447, §4 (RP).]

2-A. Qualifications of voting members. Voting members of the board must be qualified in accordance with this subsection.

A. Six of the voting members of the board must have knowledge of 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 budgeting;

(6) Health care financing;

(7) Labor or consumer advocacy; and

(8) Marketing. [PL 2007, c. 447, §4 (NEW).]

B. Three of the voting members of the board must have knowledge of and experience in one or more of the following areas:

(1) Accounting;

(2) Banking;

(3) Securities; and

(4) Insurance. [PL 2007, c. 447, §4 (NEW).]

C. Except as provided in this paragraph, a voting member of the board may not be:

(1) A representative or employee of a health insurance carrier authorized to do business in this State;

(2) A representative or employee of a health care provider operating in this State;

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

(4) A representative or employee of Dirigo Health.

A nonpracticing health care practitioner, retired or former health care administrator or retired or former employee of a health insurance carrier is not prohibited from being considered for board membership as long as that person is not currently affiliated with a health or health-related organization. [PL 2007, c. 447, §4 (NEW).]

[PL 2007, c. 447, §4 (NEW).]

3. Terms of office. Voting members serve 3-year terms. Voting members may serve up to 2 consecutive terms. Of the initial appointees, one member serves an initial term of one year, 2 members serve initial terms of 2 years and 2 members serve initial terms of 3 years. Any vacancy for an unexpired term must be filled in accordance with subsections 1 and 2-A. Members reaching the end of their terms may serve until replacements are named.

[PL 2007, c. 447, §4 (AMD).]

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

[PL 2003, c. 469, Pt. A, §8 (NEW).]

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

[PL 2007, c. 447, §4 (AMD).]

6. Affirmative vote. An affirmative vote of 5 members is required for any action taken by the board.

[PL 2007, c. 447, §4 (AMD).]

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.

[PL 2003, c. 469, Pt. A, §8 (NEW).]

8. Meetings. The board shall meet monthly and may also meet at other times at the call of the chair or the executive director. All meetings of the board are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.

[PL 2007, c. 447, §4 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2007, c. 447, §4 (AMD). PL 2011, c. 90, Pt. J, §22 (AMD).

§6905. Limitation on liability

1. Indemnification of Dirigo Health employees. 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.
[PL 2007, c. 447, §5 (NEW).]

2. Limitation on liability of board members. The personal liability of a member of the board is governed by Title 18-B, section 1010.
[PL 2007, c. 447, §5 (NEW).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2007, c. 447, §5 (RPR).

§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 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. [PL 2005, c. 400, Pt. C, §4 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2005, c. 400, §C4 (AMD).

§6907. Confidential records

Except as provided in subsections 1, 2 and 3, information obtained by Dirigo Health under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1. [PL 2005, c. 615, §2 (AMD).]

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.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

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.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

3. Practitioner-specific quality data. The confidentiality of practitioner-specific quality data is determined according to this subsection.

A. Practitioner-specific quality data is confidential and may not be disclosed by the Maine Quality Forum prior to a determination of accuracy and completeness made under paragraph B. [PL 2005, c. 615, §3 (NEW).]

B. Practitioner-specific quality data is not confidential after a determination of its accuracy and completeness is made by the Director of the Maine Quality Forum or a designee. [PL 2005, c. 615, §3 (NEW).]

[PL 2005, c. 615, §3 (NEW).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2005, c. 615, §§2,3 (AMD).

§6908. 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 payments due Dirigo Health or that are necessary for the proper administration of Dirigo Health; [PL 2007, c. 629, Pt. M, §12 (AMD).]

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; [PL 2003, c. 469, Pt. A, §8 (NEW).]

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 Program; [PL 2005, c. 400, Pt. C, §5 (AMD).]

D. 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; [PL 2003, c. 469, Pt. A, §8 (NEW).]

E. 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; [PL 2003, c. 469, Pt. A, §8 (NEW).]

F. Enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out the purposes of this chapter; [PL 2003, c. 469, Pt. A, §8 (NEW).]

G. Conduct studies and analyses related to the provision of health care, health care costs and quality; [PL 2003, c. 469, Pt. A, §8 (NEW).]

H. Establish and administer a revolving loan fund to assist health care practitioners and health care providers in the purchase of hardware and software necessary to implement the requirements for electronic submission of claims. Dirigo Health may solicit matching contributions to the fund from each health insurance carrier licensed to do business in this State; [PL 2003, c. 469, Pt. A, §8 (NEW).]

I. Apply for and receive funds, grants or contracts from public and private sources; [PL 2003, c. 469, Pt. A, §8 (NEW).]

J. Contract with the Maine Health Data Organization and other organizations with expertise in health care data, including a nonprofit health data processing entity in this State, to assist the Maine Quality Forum established in section 6951 in the performance of its responsibilities; [PL 2003, c. 469, Pt. A, §8 (NEW).]

K. Provide staff support and other assistance to the Maine Quality Forum established in section 6951, including assigning a director and other staff as needed to conduct the work of the Maine Quality Forum; and [PL 2003, c. 469, Pt. A, §8 (NEW).]

L. 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 organizations organized, created or operated under the laws of this State. [PL 2003, c. 469, Pt. A, §8 (NEW).]

[PL 2007, c. 629, Pt. M, §12 (AMD).]

2. Duties. Dirigo Health shall:

A. Establish administrative and accounting procedures as recommended by the State Controller for the operation of Dirigo Health in accordance with Title 5; [PL 2003, c. 469, Pt. A, §8 (NEW).]

B. Collect the savings offset payments provided in former section 6913 and the access payment provided in section 6917; [PL 2009, c. 359, §1 (AMD); PL 2009, c. 359, §8 (AFF).]

C. Determine the comprehensive services and benefits to be included in the Dirigo Health Program and develop the specifications for the Dirigo Health 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 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; [PL 2005, c. 400, Pt. C, §6 (AMD).]

D. Develop and implement a program to publicize the existence of Dirigo Health and the Dirigo Health Program and the eligibility requirements and the enrollment procedures for the Dirigo Health Program and to maintain public awareness of Dirigo Health and the Dirigo Health Program; [PL 2005, c. 400, Pt. C, §6 (AMD).]

E. Arrange the provision of Dirigo Health Program benefit coverage to eligible individuals and eligible employees through contracts with one or more qualified bidders in accordance with section 6910 or through the Dirigo Health Self-administered Plan authorized pursuant to section 6981; [PL 2007, c. 447, §6 (AMD).]

F. [PL 2007, c. 629, Pt. L, §2 (RP).]

G. Establish and operate the Maine Quality Forum in accordance with the provisions of section 6951 ; and [PL 2007, c. 629, Pt. L, §3 (AMD).]

H. On a quarterly basis no less than 60 days from the end of each quarter, collect and report on:

(1) The total enrollment in the Dirigo Health 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 number of new participating employers in the Dirigo Health Program;

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

(4) The duration of employers' participation in the Dirigo Health Program; and

(5) A comparison of actual enrollees in the Dirigo Health Program to projected enrollees.

Dirigo Health shall submit the quarterly reports required under this subsection to the superintendent, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the joint standing committee of the Legislature having jurisdiction over health and human services matters. [PL 2007, c. 629, Pt. L, §4 (NEW).]

[PL 2009, c. 359, §1 (AMD); PL 2009, c. 359, §8 (AFF).]

3. Budget. The revenues and expenditures of Dirigo Health are subject to legislative approval in the biennial budget process. At the direction of the board, the executive director shall prepare the budget for the administration and operation of Dirigo Health in accordance with the provisions of law that apply to departments of State Government.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

4. Audit. Dirigo Health must be audited annually by the State Auditor. The board may, in its discretion, arrange for an independent audit to be conducted. A copy of the audit must be provided to the State Controller, to the superintendent, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the joint standing committee of the Legislature having jurisdiction over health and human services matters.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

5. Rulemaking. Dirigo Health may adopt 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.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

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 Program policies issued or renewed and Dirigo Health Program premiums earned and claims incurred by health insurance carriers offering coverage under the Dirigo Health 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.
[PL 2005, c. 400, Pt. C, §7 (AMD).]

7. Technical assistance from other state agencies. Other state agencies, including, but not limited to, the bureau, the Department of Health and Human Services, Maine Revenue Services and the Maine Health Data Organization, shall provide technical assistance and expertise to Dirigo Health upon request.
[PL 2003, c. 469, Pt. A, §8 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

8. Legal counsel. The Attorney General, when requested, shall furnish any legal assistance, counsel or advice Dirigo Health requires in the discharge of its duties.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

9. 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.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

10. Initial staffing. Upon request from the board, the Governor shall provide staffing assistance to Dirigo Health in the initial phases of its operation.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

11. 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 advisory committee.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

12. Legislative jurisdiction. Notwithstanding any provision of law to the contrary, legislative jurisdiction for oversight of Dirigo Health is governed by the Joint Rules of the Legislature. In adopting the joint rules, the Legislature shall give consideration to ensuring that legislative oversight of Dirigo Health is thorough and ongoing, that normal budgetary procedures and controls are exercised and that committee jurisdiction is consistent with the subject matter jurisdiction of the joint standing committees.
[PL 2005, c. 394, §3 (NEW).]

12. (TEXT REALLOCATED TO T. 24-A, §6908, sub-§13) Report; jurisdiction.
[PL 2005, c. 400, Pt. A, §5 (NEW); PL 2005, c. 683, Pt. B, §20 (RAL).]

13. (TEXT REALLOCATED FROM T. 24-A, §6908, sub-§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 Trustees 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.
[PL 2007, c. 447, §7 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2003, c. 689, §B6 (REV). PL 2005, c. 394, §3 (AMD). PL 2005, c. 400, §§A5,C5-7 (AMD). PL 2005, c. 683, §B20 (AMD). PL 2007, c. 447, §§6, 7 (AMD). PL 2007, c. 629, Pt. L, §§1-4 (AMD). PL 2007, c. 629, Pt. M, §12 (AMD). PL 2009, c. 359, §1 (AMD). PL 2009, c. 359, §8 (AFF).

§6909. Executive director

1. Appointed position. The executive director is appointed by the board and serves at the pleasure of the board. The position of executive director is a major policy-influencing position as designated in Title 5, section 934-B.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

2. Duties of executive director. The executive director shall:

A. Serve as the liaison between the board and Dirigo Health and serve as secretary and treasurer to the board; [PL 2007, c. 447, §8 (AMD).]

B. Manage Dirigo Health's programs and services, including the Maine Quality Forum established under section 6951; [PL 2003, c. 469, Pt. A, §8 (NEW).]

C. Employ or contract on behalf of Dirigo Health for professional and nonprofessional personnel or service. Employees of Dirigo Health are subject to the Civil Service Law, except that the position of Director of the Maine Quality Forum is not subject to the Civil Service Law; [PL 2003, c. 469, Pt. A, §8 (NEW).]

D. 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 [PL 2003, c. 469, Pt. A, §8 (NEW).]

E. Perform other duties prescribed by the board to carry out the functions of this chapter. [PL 2003, c. 469, Pt. A, §8 (NEW).]
[PL 2007, c. 447, §8 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2007, c. 447, §8 (AMD).

§6910. Dirigo Health Program

1. Dirigo Health Program. Dirigo Health shall arrange for the provision of health benefits coverage through the Dirigo Health Program not later than October 1, 2004. The Dirigo Health Program must comply with all relevant requirements of this Title. Dirigo Health 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 or may be provided through the Dirigo Health Self-administered Plan pursuant to section 6981.
[PL 2007, c. 447, §9 (AMD).]

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 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.
[PL 2005, c. 400, Pt. C, §8 (AMD).]

3. Carrier participation requirements. To qualify as a carrier of Dirigo Health 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 [PL 2003, c. 469, Pt. A, §8 (NEW).]

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. [RR 2003, c. 1, §22 (COR).]

Health insurance carriers that seek to qualify to provide Dirigo Health Program coverage must also qualify as health plans in Medicaid.
[PL 2005, c. 400, Pt. C, §8 (AMD).]

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 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 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 Program contract to provide Dirigo Health 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 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. [PL 2005, c. 400, Pt. C, §8 (AMD).]

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by the Dirigo Health 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 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 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. [PL 2005, c. 400, Pt. C, §8 (AMD).]

C. Dirigo Health may permit eligible individuals to purchase Dirigo Health 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 Program to cover the cost of:

(a) Enrollment in the Dirigo Health 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 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. [PL 2005, c. 400, Pt. C, §8 (AMD).]

[PL 2005, c. 400, Pt. C, §8 (AMD).]

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

A. Dirigo Health shall publicize the availability of the Dirigo Health Program to businesses, self-employed individuals and others eligible to enroll in the Dirigo Health Program. [PL 2005, c. 400, Pt. C, §8 (AMD).]

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. [PL 2003, c. 469, Pt. A, §8 (NEW).]

C. Except as provided in this paragraph, the effective date of coverage for a new enrollee in the Dirigo Health 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 Program had prior coverage through an individual or small group policy, coverage under the Dirigo Health Program must take effect the day following termination of that enrollee's prior coverage. [PL 2005, c. 400, Pt. C, §8 (AMD).]

[PL 2005, c. 400, Pt. C, §8 (AMD).]

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 Program.

[PL 2005, c. 400, Pt. C, §8 (AMD).]

SECTION HISTORY

RR 2003, c. 1, §22 (COR). PL 2003, c. 469, §A8 (NEW). PL 2005, c. 400, §C8 (AMD). PL 2007, c. 447, §9 (AMD).

§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 Program. An individual participating in the Dirigo Health Program who applies for and is determined eligible for MaineCare is enrolled directly in MaineCare. [PL 2005, c. 400, Pt. A, §6 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2003, c. 689, §B6 (REV). PL 2005, c. 400, §A6 (AMD).

§6912. Subsidies

Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health Program coverage paid by eligible individuals or employees whose income is under 300% of the federal poverty level. 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. [PL 2005, c. 400, Pt. A, §7 (AMD).]

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

[PL 2003, c. 469, Pt. A, §8 (NEW).]

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

A. Be enrolled in the Dirigo Health Program, have an income under 300% of the federal poverty level and be a resident of the State; or [PL 2005, c. 400, Pt. A, §8 (AMD).]

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. [PL 2005, c. 400, Pt. A, §8 (AMD).]

[PL 2005, c. 400, Pt. A, §8 (AMD).]

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

[PL 2003, c. 469, Pt. A, §8 (NEW).]

4. Limitation on amount subsidized.

[PL 2007, c. 629, Pt. B, §1 (RP).]

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

[PL 2003, c. 469, Pt. A, §8 (NEW).]

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.

[PL 2005, c. 400, Pt. A, §9 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2005, c. 400, §§A7-9 (AMD). PL 2007, c. 629, Pt. B, §1 (AMD).

§6913. Savings offset payments against health insurance carriers, employee benefit excess insurance carriers and third-party administrators

(REPEALED)

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2005, c. 400, §§A10-13,C9 (AMD). PL 2005, c. 683, §§A43,44 (AMD). PL 2007, c. 1, Pt. X, §§1, 2 (AMD). PL 2007, c. 1, Pt. X, §3 (AFF). PL 2009, c. 359, §2 (RP). PL 2009, c. 359, §8 (AFF).

§6914. Intragovernmental transfer

Starting July 1, 2004, and ending September 30, 2012, 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 services provided to individuals eligible pursuant to Title 22, section 3174-G, subsection 1, paragraph E whose nonfarm income is greater than 150% of the nonfarm income official poverty line and is below or equal to 200% of the nonfarm income official poverty line. Dirigo Health shall annually set the amount of contribution. [PL 2011, c. 477, Pt. Y, §1 (AMD).]

Beginning January 1, 2012, and ending September 30, 2012, 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 services provided to individuals eligible pursuant to Title 22, section 3174-G, subsection 1, paragraph E whose nonfarm income is greater than 133% of the nonfarm income official poverty line and is below or equal to 150% of the nonfarm income official poverty line. Dirigo Health shall annually set the amount of contribution. [PL 2011, c. 477, Pt. Y, §1 (AMD).]

Beginning September 1, 2012, but not later than June 30, 2013, Dirigo Health shall transfer $7,210,000 from the Dirigo Health Enterprise Fund to the Medical Care - Payments to Providers, Other Special Revenue Funds account in the Department of Health and Human Services for the purpose of providing a state match for federal Medicaid services. [PL 2013, c. 1, Pt. X, §1 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2005, c. 400, §A14 (AMD). PL 2011, c. 380, Pt. BBB, §1 (AMD). PL 2011, c. 477, Pt. Y, §1 (AMD). PL 2013, c. 1, Pt. X, §1 (AMD).

§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. [PL 2009, c. 359, §3 (AMD); PL 2009, c. 359, §8 (AFF).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2005, c. 386, §D3 (AMD). PL 2009, c. 359, §3 (AMD). PL 2009, c. 359, §8 (AFF).

§6916. Marketing and sale of Dirigo Health Program; qualifications of insurance producers

1. Qualifications of insurance producers. An insurance producer licensed pursuant to chapter 16 may solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program if the following conditions are met prior to any such solicitation, negotiation or sale:

A. The producer is authorized by the superintendent to solicit, negotiate and sell insurance products for the health line of business; [PL 2007, c. 447, §10 (NEW).]

B. The producer has successfully completed all training offered and required by the Dirigo Health Program for the solicitation, negotiation and sale of Dirigo Health Program insurance products, including any continuing training offered and required by the Dirigo Health Program; [PL 2007, c. 447, §10 (NEW).]

C. The producer provides the carrier or carriers with which the Dirigo Health Program has contracted to underwrite and provide Dirigo Health Program coverage a current certificate from the Dirigo Health Program certifying the successful completion of all training offered and required by the Dirigo Health Program; and [PL 2007, c. 447, §10 (NEW).]

D. The producer successfully completes all training specific to the sale of Dirigo Health Program insurance products offered and required by the carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage, including any continuing training offered and required by such carrier or carriers. [PL 2007, c. 447, §10 (NEW).]

[PL 2007, c. 447, §10 (NEW).]

2. Annual certification required. Training pursuant to subsection 1 must be completed annually, and any certificate establishing successful completion of training is valid for one year from the date of issuance. If a producer fails to obtain certification following the expiration of the prior year's certification, the producer may not continue to solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program.

[PL 2007, c. 447, §10 (NEW).]

3. Carrier appointment not required. Notwithstanding any other provision of law, an insurance producer licensed pursuant to chapter 16 who complies with this section may solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program without being appointed by the

carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage. A producer may not solicit, negotiate or sell insurance products offered by or through the Dirigo Health Program if the producer is not in compliance with this subsection. Notwithstanding section 1445, the carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage are not liable for the actions of an insurance producer who has not been appointed to solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program.
[PL 2007, c. 447, §10 (NEW).]

SECTION HISTORY

PL 2007, c. 447, §10 (NEW).

§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 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 amount of the access payment is 2.14% on claims for services provided through June 30, 2011, 1.87% on claims for services provided from July 1, 2011 to June 30, 2012, 1.64% on claims for services provided from July 1, 2012 to June 30, 2013 and 1.14% on claims for services provided from July 1, 2013 to December 31, 2013. No access payment may be charged for any claims for services provided on January 1, 2014 or thereafter. 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. [PL 2009, c. 359, §4 (NEW); PL 2009, c. 359, §8 (AFF).]

B. Access payments apply to claims paid beginning on or after September 1, 2009. [PL 2009, c. 359, §4 (NEW); PL 2009, c. 359, §8 (AFF).]

C. Access payments must be made monthly to Dirigo Health and are due 30 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. [PL 2009, c. 359, §4 (NEW); PL 2009, c. 359, §8 (AFF).]

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. [PL 2009, c. 359, §4 (NEW); PL 2009, c. 359, §8 (AFF).]

[PL 2011, c. 380, Pt. BBB, §2 (AMD).]

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.
[PL 2009, c. 359, §4 (NEW); PL 2009, c. 359, §8 (AFF).]

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. [PL 2009, c. 359, §4 (NEW); PL 2009, c. 359, §8 (AFF).]

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 use disorder services. [PL 2017, c. 407, Pt. A, §99 (AMD).]

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. [PL 2009, c. 359, §4 (NEW); PL 2009, c. 359, §8 (AFF).]

[PL 2017, c. 407, Pt. A, §99 (AMD).]

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.
[PL 2009, c. 359, §4 (NEW); PL 2009, c. 359, §8 (AFF).]

SECTION HISTORY

PL 2009, c. 359, §4 (NEW). PL 2009, c. 359, §8 (AFF). PL 2011, c. 380, Pt. BBB, §2 (AMD). PL 2017, c. 407, Pt. A, §99 (AMD).

SUBCHAPTER 2

HEALTH CARE QUALITY

§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 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 access payment pursuant to section 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. [PL 2009, c. 359, §5 (AMD); PL 2009, c. 359, §8 (AFF).]

1. Research dissemination. The forum shall collect and disseminate research regarding health care quality, evidence-based medicine and patient safety to promote best practices.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

2. Quality and performance measures. The forum shall adopt a set of measures to evaluate and compare health care quality and provider performance. The measures must be adopted with guidance from the advisory council pursuant to section 6952. The quality measures adopted by the forum must be the basis for the rules for the collection of quality data adopted by the Maine Health Data Organization pursuant to Title 22, section 8708-A.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

3. Data coordination. The forum shall coordinate the collection of health care quality data in the State. The forum shall work with the Maine Health Data Organization and other entities that collect health care data to minimize duplication and to minimize the burden on providers of data.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

4. Reporting. The forum shall work collaboratively with the Maine Health Data Organization, health care providers, health insurance carriers and others to report in useable formats comparative health care quality information to consumers, purchasers, providers, insurers and policy makers. The forum shall produce annual quality reports in conjunction with the Maine Health Data Organization pursuant to Title 22, section 8712. No later than September 1, 2010, the forum shall make provider-specific information regarding quality of services available on its publicly accessible website.
[PL 2009, c. 350, Pt. A, §2 (AMD).]

5. Consumer education. The forum shall conduct education campaigns to help health care consumers make informed decisions and engage in healthy lifestyles.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

6. Technology assessment. The forum shall conduct technology assessment reviews to guide the use and distribution of new technologies in this State. The forum shall make recommendations to the certificate of need program under Title 22, chapter 103-A.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

7. Electronic data. The forum shall encourage the adoption of electronic technology and assist health care practitioners to implement electronic systems for medical records and submission of claims. The assistance may include, but is not limited to, practitioner education, identification or establishment of low-interest financing options for hardware and software and system implementation support.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

8. State health plan.
[PL 2011, c. 90, Pt. J, §23 (RP).]

9. Annual report. The forum shall make an annual report to the public. The forum shall provide the report to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs, health and human services matters and insurance and financial services matters.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

10. Health care provider-specific data. The forum shall submit to the Legislature, by January 30th each year beginning in 2009, a health care provider-specific performance report. The report must be based on health care quality data, including health care-associated infection quality data, that is submitted by providers to the Maine Health Data Organization pursuant to Title 22, section 8708-A. The forum and the Maine Center for Disease Control and Prevention shall make the report available to the citizens of the State through a variety of means, including, but not limited to, the forum's publicly accessible website and the distribution of written reports and publications.
[PL 2007, c. 594, §1 (NEW).]

11. Infection prevention activities. The forum and the Maine Center for Disease Control and Prevention shall, by January 30th of each year beginning in 2009, report to the joint standing committee of the Legislature having jurisdiction over health and human services matters on statewide collaborative efforts with health care infection control professionals in the State to control or prevent health care-associated infections.
[PL 2007, c. 594, §2 (NEW).]

12. Primary care reporting. Beginning January 15, 2020 and annually thereafter, the forum shall submit to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters a report on primary care spending using claims data from the Maine Health Data Organization and information on the methods used to reimburse primary care providers requested annually from payors, as defined in Title 22, section 8702, subsection 8. The report must include:

A. Of their respective total medical expenditures, the percentage paid for primary care by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust and the average percentage of total medical expenditures paid for primary care across all payors; and [PL 2019, c. 244, §2 (NEW).]

B. The methods used by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust to pay for primary care. [PL 2019, c. 244, §2 (NEW).]

[PL 2019, c. 244, §2 (NEW).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2007, c. 594, §§1, 2 (AMD). PL 2007, c. 629, Pt. L, §5 (AMD). PL 2009, c. 350, Pt. A, §2 (AMD). PL 2009, c. 359, §5 (AMD). PL 2009, c. 359, §8 (AFF). PL 2011, c. 90, Pt. J, §23 (AMD). PL 2019, c. 244, §2 (AMD).

§6952. Maine Quality Forum Advisory Council

The Maine Quality Forum Advisory Council, referred to in this subchapter as "the advisory council," is a 17-member body established by Title 5, section 12004-I, subsection 30-A, to advise the forum. Except as provided in section 6907, subsection 2, information obtained by the advisory council is a public record as provided by Title 1, chapter 13, subchapter 1. [PL 2003, c. 469, Pt. A, §8 (NEW).]

1. Appointment; composition. The Governor shall appoint the following members with the approval of the joint standing committee of the Legislature having jurisdiction over health and human services matters:

A. Seven members representing providers, including 3 physicians, one registered nurse, one representative of hospitals, one mental health provider and one health care practitioner who is not a physician. The 3 physician members must represent allopathic physicians, osteopathic physicians, primary care physicians and specialist physicians; [PL 2003, c. 469, Pt. A, §8 (NEW).]

B. 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; [PL 2003, c. 469, Pt. A, §8 (NEW).]

C. Four members representing employers, including one member of the State Employee Health Commission, one representative of a private employer with more than 1,000 full-time equivalent employees, one representative of a private employer with 50 to 1,000 full-time employees and one representative of a private employer with fewer than 50 employees; [PL 2003, c. 469, Pt. A, §8 (NEW).]

D. One representative of a private health plan; and [PL 2003, c. 469, Pt. A, §8 (NEW).]

E. One representative of the MaineCare program. [PL 2003, c. 469, Pt. A, §8 (NEW).]

Prior to making appointments to the advisory council, the Governor shall seek nominations from the public and from a statewide allopathic 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 statewide association representing consumers of mental health services, 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 other entities as appropriate.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

2. Terms. Members of the advisory council serve 5-year terms except for initial appointments. Initial appointments must include 5 members appointed to 3-year terms, 6 members appointed to 4-year terms and 6 members appointed to 5-year terms. A member may not serve more than 2 consecutive terms.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

3. Compensation. Members of the advisory council are eligible for compensation according to the provisions of Title 5, chapter 379.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

4. Quorum. A quorum is a majority of the members of the advisory council.
[PL 2003, c. 469, Pt. A, §8 (NEW).]

5. 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. [PL 2003, c. 469, Pt. A, §8 (NEW).]

6. Meetings. The advisory council shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chair or the executive director of Dirigo Health. Meetings of the council are public proceedings as provided by Title 1, chapter 13, subchapter 1. [PL 2003, c. 469, Pt. A, §8 (NEW).]

7. Duties. The advisory council shall:

A. Convene a group of health care providers to provide input and advice to the council. The council shall invite members broadly representing health care practitioners as defined in Title 24, section 2502, subsection 1-A, health care providers as defined in Title 24, section 2502, subsection 2, federally qualified health centers and pharmacists. Members serve as volunteers and without compensation or reimbursement for expenses; [PL 2003, c. 469, Pt. A, §8 (NEW).]

B. Provide expertise in health care quality to assist the board; [PL 2003, c. 469, Pt. A, §8 (NEW).]

C. Advise and support the forum by:

(1) Establishing and monitoring, with Dirigo Health, an annual work plan for the forum;

(2) Providing guidance in the adoption of quality and performance measures;

(3) Serving as a liaison between the provider group established in paragraph A and the forum;

(4) Conducting public hearings and meetings; and

(5) Reviewing consumer education materials developed by the forum; [PL 2003, c. 469, Pt. A, §8 (NEW).]

D. Make recommendations regarding quality assurance and quality improvement priorities; and [PL 2011, c. 90, Pt. J, §24 (AMD).]

E. Serve as a liaison between the forum and other organizations working in the field of health care quality. [PL 2003, c. 469, Pt. A, §8 (NEW).]

[PL 2011, c. 90, Pt. J, §24 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2011, c. 90, Pt. J, §24 (AMD).

SUBCHAPTER 3

DIRIGO HEALTH HIGH-RISK POOL

§6971. Dirigo Health High-risk Pool

(REPEALED)

SECTION HISTORY

PL 2003, c. 469, §A8 (NEW). PL 2005, c. 400, §C10 (AMD). PL 2007, c. 629, Pt. L, §6 (RP).

SUBCHAPTER 4

DIRIGO HEALTH SELF-ADMINISTERED PLAN

§6981. Dirigo Health Self-administered Plan

Notwithstanding section 6910, subsection 2, Dirigo Health may provide access to health benefits coverage by establishing the Dirigo Health Self-administered Plan, referred to in this subchapter as "the self-administered plan," pursuant to this section. [PL 2007, c. 447, §11 (NEW).]

1. Establishment. Dirigo Health may provide access to health benefits coverage through the self-administered plan subject to the requirements of this section. The board may make a determination that Dirigo Health will provide access to health benefits coverage through the self-administered plan after the board evaluates competitive bids for health benefits coverage for self-administered and fully underwritten health benefits coverage. If the board determines that Dirigo Health will provide access to health coverage through the self-administered plan as authorized under this section, the board shall submit a report explaining the reasons for the decision to the joint standing committee of the Legislature having jurisdiction over health insurance matters within 30 days of the decision. Upon receipt of a report from the board, the chairs of the joint standing committee of the Legislature having jurisdiction over health insurance matters may call a meeting of the committee. Following receipt of such a report, the joint standing committee of the Legislature having jurisdiction over health insurance matters may report out legislation to the next regular or special session of the Legislature relating to the establishment of the self-administered plan.
[PL 2007, c. 447, §11 (NEW).]

2. Cooperative agreements. Dirigo Health may enter into voluntary cooperative agreements with a public purchaser for purchasing purposes and administrative functions. If a cooperative agreement is entered into pursuant to this subsection, the self-administered plan and any public purchaser shall maintain separate and distinct risk pools and reserves and may not commingle risk pools or reserve funds under any circumstances. For the purposes of this subsection, "public purchaser" means an entity that purchases health coverage in whole or in part with public funds, including, but not limited to, the state employee health insurance program, the University of Maine System, the Maine Community College System, the Maine Education Association benefits trust, the Maine School Management Association benefits trust and municipal and county governments. For the purposes of this subsection, "public purchaser" does not mean the Department of Health and Human Services, Office of MaineCare Services.
[PL 2009, c. 369, Pt. A, §33 (AMD).]

3. Additional responsibilities of board. In addition to the duties and responsibilities set out in sections 6908 and 6910, the board is authorized to:

A. Operate the self-administered plan pursuant to a trust instrument in accordance with Title 18-B; [PL 2007, c. 447, §11 (NEW).]

B. Develop, maintain and modify a business plan for the self-administered plan as appropriate in consultation with the executive director; [PL 2007, c. 447, §11 (NEW).]

C. Establish an operating budget for the self-administered plan subject to legislative approval in the biennial budget process in accordance with section 6908, subsection 3; [PL 2007, c. 447, §11 (NEW).]

D. Ensure the ongoing fiscal integrity and stability of the self-administered plan in accordance with subsections 5 and 11 and monitor statistics provided by the executive director relating to the number of plan enrollees, working rates, utilization of benefits, operating costs and reimbursement for losses related to excess or stop loss coverage; [PL 2007, c. 447, §11 (NEW).]

E. Establish administrative and accounting procedures in accordance with section 6908, subsection 2, paragraph A and develop financial statements that are consistent with generally accepted accounting principles; [PL 2007, c. 447, §11 (NEW).]

F. Obtain necessary contracts for services, including, but not limited to, actuarial services, accounting services, auditing services, investment advice and counsel and custodial services for financial assets in accordance with subsection 4; [PL 2007, c. 447, §11 (NEW).]

G. Take any actions necessary to comply with federal and state Medicaid rules regarding Dirigo Health plan members eligible for MaineCare; [PL 2007, c. 447, §11 (NEW).]

H. Take any actions necessary to comply with federal Medicaid managed care organization contract requirements as provided in 42 Code of Federal Regulations, Part 438 (2002); and [PL 2007, c. 447, §11 (NEW).]

I. Have and exercise all powers necessary and appropriate to carry out the purposes of this section. [PL 2007, c. 447, §11 (NEW).]

[PL 2007, c. 447, §11 (NEW).]

4. Services. If the board determines that Dirigo Health will provide access to health coverage through the self-administered plan pursuant to subsection 2, the board shall contract for the following services through a competitive bidding process unless the requirement for competitive bidding is waived pursuant to Title 5, section 1825-B, subsection 2 or a carrier contracted by Dirigo Health to fully underwrite health benefits coverage terminates that contract.

A. The board shall secure the services of an actuary for technical advice on matters regarding the operation of the self-administered plan in accordance with this paragraph. The board shall contract for actuarial services after a competitive bidding process at least every 3 years and may award a bid only to an actuary who is a member in good standing of the American Academy of Actuaries or a successor organization. The contract must require the actuary to:

(1) Act as a technical advisor to the board on matters regarding the operation of the self-administered plan in accordance with this paragraph;

(2) Certify the amounts of the benefits paid and payable under this section;

(3) Analyze the year's operations and results and the experience of the self-administered plan;

(4) Determine appropriate actuarial assumptions for recommendation to the board; and

(5) Determine the appropriate level of reserves needed to sustain the self-administered plan and pay benefits. [PL 2007, c. 447, §11 (NEW).]

B. The board shall secure the services of one or more fiduciaries or registered investment advisors through negotiated contractual arrangements. The contract must require the fiduciary or registered investment advisor to:

(1) Invest and reinvest the funds in accordance with appropriate financial and trust standards;

(2) Advise the board as to reasonable investment philosophy; and

(3) Submit regular reports of investments and changes to the board. [PL 2007, c. 447, §11 (NEW).]

C. The board shall contract with an appropriate financial institution for custodial services for the securities and other investment assets of the self-administered plan. The contract must require the custodian to meet financial safeguards and other qualifications determined by the board, including restrictions on the manner in which deposits and withdrawals of funds are completed. [PL 2007, c. 447, §11 (NEW).]

D. When the self-administered plan is established, the board shall purchase, through contracts from one or more 3rd-party administrators or any organization necessary to administer and provide a health plan, a policy or policies or a contract to provide the benefits specified by this section. The

purchase of policies by the board must be accomplished by use of a written contract for a term determined by the board. [PL 2007, c. 447, §11 (NEW).]

The board may contract for any other applicable services necessary to comply with federal law.
[PL 2007, c. 447, §11 (NEW).]

5. Administration. The following provisions govern the administration of the self-administered plan.

A. The assets and liabilities of the self-administered plan are solely the assets and liabilities of Dirigo Health. [PL 2007, c. 447, §11 (NEW).]

B. The actuary under contract with the board pursuant to subsection 4 shall determine:

(1) The appropriate level of reserves estimated to be sufficient to pay claims and administrative costs according to subsection 11, paragraph B;

(2) Whether the program is operating on an actuarially sound basis and any recommendations based on that determination;

(3) A rate structure for the self-administered plan, including working rates actuarially sufficient to pay anticipated claims for the current claims year as well as to provide sufficient reserves for incurred but not reported claims;

(4) Recommendations as to the purchase of excess or stop loss insurance including suggested attachment levels and limits; and

(5) Recommendations as to the need for a security deposit or surety bond to protect against insolvency.

The actuary shall annually present information to the board on the determinations made pursuant to this paragraph as well as the method of distribution of any accumulations above the reserves including use of excess reserves to moderate the working rates. [PL 2007, c. 447, §11 (NEW).]

C. The superintendent shall complete a detailed review of the financial and actuarial aspects of the self-administered plan, including, but not limited to, the presentation and recommendations of the actuary and the audited financial statements of the self-administered plan. The superintendent shall report the superintendent's findings and any recommendations to the board and at a public meeting of the joint standing committee of the Legislature having jurisdiction over insurance matters on or before March 1st of each year. [PL 2007, c. 447, §11 (NEW).]

D. The self-administered plan may not obligate the General Fund beyond that amount appropriated by the Legislature. [PL 2007, c. 447, §11 (NEW).]
[PL 2007, c. 447, §11 (NEW).]

6. Audits; financial statements. The board shall arrange for an annual audit of its financial statements by an independent certified public accounting firm. Within 30 days of the completion of the audit, a copy of the audited financial statements must be distributed to the Legislature in the same manner as required by section 6908, subsection 4. A copy of the audited financial statements must also be made available for public inspection.
[PL 2007, c. 447, §11 (NEW).]

7. Public entity. The self-administered plan is a public entity for the purposes of 42 Code of Federal Regulations, Section 438.116.
[PL 2007, c. 447, §11 (NEW).]

8. Health benefit coverage. Health benefits coverage provided under the self-administered plan in accordance with this subchapter must be comprehensive and include a low deductible plan option for enrollees in the Dirigo Health Program.
[PL 2007, c. 447, §11 (NEW).]

9. Application of certain insurance provisions. The self-administered plan must meet or exceed the following requirements in the same manner as when health benefits coverage is provided by a health insurance carrier:

A. The requirements for rating practices pursuant to section 2736-C, subsection 2 and section 2808-B, subsection 2; [PL 2007, c. 447, §11 (NEW).]

B. The requirements for guaranteed issuance pursuant to section 2736-C, subsection 3 and section 2808-B, subsection 4; [PL 2007, c. 447, §11 (NEW).]

C. The requirements for guaranteed renewal pursuant to section 2736-C, subsection 3 and section 2808-B, subsection 4 subject to the limitations of available funds maintained by the self-administered plan in accordance with subsection 11; [PL 2007, c. 447, §11 (NEW).]

D. The requirements for continuity of coverage, coverage of late enrollees and preexisting condition exclusions pursuant to chapter 36; [PL 2007, c. 447, §11 (NEW).]

E. The requirements for mandated coverage of specific health care services and for specific diseases and for certain providers of health care services pursuant to Title 24 and this Title; [PL 2007, c. 447, §11 (NEW).]

F. The requirements for the benefits, rights and protections for individuals enrolled in health plans pursuant to chapter 56-A and Bureau of Insurance Rule Chapter 850. Notwithstanding any statute or common law to the contrary, an individual enrolled in the self-administered plan may maintain a cause of action against the self-administered plan subject to the requirements of section 4313. This paragraph is a waiver of the State's defense of immunity under Title 14, chapter 741; [PL 2007, c. 447, §11 (NEW).]

G. The requirements of the Insurance Information and Privacy Protection Act pursuant to chapter 24; and [PL 2007, c. 447, §11 (NEW).]

H. The provisions of sections 2159-B and 2159-C relating to discrimination against victims of domestic abuse and discrimination on the basis of genetic information or testing. [PL 2007, c. 447, §11 (NEW).]

The self-administered plan may not enter into any contract with a 3rd-party administrator, carrier or other organization to administer and provide health coverage that has not demonstrated compliance with all applicable state laws.
[PL 2007, c. 447, §11 (NEW).]

10. Self-administered plan not an insurer. The self-administered plan is not an insurer, reciprocal insurer or joint underwriting association under the laws of the State. The administration of the self-administered plan by the board does not constitute doing the business of insurance.
[PL 2007, c. 447, §11 (NEW).]

11. Reserves. This subsection applies to reserves of the self-administered plan.

A. The Dirigo Health Reserve is created as an account within the Dirigo Health Enterprise Fund, as established pursuant to section 6915, for the deposit of reserves as required by paragraph B. [PL 2007, c. 447, §11 (NEW).]

B. The self-administered plan shall maintain a reserve at least equal to the sum of:

(1) An amount estimated by a qualified actuary under subsection 5 to be necessary to pay claims and administrative costs for the assumed risk for 2 1/2 months; and

(2) The amount determined annually by a qualified actuary under subsection 5 to be necessary to fund the unpaid portion of ultimate expected losses, including incurred but not reported claims, and related expenses incurred in the provision of benefits for eligible participants, less

any credit, as determined by a qualified actuary, for excess or stop loss insurance. [PL 2007, c. 447, §11 (NEW).]

C. The Dirigo Health Reserve must be adjusted on a quarterly basis in order to maintain a reserve at least equal to the amount determined in paragraph B. [PL 2007, c. 447, §11 (NEW).]

D. The Dirigo Health Reserve is capitalized by money from the Dirigo Health Enterprise Fund, as established pursuant to section 6915, and any other fund advanced for initial operating expenses, monthly enrollee payments, any funds received from any public or private source, legislative appropriations, payments from state departments and agencies and such other means as the Legislature may approve. All money in the Dirigo Health Reserve is deemed to be the commingled assets of all covered enrollees and may be used only for the purposes of this section. [PL 2007, c. 447, §11 (NEW).]

[PL 2007, c. 447, §11 (NEW).]

12. Stop loss insurance. The board may purchase excess or stop loss insurance for the self-administered plan, with attachment levels and limits as recommended by a qualified actuary pursuant to subsection 5. If the board is unable to purchase excess or stop loss insurance at the recommended attachment levels and limits, the board does not have the authority to establish a self-administered plan as provided in this section.

[PL 2007, c. 447, §11 (NEW).]

13. Marketing and distribution. The board may contract for the marketing and distribution of the self-administered plan in accordance with the requirements of this subsection. Any entity or individual that contracts with the self-administered plan shall successfully complete all training offered by Dirigo Health for the solicitation, negotiation and sale of health benefits coverage. Training must be completed annually, and any certificate establishing successful completion of training is valid for one year from the date of issuance. If an entity or individual fails to obtain certification following the expiration of the prior year's certification, the entity or individual may not continue to solicit, negotiate and sell health benefits coverage under the self-administered plan.

[PL 2007, c. 447, §11 (NEW).]

14. Provider reimbursement. In any contract with a 3rd-party administrator, carrier or other organization to administer and provide health coverage to enrollees of the self-administered plan, the board shall ensure that:

A. Providers contracting to provide health coverage to plan enrollees are reimbursed at a rate comparable to current market reimbursement rates among commercial carriers in the State; [PL 2007, c. 447, §11 (NEW).]

B. Providers contracting to provide health coverage to plan enrollees are paid in a timely manner in accordance with the same requirements that would be required under state law for health insurance carriers pursuant to section 2436; and [PL 2007, c. 447, §11 (NEW).]

C. If the self-administered plan fails to pay for health care services as set forth in the contract, providers are governed by the standards required pursuant to section 4204, subsection 6. This paragraph does not prohibit a provider from collecting or attempting to collect from a plan enrollee any amount for services not normally payable to the self-administered plan, including any applicable copayments and deductibles. [PL 2007, c. 447, §11 (NEW).]

[PL 2007, c. 447, §11 (NEW).]

15. No liability for plan enrollees. This section does not create any liability on the part of eligible employers, eligible employees or eligible individuals enrolled in Dirigo Health in the event that the self-administered plan becomes insolvent or fails to pay claims.

[PL 2007, c. 447, §11 (NEW).]

SECTION HISTORY

PL 2007, c. 447, §11 (NEW). PL 2009, c. 369, Pt. A, §33 (AMD).

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