Options for Dirigo Board of Trustees Consideration

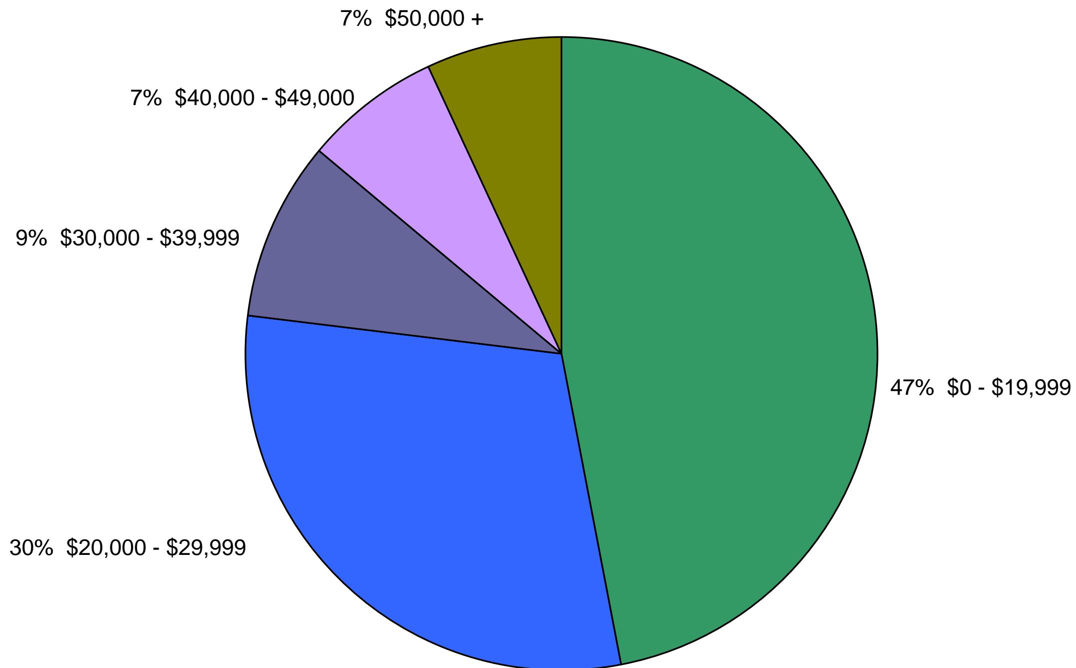
July 21, 2009

Summary Survey Results

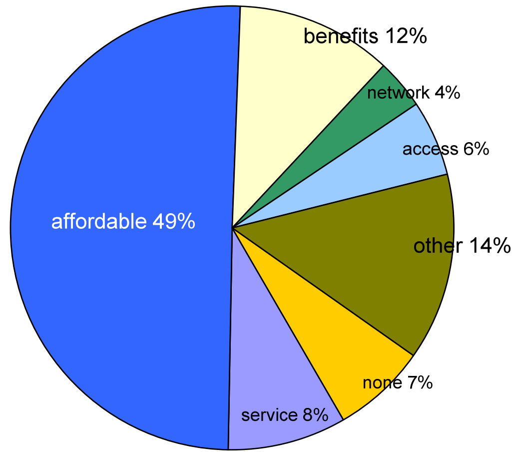
Returns (as of July 15, 2009)

	Sent				Received			
	Email	Mail/Fax	Total		Email	Mail / Fax	Total	Return Rate
Current Members	2,615	3019	5,634		131	823	954	17%
Current Employers	301	260	561		18	63	81	14%
Former Members	1331	2022	3,353		68	335	403	12%
Former Employers	170	121	291		2	18	20	7%
Interested Parties	63	0	63		0	0	0	0%
Total	4,480	5,422	9,902		219	1,239	1,458	15%

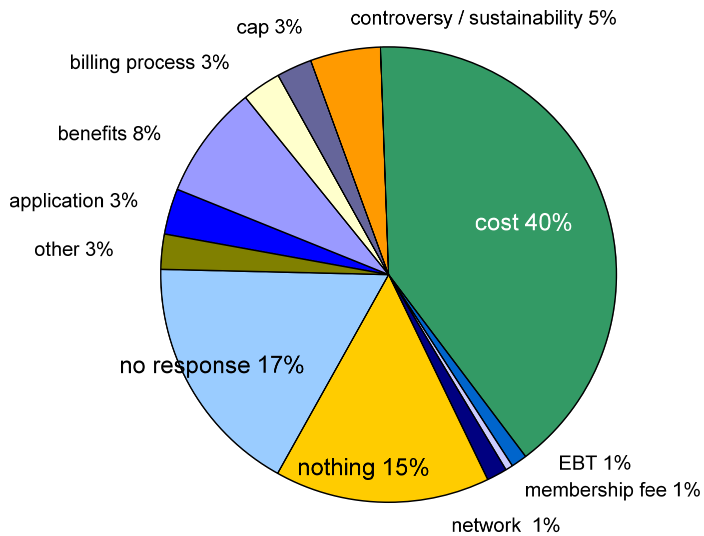
Responses by reported income level:



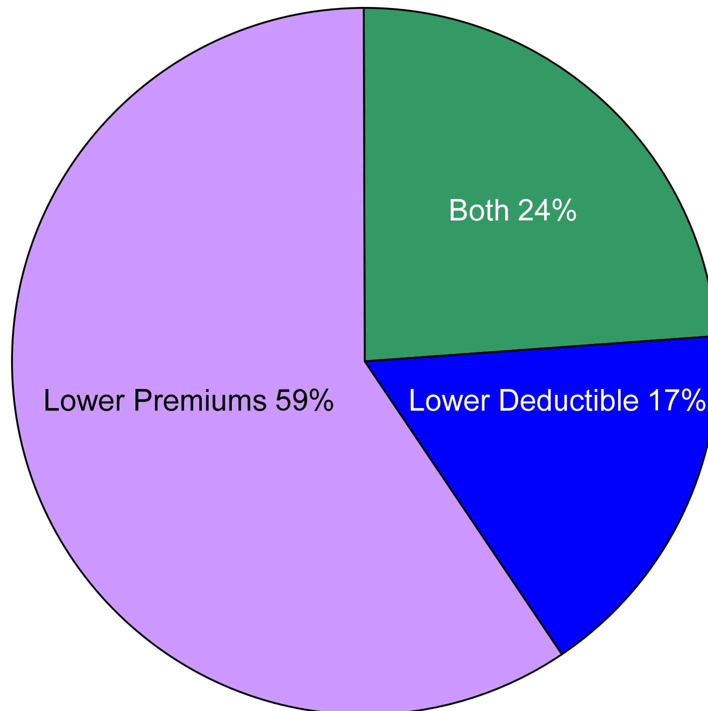
Question: What do/did you like most about DirigoChoice?



Question: What do/did you like least about DirigoChoice?



Question: What is more important to you? Lower Deductibles and Out-of-Pocket Costs/ Lower Premiums



Question: To lower the costs of DirigoChoice we need to make changes. Rank in order of priority what you would change to make the plan more affordable on a scale of 1-5 (1 represents what you would change first, 5 represents what you would change last).

1) Higher copayments
2) Generic Drugs
3) Limited Network
4) Reduced Benefits
5) Other

645 ranked higher copayments first vs. 64 for reduced benefits

Planning for the Future

Context

Dirigo Health Reform was designed to cover Maine's uninsured through a comprehensive strategy of reducing costs, improving quality and increasing access to care through three strategies:

1. strengthen and modestly increase Medicaid;
2. establish a subsidized health plan to provide affordable insurance to individuals, sole proprietors and small businesses;
3. and launch a series of public health and cost containment strategies to avoid or reduce costs.

- PL 2009 Chapter 359 - An Act To Stabilize Funding and Enable DirigoChoice To Reach More Uninsured

- Federal efforts

Subsidy Eligibility Options – Asset Test and Income Determinations

- Provide subsidies to those who have an income under 300% of the federal poverty level and limit the availability of subsidies to reflect limitations of available funds (M.R.S.A. 24-A § 6911)

- Ensure members are enrolled in the most appropriate programs for their situation and that maximize Medicaid and other Federal resources

- Stay aligned with federal initiatives

Issues and Considerations

Asset test should be the same as MaineCare (Medicaid)

- Using MaineCare asset test would require Agency to shift income test to MaineCare standard
- MaineCare has multiple eligibility categories and multiple asset tests
- The administrative resources to implement are estimated at 5 FTE
- The asset test for MaineCare does not operate on a sliding scale

Proposals

1) Asset Test

    a. Implement the Agency's 2006 proposed asset test
        i. Sliding scale (refer to attachment A)
        ii. Excludes retirement and educational accounts
        iii. Self declaration with an audit

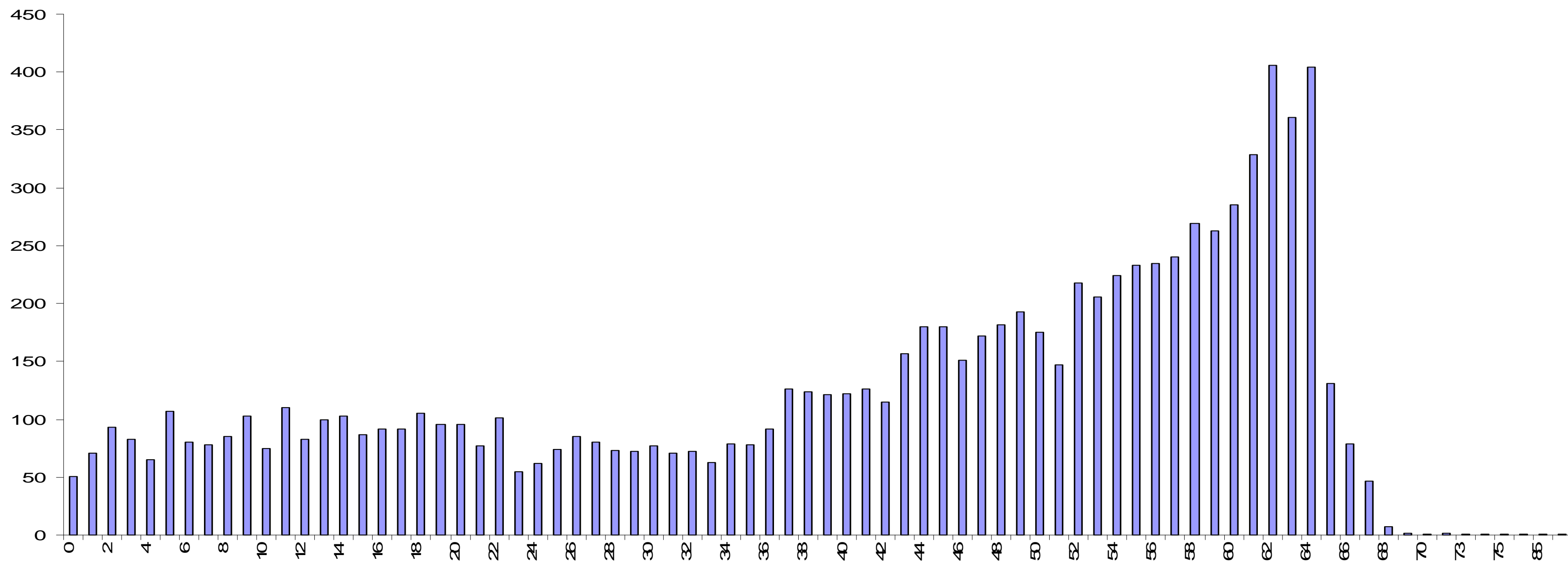
    b. Or - Require proof of Medicaid determination (denial) to be eligible for 80% subsidy
        i. Would require members to apply to DHHS prior to applying to the Agency
        ii. Would require re-implementation of Group A for Small Group employees

2) Create a supplemental companion plan Medicare Supplement Insurance - or "Medigap" - that fills the gaps in Medicare's coverage for enrollees over 65. Enrollees would pay premiums for these plans in addition to their Medicare Part B premium**.**

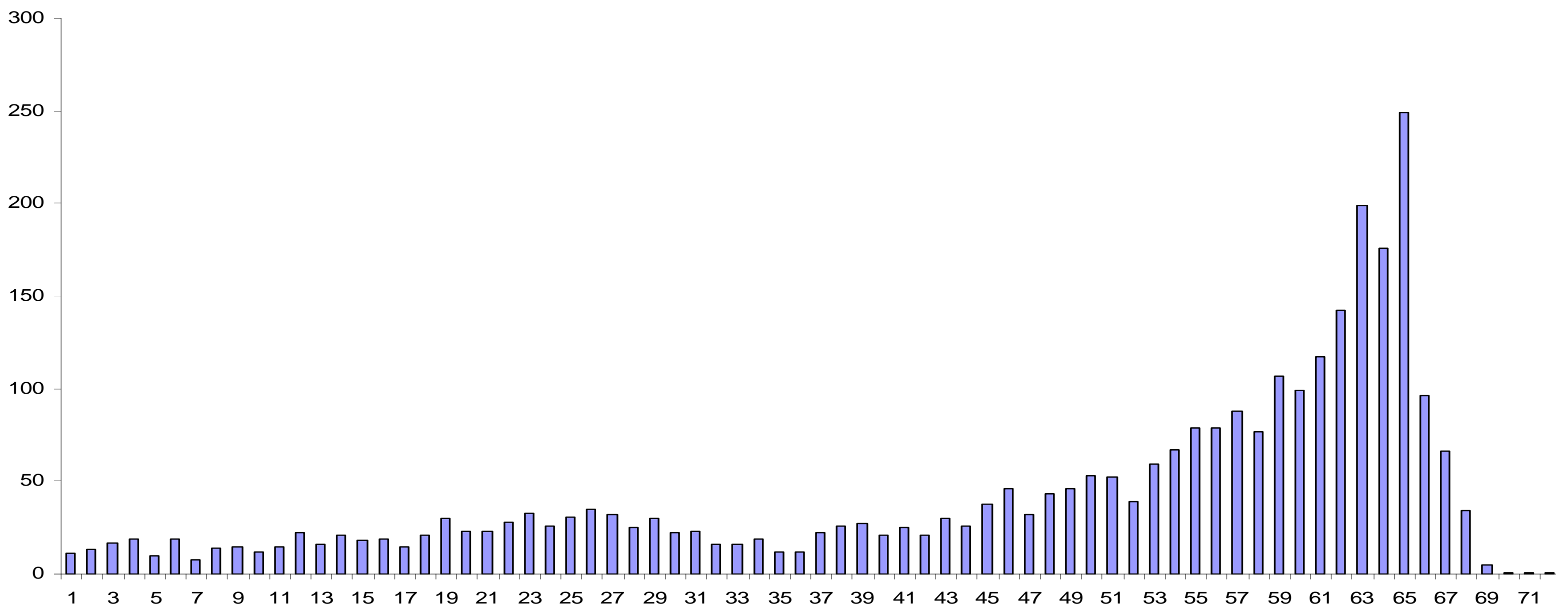
3) Income Definition: Include Social Security in income determination. 14% of total enrollment is between 62 and 65. In the Group B Individual segment, 22% of enrollment is 62-65.

The Agency estimates that implementing either the Agency's proposed asset test or the proof of Medicaid denial in conjunction with the Medigap plan and counting Social Security income would reduce expenses between $4 and 5 million (13% of planned budget).

Age distribution of all DirigoChoice members (06/01/2009 enrollment)



Age distribution of DirigoChoice Individual B members (06/01/2009 enrollment)



Coverage Options

Goal

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

The Agency is presenting five possible options:

Status Quo
No changes to existing DirigoChoice medical benefits or subsidy structure.

Deductible Subsidy Plan with HSA[1] option
A plan with similar core benefits to DirigoChoice, but where the Agency would use subsidy to primarily pay for members' medical claims (at certain levels) as opposed to subsidizing premiums.

Maximum Benefit Plan
A plan with similar core benefits to DirigoChoice, but that includes increased member cost sharing and a maximum on total annual insurance coverage.

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[1] A **health savings account** (HSA), pairs a high-deductible insurance plan (HDHP) with a tax-free savings account that the insured can use for health expenses or for a later date or retirement. Introduced in January 2004, these plans are a departure from traditional managed care plans and have some very distinct differences. The funds contributed to the account are not subject to federal income tax at the time of deposit. Unlike a Flexible Spending Account(FSA), funds roll over and accumulate year over year if not spent. HSAs are owned by the individual, which differentiates them from the company-owned Health Reimbursement Accounts (HRA) that is an alternate tax-deductible source of funds paired with HDHPs. Funds may be used to pay for qualified medical expenses at any time without federal tax liability. Withdrawals for non-medical expenses are treated very similarly to those in an IRA in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier. These accounts are a component of consumer driven health care.

Proponents of HSAs believe that they are an important reform that will help reduce the growth of health care costs and increase the efficiency of the health care system. According to proponents, HSAs encourage saving for future health care expenses, allow the patient to receive needed care without a gate keeper to determine what benefits are allowed and make consumers more responsible for their own health care choices through the required High-Deductible Health Plan.

Opponents of HSAs say they worsen, rather than improve, the U.S. health system's problems because people who are healthy will leave insurance plans while people who have health problems will avoid HSAs. There is also debate about consumer satisfaction with these plans

Reinsurance
A plan with similar core benefits to DirigoChoice, but where the Agency would pay 90% of claims between $5,000 and $75,000. The Agency would provide no premium subsidy.

Public Plan
A plan with similar core benefits to DirigoChoice, but where the Agency would partner with DHHS to provide claims processing and payment services and to negotiate reimbursement with providers.

The Agency's projections are based on most recently available data, and are subject to reforecast as market conditions and enrollment patterns change.

Comparison Table Option	Subsidy Application	Regulatory Issues	Estimated Membership (up to)	Actuarial Value	Savings
Status Quo	No change	NA	11,000	.74 .86 (B) - .58 (F)	Premium: NA Eligibility: 13%
Deductible Subsidy Plan with HSA Option Deductible schedule would be Single / Family B: $1,000 / $2,000 C: $1,500 / $3,000 D: $2,500 / $5,000 E: $3,000 / $6,000 F: $5,800 / $11,600 (for comparison to current levels, see attachment B) Deductibles represent OOP under this plan. The Agency would pay claims between member deductible and $5,800. Carrier would pay claims above $5,800.	Fixed costs (i.e., monthly premium) would be comparable to current plan. Based on overall premium reduction, the Agency's subsidy percentage would decline while member fixed costs would stay consistent. The Agency would shift these available subsidy resources to pay for variable costs (between the member deductible and $5,800). This plan would replace a set of variable costs (deductible, co-insurance, and oop) with a single oop maximum. Members would pay 100% to their oop limit, and then the carrier or the Agency would pay for all claims beyond that limit.	NA	11,000 (+)	.80 (B) - .51 (F)	Premium: 29% Eligibility: 13% Premium savings directed to subsidization of variable costs.
Maximum Benefit Plan • Maximum benefit set at $100,000 annually per member	Fixed costs (i.e., monthly premium) would be comparable to current plan.	Seeking guidance from BOI regarding current standards in law and implications.			
Scenario 1 • $2,000 deductible 30% coinsurance and $5,000 maximum out-of-pocket (oop) for all members • Rx and preventative services applied to the deductible	Based on overall premium reduction, the Agency's subsidy percentage would decline while member fixed costs would stay consistent.		22,000	.50	Premium: 36% Eligibility: 13%
Scenario 2 • $1,000 deductible/oop for B, $2,000 deductible / $5,000 oop for all others • keep Rx subject to co-pay and preventative services at 100%	Based on overall premium reduction, the Agency's subsidy percentage would decline while member fixed costs would stay consistent.		15,000	.71	Premium: 10% Eligibility: 13%
Reinsurance Benefits would be comparable to current DirigoChoice program. The Agency would pay 90% of claims between $5,000 and $75,000. This would result in a 39% reduction in premium. Would limit to previously uninsured in addition to 300% of FPL (in small businesses at least 30% of employees must be below 300% FPL)	No premium subsidy.	Review of Dirigo statute and applicability of subsidy to those enrollees over 300% FPL (members of qualifying small groups). Seeking guidance from BOI regarding current standards in law and implications.	20,000	.74	Premium: 39% Eligibility: 6.6%

Example of member currently with 80% subsidy (Group B) with $500 deductible, 30% co-insurance, and $1,600 out-of-pocket limit

	Income Category B	Costs Under Current Plan Design	Costs Under Deductible Subsidy	Variance	Costs under Maximum Benefit 1	Variance	Costs under Maximum Benefit 2	Variance	Costs under reinsurance	Variance
Scenario 1	Total Claims	$750	$750		$750		$750		$750	
	Enrollee pays	$500	$750		$750		$750		$500	
	Coinsurance	$75	$0		$0		$0		$75	
	Total Enrollee pays	$575	$750	$175	$750	$175	$750	$175	$575	$0
	Insurer pays	$175	$0		$0		$0		$175	
Scenario 2	Total Claims	$1,500	$1,500		$1,500		$1,500		$1,500	
	Enrollee pays	$500	$1,000		$1,500		$1,000		$500	
	Coinsurance	$300	$0		$0		$0		$300	
	Total Enrollee pays	$800	$1,000	$200	$1,500	$700	$1,000	$200	$800	$0
	Insurer pays	$700	$500		$0		$500		$700	
Scenario 3	Total Claims	$2,500	$2,500		$2,500		$2,500		$2,500	
	Enrollee pays	$500	$1,000		$2,000		$1,000		$500	
	Coinsurance	$600	$0		$150		$0		$600	
	Total Enrollee pays	$1,100	$1,000	($100)	$2,150	$1,050	$1,000	($100)	$1,100	$0
	Insurer pays	$1,400	$1,500		$350		$1,500		$1,400	
Scenario 4	Total Claims	$5,000	$5,000		$5,000		$5,000		$5,000	
	Enrollee pays	$500	$1,000		$2,000		$1,000		$500	
	Coinsurance	$1,350	$0		$900		$0		$1,350	
	Total Enrollee pays	$1,600	$1,000	($600)	$2,900	$1,300	$1,000	($600)	$1,600	$0
	Insurer pays	$3,400	$4,000		$2,100		$4,000		$3,400	

Example of member currently with 60% subsidy (Group C) with $800 deductible, 30% co-insurance, and $2,600 out-of-pocket limit

	Income Category B	Costs Under Current Plan Design	Costs Under Deductible Subsidy	Variance	Costs under Maximum Benefit 1	Variance	Costs under Maximum Benefit 2	Variance	Costs under reinsurance	Variance
Scenario 1	Total Claims	$750	$750		$750		$750		$750	
	Enrollee pays	$750	$750		$750		$750		$750	
	Coinsurance	$0	$0		$0		$0		$0	
	Total Enrollee pays	$750	$750	$0	$750	$0	$750	$0	$750	$0
	Insurer pays	$0	$0		$0		$0		$0	
Scenario 2	Total Claims	$1,500	$1,500		$1,500		$1,500		$1,500	
	Enrollee pays	$800	$1,500		$1,500		$1,500		$800	
	Coinsurance	$210	$0		$0		$0		$210	
	Total Enrollee pays	$1,010	$1,500	$490	$1,500	$490	$1,500	$490	$1,010	$0
	Insurer pays	$490	$0		$0		$0		$490	
Scenario 3	Total Claims	$5,000	$5,000		$5,000		$5,000		$5,000	
	Enrollee pays	$800	$1,500		$2,000		$2,000		$800	
	Coinsurance	$1,260	$0		$900		$900		$1,260	
	Total Enrollee pays	$2,060	$1,500	($560)	$2,900	$840	$2,900	$840	$2,060	$0
	Insurer pays	$2,940	$3,500		$2,100		$2,100		$2,940	
Scenario 4	Total Claims	$10,000	$10,000		$10,000		$10,000		$10,000	
	Enrollee pays	$800	$1,500		$2,000		$2,000		$800	
	Coinsurance	$2,760	$0		$2,400		$2,400		$3,561	
	Total Enrollee pays	$2,600	$1,500	($1,100)	$4,400	$1,800	$4,400	$1,800	$2,600	$0
	Insurer pays	$7,400	$8,500		$5,600		$5,600		$7,400	

For a full comparison of fixed and variable cost exposure see attachment C.

Premium / Claim Funding Options

ASO (Administrative Services Only) – An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims. This is common in self-insured health care plans (M.R.S.A. 24-A § 6981 Attachment D).

Stop-loss coverage – A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Fully Insured – An arrangement in which the insurer is responsible for paying all claims (except those subject to member cost sharing) in exchange for a set premium payment.

Member cost sharing includes:

- **Deductibles:** a portion of eligible expenses that an enrollee must pay during a calendar year before the insurance company will begin to pay benefits for covered services.

- **Copayments (copay charges):** fixed dollar amounts that enrollees must pay for certain covered services. It is generally paid at the time the service is rendered.

- **Coinsurance:** a percentage of the eligible expenses that is paid by the enrollee for covered services. Generally products will include deductibles and coinsurance together so that the enrollee pays the deductible and then the coinsurance percentage on the remaining eligible expense. Since coinsurance charges can turn into significant cash outlay for an enrollee who uses health insurance benefits often, limits of out of pocket expenditures are put in place. These limits can be in the form of **out- of- pocket maximums** or **coinsurance maximums**.

    - **out-of-pocket maximum**: the maximum dollar amount per calendar year paid by the enrollee. This limit includes the deductible and sometimes even copays.
    - **coinsurance maximum:** the most the enrollee will have to pay in out-of-pocket costs for coinsurance charges on covered services during a calendar year.

Minimum Premium - A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

Further Design Considerations:

The Agency plans to continue exploring a number of possible options / designs as it moves forward with plan design and the RFP for services effective July 1, 2010. These options are mostly consistent with the plan options presented above and would supplement those designs. These considerations include:

Value Based Purchasing

At its broadest, any purchasing practice aimed at improving the value of health care services, where value is a function of both quality and cost. It can be helpful to think about value as the result of quality divided by cost:

Value = Quality ÷ Cost

This equation shows that value increases as quality increases, holding expenditure constant.

Value-based purchasing emphasizes activities that aim to improve the quality of care that patients and other consumers of health care services receive. It does not emphasize the various strategies that purchasers use to reduce their costs, even if they are holding quality constant. While many purchasers adopt VBP strategies in an effort to lower their expenses in the long term, it is important to recognize that, although improvements in quality can and often do reduce costs, they may also increase costs or be cost-neutral.

A full guide to value based purchasing can be found at the Agency for Healthcare Research and Quality's (AHRQ) website at: http://www.ahrq.gov/about/cods/valuebased/

Tiered / Limited Networks

A network of providers and hospitals defined by quality and cost criteria. Member cost sharing may vary based on use of providers and hospitals in the tiered network. Limited networks provide opportunities for preferential reimbursement and risk sharing arrangements that ultimately reduce costs for the plan.

Attachment A – Proposed Asset Test

All DirigoChoice applicants and renewing members will be required to provide asset information if they wish to be enrolled in any subsidy level B-E.

Which Assets Are Counted?
Assets counted for Groups B-E are assets owned by the applicant/member and/or spouse or domestic partner who lives with the applicant/member, as well as assets owned jointly with another person.

They include:

- Cashable assets: This includes savings and checking accounts, certificates of deposit (CDs), credit union shares, stocks, bonds, annuities, mutual funds, Keogh or profit sharing plan assets.

- Lump sum payments (for example gifts, inheritances, lottery winnings, insurance settlements such as property damage claims, accidents, injury and death benefits)

- Real estate: You do not have to list the home and land where you live, but list any other property you own (for example, a second home, camp, land not attached to your primary home). Exclusions for real property may include rental property, jointly held real estate when the property cannot be sold because the other owner refuses to sell, or if a good faith effort is being made to sell at a reasonable price. Exclusions for income producing property may include fishing/lobster boat, commercial truck, machinery, livestock.

- Vehicles: List all vehicles you own. Include the estimated value (for example, the "Blue Book" value) as well as any amount you still owe on the vehicle.

- Recreational vehicles: List all types of motorized vehicles (for example, boat, motorcycle, snowmobile, ATV). Include the estimated value (for example, the "Blue Book" value) as well as any amount you still owe on the vehicle.

How Do Assets Affect the Subsidy Level? The charts below show how subsidy levels are affected by countable assets. The "1st Stage Level" is the subsidy based on income only. The subsequent table shows how that subsidy is affected based on the value of assets. For example, an applicant whose household size is 1, whose income would qualify for a B level subsidy, and who had $32,000 in assets would have a final subsidy level of D.

B (below 150% FPL)
C (below 200% FPL)
D (below 250% FPL)
E (below 300% FPL)
F (above 300% FPL)

If the applicant has qualified for a subsidy based on income (i.e., an initial placement of B-E), the Agency makes a final placement based on assets as detailed below:

Single						**Family**				
Income Level	**B**	**C**	**D**	**E**		**Income Level**	**B**	**C**	**D**	**E**
Asset Amount						*Asset Amount*				
< $15,000	B	C	D	E		< $30,000	B	C	D	E
< $29,999	C	D	E	F		< $59,999	C	D	E	F
< $44,999	D	E	F	F		< $89,999	D	E	F	F
< $59,999	E	F	F	F		< $119,999	E	F	F	F
>= $60,000	F	F	F	F		>= $120,000	F	F	F	F

Attachment B – Comparison of Current Deductible and OOP Limits to Proposed Deductible Subsidy Plan

Group B / 80%	Tier	Deductible	OOP Limit		OOP Limit
Plan 1	Single	$250	$800	Single	$1,000
	Family	$500	$1,600		
Plan 2	Single	$500	$1,600		
	Family	$1,000	$3,200	Family	$2,000
Plan 3	Single	$500	$700		
	Family	$1,000	$1,400		
Group C / 60%					
Plan 1	Single	$500	$1,600	Single	$1,500
	Family	$1,000	$3,200		
Plan 2	Single	$800	$2,600		
	Family	$1,600	$5,200	Family	$3,000
Plan 3	Single	$1,000	$1,400		
	Family	$2,000	$2,800		
Group D / 40%					
Plan 1	Single	$750	$2,400	Single	$2,500
	Family	$1,500	$4,800		
Plan 2	Single	$1,125	$3,600		
	Family	$2,250	$7,200	Family	$5,000
Plan 3	Single	$1,500	$2,100		
	Family	$3,000	$4,200		
Group E / 20%					
Plan 1	Single	$1,000	$3,200	Single	$3,000
	Family	$2,000	$6,400		
Plan 2	Single	$1,450	$4,600		
	Family	$2,900	$9,200	Family	$6,000
Plan 3	Single	$2,000	$2,800		
	Family	$4,000	$5,600		
Group F / 0%					
Plan 1	Single	$1,250	$4,000	Single	$5,800
	Family	$2,500	$8,000		
Plan 2	Single	$1,750	$5,600		
	Family	$3,500	$11,200	Family	$11,600
Plan 3	Single	$2,500	$3,500		
	Family	$5,000	$7,000		

Attachment C – Comparison of Proposed Plans' Potential Risk as a Percentage of Income

Discount Level	Avg. Household Income	Avg. OOP Max.	Avg. Monthly Contribution	Avg. Yearly Contribution	Avg. Total Risk	% of Income Total Risk Represents	% due to Premium	% due to OOP
Status Quo								
B	$8,178.69	$1,866.87	$113.04	$1,356.47	$3,223.34	39.41%	16.59%	22.83%
C	$24,279.31	$3,427.75	$239.39	$2,872.63	$6,300.37	25.95%	11.83%	14.12%
D	$30,459.17	$4,626.70	$336.94	$4,043.26	$8,669.95	28.46%	13.27%	15.19%
E	$36,315.56	$5,903.89	$425.59	$5,107.10	$11,010.98	30.32%	14.06%	16.26%
Deductible Subsidy								
B	$8,178.69	$1,336.02	$113.04	$1,356.47	$2,692.49	32.92%	16.59%	16.34%
C	$24,279.31	$2,115.70	$239.39	$2,872.63	$4,988.33	20.55%	11.83%	8.71%
D	$30,459.17	$3,408.14	$336.94	$4,043.26	$7,451.40	24.46%	13.27%	11.19%
E	$36,315.56	$4,090.91	$425.59	$5,107.10	$9,198.01	25.33%	14.06%	11.26%
Maximum Benefit 1								
B	$8,178.69	$6,680.11	$113.04	$1,356.47	$8,036.58	98.26%	16.59%	81.68%
C	$24,279.31	$7,052.33	$239.39	$2,872.63	$9,924.96	40.88%	11.83%	29.05%
D	$30,459.17	$6,816.28	$359.40	$4,312.81	$11,129.09	36.54%	14.16%	22.38%
E	$36,315.56	$6,818.18	$359.40	$4,312.80	$11,130.98	30.65%	11.88%	18.77%

Maximum Benefit 2								
B	$8,178.69	$1,336.02	$113.04	$1,356.47	$2,692.49	32.92%	16.59%	16.34%
C	$24,279.31	$7,052.33	$239.39	$2,872.63	$9,924.96	40.88%	11.83%	29.05%
D	$30,459.17	$6,816.28	$336.94	$4,043.26	$10,859.54	35.65%	13.27%	22.38%
E	$36,315.56	$6,818.18	$425.59	$5,107.10	$11,925.28	32.84%	14.06%	18.77%

Reinsurance								
B	$8,178.69	$1,866.87	$434.41	$5,212.92	$7,079.79	86.56%	63.74%	22.83%
C	$24,279.31	$3,427.75	$427.13	$5,125.56	$8,553.31	35.23%	21.11%	14.12%
D	$30,459.17	$4,626.70	$376.81	$4,521.72	$9,148.42	30.04%	14.85%	15.19%
E	$36,315.56	$5,903.89	$340.74	$4,088.88	$9,992.77	27.52%	11.26%	16.26%

The Agency's projections are based on most recently available data, and are subject to reforecast as market conditions and enrollment patterns change.

Attachment D

24-A §6981. DIRIGO HEALTH SELF-ADMINISTERED PLAN

24-A §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. [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.

[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 except for cooperative agreements for the purchasing of pharmaceuticals pursuant to Title 5, section 2031.

[2007, c. 447, §11 (NEW) .]

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; [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; [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; [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; [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; [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; [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; [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 [2007, c. 447, §11 (NEW).]

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

[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. [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. [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. [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. [2007, c. 447, §11 (NEW).]

The board may contract for any other applicable services necessary to comply with federal law.

[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. [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. [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. [2007, c. 447, §11 (NEW).]

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

[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.

[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.

[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.

[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; [2007, c. 447, §11 (NEW).]

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

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

G. The requirements of the Insurance Information and Privacy Protection Act pursuant to chapter 24; and [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. [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.

[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.

[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. [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. [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. [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. [2007, c. 447, §11 (NEW).]

[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.

[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.

[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; [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 [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. [2007, c. 447, §11 (NEW).]

[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.

[2007, c. 447, §11 (NEW) .]

SECTION HISTORY
2007, c. 447, §11 (NEW).

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