An Act To Create a Program To Implement Choice of Health Plans in the MaineCare Program and Amend the MaineCare Program

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

PART A

Sec. A-1. 22 MRSA §18, sub-§1, as enacted by PL 1997, c. 795, §5, is amended to read:

1. Program. The Private Health Insurance Premium Program is operated by the Bureau of Medical Services within the department and implements the provisions of 42 United States Code, Section 1396a(a)(25)(G) and 1396e. The program is mandatory for persons for whom the department has determined that the program is cost-effective under subsection 2.

Sec. A-2. 22 MRSA §18, sub-§6 is enacted to read:

6. Condition of enrollment. Cooperation of the individual with the department to determine eligibility for the Private Health Insurance Premium Program and cost-effectiveness under subsection 2 is a condition of enrollment in MaineCare. The department shall require the cooperation of the individual at the time of application or within 3 months of the date of application and at the time of review and renewal of enrollment.

Sec. A-3. 22 MRSA §3173-C, as amended by PL 2003, c. 451, Pt. H, §1 and as affected by §3, is further amended to read:

§ 3173-C. Copayments and premiums

1. Authorization required. The department may not require any MaineCare member to make any payment toward the cost of a MaineCare service unless that payment is specifically authorized by this section, except that any copayment or premium expressly approved by the federal Secretary of the Department of Health and Human Services as part of a waiver must be implemented.

2. Prescription drug services. Except as provided in subsections 3 and 4, a payment of $2.50 for each drug is to be collected from the MaineCare member for each drug prescription that is an approved MaineCare service. Copayments must be capped at $25 per month per member. If a member is prescribed a drug in a quantity specifically intended by the provider or pharmacist, for the recipient's health and welfare, to last less than one month, only one payment for that drug for that month is required.

3. Exemptions. No copayment may be imposed with respect to the following services:

A. Family planning services;

B. Services furnished to individuals under 21 years of age;

C. Services furnished to any individual who is an inpatient in a hospital, nursing facility or other institution, if that individual is required, as a condition of receiving services in that institution, to spend for costs of care all but a minimal amount of income required for personal needs;

D. Services furnished to pregnant women, and services furnished during the post-partum phase of maternity care to the extent permitted by federal law;

E. Emergency services, as defined by the department;

F. Services furnished to an individual by a Health Maintenance Organization, as defined in the United States Social Security Act, Section 1903(m), in which ~~he~~the individual is enrolled; and

G. Any other service or services required to be exempt under the provisions of the United States Social Security Act, Title XIX and successors to it.

4. Persons in state custody. Any copayment imposed on a Medicaid recipient in the custody of the State is to be collected from the state agency having custody of the recipient.

~~**7. Copayments.** Notwithstanding any other provision of law, the following copayments per service per day are imposed and reimbursements are reduced, or both, to the following levels:~~

~~A. Outpatient hospital services, $3;~~

~~B. Home health services, $3;~~

~~C. Durable medical equipment services, $3;~~

~~D. Private duty nursing and personal care services, $5 per month;~~

~~E. Ambulance services, $3;~~

~~F. Physical therapy services, $2;~~

~~G. Occupational therapy services, $2;~~

~~H. Speech therapy services, $2;~~

~~I. Podiatry services, $2;~~

~~J. Psychologist services, $2;~~

~~K. Chiropractic services, $2;~~

~~L. Laboratory and x-ray services, $1;~~

~~M. Optical services, $2;~~

~~N. Optometric services, $3;~~

~~O. Mental health clinic services, $2;~~

~~P. Substance abuse services, $2;~~

~~Q. Hospital inpatient services, $3 per patient day;~~

~~R. Federally qualified health center services, $3 per patient day, effective July 1, 2004; and~~

~~S. Rural health center services, $3 per patient day.~~

~~The department may adopt rules to adjust the copayments set forth in this subsection. The rules may adjust amounts to ensure that copayments are deemed nominal in amount and may include monthly limits or exclusions per service category. The need to maintain provider participation in the Medicaid program to the extent required by 42 United States Code, Section 1392(a)(30)(A) or any successor provision of law must be considered in any reduction in reimbursement to providers or imposition of copayments.~~

8. Copayments. Notwithstanding any other provision of law, copayments to be paid by members are subject to the provisions of this subsection. In accordance with this subsection a provider may charge a copayment to a member and, if the member does not pay the copayment, the provider may refuse to provide the service or item for which the copayment was charged.

A. Copayments may not be charged to the following populations or for the following services:

(1) Children under 6 years of age whose family incomes are below 133% of the nonfarm income official poverty line;

(2) Children 6 years of age or older and under 19 years of age whose family incomes are below 100% of the nonfarm income official poverty line;

(3) Pregnant women and women who are within 60 days of having delivered a child;

(4) Recipients of federal supplemental security income benefits;

(5) Women being treated for breast or cervical cancer;

(6) Children in foster care and adoption assistance programs under chapter 1071;

(7) Members who reside in licensed residential facilities run by or contracted for by the State in which the residents are subject to a personal needs allowance under rules adopted by the department; and

(8) Copayments may not be charged for pregnancy-related services, family planning services, hospice or preventive services for children under 18 years of age.

B. Except as otherwise provided in this paragraph, copayments must be charged by providers of services and items, and reimbursements are reduced as follows.

(1) For members whose income is below 100% of the nonfarm income official poverty line, copayments are limited to nominal amounts as determined by rule adopted by the department and may not be required in order for the member to receive the service or item.

(2) For members whose income is between 100% and 150% of the nonfarm income official poverty line, except as otherwise provided in this subparagraph, copayments are set at 10% of the cost of the service or item.

(3) For members whose income is above 150% of the nonfarm income official poverty line, except as otherwise provided in this subparagraph, copayments are set at 20% of the cost of the service or item.

C. For all members, copayments and premiums are limited to an aggregate limit of 5% of family income over a 3-month period.

9. Premiums. Premiums for health coverage are subject to the provisions of this subsection.

A. Premiums may not be charged to the following populations and for the following services:

(1) Children under 6 years of age whose family incomes are below 133% of the nonfarm income official poverty line;

(2) Children 6 years of age or older and under 19 years of age whose family incomes area below 100% of the nonfarm income official poverty line;

(3) Pregnant women and women who are within 60 days of having delivered a child;

(4) Recipients of federal supplemental security income benefits;

(5) Women being treated for breast or cervical cancer;

(6) Children in foster care and adoption assistance programs under chapter 1071;

(7) Members who reside in licensed residential facilities run by or contracted for by the State in which the residents are subject to a personal needs allowance under rules adopted by the department; and

(8) All members whose family income is below 150% of the nonfarm income official poverty line.

B. Except as provided in paragraph A, for all members whose family income is at or above 150% of the nonfarm income official poverty line, premiums are set at 3% of family income.

C. For all members, copayments and premiums are limited to an aggregate limit of 5% of family income over a 3-month period.

D. The department shall suspend coverage for a member who is more than 60 days in arrears in the payment of premiums required by this subsection.

Sec. A-4. Rulemaking. The Department of Health and Human Services shall adopt rules to implement this Part. Rules adopted pursuant to this Part are routine technical rules as defined by the Maine Revised Statutes, Title 5, chapter 375, subchapter 2-A and take effect October 1, 2007.

Sec. A-5. Effective date. This Part takes effect October 1, 2007, except that prior to that date the Department of Health and Human Services is authorized to commence rulemaking as provided in section 4 in order for those rules to take effect October 1, 2007.

PART B

Sec. B-1. 22 MRSA §3174-LL is enacted to read:

§ 3174-LL. MaineCare Choice program

There is established within the MaineCare program the MaineCare Choice program to provide members a choice of customized benefit plans from health carriers beginning 90 days after approval of a waiver for the program by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services.

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

A. "Carrier" has the same meaning as in Title 24-A, section 4301-A, subsection 3 with the additional requirement that the carrier must be approved by the department to offer a customized plan for members who choose to enroll in the plan or who are enrolled by the department and do not disenroll in order to obtain employer-based health coverage using the procedures for disenrollment established by the department under rules adopted for enrollment and disenrollment.

B. "Customized plan" or "plan" means a package of medically necessary health benefits and enhanced health benefits, offered by a health carrier, that has been approved by the department as meeting the benchmark standards established in the federal Deficit Reduction Act of 2005.

C. "Members" means members of the MaineCare program under this chapter who are adults without minor children or who are adults and children without a disability.

D. "Participating drug outlet" has the same meaning as "drug outlet" in Title 32, section 13702, subsection 10 with the additional requirement that the drug outlet has chosen to voluntarily participate in the program.

E. "Program" means the MaineCare Choice program established under this section.

2. Coverage. The program shall offer health coverage to members through a choice of customized plans. A carrier shall include in a plan coverage for medically necessary health benefits and may include enhanced benefits designed to promote the involvement of the member in personal health decisions, behaviors and care and treatment, as determined by rules of the department for the plan. Enhanced health benefits may be used by the carrier to provide incentives to improve health status up to the amount of $125 per member per year in credit dollars that may be used at participating drug outlets.

3. Department responsibilities. The department has the following responsibilities with regard to the program.

A. The department shall pay premiums to the carriers who offer plans under the program. Premiums must be calculated by the department using formulas that reflect the level of need of the member and that require risk to be borne by the carrier.

B. If a member disenrolls from a plan or is disenrolled by the department in order to obtain coverage in employer-sponsored health coverage, the department shall provide for payment of premiums, deductibles, coinsurance and cost-sharing obligations for the member using the Private Health Insurance Premium Program under section 18.

C. The department shall provide reinsurance for plans providing coverage for members that live in rural areas.

D. The department shall provide informational materials for members eligible for enrollment in the program and counseling on a group and an individual basis to assist members and applicants with the choice of a plan. Individual counseling must be available statewide, including at the home of members for whom traveling to an office would be a hardship, and must be specific to the member. Counseling may be provided by department staff or through contracted services. Counselors who provide individual counseling must have access to the member’s MaineCare health record in order to assist the member in choosing a plan that is appropriate to the member’s health care needs.

E. The department shall adopt rules to implement this section. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. B-2. Submission required. By January 1, 2008 the Department of Health and Human Services shall submit to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services a completed application for a waiver for the MaineCare Choice program as established in the Maine Revised Statutes, Title 22, section 3174-LL.

PART C

Sec. C-1. 22 MRSA §3174-MM is enacted to read:

§ 3174-MM. Enhanced benefits plan

The department shall establish an enhanced benefits plan, referred to in this section as "the plan," to provide incentives for members enrolled in the plan to participate in wellness activities.

1. Plan components. The plan must include the following components:

A. A schedule of qualifying activities that earn a member enhanced benefits, including but not limited to compliance with preventive health care, health screenings and physical examinations, participation in wellness activities and adherence to prescribed regimens of care for the prevention, management, care and treatment of chronic diseases and conditions;

B. An enrollment process that establishes the member's enhanced benefits account after the member has enrolled and completed qualifying activities under paragraph A;

C. A system for recording when an enrolled member earns and spends enhanced benefits, which must include an efficient method by which the member may use enhanced benefits. The system must limit use to qualified health-related expenditures, which may include the purchase of health coverage but may not include payment in cash to the enrolled member. The system must provide for return to the department of unused funds when an enrolled member's account has been dormant for 3 years; and

D. Oversight by the enhanced benefits plan oversight committee as provided in subsection 2.

2. Oversight. The commissioner shall appoint a volunteer enhanced benefits plan oversight committee to guide in the development and oversee the implementation of the plan. The oversight committee shall advise the department regarding the designation of activities that will be used to qualify a member for enhanced benefits, determination of the process for enrollment and the system for earning and recording enhanced benefits.

Sec. C-2. Application for waiver; implementation. The Department of Health and Human Services shall apply to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services for a waiver to establish and implement the enhanced benefits plan under the MaineCare program. Implementation of the enhanced benefits plan must begin within 120 days of receipt of approval by the department.

SUMMARY

This bill amends the MaineCare program consistent with the federal Deficit Reduction Act of 2005.

The bill expands the operation of the private health insurance premium program, changes the structure of copayment requirements, adds premiums for certain members and establishes the MaineCare Choice program and the enhanced benefits program.