

September 30, 2005

Via First Class Mail & email

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-05-700
Bureau of Insurance
Maine Department of Professional and Financial Regulation
34 State House Station
Augusta, Maine 04333-0034
vanessa.j.leon@maine.gov

Re: Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the First Assessment Year, Docket No. INS-05-700

Dear Superintendent Iuppa:

Please find enclosed the following:

1. Filing Cover Sheet.
2. Two hard copies of Dirigo Health Response to Maine Automobile Dealers Association Insurance Trust and Bankers Health Trust Motion to Dismiss.

Thank you for your assistance with this matter.

Yours very truly,

/s/William H. Laubenstein, III

William H. Laubenstein, III
Assistant Attorney General

cc: William H. Stiles, Esq.(Via U. S. Mail and Email)
Thomas C. Sturtevant, Jr., Esq. (Via U. S. Mail and Email)
Roy T. Pierce, Esq. (Via U. S. Mail and Email)
Christopher T. Roach, Esq. (Via U. S. Mail and Email)
Rufus E. Brown, Esq. (Via U. S. Mail and Email)
D. Michael Frink, Esq. (Via U. S. Mail and Email)
Karynlee Harrington (Via U. S. Mail and Email)
Trish Riley (Via U. S. Mail and Email)
John Kelly (Via U. S. Mail and Email)

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS)
DETERMINED BY DIRIGO) FILING COVER SHEET
HEALTH FOR THE FIRST)
ASSESSMENT YEAR)
)
)
Docket No. INS-05-700)

TO: Alessandro Iuppa, Superintendent of Insurance
Attn: Vanessa J. Leon

Date Filed: September 30, 2005

Name of Party: Dirigo Health Board of Directors

Document Title: Response of Dirigo Health to Maine Automobile Dealers
Association of Insurance Trust, et al, Motion to Dismiss

Document Type: Memorandum In Opposition to Motion

Confidential: No

Dated: September 30, 2005

Respectively submitted,

/s/ William H. Laubenstein, III

William H. Laubenstein, III
Assistant Attorney General

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE)	RESPONSE OF DIRIGO
MEASURABLE COST SAVINGS)	HEALTH TO MAINE
DETERMINED BY DIRIGO)	AUTOMOBILE DEALERS
HEALTH FOR THE FIRST)	ASSOCIATION
ASSESSMENT YEAR)	INSURANCE TRUST, ET
)	AL, MOTION TO DISMISS
Docket No. INS-05-700)	

INTRODUCTION

Intervenors, Maine Automobile Dealers Association Insurance Trust and Bankers Health Trust (collectively the “Trusts”) have moved to dismiss this proceeding on the grounds that (1) the filing by the Dirigo Health Board of Directors (the “Board”) of its determination of aggregate measurable cost savings was untimely and therefore deprived the Superintendent of Insurance (the “Superintendent”) of jurisdiction and (2) the Board did not provide interested parties with an opportunity for an adjudicatory hearing as required by P. L. 2005, § B-2.

The motion should be dismissed because, among other reasons as set forth herein, (1) the date set for filing of the Board’s determination of aggregate measurable cost savings was directory and not mandatory; (2) the Superintendent lacks authority to determine whether the Board complied with the statutory provision on the process for determination of aggregate measurable cost savings; and, (3) the statutory scheme for determining aggregate measurable cost savings for this first assessment year did not require an adjudicatory hearing by the Board.

TABLE OF CONTENTS

I. Argument

A. The date for filing the Board’s determination of aggregate measurable cost savings was directory and not mandatory.....3

B. The Superintendent lacks the authority to determine whether the Board complied with the statutory provision on the process for determination of aggregate measurable cost savings.....6

C. The statutory scheme for determining aggregate measurable cost savings for the first assessment year did not require an adjudicatory hearing.....6

 1. Legislative History.....7

 2. Aggregate Measurable Cost Savings Process.....9

II. Conclusion.....14

Certificate of Service

Attachments

- A. LD 1577
- B. Committee Amendment “A” to LD 1577
- C. House Amendment “B” to Committee Amendment “A” to LD 1577
- D. Transcript of Dirigo Board Meeting on August 29, 2005, p. 42.
- E. Transcript of Dirigo Board Meeting on September 14, 2005, pp. 20-23.

Certificate of Service

ARGUMENT

A. The date for filing the Board's determination of aggregate measurable cost savings was directory and not mandatory.

The Legislature in P. L. 2005, ch. 400, (the "Act"), established the process for determining aggregate measurable cost savings in the first year of savings. First, a working group, convened by the Superintendent of Insurance, was to meet and make a recommendation on the Board's proposed methodology for calculating aggregate measurable cost savings "no later than September 20, 2005." P. L. 2005, ch. 400, § B-1. Second, "[n]o later than the effective date" of the Act, which was September 17, 2005, the Board was to file with the Superintendent its determination of aggregate measurable cost savings. P. L. 500, ch. 400, § B-2. The Board filed its determination of aggregate measurable cost savings on September 19, 2005. The Trusts argue that even though September 17, 2005, was a Saturday, the filing by the Board of its determination by the close of business on the next business day was untimely and deprived the Superintendent of jurisdiction. This argument should be rejected.

A review of the entire statutory scheme for determining aggregate measurable cost savings and the subsequent assessment of a savings offset payment, 24-A M. R. S. A A. § 6913, reveals that the Legislature intended that an assessment be made for 2004,¹ the first year of operation of Dirigo Health, and that this assessment would be made after a decision by the Superintendent on the reasonableness of the determination of aggregate measurable cost savings by the Board, no later than 6 weeks after the effective date of the Act. If the argument of the Trustees is accepted, there

¹ The assessment, which is based on cost savings attributable to Dirigo Health during its first year of operation, is determined during 2005 and applies to policies issued on or after January 1, 2006.

would be no assessment for 2004 and the intent of the Legislature would be frustrated. This is an absurd result. See, *Botting v. Department of Behavioral and Developmental Services*, 2003 ME 152, ¶ 20, 838 A. 2d 1168, 1175 (when interpreting statutes the court seeks “to discern from the plain language the real purpose of the legislation, avoiding results that are absurd, inconsistent, unreasonable, or illogical”).² This conclusion is also supported by the fact that the working group’s recommendations were not required to be submitted to the Board until September 20, a date that turned out to fall after the effective date of the Act.

When viewed in this regard, it becomes apparent that the provision for the filing of the Board’s determination “no later than the effective date” of the Act was intended to insure a prompt orderly process and not a jurisdictional requirement. In *Anderson v. Commissioner of the Department of Human Services*, 489 A. 2d 1094 (Me. 1985), the Law Court rejected an argument that the Department of Human Services was estopped from recouping an over payment of AFDC payments because it failed to take action within the regulatory timeframe. The Court found that the time established for seeking recoupment was directory rather than mandatory, citing with approval 1A Sutherland, Statutes and Statutory Construction § 25.03 at 289-99 (4th ed. C. Sands ed. 1972).

Generally those directions which are not of the essence of the thing to be done, but which are given with a view merely to the proper, orderly and prompt conduct of the business, and by the failure to obey no prejudice will occur to those whose rights are protected by the statute, are not commonly considered mandatory. Likewise, if the act is performed but not in the time or in the precise manner directed by the statute, the

² See also *Bradbury Memorial Nursing Home v. Tall Pines Manor Associates and the Department of Human Services*, 485 A. 2d 634 (Me. 1984), where the Law Court rejected the argument that the failure of the Department of Human Services to act on competing applications for a certificate of need before the expiration of the 150-day review period ousted the Department of jurisdiction. Had the argument been accepted, there would have been no applications pending before the Department and no developer could have been selected to build 70 need nursing home beds in the Belfast area. This was the result Bradbury favored because it would have eliminated competition for the Bradbury Memorial facility.

provision will not be considered mandatory if the purpose of the statute has been substantially complied with and no substantial rights have been prejudiced.

Anderson, 489 A. 2d at 1098. A similar result was reached in *Bradbury Memorial Nursing Home v. Tall Pines Manor Associates and Department of Human Services*, 485 A. 2d 634 (Me. 1984), the case relied upon by the Trusts. In that case the Law Court found the statutory 150-day review period for applications for a certificate of need was directory not mandatory. The Court stated that the time periods served the “hortatory purpose of curbing bureaucratic delay” and that it would be a disservice to the drafters of the provision to suggest that they intended that the procedural failure of the Department to meet the 150-day deadline to be fatal. *Id.* at 641-642.

Moreover, the Court stated in *Anderson* that “consideration of legislative intent in enacting a statute is fundamental in determining whether its provisions are mandatory or directory.” *Anderson*, 489 A. 2d at 1097-1098. The Legislature’s intent in enacting Part B of chapter 400 was to make sure a determination of aggregate measurable cost savings was made no later than 6 weeks after the effective date of the Act. This clear expression of legislative intent requires a finding that the time period for the Board to file its determination was directory. And just as in *Bradbury Memorial* where the Court could find no clearly expressed intent to make the time period mandatory or jurisdictional, in the present case there is no such clearly expressed intent.

The “essence of the thing the thing to be done” in the present matter is a determination of aggregate measurable cost savings in the first assessment year no later than 6 weeks after September 17, 2005. The date established for the filing of its determination by the Board is designed to insure the prompt and orderly progress toward

this goal. The filing two days later is substantially in compliance with the Act and has not resulted in, and the Trusts have not argued it will result in prejudice to any substantial rights. Under these circumstances, it must be found that the filing by the Board was timely and the motion to dismiss be denied.

B. The Superintendent lacks the authority to determine whether the Board complied with the statutory provision on the process for determination of aggregate measurable cost savings.

The Trusts have asked the Superintendent to dismiss the proceeding because the Board, in their view, did not comply with the statutory process for determining aggregate measurable cost savings. The Superintendent, however, need not address this issue. Administrative agencies have only such power as is conferred upon them by the legislature. *Valente v. Board of Environmental Protection*, 461 A. 2d 716, 718 (Me. 1983); *Clark v. State Employees Appeals Board*, 363 A. 2d 735, 737 (Me. 1976) (absent an express grant of power by the legislature administrative agency lacked the power to grant a rehearing or to modify or set aside a final decision); *Berry v. Board of Trustees*, 663 A. 2d 14, 19 (Me. 1995) (Board of Trustees of Maine State Retirement System had no authority resolve issue of equitable estoppel). The granting of authority to the Superintendent to make a determination as to the reasonableness of the Board's determination of aggregate measurable cost savings does not include any express authority to determine whether the Board complied with the statutory process for its determination and no such authority can be implied as necessary to carry out this power. *Valente*, 461 A. 2d at 718.

C. The statutory scheme for determining aggregate measurable cost savings

for the first assessment year did not require an adjudicatory hearing before the Board.

Due to delays in the implementation of Dirigo Health, the Board was unable to make a determination of aggregate measurable cost savings by April 2005 for 2004, the first year of the operation of Dirigo Health. As a result, the Legislature undertook to enact a process to ensure that such a determination was made. The result of this legislative effort was the Act and the process that culminates with a conducting of a public hearing by the Superintendent after which he will decide whether the determination by the Board was reasonably supported by the evidence in the record before the Board.

The statutory scheme for determining aggregate measurable cost savings prior to the effective date of the Act was set forth in 24-A M. R. S. A. § 6913:

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

24-A M. R. S. A. § 6913 (1). After the Board determined aggregate measurable cost savings, it would then establish a savings offset amount to be paid by health insurance carriers, employee benefit excess insurance carriers and third-party administrators.

24-A M. R. S. A. 6913 (2). There was no provision for a review by the Superintendent of the determinations made by Board. It was not then until September 17, 2005 that any provision for any action by the Superintendent of Insurance was in effect.

In evaluating the argument of the Trusts that the statutory procedures that took effect on September 17, 2005 required the Board to conduct an adjudicative hearing it is

helpful to examine the legislative history of the Act and the entire process put in place by the legislature for the first assessment year.

1. Legislative History.

The legislative history of the savings offset payment statute contradicts the assertion that the Legislature intended there to be two adjudicatory hearings, one before the Dirigo Board and the other before the Superintendent,³ to determine the aggregate measurable cost savings. As originally enacted, 24-A M.R.S.A. § 6913 (Supp. 2004) provided for the Dirigo Board to determine, not later than April of each year, the aggregate measurable cost savings attributable to the operation of Dirigo Health, following the opportunity for an adjudicatory hearing held pursuant to the Administrative Procedure Act. 24-A M.R.S.A § 6913(1). The Board was also required to determine the amount of the offset payment resulting from these savings by April of each year. § 6913(6). Changes in these statutory dates were required due to a delay in the implementation of the Dirigo health plan, and were proposed (together with a change in the calculation itself) in L.D. 1577, “An Act to Modify the Calculation and Implementation Date of Savings Offset Payments under the Dirigo Health Act” (122d Legis.). Attachment A. L.D. 1577 proposed that the offset payment be determined by the Board no later than August of each year, and apply to premiums paid on or after January 1, 2006 (rather than July 1, 2005 as then provided in the statute).

The Joint Standing Committee on Insurance and Financial Affairs amended L.D. 1577 (Committee Amendment “A”, Filing No. S-359), Attachment B, in several respects. Among other things, the Committee Amendment created the working group and

³ The Superintendent’s Notice of Pending Proceeding and Hearing of June 29, 2005 makes its clear that the Superintendent will hold an adjudicatory hearing.

established deadlines for various reports to be made by the working group to the Board, as well as to the legislative committee. The Committee Amendment, in Part B, also established a separate process, applicable only to the first assessment year, that called for the Board to determine the aggregate measurable cost savings following an adjudicatory hearing to be begun no later than September 15, 2005. Part B, Sec. B-2(2)(A). The Board was also directed to determine both the aggregate measurable cost savings and the amount of the savings offset payment no later than October 30, 2005. Part B, Sec. B-2(2)(B) &(C). Most importantly, Sec. B-2 established all these deadlines “notwithstanding any deadlines specified in the Maine Revised Statutes, Title 24-A, section 6913...” It is clear from this amendment that at this point a separate timeline was being crafted for establishing the first year’s savings offset payment, and the aggregate measurable cost savings on which those payments were to be based, due to the delayed implementation of Dirigo and the practical inability to meet the deadlines in the statute as originally enacted.

After the bill was reported out of committee, further amendments were made in House Amendment “B” to Committee Amendment “A” (House Filing No. 687). Attachment C. The House Amendment shifted the duty of holding a hearing to the Superintendent of Insurance for the first assessment year by requiring the he conduct an adjudicatory hearing for purposes of approving or disapproving the Board’s aggregate cost savings determination pursuant to Section 6913(1). Section 6913(1) does contemplate an adjudicatory hearing being held by both the Board and the Superintendent, in that order, for later assessment years. However, the House Amendment retains most of the provisions of the Committee Amendment, including the concept of a separate set of procedures for the first assessment year. While those

procedures, still set out in Part B, are changed by the addition of the requirement that the Board make a filing with the Superintendent, only the Superintendent is required to conduct an adjudicatory hearing.⁴ As a practical matter, this approach makes perfect sense: the Board could not have conducted such a hearing after receiving the working group's input and still meet the September 17th deadline for filing with the Superintendent.

2. Aggregate measurable cost savings process.

As should be apparent from the legislative history of the Act, and particularly the date established for submission of a recommendation by the working group and the compressed time frame for a determination of aggregate measurable cost savings by the Board and a determination of reasonableness by the Superintendent, the Legislature did not intend or expect that the Board would hold an adjudicatory hearing followed by an adjudicatory hearing by the Superintendent. Rather, the legislature intended that the yeoman's share of the work on developing a methodology would be done by the working group and that the Board would then evaluate the working group's recommendation, adopt a methodology and then determine aggregate measurable cost savings. This analysis is supported by the legislative scheme set forth in Part B of the Act.

The analysis of the Part B of the Act begins with the well established principle of statutory construction, that “[w]hen interpreting a statute, we first examine the plain

⁴ In Part B of Chapter 400, the Legislature adopted virtually identical language for the process before the Superintendent in the first assessment year and later years. In contrast, the legislature changed the process for the Board's determination in the first assessment year, deleting the requirement for a hearing conducted in accordance with the Administrative Procedure Act. Since the process to govern the determination of cost savings after the first assessment year and the process for determining cost savings in the first year were enacted at the same time, it is reasonable to assume that the Legislature was aware that the process for the assessment year was to be different than the process for subsequent years. *cf. State of Maine v. Beck*, 156 Me. 403, 165 A. 2d 433, 435 (Me. 1960) (Legislature assumed to have been cognizant of the provisions of previous act when adopting new legislation on same subject matter).

meaning of the statutory language, attempting to give effect to the legislative intent...In doing so we consider the entire statutory scheme, so that a harmonious result may be achieved. If the plain meaning of the statute is clear, we need investigate no further.” *York Insurance of Maine, Inc. v. Superintendent of Insurance*, 2004 ME 45, ¶ 14, 845 A. 2d 1155, 1159, (internal quotes omitted) citing *Botting v. Department of Behavioral and Developmental Services*, 2003 ME 152, ¶ 9, 838 A. 2d 1168, 1171.

An examination of the entire statutory scheme for determining aggregate measurable cost savings in the first assessment year shows that first, a working group, made up of 5 members representing the interests of insurers, self-insured and third-party administrators and 5 members representing the interests of Dirigo Health, was to make a recommendation to the Board on the methodology for calculating aggregate measurable cost savings no later than September 20, 2005.⁵ P. L. 2005, ch. 400, § B-1 (1, 3). Second, the Board was to file with the Superintendent no later than the effective date of the Act its determination of aggregate measurable cost savings. P. L. 2005, ch. 400, § B-2 (2)(A) Third, the Superintendent, “[f]ollowing a public hearing held in accordance with the Maine Administrative Procedure Act and no later than 6 weeks following the effective date of this Act...shall issue an order approving, in whole or in part, or disapproving the filing made” by the Board. P. L. 2005, ch. 400, § B-2 (2) (B). This compressed time frame and the absence of any express statement that the Board was to hold an adjudicatory hearing demonstrates that no such hearing was required.

Section B-2 (2) of Chapter 400 states:

2. Timeline. Notwithstanding any deadlines specified in the Maine Revised Statutes, Title 24-A, section 6913, the Board of Directors of

⁵ This date is three days after the date, September 17, 2005, the Trusts argue the Board was required to file its determination with the Superintendent.

Dirigo Health shall comply with the following deadlines for the first assessment year:

A. No later than the effective date of this Act, the board shall file with the Superintendent of Insurance its determination as to the aggregate measurable cost savings in this State...

The Trusts argue that this section only relieves the Board from meeting the April 1st deadline for determining aggregate measurable cost savings in 24-A M. R. S. A. § 6913 and does not relieve it of the responsibility to hold an adjudicatory hearing. In making this argument the Trusts ignore the legislative history and the role of the working group in the first assessment year⁶; and fail to examine the plain wording of the statute. The working group, as noted above, was to meet and make a recommendation to the Board on a methodology for calculating aggregate measurable cost savings. It was within this process that all parties were represented and had a full opportunity to present their proposals for calculating aggregate measurable cost savings. Unfortunately, the record shows that the members representing the interests of the insured, the “payor group”, did not take this opportunity to make a credible case for a methodology different than the one adopted by the Board. Rather, the payor group only undertook, until the last moment, to critique the methodology proposed by the Dirigo group. See, Attachment D, Minutes of Board Meeting (Draft) of August 29, 2005, p. 42; and Attachment E, Transcript of Board Meeting on September 14, 2005, pp. 20-23.⁷

⁶ The working group terminates on December 31, 2005. P. L. 2005, ch. 400, § B-1(6).

⁷ The Trusts complaint that they did not have adequate notice of proceedings before the Board or a fair opportunity to present evidence is belied by the record. The Trusts knew in 2003 when Dirigo Health was enacted that the Board was going to be making a determination of aggregate measurable cost savings; were aware through the working group and public announcements when the Board would be meeting; were aware that the working group had not reached consensus on a methodology; and were aware as of June 27, 2005 that the Board would not be conducting an adjudicatory hearing. The Board then met four times to consider the proposed methodologies and gave all interested persons the opportunity to make a presentation. And even though there was no formal cross examination of witnesses, the Board permitted all persons to ask questions of the persons appearing before the Board.

The legislative history of Chapter 400, the clearly expressed legislative intent that a determination of aggregate measurable cost savings be made for 2004, the compressed time frame for the determination and the reasonable assumption that the Legislature was aware that there would not be an adjudicatory hearing by the Board in the first year all support the Board's action in determining aggregate measurable cost savings without conducting an adjudicatory hearing.

CONCLUSION

For the reasons set forth above, the motion to dismiss should be denied.

Dated: September 30, 2005

/s/ William H. Laubenstein, III
William H. Laubenstein, III
Assistant Attorney General

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

Sec. 1. 24-A MRSA §6913, sub-§§2, 3 and 6, as enacted by PL 2003, c. 469, Pt. A, §8, are amended to read:

2. Savings offset payments. For the purpose of providing the funds necessary to provide subsidies pursuant to section 6912 and support the Maine Quality Forum established pursuant to subchapter 2, the board shall establish a savings offset amount to be paid by health insurance carriers, employee benefit excess insurance carriers and third-party administrators, not including carriers and third-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, annually at a rate that may not exceed savings resulting from decreasing rates of growth in the State's health care spending and in bad debt and charity care costs. Payment of the savings offset amount ~~must~~ may not begin until 12 months after Dirigo Health begins providing health insurance coverage. The savings offset payment amount, as determined by the board, is the determining factor for inclusion of savings offset payments in premiums through rate setting review by the bureau. Savings offset payments must be made quarterly and are due not less than 30 days after written notice to the health insurance carriers, employee benefit excess insurance carriers and third-party administrators and must accrue interest at 12% per annum on or after the due date.

3. Maximum savings offset payments on health insurance carriers and employee benefit excess insurance carriers. Each health insurance carrier and employee benefit excess insurance carrier ~~must~~ shall pay a savings offset in an amount not to exceed 4.0% of annual health insurance ~~premiums paid~~ claims and employee benefit excess insurance ~~premiums paid~~ claims on policies issued pursuant to the laws of this State that insure residents of this State. The savings offset payment may not exceed savings resulting from decreasing rates of growth in the State's health care spending and bad debt and charity care costs. The savings offset payment applies to premiums paid on or after ~~July 1, 2005~~ January 1, 2006. Savings offset payments must reflect aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State, as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004, as determined by the board consistent with subsection 1. A health insurance carrier and employee benefit excess insurance carrier may not be required to pay a savings offset payment on policies or contracts insuring federal employees.

6. Savings offset payments through reductions in growth in State's health care spending and bad debt and charity care. On an annual basis no later than ~~April~~ August of each year, the board shall prospectively determine the savings offset to be applied during each 12-month period. To make its determination, the board shall use the criteria and reports described in subsections 7 and 8. Annual offset payments must be reconciled to determine whether unused payments may be returned to health insurance carriers, employee benefit excess insurance carriers and third-party administrators according to a formula developed by the board. Savings offset payments must be used solely to fund the subsidies authorized by section 6912 and to support the Maine Quality Forum established in subchapter 2 and may not exceed savings from reductions in growth of the State's health care spending and bad debt and charity care.

SUMMARY

This bill clarifies and makes changes to the date the savings offset payment determination is made and the dates payments may begin under the Dirigo Health Act. The changes reflect the delay in the implementation of the Dirigo health plan. In addition, the bill changes the basis for computing savings offset payments from premiums to paid claims. This change puts the calculation of the savings offset payments on an equal footing with likely payments from self-insured plans.

Further amend the bill by striking out everything after the title and before the summary and inserting in its place the following:

'Emergency preamble. Whereas, acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation needs to be enacted immediately to ensure the sustainability of Dirigo Health; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

PART A

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

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

This subsection is repealed January 1, 2007.

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

This subsection is repealed January 1, 2007.

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

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

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

This subsection is repealed January 1, 2007.

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

This subsection is repealed January 1, 2007.

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

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

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

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

12. Jurisdiction. The joint standing committee of the Legislature having jurisdiction over insurance matters has legislative oversight and jurisdiction, including financial oversight, over Dirigo Health.

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

§6911. Coordination with MaineCare

The Department of Health and Human Services is the state agency responsible for the financing and administration of MaineCare. It shall pay for MaineCare benefits for MaineCare-eligible individuals, including those enrolled in health plans in MaineCare that are providing coverage under the Dirigo Health Insurance Program. An individual participating in

the Dirigo Health Program who applies for and is determined eligible for MaineCare is enrolled directly in MaineCare.

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

Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health Insurance Program coverage paid by eligible individuals or employees whose income is under 300% of the federal poverty level ~~and who are not eligible for MaineCare.~~ Dirigo Health may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than 50 employees, whose income is under 300% of the federal poverty level ~~and who are not eligible for MaineCare.~~

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

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

A. ~~Have~~ Be enrolled in the Dirigo Health Program, have an income under 300% of the federal poverty level, ~~and be a resident of the State, be ineligible for MaineCare coverage and be enrolled in Dirigo Health Insurance;~~ or

B. Be enrolled in a health plan of an employer with more than 50 employees and have an income under 300% of the federal poverty level. The health plan must meet any criteria established by Dirigo Health. The individual must meet other eligibility criteria established by Dirigo Health.

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

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

Sec. A-10. 24-A MRSA §6913, sub-§1, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

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

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

2. Determination of savings offset amount. The board shall determine annually a savings offset amount to be paid by health insurance carriers, employee benefit excess insurance carriers and 3rd-party administrators, not including carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance. The board shall determine the savings offset amount in accordance with the following:

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

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

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

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

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

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

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

B. Maximum savings offset payments are as follows:

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

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

(3) For employee benefit excess insurance carriers, the savings offset payment may not exceed 4.0% of annual paid claims on employee benefit excess insurance policies, as defined in section 707, subsection 1, paragraph C-1, issued pursuant to the laws of this State that insure residents of this State.

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

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

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

F. Savings offset payments must be made quarterly and are due not less than 60 days after the close of the quarter and

with a minimum of 30 days' written notice by Dirigo Health to health insurance carriers, employee benefit excess insurance carriers and 3rd-party administrators and must accrue interest at 12% per annum on or after the due date, except that:

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

(2) Savings offset payments for 3rd-party administrators for groups of 500 or fewer members may be made annually not less than 60 days after the close of the plan year.

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

H. Annual savings offset payments received must be reconciled by Dirigo Health to determine whether unused payments may be returned to health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers according to a formula developed by the board.

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

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

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

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

§6914. Intragovernmental transfer

Starting July 1, 2004, Dirigo Health shall transfer funds, as necessary, to a special dedicated, nonlapsing revenue account administered by the agency of State Government that administers

MaineCare for the purpose of providing a state match for federal Medicaid dollars. Dirigo Health shall annually set the amount of contribution. ~~The transfer may not include money collected as a savings payment offset pursuant to section 6913.~~

PART B

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

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

2. Convening of working group. The Superintendent of Insurance shall convene the first meeting of the working group within 15 days of the effective date of this Act.

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

A. The definition of "subsidy" within the Dirigo Health Program. This recommendation must be made no later than July 15, 2005;

B. The definition of "paid claims" for the purpose of using paid claims as the base for savings offset payment assessments on health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. This recommendation must be made no later than July 15, 2005;

C. The process for implementing and invoicing savings offset payment assessments based on the recommended definition of paid claims. This recommendation must be made no later than August 15, 2005;

D. The board's proposed methodology for calculating aggregate measurable cost savings. This recommendation must be made no later than September 15, 2005; and

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

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

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

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

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

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

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

A. No later than September 15, 2005, the board shall begin the adjudicatory hearing regarding aggregate measurable cost savings, as required by Title 24-A, section 6913, subsection 1;

B. No later than October 30, 2005, the board shall determine aggregate measurable cost savings, as required by Title 24-A, section 6913, subsection 1; and

C. No later than October 30, 2005, the board shall establish the amount of the savings offset payment, as required by Title 24-A, section 6913, subsection 2.

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

PART C

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

2. Contracted services. When a federally qualified health center otherwise meeting the requirements of subsection 1 contracts with a managed care plan or the Dirigo Health Insurance Program for the provision of MaineCare services, the department shall reimburse that center the difference between the payment received by the center from the managed care plan or the Dirigo Health Insurance Program and 100% of the reasonable cost, reduced by the total copayments for which members are responsible, incurred in providing services within the scope of service approved by the federal Health Resources and Services Administration or the commissioner. Any such managed care contract must provide payments for the services of a center that are not less than the level and amount of payment that the managed care plan or the Dirigo Health Insurance Program would

make for services provided by an entity not defined as a federally qualified health center.

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

§3174-DD. Dirigo Health coverage

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

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

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

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

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

§6906. Prohibited interests of board members and employees

Board members and employees of Dirigo Health and their spouses and dependent children may not receive any direct personal benefit from the activities of Dirigo Health in assisting any private entity, except that they may participate in the Dirigo Health Insurance Program on the same terms as others may under this chapter. This section does not prohibit corporations or other entities with which board members are associated by reason of ownership or employment from participating in activities of Dirigo Health or receiving services offered by Dirigo Health as long as the ownership or employment is made known to the board and, if applicable, the

board members abstain from voting on matters relating to that participation.

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

C. Have and exercise all powers necessary or convenient to effect the purposes for which Dirigo Health is organized or to further the activities in which Dirigo Health may lawfully be engaged, including the establishment of the Dirigo Health Insurance Program;

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

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

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

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

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

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

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

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

§6910. Dirigo Health Program

1. Dirigo Health Program. Dirigo Health shall arrange for the provision of health benefits coverage through the Dirigo Health ~~Insurance Program~~ not later than October 1, 2004. The Dirigo Health ~~Insurance Program~~ must comply with all relevant requirements of this Title. Dirigo Health ~~Insurance Program~~ coverage may be offered by health insurance carriers that apply to the board and meet qualifications described in this section and any additional qualifications set by the board.

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

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

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

B. Ensure that:

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

(2) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

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

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

4. Contracting authority. Dirigo Health has contracting authority and powers to administer Dirigo Health Insurance as set out in this subsection.

A. Dirigo Health may contract with health insurance carriers licensed to sell health insurance in this State or other private or public third-party administrators to

provide Dirigo Health Insurance Program coverage. In addition:

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

(2) Dirigo Health may include quality improvement, disease prevention, disease management and cost-containment provisions in the contracts with participating health insurance carriers or may arrange for the provision of such services through contracts with other entities;

(3) Dirigo Health shall require participating health insurance carriers to offer a benefit plan identical to the Dirigo Health Insurance Program, for which no Dirigo Health subsidies are available, in the general small group market;

(4) Dirigo Health shall make payments to participating health insurance carriers under a Dirigo Health Insurance Program contract to provide Dirigo Health Insurance Program benefits to plan enrollees not enrolled in MaineCare;

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

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

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

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by the Dirigo Health Insurance Program for their employees and dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(a) The Dirigo Health Insurance Program for enrolled employees and dependents in contribution amounts determined by the board;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

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

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6912 accordingly. Dirigo Health shall return any payments made by plan enrollees also enrolled in MaineCare to those enrollees.

(6) Dirigo Health shall require participating employers to pass on any subsidy in section 6912 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(7) Dirigo Health may establish other criteria for participation.

(8) Dirigo Health may limit the number of participating employers.

C. Dirigo Health may permit eligible individuals to purchase Dirigo Health Insurance Program coverage for themselves and their dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health may collect payments from eligible individuals participating in the Dirigo Health Insurance Program to cover the cost of:

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

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall reduce the payment amounts for individuals eligible for a subsidy under section 6912 accordingly.

(4) Dirigo Health may require that eligible individuals certify that all their dependents are enrolled in the Dirigo Health Insurance Program or are covered by another creditable plan.

(5) Dirigo Health may require an eligible individual who is currently employed by an eligible employer that does not offer health insurance to certify that the current employer did not provide access to an employer-sponsored benefits plan in the 12-month period immediately preceding the eligible individual's application.

(6) Dirigo Health may limit the number of plan enrollees.

(7) Dirigo Health may establish other criteria for participation.

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

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

B. Dirigo Health shall screen all eligible individuals and employees for eligibility for subsidies under section 6912 and eligibility for MaineCare. To facilitate the screening and referral process, Dirigo Health shall provide a single application form for Dirigo Health and MaineCare. The application materials must inform applicants of subsidies available through Dirigo Health and of the additional coverage available through MaineCare. It must allow an applicant to choose on the application form to apply or not to apply for MaineCare or for a subsidy. It must allow an applicant to provide household financial information necessary to determine eligibility for MaineCare or a subsidy. Except when the applicant has declined to apply for MaineCare or a subsidy, an application must be treated as an application for Dirigo Health, for a subsidy and for MaineCare. MaineCare must make the final determination of eligibility for MaineCare.

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

6. Quality improvement, disease management and cost containment. Dirigo Health shall promote quality improvement, disease prevention, disease management and cost-containment

programs as part of its administration of the Dirigo Health Insurance Program.

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

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

(1) The total enrollment in the Dirigo Health Insurance Program, including the number of enrollees previously underinsured or uninsured, the number of enrollees previously insured, the number of individual enrollees and the number of enrollees enrolled through small employers;

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

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

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

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

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

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

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

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

2. Disease management. Dirigo Health shall develop appropriate disease management protocols, develop procedures for

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

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

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved.'

SUMMARY

This amendment replaces the bill and is the majority report. The amendment adds an emergency preamble and emergency clause. Part A of the amendment does the following.

1. It allows insurers, for the calendar year 2006, to give 30 days' notice of changes in rates to policyholders instead of the 60 days' or 90 days' notice required under current law.

2. It changes the term "Dirigo Health Insurance" to "Dirigo Health Program" and revises the definition accordingly.

3. It specifies the joint standing committee of the Legislature having jurisdiction over insurance matters as the committee of jurisdiction for Dirigo Health.

4. It amends the Dirigo Health Act in several places to bring the law into compliance with federal requirements related to pooling of funds for providing a state match for federal Medicaid dollars.

5. It allows for the pooling of savings offset payment revenue and clearly states that the calculation of the savings offset payment amount is limited to the amount of funds necessary to provide subsidies and to support the Maine Quality Forum, and that the calculation may not include general administrative expenses of Dirigo Health.

6. It changes from premiums to paid claims the assessment base for savings offset payments required from health insurance carriers and employee benefit excess insurance carriers and establishes paid claims as the assessment base for savings offset payments required from 3rd-party administrators.

7. It provides for savings offset payments to apply to claims paid on or after January 1, 2006, 6 months later than in current law, to reflect delays in the implementation of Dirigo Health. It provides an exception to the quarterly savings offset payments for the first 3 months of 2006, during which time monthly savings offset payments, due not less than 60 days after the close of the month, are required for plan years starting during those months. It allows 3rd-party administrators for groups of 500 or fewer members to make savings offset payments annually.

8. It specifies that rules regarding the definition of paid claims for the purpose of savings offset payments are major substantive rules after the first assessment year. During the first assessment year the rules are routine technical as provided in Part B of the amendment.

Part B of the amendment does the following.

1. It establishes a 10-member working group, convened by the Superintendent of Insurance, to advise the Board of Directors of Dirigo Health on certain issues relating to savings offset payments, including the definition of "subsidy," the definition of "paid claims," the methodology for calculating and invoicing paid claims, the board's proposed methodology for calculating aggregate measurable cost savings and a funding strategy for Dirigo Health's administrative expenses. The working group is required to provide monthly reports to the Joint Standing Committee on Insurance and Financial Services.

2. It provides a timeline for the start-up of savings offset payments, including deadlines for the determination of aggregate measurable cost savings and the amount of the savings offset payment.

3. It specifies that Dirigo Health may use the \$53,000,000 in start-up funds it received pursuant to Public Law 2003,

chapter 469 to cover administrative expenses but may not cover those expenses with savings offset payments. It requires the Board of Directors of Dirigo Health, with input from the working group, to make recommendations to the Joint Standing Committee on Insurance and Financial Services regarding how to finance Dirigo Health's administrative expenses and authorizes the committee to report out a bill after reviewing the board's recommendation.

Part C updates the Maine Revised Statutes, Title 24-A, chapter 87 to reflect the change from "Dirigo Health Insurance" to "Dirigo Health Program," as provided in Part A.

Amend the amendment by striking out all of the emergency preamble.

Further amend the amendment in Part A in section 5 by striking out all of subsection 12 and inserting in its place the following:

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

Further amend the amendment in Part A by striking out all of section 10 (page 4, lines 49 to 50 and page 5, lines 2 to 10 in amendment) and inserting in its place the following:

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

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

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

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

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

Further amend the amendment in Part A in section 11 in subsection 3 by striking out all of paragraph H (page 7, lines 23 to 28 in amendment) and inserting in its place the following:

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

Further amend the amendment in Part B in section 1 by striking out all of subsections 2 and 3 (page 8, lines 19 to 48 in amendment) and inserting in their place the following:

'2. Convening of working group; schedule. The Superintendent of Insurance shall convene the first meeting of the working group. In order to complete its work in a timely fashion, the

working group may make its recommendations in accordance with time frames discussed with the Joint Standing Committee on Insurance and Financial Services.

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

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

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

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

D. The board's proposed methodology for calculating aggregate measurable cost savings. This recommendation must be made no later than September 20, 2005; and

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

Further amend the amendment in Part B in section 2 in subsection 2 by striking out all of paragraphs A to C and inserting in their place the following:

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

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

that the aggregate measurable cost savings filed by the board are reasonably supported by the evidence in the record.'

Further amend the amendment by inserting after Part C the following:

'PART D

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

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Bureau of Insurance 0092

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

OTHER SPECIAL REVENUE FUNDS	2005-06	2006-07
All Other	\$50,000	\$50,000
OTHER SPECIAL REVENUE FUNDS TOTAL	<u>\$50,000</u>	<u>\$50,000'</u>

Further amend the amendment by striking out all of the emergency clause.

SUMMARY

This amendment incorporates the changes proposed by House Amendment "A" to Committee Amendment "A" with the following changes:

1. House Amendment "A" to Committee Amendment "A" specifies that, not later than the effective date of the bill, the Board of Directors of Dirigo Health is required to file with the Superintendent of Insurance its determination of the aggregate measurable cost savings. The superintendent is then required to hold a public hearing and issue an order approving or disapproving the filing. This amendment places that requirement in statute, thus making it an ongoing requirement; and

2. Committee Amendment "A" requires Dirigo Health to determine whether unused payments may be returned to insurance carriers. This amendment requires the unused payments to be used to reduce the next savings offset payment charged to health

insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers according to a formula developed by the board.

FISCAL NOTE REQUIRED
(See attached)

**Transcript of
Dirigo Health
BOARD OF DIRECTORS
AUGUST 29, 2005 Board Meeting**

DR. ROBERT MCAFEE: OK, ladies and gentlemen, could we bring the meeting to order? We apologize for being a bit tardy today, and thank you all for being with us for this very significant meeting, the culmination of a great deal of work and effort by many people. To begin, we thank you all for the effort that you've put in to date. It's been an interesting process I understand, and we look forward to getting your recommendations and report. We're going to devote the meeting today to this initiative and discussion of the savings process payment and determination. We have our next scheduled meeting which is the day after Labor Day. We will do the rest of our business at that point. To bring you up to date, the 17th (that's a Saturday) is due date. Our recommendations from your endeavor are due in on the 17th of September. So we will have at least one and possibly two meetings between now and then in order to finalize our recommendations unless there's a uniform agreement at our next meeting. I expect that simply from the complexity of the issue there will be a number of questions that we'd like to formalize and a number of recommendations both broad and narrow, that the board wishes to make and at the same time, some declaration of future activities that we need to anticipate as a board to carry out our fiduciary responsibilities of our job here. Charlene Rydell, I believe is on the speakerphone, Charlene?

CHARLENE RYDELL: Yes, I am.

REBECCA WYKE: Mr. Chairman, I have a question. Was that ever discussed in the working group?

FRANK MCGINTY: When we were bringing forth our proposal to go to charges rather than costs, we did propose that.

REBECCA WYKE: How long ago would that have been?

FRANK MCGINTY: Probably within the last week.

REBECCA WYKE: Would that have been late-breaking, in terms of when it came forth.

FRANK MCGINTY: Well, late breaking in the sense that the discussion didn't start until August 2nd on the savings offset payment. So we've only been discussing it for 3 ½ weeks.

REBECCA WYKE: I have a private insurance, and isn't it true, that I would not pay the charge amount. I would also pay a discounted price based on whatever. So who pays the full charge?

FRANK MCGINTY: People who do not have a party bargaining on their behalf, who has negotiated a contract for less than the full charge. People who have limited means, and qualify for hospital's reduced prices or free care.

REBECCA WYKE: So the vast majority of the people who pay the full charge are people who don't have insurance, or the underinsured. That's basically the bad debt and charity care we've been talking about.

FRANK MCGINTY: Well, if they don't have insurance coverage and they are low income, most hospitals in Maine will provide their care without any expectation of payment.

**Transcript of
DIRIGO HEALTH
BOARD OF DIRECTORS
September 14, 2005 Board Meeting**

ROBERT MCAFEE: For those of you who are HBO fans, this must be like the final episodes of Sopranos. On the other hand I suspect for many of us it will be another season, another opportunity. Let me tell you how we're going to do things today because it's going to be a little bit different than the usual workload. I'm going to make a few statements to begin with, just a couple of housekeeping things I want to bring up to date. We are then inviting each side to present to us, up to 15 minutes, final presentation with the accompanying financial data that we've been waiting for to see. We then are going to start the process of deliberation which will be limited to the board. This includes the voting members of the board and the non-members of the board. The board has an opportunity to question anyone in the room for additional information if they need it today. But, in order to expedite things I'm not going to allow additional presentations unless it is something that is specific to our needs in order to reach our decision. I just want to be mindful of the time and be sure that we get our work done today in order to meet our deadlines for filing. Several of us are committed beyond today to a variety of things that at this point. And then we have some other agency issues that we'll deal with as we finish that we talked about yesterday we need to vote on. And then we'll set a date for that next meeting. We still have an agenda of other things to do that the legislation demands of us and we'll continue to do that up until the date of filing. Let me first explain the absence of Charlene Rydell. I chatted with her late last evening; I've been aware of her medical

health plan, or some other thing so the old fee for service model of the primary care doctor direct impact on access is extremely hard to manage these days.

ROBERT MCAFEE: Questions.

REBECCA WYKE: I do have one question if this is the appropriate time to ask a question of the audience or should we wait for that.

ROBERT MCAFEE: Would their participation be helpful in that?

REBECCA WYKE: We got part of the way yesterday. The question is, yesterday, I did ask the question of who was compensating the group. The answer was the Chamber of Commerce and I did make a call to Dana earlier today ask him if that was something the board had voted on if it was coming out of the Chamber resources or if the Chamber was actually the coordinator. He indicated that it was a coordinator and he did not know who was paying for the services. My understanding is that Kris Ossenfort in a kind of Chinese screen out is coordinating that. So my question is for Kris in the back of the room as to whether or not she's prepared to disclose who's been paying the bills for.

KRISTINE OSSENFORT: (Inaudible)

REBECCA WYKE: I think then I would just state that this is a critical process. There are differences of opinions between the two qualified actuarial groups in terms of where we're headed here. I think the transparency of what is driving that is critical. Not just in terms of the methodology applied but in public service, we often look at where the money comes from and I would urge the Chamber to talk with their partners and to disclose that information to us.

KRISTINE OSSENFORT: It is a group of interested parties including various businesses and employer groups. Beyond that, I'm not sure it really matters and second of all, I would remind the board that we were asked to provide that presentation. We did not seek that opportunity.

REBECCA WYKE: You gave a presentation before the group, but I believe that you had presented information on methodology that you had paid to have developed.

KRISTINE OSSENFORT: We provided you with the methodology developed by the provider's group (inaudible).

UNIDENTIFIED FEMALE: Could I ask for clarification on that, Christine? Are you saying that Payers Group themselves, without the assistance of actuaries, developed the methodology and then hired an actuary firm to come in an present?

KRISTINE OSSENFORT: The price methodology, not the entire analysis of the Mercer Group, but the price methodology was developed by the Payer Group (inaudible) realized the data wasn't available and (inaudible) not involved in the development of measures for the hospital.

REBECCA WYKE: I still think it is a valid question to the extent that you declined to answer it now or in the future. It's your choice, but I still think it's a valid question.

KRISTINE OSSENFORT: I'll be happy to check with people, but if I'd known about this question before this morning.

REBECCA WYKE: Well, that's why I did make a courtesy call to Dana in advance. First of all he explained that there was an arrangement within the Chamber and second of all he explained that under the rules we kind of agreed to operate by that he did not feel comfortable contacting anyone in the working group. Him just saying that, reinforced that I shouldn't contact you, that the proper place for that was in a public forum as we had discussed previously. I apologize for not giving you advanced notice; I did attempt to do that.

DANA CONNORS: Thank you.

CARL LEINONEN: A question or comment – to the issue of funding sources, I do find that a relevant question. Yesterday, we had a member of the audience stand up and challenge the competency of this board to make a decision, claiming there was a conflict of interest because of our relationship to the process. We have a presentation here that we're being asked to consider and give at least equal, if not greater weight to than the presentation given by Mercer and we don't know where that comes from? That does bother me a little bit. And secondly, I'm not sure whether this question should go to Mr. SHEILS or not, or whomever. I was intrigued to find out that the basic methodology was not a product of your group. Do I understand that correctly?

JOHN SHEILS: We did not come and say, you ought to do this.

CARL LEINONEN : That's what I'm trying to get at, ok.

JOHN SHEILS: We talked and we refined it in our discussions but it was not our idea at all. We were just trying to find a way to keep pace with what they wanted us to make.

CARL LEINONEN: So basically, they had a, whoever it was, a group of people, there's nothing wrong with coming up with an idea. That's perfectly reasonable. There's no crime there. They basically asked the actuaries to run with the ball; if we take this concept, what would you get for a result? Is that fair?

JOHN SHEILS: And they asked for our opinion along the way, but yes that's basically the process. We didn't just sit there and just go off and calculate some numbers. We talked to them and made sure we understood what was going on. We learned a lot.

ROBERT MCAFEE: I assume it was actually Frank McGinty's presentation to us and the accompanying material that came with that, the complex formula, etc., that emanated from the group, and then from that you have added your expertise. Is that correct?

JOHN SHEILS: Yes.

ROBERT MCAFEE: Bob, on this issue?

BOB DOWNS: On this issue. I would say (inaudible) Pilgrim Health Care did contribute a small amount of money to this endeavor. I'm not sure why the questions are being asked, but let me give you my opinion on why they are being asked because you think there is some bias here. I would say that we contributed to this because we are concerned about making sure we come up with a methodology that is sustainable and creditable and we thought it was a worthwhile effort to do some analysis on the initiative that was originally proposed by Mercer. I was an alternate on the Work Group, and I was very, very surprised by the work of the Work Group, because when we talked about this

CERTIFICATE OF SERVICE

I, William H. Laubenstein, III, Assistant Attorney General for DIRIGO Health, do hereby certify that on this date the foregoing document was served on all counsel of record via U.S. first class mail, postage prepaid, and electronic mail as follows:

Roy T. Pierce, Esq.
Preti Flaherty Beliveau Pachios & Haley
45 Memorial Circle
P.O. Box 1058
Augusta, ME 04332-1058
rpierce@preti.com

John Kelly, Esq.
Compass Health Analytics, Inc.
465 Congress St., 7th Fl.
Portland, ME 04101
jck@compass-inc.com

William H. Stiles, Esq.
Verrill Dana, LLP
One Portland Square
P.O. Box 586
Portland, ME 04112-0586
wstiles@verrilldana.com

Thomas C. Sturtevant, Jr., AAG
Office of Attorney General
6 State House Station
Augusta, ME 04333-0006
tom.sturtevant@maine.gov

Christopher T. Roach, Esq.
Pierce Atwood, LLP
One Monument Square
Portland, ME 04101
croach@pierceatwood.com

Rufus E. Brown, Esq.
Brown & Burke
85 Exchange Street, Suite 201
P.O. Box 7530
Portland, ME 04112
rbrown@brownburkelaw.com

D. Michael Frink, Esq.
Curtis, Thaxter, Stevens, Broder & Micoleau, LLC
One Canal Plaza
P.O. Box 7320
Portland, ME 04112-7320
dfrink@curtisthaxter.com

Dated: September 30, 2005

/s/William H. Laubenstein, III
William H. Laubenstein, III, Bar No. 1394
Assistant Attorney General
Office of Attorney General
6 State House Station
Augusta, ME 04333-0006
(207) 626-8800