An Act To Reform Dirigo Health

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

Sec. 1. 3 MRSA §522-C is enacted to read:

§ 522-C. Dirigo Health budget review

The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters shall review the budget of Dirigo Health biennially and submit its recommendations in a written report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.

Sec. 2. 3 MRSA §959, sub-§1, ¶B, as amended by PL 2003, c. 600, §1, is further amended to read:

B. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters shall use the following list as a guideline for scheduling reviews:

(1) State Employee Health Commission in 2009; ~~and~~

(2) Department of Professional and Financial Regulation, in conjunction with the joint standing committee of the Legislature having jurisdiction over business and economic development matters, in 2007.; and

(3) Dirigo Health in 2008.

Sec. 3. 22 MRSA §3174-DD, as amended by PL 2005, c. 400, Pt. C, §2, is further amended to read:

§ 3174-DD. Dirigo health coverage

The department may contract with one or more health insurance carriers to purchase Dirigo Health 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 the Dirigo Health Program as a member of an employer group receives full MaineCare benefits through the Dirigo Health 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)~~1396o (2003) and additional coverage provided under contract by the department. The department may not consider the amount of a subsidy received by a MaineCare member enrolled in the Dirigo Health Program as income when determining eligibility for MaineCare.

Sec. 4. 24-A MRSA §2736, sub-§3, ¶B, as amended by PL 2003, c. 469, Pt. E, §9, is further amended to read:

B. The insurer must demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratios of benefits incurred to premiums earned for those products average no less than 80% for the previous 12-month period. ~~For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. 5. 24-A MRSA §2736, sub-§4, ¶C, as amended by PL 2003, c. 469, Pt. E, §10, is further amended to read:

C. In any hearing conducted under this subsection, the Bureau of Insurance and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate~~,~~and not unfairly discriminatory ~~and in compliance with the requirements of section 6913~~ remains with the insurer.

Sec. 6. 24-A MRSA §2736-A, first ¶, as amended by PL 2003, c. 469, Pt. E, §11, is further amended to read:

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate~~,~~and unfairly discriminatory ~~or not in compliance with section 6913~~ or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held.

Sec. 7. 24-A MRSA §2736-C, sub-§2, ¶F, as enacted by PL 2003, c. 469, Pt. E, §12, is repealed.

Sec. 8. 24-A MRSA §2736-C, sub-§5, as amended by PL 2003, c. 469, Pt. E, §13, is further amended to read:

5. Loss ratios. For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. ~~For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. 9. 24-A MRSA §2808-B, sub-§2-A, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C for premium rates effective on or after July 1, 2004~~, except that the filing of rates for small group health plans are not required to account for any savings offset payment or any recovery of that offset payment pursuant to subsection 2-B, paragraph D and section 6913 for rates effective before July 1, 2005~~.

Sec. 10. 24-A MRSA §2808-B, sub-§2-B, ¶A, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

A. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. ~~For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. 11. 24-A MRSA §2808-B, sub-§2-B, ¶D, as enacted by PL 2003, c. 469, Pt. E, §16, is repealed.

Sec. 12. 24-A MRSA §2808-B, sub-§2-B, ¶F, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

F. Any rate hearing conducted with respect to filings that meet the criteria in paragraph E is subject to this paragraph.

(1) A person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(2) If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(3) In any hearing conducted under this paragraph, the bureau and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate~~,~~and not unfairly discriminatory ~~and in compliance with the requirements of section 6913~~ remains with the carrier.

Sec. 13. 24-A MRSA §2839-B, sub-§2, as enacted by PL 2003, c. 469, Pt. E, §17, is amended to read:

2. Annual filing. Every carrier offering group health insurance specified in subsection 1 shall annually file with the superintendent on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board. ~~The filing must also certify that the carrier has included in its experience any savings offset payments or recovery of those savings offset payments consistent with section 6913.~~ The filing also must state the number of

policyholders, certificate holders and dependents, as of the close of the preceding calendar year, enrolled in large group health insurance plans offered by the carrier. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3.

Sec. 14. 24-A MRSA §6904, sub-§1, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

1. Appointments. The board consists of 5 voting members and ~~3 ex officio,~~5 nonvoting members as follows.

A. ~~The~~Of the 5 voting members of the board, 3 members must be appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate, and 2 members must be elected by written ballot of plan enrollees in the Dirigo Health Program.

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

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

(2) The director of the Governor's Office of Health Policy and Finance or the director of a successor agency; and

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

C. Two nonvoting members of the board must be appointed by the Governor to represent labor and consumer advocacy interests, respectively.

Sec. 15. 24-A MRSA §6904, sub-§2, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

2. Qualifications of voting members. Voting members of the board appointed by the Governor:

A. Must have knowledge of and experience in one or more of the following areas:

(1) Health care purchasing;

(2) Health insurance;

~~(3) MaineCare;~~

(4) Health policy and law; or

~~(5) State management and budget; or~~

(6) Health care financing; and

B. Except as provided in this paragraph, may not be:

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

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

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

A nonpracticing health care practitioner, retired or former health care administrator or retired or former employee of a health insurance carrier is not prohibited from being considered for board membership as long as that person is not currently affiliated with a health or health-related organization.

Sec. 16. 24-A MRSA §6904, sub-§4, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

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

Sec. 17. 24-A MRSA §6908, sub-§2, ¶B, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

Sec. 18. 24-A MRSA §6908, sub-§2, ¶C, as amended by PL 2005, c. 400, Pt. C, §6, is further amended to read:

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

Sec. 19. 24-A MRSA §6908, sub-§2, ¶E, as amended by PL 2005, c. 400, Pt. C, §6, is further amended to read:

E. Arrange the provision of Dirigo Health Program benefit coverage to eligible individuals and eligible employees ~~through contracts with one or more qualified bidders~~in accordance with sections 6910 and 6912-A;

Sec. 20. 24-A MRSA §6908, sub-§13, as reallocated by PL 2005, c. 683, Pt. B, §20, is repealed and the following enacted in its place:

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

Sec. 21. 24-A MRSA §6910, sub-§1, as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

1. Dirigo Health Program. Dirigo Health shall arrange for the provision of health benefits coverage through the Dirigo Health Program not later than October 1, 2004. The Dirigo Health Program must comply with all relevant requirements of this Title. Dirigo Health Program coverage may be offered by all health insurance carriers licensed to transact health insurance in this State that ~~apply to the board and~~ meet qualifications described in this section and any additional qualifications set by the board and are approved by the superintendent in accordance with section 6912-A.

Sec. 22. 24-A MRSA §6910, sub-§2, as amended by PL 2005, c. 400, Pt. C, §8, is repealed.

Sec. 23. 24-A MRSA §6910, sub-§3, as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

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

A. Provide ~~the comprehensive health services and benefits~~a health plan comparable to the prototype for a health benefits package under section 6908, subsection 2, paragraph C as ~~determined~~developed by the board~~, including a standard benefit package~~ that meets the requirements for mandated coverage for specific health services,and 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.; and

C. Unless otherwise provided in this chapter, comply with all applicable provisions of this Title, including, but not limited to, sections 2736-C and 2808-B and chapters 36 and 56-A.

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

Sec. 24. 24-A MRSA §6910, sub-§4, as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

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 withshall permit all health insurance carriers licensed to sell health insurance in this State or other private or public third-party administrators to provide Dirigo Health Program coverage. In addition:

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

(2) Dirigo Health may includeshall require a carrier to 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 entitiesDirigo Health Program coverage;

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

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

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

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

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

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

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

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

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

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

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by

employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

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

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

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

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

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

(9) Dirigo Health shall limit participation to employers that have certified that the employer did not provide access to an employer-sponsored benefits plan to its employees in the 6-month period immediately preceding the employer's application.

(10) Notwithstanding section 2849-B, a carrier that provides Dirigo Health Program coverage may impose a preexisting condition exclusion not to exceed 6 months for a plan enrollee, except that a preexisting condition exclusion may not be imposed on a plan enrollee who is a federally eligible individual.

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

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

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

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

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

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

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

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

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

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

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

(8) Dirigo Health shall require an eligible individual to certify that the individual was uninsured for the 6-month period immediately preceding the eligible individual's application.

(9) Notwithstanding section 2849-B, a carrier that provides Dirigo Health Program coverage may impose a preexisting condition exclusion not to exceed 6 months for an eligible individual except that a preexisting condition exclusion may not be imposed on an eligible individual who is a federally eligible individual.

Sec. 25. 24-A MRSA §6912, first ¶, as amended by PL 2005, c. 400, Pt. A, §7, is further amended to read:

Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health Program coverage paid by eligible individuals or employees ~~whose income is under 300% of the federal poverty level~~in accordance with the eligibility requirements in subsection 2. 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~~in accordance with the eligibility requirements in subsection 2.

Sec. 26. 24-A MRSA §6912, sub-§2, as amended by PL 2005, c. 400, Pt. A, §8, is further amended to read:

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

A. Be enrolled in the Dirigo Health Program and covered by a health plan certified pursuant to section 6912-A, have an income under 300% of the federal poverty level and assets that do not exceed 4 times the limits established for MaineCare eligibility and be a resident of the State; 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 and have assets that do not exceed 4 times the limits established for MaineCare eligibility. The health plan must be certified pursuant to section 6912-A and meet any criteria established by Dirigo Health. The individual must meet other eligibility criteria established by Dirigo Health.

Sec. 27. 24-A MRSA §6912, sub-§4, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

4. Limitation on amount subsidized. Dirigo Health may limit the amount subsidized of the payment made by individual plan enrollees under section 6910, subsection 4, paragraph C to 40% of the payment to more closely parallel the subsidy received by employees. In no case may the subsidy granted to eligible individuals in accordance with subsection 2, paragraph A exceed the maximum subsidy level available to other eligible individuals. Dirigo Health shall limit the subsidy to the premium cost for Dirigo Health Program coverage and may not apply a subsidy or discount to deductibles, copayments or other financial contributions required for eligible individuals and employees.

Sec. 28. 24-A MRSA §6912-A is enacted to read:

§ 6912-A. Approval of health insurance plans eligible for subsidies

Upon application of a carrier, the superintendent shall certify to Dirigo Health that an individual or small group health plan offered by the carrier qualifies for a subsidy for the purchase of those health plans because the plan provides a comparable health benefits package developed by Dirigo Health in accordance with section 6908, subsection 2, paragraph C and meets the requirements of section 6910. The superintendent may adopt rules as necessary for the administration of this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 29. 24-A MRSA §6913, as amended by PL 2005, c. 683, Pt. A, §§43 and 44, is repealed.

Sec. 30. 24-A MRSA §6914, as amended by PL 2005, c. 400, Pt. A, §14, is further 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 only for those employees enrolled in the Dirigo Health Program through their employer who are determined eligible for MaineCare. Dirigo Health may not transfer funds for the purpose of providing a state match for federal Medicaid dollars for individuals directly enrolled in MaineCare due to any expansion in MaineCare eligibility. Dirigo Health shall annually set the amount of contribution.

Sec. 31. 24-A MRSA §6915, as amended by PL 2005, c. 386, Pt. D, §3, is further amended to read:

§ 6915. Dirigo Health Enterprise Fund

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals~~, any savings offset payments made pursuant to section 6913~~ and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. 32. 24-A MRSA §6951, first ¶, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within Dirigo Health. The forum is governed by the board with advice from the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded~~, at least in part, through the savings offset payments made pursuant to section 6913~~within the limitations of available funds. Except as provided in section 6907, subsection 2, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties.

Sec. 33. Terms of Board of Directors of Dirigo Health end on September 30, 2007; staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 6904, subsection 3, the terms of office for voting members of the Board of Directors of Dirigo Health who are serving on the board on the effective date of this Act end on September 30, 2007, after which members of the board must be appointed in accordance with Title 24-A, section 6904, subsection 1. The terms of initial members appointed on or after October 1, 2007 must be staggered as follows: The Governor shall appoint one member for a term of one year, one member for a term of 2 years and one member for a term of 3 years; and the 2 members elected by written ballot pursuant to Title 24-A, section 6904, subsection 1 are elected for terms of 3 years.

Sec. 34. Transfer. Notwithstanding any other provision of law, beginning in fiscal year 2007-08 the State Controller shall transfer $15,000,000 at the beginning of each fiscal year from General Fund undedicated revenue to the Dirigo Health Enterprise Fund for the purpose of providing subsidies to eligible individuals and employees enrolled in Dirigo Health Program coverage.

SUMMARY

This bill does the following.

The bill ends the terms of current members of the Board of Directors of Dirigo Health on September 30, 2007 and requires that the terms of new members be staggered. The bill retains the 5-member board but requires that 2 of the 5 members be elected by Dirigo plan enrollees by written ballot. The bill also adds 2 nonvoting members appointed by the Governor to represent labor and consumer advocacy interests.

The bill clarifies that the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters is the committee of jurisdiction over Dirigo Health. The bill requires the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters to review the Dirigo Health budget and make recommendations to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs. The bill also requires that Dirigo Health be subject to review under the State Government Evaluation Act in 2008

The bill provides that all carriers licensed to transact health insurance in this State may offer health insurance plans eligible for subsidy under the Dirigo Health Program if the plan is comparable to the prototype for a health benefits package developed by Dirigo Health and certified by the Superintendent of Insurance.

The bill limits eligibility for Dirigo Health Program coverage to employers and individuals who did not have prior health insurance coverage for 6 months. The bill also requires that Dirigo Health apply an asset limit that is 3 times the limits applied by MaineCare to determine eligibility for subsidies in addition to the requirement that an individual's income be under 300% of the federal poverty level. The bill requires that the subsidies be applied only to the premium cost for Dirigo Health Program coverage.

The bill repeals the savings offset payment as the source of funding for subsidies for the Dirigo Health Program and instead appropriates $15,000,000 from the General Fund to support subsidies. The bill also prohibits any funds collected by Dirigo Health from being used as the state share for an individual directly enrolled in MaineCare.

The bill clarifies that the amount of the subsidy individuals enrolled in Dirigo Health receive is not included as income for the purposes of determining eligibility for MaineCare.

The bill requires an annual transfer from General Fund undedicated revenue to permit subsidies.