PLEASE NOTE: Legislative Information ***cannot*** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

An Act To Amend the Maine Health Data Organization Laws

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

Sec. 1. 22 MRSA §8702, as amended by PL 2005, c. 253, §2, is further amended to read:

§ 8702.Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Board. "Board" means the Board of Directors of the Maine Health Data Organization established pursuant to section 8703.

1-A. Carrier. "Carrier" means an insurance company licensed in accordance with Title 24-A, including a health maintenance organization, a multiple employer welfare arrangement licensed pursuant to Title 24-A, chapter 81, a preferred provider organization, a fraternal benefit society or a nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24. An employer exempted from the applicability of Title 24-A, chapter 56-A under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

2. Clinical data. "Clinical data" includes but is not limited to the data required to be submitted by providers,and payors~~, 3rd-party administrators and carriers that provide only administrative services for a plan sponsor~~ pursuant to sections 8708 and 8711.

3. Financial data. "Financial data" includes but is not limited to financial information required to be submitted pursuant to section 8709.

4. Health care facility. "Health care facility" means a public or private, proprietary or not-for-profit entity or institution providing health services, including, but not limited to, a radiological facility licensed under chapter 160, a health care facility licensed under chapter 405 or certified under chapter 405-A, an independent radiological service center, a federally qualified health center certified by the United States Department of Health and Human Services, Health Resources and Services Administration, a rural health clinic or rehabilitation agency certified or otherwise approved by the Division of Licensing and ~~Certification~~Regulatory Services within the Department of Health and Human Services, a home health care provider licensed under chapter 419, an assisted living program or a residential care facility licensed under chapter 1663, a hospice provider licensed under chapter 1681, a retail store drug outlet licensed under Title 32, chapter 117, a state institution as defined under Title 34-B, chapter 1 and a mental health facility licensed under Title 34-B, chapter 1.

4-A. Health care practitioner. "Health care practitioner" has the meaning provided in Title 24, section 2502, subsection 1-A.

5. Managed care organization. "Managed care organization" means an organization that manages and controls medical services, including but not limited to a health maintenance organization, a preferred provider organization, a competitive medical plan, a managed indemnity insurance program and a nonprofit hospital and medical service organization, licensed in the State.

5-A. Medicare prescription drug sponsor. "Medicare prescription drug sponsor" means a health insurance carrier or other private company authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services to administer Medicare Part C and Part D benefits under a health plan or prescription drug plan.

5-B. Nonlicensed carrier. "Nonlicensed carrier" means a health insurance carrier that is not required to obtain a license in accordance with Title 24-A and pays health care claims on behalf of residents of this State.

6. Organization. "Organization" means the Maine Health Data Organization established under this chapter.

7. Outpatient services. "Outpatient services" means all therapeutic or diagnostic health care services rendered to a person who has not been admitted to a hospital as an inpatient.

8. Payor. "Payor" means a 3rd-party payor ~~or~~, 3rd-party administrator, Medicare prescription drug sponsor, pharmacy benefits manager or nonlicensed carrier.

8-A. Plan sponsor. "Plan sponsor" means any person, other than an insurer, who establishes or maintains a plan covering residents of this State, including, but not limited to, plans established or maintained by 2 or more employers or jointly by one or more employers and one or more employee organizations or the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

8-B. Pharmacy benefits manager. "Pharmacy benefits manager" means an entity that performs pharmacy benefits management as defined in section 2699, paragraph E.

9. Provider. "Provider" means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.

9-A. Quality data. "Quality data" means information on health care quality required to be submitted pursuant to section 8708-A.

10. Restructuring data. "Restructuring data" means reports, charts and information required to be submitted pursuant to section 8710.

10-A. Third-party administrator. "Third-party administrator" means any person who, on behalf of a plan sponsor, health care service plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on, residents of this State.

11. Third-party payor. "Third-party payor" means a health insurer, carrier, including a carrier that provides only administrative services for plan sponsors, nonprofit hospital, medical services organization or managed care organization licensed in the State or the plan established in chapter 854. "Third-party payor" does not include carriers licensed to issue limited benefit health policies or accident, specified disease, vision, disability, long-term care or nursing home care policies.

Sec. 2. 22 MRSA §8703, sub-§2, ¶A, as amended by PL 2005, c. 253, §3, is further amended to read:

A. The Governor shall appoint 18 board members in accordance with the following requirements. Appointments by the Governor are not subject to review or confirmation.

(1) Four members must represent consumers. For the purposes of this section, "consumer" means a person who is not affiliated with or employed by a 3rd-party payor, a provider or an association representing those providers or those 3rd-party payors.

(2) Three members must represent employers. One member must be chosen from a list provided by a health management coalition in this State. One member must be chosen from a list provided by a statewide chamber of commerce.

(3) Two members must represent 3rd-party payors chosen from a list provided by a statewide organization representing 3rd-party payors.

(4) Nine members must represent providers. Two provider members must represent hospitals chosen from a list provided by the Maine Hospital Association. Two provider members must be physicians or representatives of physicians, one chosen from a list provided by the Maine Medical Association and one chosen from a list provided by the Maine Osteopathic Association. One provider member must be a doctor of chiropractic chosen from a list provided by a statewide chiropractic association. One provider member must be a representative, chosen from a list provided by the Maine Primary Care Association, of a federally qualified health center. One provider member must be a pharmacist chosen from a list provided by the Maine Pharmacy Association. One provider member must be a mental health provider chosen from a list provided by the Maine Association of Mental Health Services. One provider member must represent a home health care company.

Sec. 3. 22 MRSA §8704, sub-§3, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

3. Contracts generally. The board may enter into all other contracts necessary or proper to carry out the powers and duties of this chapter, including contracts allowing organization staff to provide technical assistance to other public or private entities, with the proceeds used to offset the operational costs of the organization.

Sec. 4. 22 MRSA §8705-A, sub-§3, ¶A, as enacted by PL 2003, c. 659, §2, is amended to read:

A. When a person or entity that is a health care facility,or payor, 3rd-party administrator or carrier that provides only administrative services for a plan sponsor violates the requirements of this chapter, except for section 8707, that person or entity commits a civil violation for which a fine of not more than $1,000 per day may be adjudged. A fine imposed under this paragraph may not exceed $25,000 for any one occurrence.

Sec. 5. 22 MRSA §8706, sub-§2, ¶C, as amended by PL 2005, c. 565, §7, is further amended to read:

C. The operations of the organization must be supported from 3 sources as provided in this paragraph:

(1) Fees collected pursuant to paragraphs A and B;

(2) Annual assessments of not less than $100 assessed against the following entities licensed under Titles 24 and 24-A: nonprofit hospital and medical service organizations, health insurance carriers and health maintenance organizations on the basis of the total annual health care premium; and 3rd-party administrators ~~and~~, carriers that provide only administrative services for a plan sponsor and pharmacy benefits managers that process and pay claims on the basis of claims processed or paid for each plan sponsor. The assessments are to be determined on an annual basis by the board. Health care policies issued for specified disease, accident, injury, hospital indemnity, disability, long-term care or other limited benefit health insurance policies are not subject to assessment under this subparagraph. For purposes of this subparagraph, policies issued for dental services are not considered to be limited benefit health insurance policies. The total dollar amount of assessments under this subparagraph must equal the assessments under subparagraph (3); and

(3) Annual assessments of not less than $100 assessed by the organization against providers. The assessments are to be determined on an annual basis by the board. The total dollar amount of assessments under this subparagraph must equal the assessments under subparagraph (2).

The aggregate level of annual assessments under subparagraphs (2) and (3) must be an amount sufficient to meet the organization's expenditures authorized in the state budget established under Title 5, chapter 149. The annual assessment may not exceed $1,346,904 in fiscal year 2002-03. In subsequent fiscal years, the annual assessment may increase above $1,346,904 by an amount not to exceed 5% per fiscal year. The board may waive assessments otherwise due under subparagraphs (2) and (3) when a waiver is determined to be in the interests of the organization and the parties to be assessed.

Sec. 6. 22 MRSA §8708, sub-§6-A, as amended by PL 2001, c. 457, §18, is further amended to read:

6-A. Additional data. Subject to the limitations of section 8704, subsection 1, the board may adopt rules requiring the filing of additional clinical data from other providers,and payors~~, 3rd-party administrators and carriers that provide only administrative services for a plan sponsor~~as long as the submission of data to the organization is consistent with federal law. Data filed by payors~~, 3rd-party administrators or carriers that provide administrative services only for a plan sponsor~~ must be provided in a format that does not directly identify the patient.

Sec. 7. 22 MRSA §8711, sub-§1, as amended by PL 2001, c. 457, §19, is further amended to read:

1. Development of health care information systems. In addition to its authority to obtain information to carry out the specific provisions of this chapter, the organization may require providers,and payors~~, 3rd-party administrators and carriers that provide only administrative services for a plan sponsor~~ to furnish information with respect to the nature and quantity of services or coverage provided to the extent necessary to develop proposals for the modification, refinement or expansion of the systems of information disclosure established under this chapter. The organization's authority under this subsection includes the design and implementation of pilot information reporting systems affecting selected categories or representative samples of providers,and payors~~, 3rd-party administrators and carriers that provide only administrative services for a plan sponsor~~.

Effective September 20, 2007