90-590 MAINE HEALTH DATA ORGANIZATION

Chapter 10: DETERMINATION OF ASSESSMENTS

SUMMARY: This Chapter identifies those health care providers, health insurance entities, carriers that provide only administrative services for a plan sponsor, third-party administrators, manufacturers, wholesale drug distributors and pharmacy benefits managers required to pay annual assessments for the operational costs, which include staff salaries, administrative expenses, data system expenses, and consulting fees of the Maine Health Data Organization. This Chapter also establishes the process for determining the individual assessments for each entity and the time frame for payment.

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1. Definitions.

A. **Carrier.** "Carrier" means an insurance company licensed in accordance with 24-A M.R.S., including a health maintenance organization, a multiple employer welfare arrangement licensed pursuant to 24-A M.R.S., chapter 81, a preferred provider organization, a fraternal benefit society, or a nonprofit hospital or medical service organization or health plan licensed pursuant to 24 M.R.S. An employer exempted from the applicability of 24-A M.R.S., 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.

B. **Health Care Claims Processed or Paid.** "Health care claims processed or paid" by third-party administrators or carriers that provide administrative services only do not include claims for specified disease, accident, injury, hospital indemnity, long term care, disability income, or other limited benefits.

C. **Health Care Premiums.** "Health care premiums" means the dollar amount charged for any policies offered by health insurance entities which partially or fully cover the cost of health care services but do not include policies issued for specified disease, accident, injury, hospital indemnity, long term care, disability income, or other limited benefit health insurance policies.

D. **Health Care Provider.** "Health care provider" is a hospital or a non-hospital health care facility. Riverview Psychiatric Center and Dorothea Dix Psychiatric Center are excluded.

E. **Health Insurance Entity.** "Health insurance entity" means a health insurance company, a health maintenance organization, or a nonprofit hospital or medical services organization with greater than $ 500,000 of premiums written per year in Maine that is licensed by the Maine Bureau

of Insurance under 24-A M.R.S. All preferred payor organizations licensed by the Maine Bureau of Insurance under 24-A M.R.S. are excluded.

F. **Hospital.** “Hospital” means any acute care institution required to be licensed pursuant to 22 M.R.S., chapter 405.

G. **Manufacturer.** “Manufacturer” means an entity that manufactures, and sets the wholesale acquisition cost for, prescription drugs that are distributed in the State.

H. **MHDO.** "MHDO" means the Maine Health Data Organization.

I. **M.R.S.** " M.R.S." means Maine Revised Statutes.

J. **Non-Hospital Health Care Facility.** "Non-hospital health care facility" means a public or private, proprietary or not-for-profit entity or institution providing health services licensed or certified under 22 M.R.S., including, but not limited to, a radiological facility licensed under chapter 160, a health care facility licensed under chapter 405, an independent radiological service center, a federally qualified health center certified by the United States Department of Health and Human Services, Health Resources Service Administration, a rural health clinic, or rehabilitative agency, certified, or otherwise approved by the Division of Licensing within the Department of Health and Human Services, a home health care provider licensed under chapter 419, a residential care facility licensed under chapter 1663, a hospice provider licensed under chapter 1681, a state institution as defined under 34-B M.R.S., chapter 1 and a mental health facility licensed under 34-B M.R.S., chapter 1, and a retail store drug outlet licensed under 32 M.R.S., chapter 117.

K. **Pharmacy Benefits Manager (PBM).** "Pharmacy benefits manager (PBM)" means an entity that performs pharmacy benefits management as defined in 24-A M.R.S. §1913.

L. **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, the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

M. **Retail Store Drug Outlet.** "Retail store drug outlet" means any pharmacy located in a retail store in this state which is engaged in dispensing, delivering, or distributing prescription drugs.

N. **Third-Party Administrator.** "Third-party administrator" means any person licensed by the Maine Bureau of Insurance under 24-A M.R.S., chapter 18 and 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 that in aggregate exceeds $500,000 per year in Maine.

O. **Total Net Patient Service Revenue.** "Total net patient service revenue" means gross charges for patient services less contractual adjustments, charity care and bad debt costs as provided in the standardized accounting templates submitted in accordance the requirements of *90-590 CMR, Chapter 300: Uniform Reporting System for Hospital Financial Data.*

P. **Wholesale drug distributor.** “Wholesale drug distributor” means an entity licensed by the State to engage in the sale of prescription drugs, of which it is not the manufacturer, to persons and/or entities other than a consumer or patient.

2. Assessments.

A. **Determination.** Total annual assessments shall be based upon the total annual allocation authorized by the Maine State Legislature for the operational costs of the MHDO as indicated in the biennial budget. The amount to be assessed shall be reduced by the difference between the total annual authorized allocation for the next fiscal year and the beginning fund balance in the account established pursuant to 22 M.R.S. §8706, sub-§6 for the prior fiscal year. Any assessment reduction shall be applied proportionately to the categorical groups assessed and shall be based upon the maximum percentages of the total assessment as described in this section.

Non-hospital health care facilities shall be assessed an aggregate amount that is 11.5% of the total annual authorized allocation and shall be individually assessed in the manner described in subsection B. Third-party administrators and carriers that provide only administrative services for a plan sponsor shall also be assessed an aggregate amount that is 11.5% of the total annual authorized allocation and shall be individually assessed in the manner described in subsection D. The remaining assessment balance shall be divided equally between hospitals and health insurance entities. The assessment share for hospitals and the assessment share for health insurance entities shall each not exceed 38.5% of the total annual authorized allocation. Individual hospitals and health insurance entities shall be assessed in the manner described in subsections C and E, respectively. Annual assessments shall be at least $100 for each individual entity required to pay an assessment under this Chapter.

B. **Non-Hospital Health Care Facilities.** The maximum assessment for each non-hospital health care facility by category is listed below. The specific dollar amount to be assessed for each non-hospital health care facility shall be established from the determination of the relative percentage reduction as described in subsection A. If an individual non-hospital health care facility is licensed or certified under multiple categories, only one assessment shall be imposed and it shall be the per facility assessment with the highest dollar amount.

Non-Hospital Health Care Facility Category	Maximum Per Facility Assessment
End-Stage Renal Disease	$2,500
Federally Qualified Health Center	$150
Freestanding Ambulatory Surgical Center	$2,500
Independent Radiological Service Center	$2,500
Home Health Agency	$150
Mental Health Agency	$150
Portable X-Ray Units	$150
Rehabilitation Agencies	$150
Rural Health Clinic	$150

C. **Hospitals.** Hospitals shall be assessed by establishing the total net patient service revenue for each as a percentage of the total net patient service revenue for all. The individual total net patient service revenue numbers are to be established from the most recently completed fiscal year standardized accounting template for each hospital. The specific dollar amount to be assessed shall be determined by multiplying each percentage by the hospital assessment share as determined in subsection A.

D. **Third-Party Administrators and Carriers that Provide Administrative Services Only for a Plan Sponsor.** Third-party administrators, carriers that provide administrative services only for a plan sponsor, and PBMs that process and pay claims shall be assessed by establishing the total dollar amount of health care claims processed or paid for each as a percentage of the total dollar amount of health care claims processed or paid for all. The total dollar amounts of health care claims processed or paid shall be derived from the most recent annual numbers for all covered

individuals in the State compiled by the Maine Bureau of Insurance with direct verification from the third-party administrators and carriers that provide administrative services only for a plan sponsor and from the MHDO claims database. The specific dollar amount to be assessed shall be determined by multiplying each percentage by the third-party administrators, carriers that provide administrative services only for a plan sponsor, and PBMs that process and pay claims assessment share as determined in subsection A.

E. **Health Insurance Entities.** Health insurance entities shall be assessed by establishing the total dollar amount of health care premiums written for each as a percentage of the total dollar amount of health care premiums written for all. The total dollar amounts of health care premiums written shall be derived from the most recent annual numbers compiled by the Maine Bureau of Insurance with direct verification from the health insurance entities. The specific dollar amount to be assessed shall be determined by multiplying each percentage by the health insurance entity assessment share as determined in subsection A.

F. **Manufacturers, wholesale drug distributors and PBMs.** Each of these entities shall be assessed $500 annually.

3. Submittals and Time Frames.

A. **Health Insurance Entities, Third-Party Administrators, Carriers that Provide Administrative Services Only for a Plan Sponsor, PBMs.** The MHDO shall provide an annual survey for the purpose of determining assessments to all health insurance entities, third-party administrators, carriers that provide administrative services only for a plan sponsor, and PBMs that process and pay claims. These entities shall within 30 days submit completed surveys indicating the volumes of exempted health care premiums or claims processed or paid during the last complete calendar year.

B. **Requests For Payment.** The MHDO shall send annually requests for payments and invoices to all entities identified in Subsections 2B-F.

C. **Assessments Due.** All assessments shall be due to the MHDO within 30 days of receipt of the requests for payment and invoices.

4. Compliance.

Failure to pay an assessment in accordance with the provisions of this Chapter may be considered a violation under 22 M.R.S. §8705-A.

STATUTORY AUTHORITY: 22 M.R.S. §8704, sub-§4, and §8706, sub-§2.

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