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Legislative Document

No. 1397

H.P. 1026

House of Representatives, April 4, 2011

**An Act To Establish a Single-payor Health Care System To Be
Effective in 2017**

Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

A handwritten signature in cursive script that reads "Heather J.R. Priest".

HEATHER J.R. PRIEST
Clerk

Presented by Representative PRIEST of Brunswick.

Cosponsored by Senator GERZOFKY of Cumberland and

Representatives: BEAUDOIN of Biddeford, BERRY of Bowdoinham, BOLAND of Sanford, BRIGGS of Mexico, BRYANT of Windham, CAIN of Orono, CASAVANT of Biddeford, CHAPMAN of Brooksville, CLARK of Millinocket, CLARKE of Bath, CORNELL du HOUX of Brunswick, DION of Portland, DRISCOLL of Westbrook, DUCHESNE of Hudson, EVES of North Berwick, FLEMINGS of Bar Harbor, GILBERT of Jay, GOODE of Bangor, GRAHAM of North Yarmouth, HASKELL of Portland, HAYES of Buckfield, HINCK of Portland, HOGAN of Old Orchard Beach, KENT of Woolwich, KRUGER of Thomaston, KUMIEGA of Deer Isle, LONGSTAFF of Waterville, LOVEJOY of Portland, MacDONALD of Boothbay, MARTIN of Eagle Lake, MAZUREK of Rockland, McCABE of Skowhegan, MITCHELL of the Penobscot Nation, MORRISON of South Portland, PEOPLES of Westbrook, PETERSON of Rumford, PILON of Saco, RANKIN of Hiram, ROCHELO of Biddeford, ROTUNDO of Lewiston, RUSSELL of Portland, SANBORN of Gorham, STUCKEY of Portland, TREAT of Hallowell, TUTTLE of Sanford, WAGNER of Lewiston, WEBSTER of Freeport, WELSH of Rockport, Senators: ALFOND of Cumberland, BLISS of Cumberland, BRANNIGAN of Cumberland, CRAVEN of Androscoggin, JACKSON of Aroostook, PATRICK of Oxford.

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

2 **PART A**

3 **Sec. A-1. 22 MRSA c. 106** is enacted to read:

4 **CHAPTER 106**

5 **ACCESS TO AFFORDABLE HEALTH CARE**

6 **SUBCHAPTER 1**

7 **GENERAL PROVISIONS**

8 **§371. Definitions**

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

11 **1. Agency.** "Agency" means the Maine Health Care Agency established by section
12 375.

13 **2. Council.** "Council" means the Maine Health Care Council established by section
14 377.

15 **3. Fund.** "Fund" means the Maine Health Care Trust Fund established by section
16 374, subsection 1.

17 **4. Global budget.** "Global budget" means a statewide aggregate amount budgeted
18 for the provision of all health care services or for any sector of health care services.

19 **5. Open plan.** "Open plan" means the benefit delivery system for the Maine Health
20 Care Plan that is open to all plan members and all participating providers, as specified in
21 rules adopted pursuant to section 372, subsection 4, paragraph B.

22 **6. Organized delivery system.** "Organized delivery system" means an organization
23 that provides or contracts for a complete range of health care services, as specified in
24 rules adopted pursuant to section 372, subsection 4, paragraph A.

25 **7. Participating provider.** "Participating provider" means a provider approved for
26 the delivery of health care services pursuant to section 372, subsection 4.

27 **8. Plan.** "Plan" means the Maine Health Care Plan established by section 372.

28 **9. Plan card.** "Plan card" means a card to authenticate patient identity, which,
29 consistent with privacy and security standards established by the agency, enables a health
30 care professional or provider to access patient records and facilitate payment for services.

31 **10. Premium.** "Premium" means the required payment by a Maine resident and
32 eligible nonresident into the fund as required by Title 36, chapter 379.

1 11. Provider. "Provider" means any person, organization, corporation or association
2 that provides health care services and is authorized to provide those services under the
3 laws of this State. "Provider" includes persons and entities that provide healing,
4 treatment and care for those relying on a recognized religious method of healing as
5 provided for in the federal Social Security Act, Title XVIII and permitted under state law.

6 12. Resident. "Resident" means a person who resides within the State as defined by
7 rules adopted by the agency pursuant to section 376, subsection 1.

8 SUBCHAPTER 2

9 ENSURING ACCESS TO HEALTH CARE

10 §372. Maine Health Care Plan

11 The Maine Health Care Plan is established to provide security through high-quality,
12 affordable health care for the people of the State. The plan becomes effective and
13 binding upon the approval of a state waiver from the Secretary of the United States
14 Department of Health and Human Services pursuant to Section 1332 of the federal
15 Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the
16 federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The
17 plan must offer health care services no later than 10 months after the plan becomes
18 effective, and the agency shall administer and oversee the plan in accordance with this
19 chapter.

20 1. Goals of Maine Health Care Plan. The plan has the following goals:

21 A. To provide uniform access to health care for every resident of this State;

22 B. To eliminate income-based disparity in the health care status of residents;

23 C. To reduce the rate of growth in the cost of health care services;

24 D. To reduce waste and inefficiency in the administration of health care services and
25 health insurance;

26 E. To increase access to primary and preventive health care services;

27 F. To reduce the number of excessively expensive health care procedures and
28 eliminate unnecessary and harmful procedures;

29 G. To promote cooperation among communities and providers of health care, to
30 eliminate cost-accelerating practices, to coordinate the delivery of care and use of
31 technology and equipment and to increase quality and cost efficiency;

32 H. To distribute the costs of health care fairly and equitably;

33 I. To simplify the health care system for consumers, businesses and providers;

34 J. To ensure providers clinical freedom to treat patients based on health care needs
35 and criteria; and

36 K. To ensure accountability in all aspects of the health care system to promote public
37 confidence and control of costs.

1 **2. Eligibility for Maine Health Care Plan.** In accordance with this subsection,
2 residents and nonresidents are eligible to receive covered health care services from
3 participating providers under the plan within this State if the service is necessary or
4 appropriate for the prevention, diagnosis or treatment of, or maintenance or rehabilitation
5 following, injury, disability or disease. The agency shall adopt rules regarding payment
6 of premiums, application for a plan card and membership in the plan. Rules adopted
7 pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375,
8 subchapter 2-A. The rules must provide for at least the following.

9 A. Each resident of the State is eligible to receive health care under the plan and may
10 enroll in the plan.

11 B. A nonresident of the State who maintains significant contact with the State,
12 including employment or self-employment within the State or attendance at a college,
13 university or other institution of higher education in the State, is eligible to receive
14 health care under the plan. Eligibility extends to a person qualifying under this
15 paragraph and to that person's spouse and dependents. The agency shall adopt rules
16 establishing criteria for eligibility for nonresidents.

17 C. A plan member who ceases to be eligible for the plan may elect, within 60 days of
18 the event that causes ineligibility, to continue participation in the plan for a period of
19 up to 18 months. For the purposes of this paragraph, a plan member is considered to
20 have lost eligibility due to disability if the member could be determined disabled
21 under the federal Social Security Act, Title II or Title XVI. The agency shall ensure
22 that plan members who become ineligible for enrollment in the plan are promptly
23 notified of the provisions of this paragraph. The agency shall adopt rules establishing
24 the premium to be paid by persons eligible under this paragraph and the method of
25 payment.

26 D. To establish eligibility, a person must apply for a plan card, pay to the fund the
27 premium determined applicable pursuant to section 374, subsection 1, paragraph A
28 and satisfy the application requirements established by the agency.

29 **3. Health care benefits.** As provided in this subsection, the plan must provide
30 coverage for health care services from participating providers within this State if those
31 services are necessary or appropriate for the prevention, diagnosis or treatment of, or
32 maintenance or rehabilitation following, injury, disability or disease. The agency shall
33 adopt rules regarding provision of the covered health care services in this subsection:

34 A. Hospital services;

35 B. Medical and other professional services furnished by participating providers;

36 C. Laboratory tests and imaging procedures;

37 D. Home health care for persons requiring services performed by or under the
38 supervision of professional or technical personnel, including, but not limited to, home
39 care for acute illness, personal care attendant services and the medical component of
40 home care for chronic illness. Notwithstanding any other provision of law, the plan
41 may use nominal copayments for permanent care services;

42 E. Rehabilitative services for persons receiving therapeutic care;

1 F. Prescription drugs and devices. Unless the prescribing practitioner certifies that a
2 more expensive drug is medically necessary, the plan may cover only part of the cost
3 of a drug dispensed in a package or form of dosage or administration when the
4 agency determines that a less expensive package or form of dosage or administration
5 is available that is pharmaceutically equivalent in its therapeutic effect. If a plan
6 member chooses to purchase a more expensive drug under this paragraph, the plan
7 member is responsible for paying the amount not covered by the plan;

8 G. Mental health services;

9 H. Substance abuse treatment;

10 I. Primary and acute dental services;

11 J. Vision appliances, including lenses, frames and contact lenses, according to a
12 schedule established by the agency;

13 K. Medical supplies and durable medical equipment and selected assistance devices;

14 L. Hospice care; and

15 M. Health care services payable pursuant to Title 39-A for all employees whose date
16 of injury is on or after the effective date of this section.

17 Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5,
18 chapter 375, subchapter 2-A.

19 **4. Benefit delivery.** Covered health care services must be provided to plan members
20 by the participating providers of their choice through organized delivery systems or the
21 open plan. The delivery of covered health care services to plan members is subject to the
22 provisions of this subsection. The agency shall adopt rules regarding benefit delivery by
23 the plan that include, but are not limited to, the following.

24 A. Organized delivery systems authorized by the agency may provide health care
25 services to plan members.

26 B. The open plan is available to all plan members and to all participating providers.

27 C. The plan must pay for health care services provided to a plan member while the
28 plan member is out of the State. The plan member must have been out of the State
29 temporarily for reasons other than to obtain the health care services, or the plan
30 member must have obtained the health care services out of the State for compelling
31 reasons related to the suitability of the services, the nature of the condition and
32 personal circumstances. The agency shall establish and operate a plan to pay for
33 health care services provided to a plan member while the plan member is out of the
34 State. The payments must be made at the rates established by the agency for
35 comparable services provided by the plan in the State. Charges in excess of the
36 payment rates established in accordance with this paragraph are the responsibility of
37 the plan member.

38 D. The plan must pay cash benefits to a provider of health care services or to a plan
39 member for a reasonable amount charged for medically necessary emergency health
40 care services obtained by a plan member from a provider who is not a participating
41 provider.

1 E. Copayments or deductibles do not apply to health care services provided through
2 the plan, except that, to encourage the use of the most appropriate and cost-effective
3 mode of service, an organized delivery system may require reasonable payments by a
4 plan member if payment is approved by the agency and does not substantially
5 interfere with access to needed health care services.

6 F. Accountability to the public of the open plan and organized delivery systems must
7 be ensured in order to promote public confidence in the health care delivery system
8 and awareness of the costs of care.

9 G. Flexible enrollment and transfer processes that preserve plan member confidence
10 and ensure that health care needs are met must be provided.

11 H. An opportunity for negotiation of fair rates of compensation with participating
12 providers in the open plan and organized delivery systems and negotiation with
13 pharmaceutical companies for similarly classified pharmaceuticals must be provided.

14 I. A program to expand services to underserved rural and low-income communities
15 must be established.

16 J. Mechanisms must be developed to provide incentives to participating providers in
17 the open plan and to organized delivery systems for additional savings that do not
18 compromise the quality of health care.

19 Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5,
20 chapter 375, subchapter 2-A.

21 **5. Provider requirements.** Participating providers, the open plan and organized
22 delivery systems may not charge a plan member or a 3rd party for covered health care
23 services and may not charge rates in excess of the reimbursement levels set by the
24 agency. A participating provider of health care services, the open plan and organized
25 delivery systems may not refuse to provide services to a plan member on the basis of
26 health status, medical condition, previous insurance status, race, color, creed, age,
27 national origin, citizenship status, gender, sexual orientation, disability, marital status or
28 arrest record except as appropriate to the provider's professional specialization or other
29 medically appropriate circumstances.

30 **6. Provision of information by participating providers.** A participating provider
31 shall make information available to the agency and permit examination of its records by
32 the agency as necessary for the purposes of this section and section 374.

33 **7. Organized delivery system requirements.** Organized delivery systems may not
34 have loss ratios that exceed 90% and administrative costs may not exceed 10%.

35 **8. Role of other health care programs.** Until the agency determines otherwise, the
36 plan is supplemental to all coverage available to a plan member from another health care
37 program, including, but not limited to, the Medicare program of the federal Social
38 Security Act, Title XVIII; the Medicaid program of the federal Social Security Act, Title
39 XIX; the Civilian Health and Medical Program of the Uniformed Services, 10 United
40 States Code, Sections 1071 to 1106; the federal Indian Health Care Improvement Act, 25
41 United States Code, Sections 1601 to 1682; the statewide plan provided through the
42 Dirigo Health Program pursuant to Title 24-A, chapter 87; other 3rd-party payors who

1 may be billable for health care services; and any state and local health care programs,
2 including, but not limited to, workers' compensation and employers' liability insurance,
3 pursuant to former Title 39 and Title 39-A. Health care services billed to 3rd-party
4 payors other than the plan must be paid for by those programs, and coverage under the
5 plan is supplemental to that coverage. The plan may require a plan member who receives
6 health care services under another health care program or from a 3rd-party payor to which
7 the plan is supplemental to pay a premium to the fund in proportion to the health care
8 benefits available to the plan member under the plan.

9 **SUBCHAPTER 3**

10 **ENSURING THE QUALITY, AFFORDABILITY AND EFFICIENCY OF**
11 **HEALTH CARE**

12 **§373. Quality; affordability; efficiency; health planning**

13 The agency shall undertake the following duties to ensure the quality, affordability,
14 efficiency and planning of health care for the citizens of the State.

15 **1. Quality of care.** The agency shall establish a quality assurance program and shall
16 adopt rules to implement that program. Rules adopted pursuant to this subsection are
17 routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The program
18 must include, but is not limited to:

19 A. Operation of the plan;

20 B. Use of covered health care services of participating providers and
21 nonparticipating providers;

22 C. Evaluation of the performance of participating providers;

23 D. Standards and continuity of care;

24 E. A plan for increased delivery of preventive and primary care;

25 F. Access to information and data for the agency;

26 G. A plan to ensure that the open plan and organized delivery systems address public
27 health needs;

28 H. Plan member involvement in policy decisions; and

29 I. An efficient complaint resolution process regarding quality of care and utilization
30 and rate controls.

31 **2. Affordability of care.** The agency shall establish an affordability assurance
32 program and adopt rules to implement that program. Rules adopted pursuant to this
33 subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
34 A program must include, but is not limited to:

35 A. Rates of compensation for participating providers in organized delivery systems
36 and in the open plan;

1 B. Rates of payment for durable and nondurable medical devices, supplies and
2 related items;

3 C. Rates of payment for medical tests to detect or evaluate disease and to determine
4 treatment, including, but not limited to, blood tests, computerized tomography scans,
5 DNA testing, electrocardiogram screening, HIV screening, magnetic resonance
6 imaging and positron emission tomography scans and ultrasounds;

7 D. Maintenance of a prescription drug formulary; and

8 E. Cost-containment mechanisms for organized delivery systems and for the open
9 plan. Cost-containment mechanisms may include primary care case management,
10 guaranteed provider payment, variable reimbursement rates for providers, review of
11 treatment and services concurrent with the provision of the treatment and services,
12 expenditure targets, practice parameters and treatment norms.

13 **3. Efficiency of care.** The agency shall establish an efficiency of care program and
14 adopt rules to implement that program. Rules adopted pursuant to this subsection are
15 routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The agency
16 shall review health care malpractice insurance costs and work with organized delivery
17 systems, participating providers and insurers to ensure that the resources of the fund are
18 used for maximum service delivery. The agency shall contract with a 3rd-party
19 administrator located in this State to provide claims handling and data collection services,
20 including, but not limited to, uniform billing procedures to facilitate the exchange of
21 information and communication between the agency and participating providers.

22 **4. Health planning.** The agency shall establish a health planning program and adopt
23 rules to implement that program. Rules adopted pursuant to this subsection are routine
24 technical rules as defined in Title 5, chapter 375, subchapter 2-A. Health planning must
25 be considered in light of the programs on quality, affordability and efficiency established
26 under subsections 1 to 3. The program must include, but is not limited to:

27 A. Global budgets for all expenditures of the plan for the base year of the plan and
28 for each following year based on the level of expenditures in the preceding year as
29 increased by the percentage of increase in the average per capita personal income
30 applicable to the State, as developed by the United States Department of Commerce;

31 B. Global budgets for hospitals and institutional providers with adjustments for case
32 mix, volume and region and separate capital budgets for hospitals and institutional
33 providers;

34 C. A certificate of need program pursuant to chapter 103-A;

35 D. A health planning program; and

36 E. Data collection regarding health care needs, resources and expenditures.

37 **SUBCHAPTER 4**

38 **FINANCING OF THE MAINE HEALTH CARE PLAN**

1 **§374. Financing of Maine Health Care Plan**

2 Financing of the plan is accomplished by the fund.

3 **1. Maine Health Care Trust Fund.** The Maine Health Care Trust Fund is
4 established to finance the plan. Deposits into the fund and expenditures from the fund
5 must be made pursuant to this section and to rules adopted by the agency to carry out the
6 purposes of this section. All income generated pursuant to this chapter must be deposited
7 in the fund, which does not lapse but carries forward from one fiscal year to the next.
8 Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5,
9 chapter 375, subchapter 2-A.

10 A. Payments are deposited into the fund from the following sources:

11 (1) Dedicated premium assessments paid by residents and eligible nonresidents
12 based on adjusted gross income pursuant to Title 36, chapter 379;

13 (2) Payments made by federal, state and local governmental units;

14 (3) Copayments for permanent care made pursuant to section 372, subsection 3,
15 paragraph D; and

16 (4) Other payments made pursuant to law.

17 B. Expenditures from the fund are authorized for the following purposes:

18 (1) One percent of the budget of the fund for health promotion and injury,
19 disease and disability prevention programs;

20 (2) Payments to participating providers for health care services rendered
21 pursuant to section 372, subsection 4;

22 (3) Payments to nonparticipating providers for health care services rendered
23 pursuant to section 372, subsection 4;

24 (4) Payments for capital expenditures approved pursuant to chapter 103-A;

25 (5) Payments for administration of the fund and the plan;

26 (6) Payments for the operations and expenditures of the agency, the council and
27 any advisory committees authorized by law or appointed by the agency; and

28 (7) Other payments made pursuant to law.

29 **2. Requirements for expenditures.** The agency shall adopt rules setting the
30 requirements for expenditures from the fund. Rules adopted pursuant to this subsection
31 are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The agency
32 shall perform quarterly reviews of expenditures within the open plan and organized
33 delivery systems to determine whether the expenditures are within the budget of the
34 agency. The requirements include:

35 A. For organized delivery systems, rates that are based on capitation, that utilize risk
36 adjustment and that are set to reflect whether a region is underserved or has low
37 income and low utilization rates;

1 B. For participating providers in the open plan, rates that are set to reflect costs,
2 volume and relative value of services and that may be based on contracts and
3 capitation;

4 C. For institutional providers and hospitals, rates that are based on global budgets;
5 and

6 D. For rural health centers, as defined in Title 32, section 13702-A, subsection 32,
7 and the system of family planning services, as defined in section 1902, subsection 4,
8 rates that reflect their special missions and needs.

9 **SUBCHAPTER 5**

10 **MAINE HEALTH CARE AGENCY**

11 **§375. Establishment**

12 The Maine Health Care Agency is established as an independent executive agency to:

13 **1. Maine Health Care Plan.** Administer and oversee the Maine Health Care Plan;

14 **2. Maine Health Care Council.** Take action under the direction of the Maine
15 Health Care Council; and

16 **3. Maine Health Care Trust Fund.** Administer and oversee the Maine Health Care
17 Trust Fund.

18 **§376. General powers**

19 In addition to the powers granted to the agency elsewhere in this chapter, the agency
20 is authorized to act as necessary to carry out the purposes of this chapter.

21 **1. Rulemaking.** The agency may adopt, amend and repeal rules as necessary for the
22 proper administration and enforcement of this chapter, subject to the Maine
23 Administrative Procedure Act. Rules adopted pursuant to this subsection are routine
24 technical rules as defined in Title 5, chapter 375, subchapter 2-A.

25 **2. Executive director and staff.** The agency shall employ an executive director,
26 who has experience in the organization, financing or delivery of health care and who shall
27 perform the duties delegated by the agency. The agency may delegate to the executive
28 director any of its functions and duties except the adoption of rules, the establishment of a
29 global budget for health care for the State under section 373, subsection 4. The executive
30 director is an unclassified employee and serves at the pleasure of the council. The
31 executive director, at the direction of the agency, shall hire personnel to administer this
32 chapter, subject to the Civil Service Law and within the budget set by the agency.

33 **3. Receipt of gifts, grants and payments; fees.** The agency may solicit, receive and
34 accept gifts, grants, payments and other funds and advances from any person and enter
35 into agreements with respect to those grants, gifts, payments and other funds and
36 advances, including agreements that involve the undertaking of studies, plans,
37 demonstrations and projects. The agency may charge and retain fees to recover the

1 reasonable costs incurred in reproducing and distributing reports, studies and other
2 publications and in responding to requests for information.

3 **4. Studies and analyses.** The agency may conduct studies and analyses related to
4 the provision of health care, health care costs and matters it considers appropriate.

5 **5. Grants.** The agency may make grants to persons to support research or other
6 activities undertaken in furtherance of the purposes of this chapter. Without the specific
7 written authorization of the agency, a party receiving a grant from the agency may not
8 release, publish or otherwise use results of the research or information made available by
9 the agency.

10 **6. Contracts.** The agency may contract with anyone for services necessary to carry
11 out the activities of the agency. Without the specific written authorization of the agency, a
12 party entering into a contract with the agency may not release, publish or otherwise use
13 information made available to that party under contracted responsibilities.

14 **7. Audits.** To the extent necessary to carry out its responsibilities, the agency,
15 during normal business hours and upon reasonable notification, may audit, examine and
16 inspect any records of any health care provider, organized delivery system or contractor
17 under subsection 6.

18 **8. Data collection and analysis.** The agency shall institute a data collection system
19 to acquire and analyze information on the provision of health care and health care costs.
20 The agency shall coordinate with existing medical information centers that currently
21 provide such services to the State. All data released by the agency must protect the
22 confidentiality of the health care provider and the plan member and, whenever possible,
23 must be released as aggregate data.

24 **9. Complaint resolution.** In cooperation with health care providers and plan
25 members, the agency shall institute a complaint resolution system to handle the
26 complaints of health care providers and plan members.

27 **10. Funding.** The agency shall determine the level of funding required to carry out
28 the purposes of this chapter. The agency shall submit biennially to the Legislature for
29 approval a proposed budget with levels of premiums and assessments under Title 36,
30 section 2897 and taxes under Title 36, section 4365. Funding for the agency budget
31 approved by the Legislature is paid from the fund.

32 **11. Coordination with federal, state and local health care systems.** The agency
33 shall institute a system to coordinate the activities of the agency and the plan with the
34 health care programs of federal, state and municipal governments.

35 **12. Reports.** By March 1st of each year, the agency shall submit to the Governor
36 and the Legislature a report of its operations and activities during the previous year,
37 including its operations and activity with respect to the funding, tax and budget
38 requirements pursuant to subsection 10. This report must include facts and suggestions
39 and policy recommendations that the agency considers necessary. As it determines
40 appropriate, the agency shall publish and disseminate information helpful to the citizens

1 of this State in making informed choices in obtaining health care, including the results of
2 studies or analyses undertaken by the agency.

3 **13. Advisory committees.** The agency may appoint advisory committees to advise
4 and assist the agency. Members of those committees serve without compensation but
5 may be reimbursed by the agency for necessary expenses while on official business of the
6 committee.

7 **14. Headquarters.** The agency's central office must be in the Augusta area, but the
8 agency may hold hearings and sessions at any place in the State.

9 **15. Seal.** The agency may have a seal bearing the words "Maine Health Care
10 Agency."

11 **§377. Maine Health Care Council**

12 The Maine Health Care Council is established as the decision-making and directing
13 council for the agency.

14 **1. Membership.** The council is composed of 5 members who serve full time,
15 appointed by the Governor and, within 30 days after appointment, subject to review by
16 the joint standing committee of the Legislature having jurisdiction over insurance and
17 financial services matters and the joint standing committee of the Legislature having
18 jurisdiction over health and human services matters and to confirmation by the
19 Legislature.

20 Persons eligible for appointment to the council must have experience in the organization,
21 delivery or financing of health care. At least one member of the council must be an
22 individual with experience in the delivery and organization of primary and preventive
23 care and public health services. At least one member of the council must be an individual
24 who is not a health care provider and has not worked for a health care provider or health
25 insurer.

26 **2. Terms.** All appointments are for 5-year terms, except that a member appointed to
27 fill a vacancy in an unexpired term serves only for the remainder of that term. Members
28 hold office until the appointment and confirmation of their successors.

29 **3. Chair; voting.** The Governor shall designate one member of the council as chair.
30 The chair shall preside at meetings of the council, is responsible for the expedient
31 organization of the agency's work and may vote on all matters before the council. Three
32 council members constitute a quorum. The council may take action only by an
33 affirmative vote of at least 3 members.

34 **4. Duties.** The council shall direct, administer and oversee the agency in the
35 performance of its duties under this chapter. The council shall annually prepare a state
36 health plan in accordance with Title 2, chapter 5. The council has broad authority to
37 carry out the purposes of this chapter.

38 **Sec. A-2. Working capital advance.** The State Controller shall transfer a
39 \$600,000 working capital advance to the dedicated account of the Maine Health Care

1 Trust Fund on the effective date of this Part. The Maine Health Care Agency shall repay
2 this working capital advance by June 30, 2018.

3 **Sec. A-3. Initial appointees; staggered terms.** The terms of the members of
4 the Maine Health Care Council, established in the Maine Revised Statutes, Title 22,
5 section 377, subsection 2, are staggered. Of the initial appointees, one must be appointed
6 for 2 years, 2 for 3 years and 2 for 5 years.

7 **Sec. A-4. Effective date.** This Part takes effect January 1, 2017.

8 **PART B**

9 **Sec. B-1. Maine Health Care Plan Transition Advisory Committee.** The
10 Maine Health Care Plan Transition Advisory Committee, referred to in this section as
11 "the committee," is established to advise the members of the Maine Health Care Council
12 as established in the Maine Revised Statutes, Title 22, section 377.

13 **1. Membership.** The committee consists of 20 members, who are appointed as
14 specified in this subsection and are subject to confirmation by the Legislature.

15 Four members must be Legislators. Two of those members must be appointed by the
16 President of the Senate, one from each of the 2 political parties having the largest number
17 of members in the Senate, and 2 must be appointed by the Speaker of the House of
18 Representatives, one from each of the 2 political parties having the largest number of
19 members in the House.

20 Sixteen members must be representatives of the public. Eight of those members must be
21 appointed by the Governor, 4 of those members must be appointed by the President of the
22 Senate and 4 of those members must be appointed by the Speaker of the House of
23 Representatives.

24 The public members must represent statewide organizations from the following groups:
25 consumers, uninsured persons, providers of maternal and child health services, Medicaid
26 recipients, persons with disabilities, persons who are elderly, organized labor, allopathic
27 and osteopathic physicians, nurses and allied health care professionals, organized delivery
28 systems, hospitals, community health centers, the family planning system and the
29 business community, including a representative of small business.

30 The appointing authorities shall notify the Executive Director of the Legislative Council
31 upon making their appointments. All appointments must be made within 30 days of the
32 effective date of this Part. Within the following 30 days, the appointments must be
33 reviewed and approved by a joint committee consisting of the members of the joint
34 standing committee of the Legislature having jurisdiction over insurance and financial
35 services matters and the joint standing committee of the Legislature having jurisdiction
36 over health and human services matters and must be confirmed by the Legislature.

37 When appointment of all members of the committee is completed, the chair of the
38 Legislative Council shall call the committee together for its first meeting. The first
39 meeting must be held within 90 days of the effective date of this Part. The members of
40 the committee shall elect a chair from among the members.

1 1. Prohibited conduct. A person, insurer, health maintenance organization or
2 nonprofit hospital or medical service organization may not sell or offer for sale in this
3 State a health insurance policy or contract or a health care contract or plan that offers
4 benefits that duplicate the health care benefits offered by the Maine Health Care Plan
5 under Title 22, section 372, subsection 3 unless that person, insurer, health maintenance
6 organization or nonprofit hospital or medical service organization has been authorized as
7 an organized delivery system by the Maine Health Care Agency pursuant to Title 22,
8 section 372, subsection 4, paragraph A. A violation of this section constitutes an unfair
9 and deceptive trade practice under section 2152.

10 2. Allowed conduct. A person, insurer, health maintenance organization or
11 nonprofit hospital or medical service organization may sell or offer for sale in the State a
12 health insurance policy or contract or a health care contract or plan that offers coverage
13 and benefits that are supplemental to and do not duplicate covered health care benefits
14 offered by the Maine Health Care Plan under Title 22, section 372, subsection 3.

15 **Sec. D-2. Effective date.** This Part takes effect January 1, 2017.

16 **PART E**

17 **Sec. E-1. Employment retraining.** The Maine Health Care Agency, as
18 established in the Maine Revised Statutes, Title 22, section 375, shall coordinate with the
19 Department of Economic and Community Development, the Department of Labor and
20 private industry councils to ensure that employment retraining services are available for
21 administrative workers employed by insurers and providers who are displaced due to the
22 transition to the Maine Health Care Plan established in Title 22, section 372.

23 **Sec. E-2. Delivery of long-term health care services.** The Maine Health Care
24 Agency, as established in the Maine Revised Statutes, Title 22, section 375, shall study
25 the delivery of long-term health care services to Maine Health Care Plan members under
26 Title 22, chapter 106. The study must address the best and most efficient manner of
27 delivery of health care services to individuals needing long-term care and funding sources
28 for long-term care. In undertaking the study, the agency shall consult with the Maine
29 Health Care Plan Transition Advisory Committee established in Part B of this Act,
30 representatives of consumers and potential consumers of long-term care services,
31 representatives of providers of long-term care services and representatives of employers,
32 employees and the public. The agency shall report to the Legislature on or before
33 January 1, 2018 and may include suggested legislation in the report.

34 **Sec. E-3. Provision of health care services.** The Maine Health Care Agency, as
35 established in the Maine Revised Statutes, Title 22, section 375, shall study the provision
36 of health care services under the MaineCare and Medicare programs. The study must
37 consider the waivers necessary to coordinate the MaineCare and Medicare programs with
38 the Maine Health Care Plan established in Title 22, section 372; the method of
39 coordination of benefit delivery and compensation; reorganization of State Government
40 necessary to achieve the objectives of the agency; and any other changes in law needed to
41 carry out the purposes of Title 22, chapter 106. The agency shall apply for all waivers
42 required to coordinate the benefits of the Maine Health Care Plan and the MaineCare and

1 Medicare programs. The agency shall report to the Legislature on or before March 1,
2 2017 and may include suggested legislation in the report.

3 **Sec. E-4. Effective date.** This Part takes effect January 1, 2017.

4 **PART F**

5 **Sec. F-1. Waiver for state innovation.** The Maine Health Care Agency shall
6 submit a request for waiver to the Secretary of the United States Department of Health
7 and Human Services pursuant to Section 1332 of the federal Patient Protection and
8 Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and
9 Education Reconciliation Act of 2010, Public Law 111-152. The waiver request must be
10 submitted no later than March 1, 2017.

11 **Sec. F-2. Effective date.** This Part takes effect January 1, 2017.

12 **PART G**

13 **Sec. G-1. 1 MRSA §71, sub-§7-B** is enacted to read:

14 **7-B. Payer; payor.** The words "payer" and "payor" may be used interchangeably in
15 the statutes and have the same meaning.

16 **PART H**

17 **Sec. H-1. 36 MRSA c. 379** is enacted to read:

18 **CHAPTER 379**

19 **HEALTH CARE PREMIUM ASSESSMENT**

20 **§2897. Health care premium assessment**

21 **1. Premium assessment established.** Residents of this State and eligible
22 nonresidents as described in Title 22, section 372, subsection 2, paragraph B shall pay
23 premium assessments in accordance with this subsection to the Maine Health Care Trust
24 Fund established in Title 22, section 374, subsection 1 to finance the Maine Health Care
25 Plan established in Title 22, section 372.

26 A. A resident or eligible nonresident shall pay 9% of federal adjusted gross income
27 except those residents or nonresidents with a federal adjusted gross income at or
28 under 300% of the federal poverty level as provided in paragraph B.

29 B. The premium assessment paid by a resident or eligible nonresident with a federal
30 adjusted gross income at or under 300% of the federal poverty level is determined as
31 follows:

32 (1) The premium assessment for an individual with federal adjusted gross
33 income from 300% to 276% of the federal poverty level is 8%;

- 1 (2) The premium assessment for an individual with federal adjusted gross
2 income from 275% to 251% of the federal poverty level is 7%;
- 3 (3) The premium assessment for an individual with federal adjusted gross
4 income from 250% to 226% of the federal poverty level is 6%;
- 5 (4) The premium assessment for an individual with federal adjusted gross
6 income from 225% to 201% of the federal poverty level is 5%;
- 7 (5) The premium assessment for an individual with federal adjusted gross
8 income from 200% to 176% of the federal poverty level is 4%;
- 9 (6) The premium assessment for an individual with federal adjusted gross
10 income from 175% to 151% of the federal poverty level is 3%;
- 11 (7) The premium assessment for an individual with federal adjusted gross
12 income from 150% to 133% of the federal poverty level is 2%; and
- 13 (8) The premium assessment for an individual with federal adjusted gross
14 income at or under 132% of the federal poverty level is zero.

15 **2. Premium adjustment.** The Maine Health Care Agency established in Title 22,
16 section 375 may submit legislation to adjust the premium assessment established in this
17 section if the agency determines the adjustment is necessary to the operation of the Maine
18 Health Care Plan established in Title 22, section 372 in a fiscally responsible manner. A
19 proposal to adjust the premium assessment may not exceed 1% per year and may not
20 exceed 13% of a resident's or eligible nonresident's adjusted gross income.

21 **3. Payment of premium assessment; returns.** Premium assessments are paid in the
22 following manner.

23 A. If a resident or eligible nonresident is employed by an employer in the State, the
24 employer shall deduct the premium assessment from the employee's wages and
25 forward the assessment to the assessor. An employer may pay the premium
26 assessment on behalf of an employee for a period of 5 years after the Maine Health
27 Care Plan becomes effective and treat any amount used for that purpose as a business
28 expense on the employer's tax return.

29 B. An employee may receive employer-sponsored health care coverage for a period
30 of 5 years after the Maine Health Care Plan becomes effective.

31 C. For a resident or eligible nonresident who is not employed by an employer in this
32 State, that resident or eligible nonresident, including a self-employed person, shall
33 submit the premium assessment required under this section and quarterly income
34 statements to the assessor on forms approved by the assessor. The premium
35 assessment and quarterly income statement must be submitted on or before the last
36 day of April, June and October in each calendar year, and the final income statement
37 and premium assessment payment for a calendar year are due on March 15th of the
38 succeeding calendar year. With the approval of the assessor, a resident or eligible
39 nonresident with an annual liability for a premium assessment not exceeding \$500
40 may file an annual income statement with the premium assessment payment on or
41 before March 15th for the prior calendar year.

1 **4. Transfer to Maine Health Care Trust Fund.** The assessor shall transfer
2 premium assessments collected under this section to the Maine Health Care Trust Fund
3 established in Title 22, section 374.

4 **Sec. H-2. Effective date.** This Part takes effect January 1, 2017.

5 SUMMARY

6 This bill establishes a universal access health care system that offers a choice of
7 coverage through organized delivery systems or through a managed care system operated
8 by the Maine Health Care Agency. The system becomes effective January 1, 2017 and is
9 contingent on the approval of a waiver from the United States Department of Health and
10 Human Services in accordance with the federal Patient Protection and Affordable Care
11 Act.

12 1. Part A of the bill does the following.

13 It establishes the Maine Health Care Plan to provide security through high-quality,
14 affordable health care for the people of the State. The plan will become effective and
15 binding on the State upon the approval of a waiver from the United States Department of
16 Health and Human Services. All residents and nonresidents who maintain significant
17 contact with the State are eligible for covered health care services through the Maine
18 Health Care Plan. The plan is funded by the Maine Health Care Trust Fund, a dedicated
19 fund receiving payments from employers, individuals and plan members. The Maine
20 Health Care Plan must conform to the minimum essential benefits required under federal
21 law, but may require additional benefits within existing resources. Health care services
22 under the Maine Health Care Plan are provided by participating providers in organized
23 delivery systems and through the open plan, which is available to all providers. The plan
24 is supplemental to other health care programs that may be available to plan members,
25 such as Medicare, Medicaid, the federal Civilian Health and Medical Program of the
26 Uniformed Services, the federal Indian Health Care Improvement Act and workers'
27 compensation.

28 It establishes the Maine Health Care Agency to administer and oversee the Maine
29 Health Care Plan, to act under the direction of the Maine Health Care Council and to
30 administer and oversee the Maine Health Care Trust Fund. The Maine Health Care
31 Council is the decision-making and directing council for the agency and is composed of 3
32 full-time appointees.

33 It directs the Maine Health Care Agency to establish programs to ensure quality,
34 affordability, efficiency of care and health planning. The agency health planning
35 program includes the establishment of global budgets for health care expenditures for the
36 State and for institutions and hospitals. The health planning program also encompasses
37 the certificate of need responsibilities of the agency pursuant to the Maine Revised
38 Statutes, Title 22, chapter 103-A and the health planning responsibilities pursuant to Title
39 2, chapter 5.

1 It contains a directive to the State Controller to advance \$600,000 to the Maine
2 Health Care Trust Fund on the effective date, January 1, 2017. This amount must be
3 repaid by the Maine Health Care Agency by June 30, 2018.

4 2. Part B of the bill establishes the Maine Health Care Plan Transition Advisory
5 Committee. Composed of 20 members, appointed by the Governor, President of the
6 Senate and Speaker of the House of Representatives and subject to confirmation by the
7 Legislature, the committee is charged with holding public hearings, soliciting public
8 comments and advising the Maine Health Care Agency on the transition from the current
9 health care system to the Maine Health Care Plan. Members of the committee serve
10 without compensation but may be reimbursed for their expenses. The committee is
11 directed to report to the Governor and to the Legislature every 6 months beginning July 1,
12 2017. The committee completes its work when the Maine Health Care Plan becomes
13 effective.

14 3. Part C of the bill establishes the salaries of the members of the Maine Health Care
15 Council and the executive director of the Maine Health Care Agency.

16 4. Part D of the bill prohibits the sale on the commercial market of health insurance
17 policies and contracts that duplicate the coverage provided by the Maine Health Care
18 Plan. It allows the sale of health care policies and contracts that do not duplicate and are
19 supplemental to the coverage of the Maine Health Care Plan.

20 5. Part E of the bill directs the Maine Health Care Agency to ensure employment
21 retraining for administrative workers employed by insurers and providers who are
22 displaced by the transition to the Maine Health Care Plan. It directs the Maine Health
23 Care Agency to study the delivery and financing of long-term care services to plan
24 members. Consultation is required with the Maine Health Care Plan Transition Advisory
25 Committee, representatives of consumers and potential consumers of long-term care
26 services and representatives of providers of long-term care services, employers,
27 employees and the public. A report by the committee to the Legislature is due January 1,
28 2018.

29 The Maine Health Care Agency is directed to study the provision of health care
30 services under the MaineCare, Medicaid and Medicare programs, waivers, coordination
31 of benefit delivery and compensation, reorganization of State Government necessary to
32 accomplish the objectives of the Maine Health Care Agency and legislation needed to
33 carry out the purposes of the bill. The agency is directed to apply for all waivers required
34 to coordinate the benefits of the Maine Health Care Plan and the Medicaid and Medicare
35 programs. A report by the agency is due to the Legislature by March 1, 2017.

36 6. Part F of the bill requires the Maine Health Care Agency to submit a request for a
37 state waiver pursuant to federal law no later than March 1, 2017.

38 7. Part G clarifies that throughout the Maine Revised Statutes, the words "payer" and
39 "payor" have the same meaning.

40 8. Part H establishes a 9% premium assessment on a resident's or eligible
41 nonresident's federal adjusted gross income and dedicates that revenue to the Maine

1 Health Care Trust Fund, except that those persons with federal adjusted gross incomes at
2 or under 300% of the federal poverty level pay progressively lower premium
3 assessments. Part H also defines a process for premium adjustment requests by the
4 agency in order to operate in a fiscally responsible manner.