129th MAINE LEGISLATURE

SECOND REGULAR SESSION-2020

Legislative Document **No. 2110**

S.P. 755 In Senate, February 18, 2020

An Act To Lower Health Care Costs

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 203.

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

DAREK M. GRANT
Secretary of the Senate

Presented by President JACKSON of Aroostook.
Cosponsored by Speaker GIDEON of Freeport and
Senators: BELLOWS of Kennebec, BREEN of Cumberland, CARPENTER of Aroostook, HERBIG of Waldo, LIBBY of Androscoggin, SANBORN, H. of Cumberland, VITELLI of Sagadahoc, Representative: TEPLER of Topsham.

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

Sec. 1. 5 MRSA c. 167, as enacted by PL 2019, c. 471, §1, is repealed.

Sec. 2. 5 MRSA §12004-G, sub-§14-I, as enacted by PL 2019, c. 471, §2, is repealed.

Sec. 3. 5 MRSA §12004-G, sub-§14-J is enacted to read:

14-J.			
Health Care	Maine Commission on Affordable Health Care, Board of Directors	Expenses Only	24-A MRSA §7703

Sec. 4. 22 MRSA §8712, sub-§6, as enacted by PL 2019, c. 471, §3, is amended to read:

6. Data shared with Maine ~~Prescription Drug Affordability Board~~ Commission on Affordable Health Care. The organization may share data collected under this chapter with the Maine ~~Prescription Drug Affordability Board~~ Commission on Affordable Health Care, established under Title ~~5, section 12004-G, subsection 14-I~~ 24-A, chapter 97, as long as any data shared pursuant to this subsection is not further disseminated.

Sec. 5. 24-A MRSA c. 97 is enacted to read:

CHAPTER 97

MAINE COMMISSION ON AFFORDABLE HEALTH CARE

§7701. 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 Commission on Affordable Health Care established in section 7703.

2. Carrier. "Carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance;

B. A health maintenance organization licensed pursuant to chapter 56;

C. A preferred provider arrangement administrator registered pursuant to chapter 32;

D. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; or

E. An employee benefit excess insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance pursuant to section 707, subsection 1, paragraph C-1.

3. Commission. "Commission" means the Maine Commission on Affordable Health Care established in section 7702.

4. Executive director. "Executive director" means the executive director of the commission.

§7702. Maine Commission on Affordable Health Care

The Maine Commission on Affordable Health Care is established as an independent executive agency to oversee the health care delivery and payment system in this State for the purposes set forth in this chapter and as provided in this section. The exercise by the Maine Commission on Affordable Health Care of the powers conferred by this chapter is the performance of essential governmental functions.

1. Purposes. The commission is established to:

A. Set health care cost growth goals for the State;

B. Set health care quality goals for the State;

C. Enhance the transparency of provider organizations;

D. Monitor the adoption of alternative payment methods;

E. Foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care;

F. Monitor and review the impact of changes in the health care market;

G. Protect patient access to necessary health care services;

H. Set health care spending targets for public payors, including separate targets for prescription drug spending; and

I. Serve as a resource for consumers experiencing problems accessing health coverage and to resolve consumer complaints in cooperation with the Consumer Health Care Division within the bureau as provided in section 4321.

§7703. Board of Directors of the Maine Commission on Affordable Health Care

The commission is overseen by a board of directors, as established in Title 5, section 12004-G, subsection 14-J.

1. Appointments. The board consists of 11 members as follows:

A. Nine members of the board appointed as follows, subject to review by the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters and confirmation by the Senate:

(1) Three members appointed by the Governor, including one member as chair with demonstrated expertise in health care delivery, health care management at a

senior level or health care finance and administration, one member with demonstrated expertise in health care finance and administration and one member who is a primary care physician;

(2) Three members appointed by the President of the Senate, including one member who represents a health care consumer advocacy organization, one member who is a health economist and one member who has demonstrated expertise in behavioral health, substance use disorder and mental health services and mental health care reimbursement systems; and

(3) Three members appointed by the Speaker of the House, including one member who represents the health care workforce, one member who is a purchaser of health care representing business management or health benefits administration and one member with demonstrated expertise in innovative medical technologies and treatments for patient care; and

B. Two ex officio members:

(1) The Commissioner of Health and Human Services or the commissioner's designee; and

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

A member of the board may not be employed by, a consultant to, a member of the board of directors of, affiliated with or otherwise a representative of a carrier or other insurer, an agent or broker, a health care provider or a health care facility or health clinic while serving on the board. A member of the board may not be a member, a board member or an employee of a trade association of carriers, health facilities, health clinics or health care providers while serving on the board. A member of the board may not be a health care provider unless the member receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

2. Terms of office. Appointed members of the board serve 5-year terms and may be reappointed. A vacancy for an unexpired term must be filled in accordance with subsection 1, paragraph A or B. A member may serve until a replacement is appointed and qualified.

3. Chair; vice-chair. The Governor shall appoint the chair of the board as provided in subsection 1, paragraph A, subparagraph (1). The board shall annually elect a vice-chair from among its members.

4. Quorum. Six members of the board constitute a quorum.

5. Affirmative vote. An affirmative vote of a majority of the members is required for any action taken by the board.

6. Reimbursement for expenses. Except for the ex officio members, a member of the board is entitled to reimbursement for expenses according to the provisions of Title 5, section 12004-G, subsection 14-J and is eligible for reimbursement whenever that member fulfills any board duties in accordance with board bylaws.

7. Meetings. The board shall meet monthly and may also meet at other times at the call of the chair or the executive director appointed under section 7707. All meetings of the board are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.

§7704. Powers of the Maine Commission on Affordable Health Care

1. Powers. Subject to any limitations contained in this chapter or in any other law, the commission may:

A. Develop a plan of operation;

B. Take any legal actions necessary or proper to recover or collect payments due the commission or that are necessary for the proper administration of the commission;

C. Make and alter bylaws, not inconsistent with this chapter or with the laws of this State, for the administration and regulation of the activities of the commission;

D. Have and exercise all powers necessary or convenient to effect the purposes for which the commission is organized or to further the activities in which the commission may lawfully be engaged;

E. Enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out the purposes of this chapter;

F. Apply for and receive funds, grants or contracts from public and private sources, including a portion of any user fee to support the costs of any state-based marketplace established in accordance with the federal Affordable Care Act;

G. Contract with the Maine Health Data Organization and other organizations with expertise in health care data, including a nonprofit health data processing entity in this State, to assist the commission in the performance of its responsibilities;

H. Acquire, own, hold, dispose of and encumber personal property and lease real property in the exercise of its powers and the performance of its duties;

I. Enter into and execute instruments in connection with agreements or transactions with any federal, state or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association or other entity, including contracts with professional service firms as may be necessary in its judgment, and fix their compensation;

J. Enter into interdepartmental agreements with any other state agencies as the board considers necessary to implement this chapter; and

K. In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried out by one or more organizations organized, created or operated under the laws of this State.

§7705. Limitation on liability

1. Indemnification. A board member or employee of the commission is not subject to personal liability for having acted within the course and scope of membership or employment to carry out any power or duty under this chapter. The commission shall indemnify a board member or an employee of the commission against expenses actually

and necessarily incurred by that member or employee in connection with the defense of an action or proceeding in which that member or employee is made a party by reason of past or present authority.

2. Limitation on liability of board members. The personal liability of a board member is governed by Title 18-B, section 1010.

§7706. Conflicts of interest

The following provisions govern any conflict of interest for a member of the board, a member of the advisory council established pursuant to section 7709 or any staff member or contractor of the board.

1. Consideration of prospective member. When appointing a member of the board or the advisory council established pursuant to section 7709, the appointing authority shall consider any conflict of interest disclosed by the prospective member. A member shall elect to be recused from any board activity in the case in which the member or an immediate family member of the member has a conflict of interest. For the purposes of this subsection, "conflict of interest" means an association, including a financial or personal association, that has the potential to bias or have the appearance of biasing an individual's decisions in matters related to the board or the conduct of the board's activities.

2. Recusal. A member, staff or contractor of the board with a conflict of interest shall elect to be recused. For purposes of this subsection, "conflict of interest" means any instance in which a member, staff or contractor of the board or an immediate family member of the member, staff or contractor of the board has received or could receive either of the following:

A. A direct financial benefit of any amount deriving from the results or findings of a study or determination by or for the board; or

B. A financial benefit from individuals or companies that own or manufacture prescription drugs or health care services or items to be studied by the board that in the aggregate exceeds $5,000 per year. For purposes of this paragraph, "financial benefit" includes honoraria, fees, stock or other financial benefit and the current value of already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study or determination by or for the board.

3. Disclosure. A conflict of interest must be disclosed in the following manner:

A. By the board in the employment of board senior staff;

B. By the Governor, President of the Senate or Speaker of the House of Representatives when appointing members to the board and advisory council established pursuant to section 7709;

C. By the board, describing any recusals as part of any final decision relating to a prescription drug; and

D. By the 5th day after a conflict is identified or, if a public meeting of the board will occur within that 5-day period, in advance of the public meeting.

4. Public disclosure. Conflicts of interest must be publicly posted on the website of the board. The information disclosed must include the type, nature and magnitude of the interests of the individual involved, except to the extent that the individual elects to be recused from participation in any activity with respect to which a potential conflict of interest exists.

5. Gifts. The board, the advisory council established pursuant to section 7709, a member of the board or staff or a contractor of the board may not accept gifts, bequests or donations of services or property that suggest a conflict of interest or have the appearance of creating bias in the work of the board or advisory council. A member of the advisory council established pursuant to section 7709 who accepts a gift, bequest or donation of services or property that suggests a conflict of interest or has the appearance of creating bias in the work of the advisory council shall disclose the gift, bequest or donation publicly.

§7707. Executive director

1. Appointed position. The board shall appoint an executive director, who serves at the pleasure of the board.

2. Duties of executive director. The executive director appointed under subsection 1 shall:

A. Serve as the liaison between the board and the commission and serve as secretary and treasurer to the board;

B. Manage the commission's programs and services;

C. Employ or contract on behalf of the commission for professional and nonprofessional personnel or services. Employees of the commission are subject to the Civil Service Law;

D. Approve all accounts for salaries, per diems and allowable expenses of the commission and of any employee or consultant and expenses incidental to the operation of the commission; and

E. Perform other duties prescribed by the board to carry out the functions of this chapter.

§7708. Records

Except as provided in subsections 1 and 2, information obtained by the commission under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

1. Financial information. Any personally identifiable financial information, supporting data or tax return of any person obtained by the commission under this chapter is confidential and not a public record.

2. Health information. Health information obtained by the commission under this chapter that is covered by the federal Health Insurance Portability and Accountability Act

of 1996, Public Law 104-191 or information covered by chapter 24 or Title 22, section 1711-C is confidential and not a public record.

§7709. Advisory council

1. Advisory council. A 12-member advisory council is established to advise the board on establishing annual spending targets pursuant to section 7711. The advisory council consists of:

A. The Governor or the Governor's designee;

B. The Commissioner of Administrative and Financial Services or the commissioner's designee;

C. The Commissioner of Corrections or the commissioner's designee;

D. The Commissioner of Health and Human Services or the commissioner's designee;

E. The Attorney General or the Attorney General's designee;

F. The executive director of the office of employee health and benefits within the Department of Administrative and Financial Services, Bureau of Human Resources or the executive director's designee;

G. A representative from the Maine Service Employees Association or a successor organization, appointed by the Governor from a list of nominees submitted by the association;

H. A representative from the Maine Education Association or a successor organization, appointed by the Governor from a list of nominees submitted by the association;

I. A representative from the Maine Municipal Association or a successor organization, appointed by the Governor from a list of nominees submitted by the association;

J. A representative from the University of Maine System, appointed by the Governor from a list of nominees submitted by the system;

K. A representative from the Maine Community College System, appointed by the Governor from a list of nominees submitted by the system; and

L. A representative of consumer interests, who serves a 3-year term and is appointed by the Governor.

§7710. Establishment of health care cost growth targets and health care quality targets

1. Public cost trend hearings. In accordance with this subsection and not later than October 1st of every year, the commission shall hold public cost trend hearings based on data provided by the Maine Health Data Organization comparing the growth in total health care expenditures to the health care cost growth benchmark established under subsection 3 for the previous calendar year. The hearings must examine health care provider, provider organization and private and public health care payor costs, prices and

cost trends, with particular attention to factors that contribute to cost growth within the State's health care system.

A. The Attorney General may intervene in hearings under this subsection.

B. The commission shall provide public notice of any hearing under this subsection at least 60 days in advance.

C. The commission shall solicit the participation as witnesses for a public hearing under this subsection of a representative sample of providers, provider organizations, payors and others.

The commission shall solicit testimony from a payor paying providers more than 10% above or more than 10% below the average relative price or entering into alternative payment contracts that vary by more than 10%. A payor that provides testimony shall explain the extent of price variation between the payor's participating providers and describe any efforts to reduce such price variation.

D. Witnesses under paragraph C shall provide testimony under oath and subject to examination and cross-examination by the commission, the executive director and the Attorney General, if the Attorney General has intervened at the public hearing, in a manner and form to be determined by the commission.

E. In the event that the data provided by the Maine Health Data Organization demonstrates that the percentage change in total health care expenditures exceeded the health care cost growth benchmark established under subsection 3 in the previous calendar year, the commission may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross-examination by the commission, the executive director and the Attorney General at the public hearing in a manner and form to be determined by the commission, including, but not limited to:

(1) Testimony concerning unanticipated events that may have affected the total health care cost expenditures, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster;

(2) Testimony concerning trends in the severity or complexity of patient conditions or use of services;

(3) Testimony concerning trends in input cost structures, including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies;

(4) Testimony concerning the cost of providing certain specialty services, including, but not limited to, the provision of health care to children, cancer-related health care and medical education;

(5) Testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts;

(6) Testimony related to costs due to the implementation of state or federal legislation or government regulation; and

(7) Any other factors that may have led to excessive health care cost growth.

2. Annual report. The commission shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report must be based on the commission's analysis of information provided at the hearings by providers, provider organizations and insurers, data from the Maine Health Data Organization and any other information the commission considers necessary to fulfill its duties under this section and any rules adopted by the commission. The report must be submitted to the Governor and the Legislature and must be published and available to the public not later than December 31st of each year, beginning in 2021. The report may include suggested legislation necessary to implement any recommendations contained in the report.

3. Health care cost growth benchmark. Not later than April 15th of every year, beginning in 2021, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the State for the next calendar year. The commission shall establish procedures to prominently publish the annual health care cost growth benchmark on a publicly accessible website maintained by the commission. The commission shall establish the annual health care cost growth benchmark as follows.

A. For calendar year 2021, the health care cost growth benchmark must be equal to the growth rate of potential gross state product as long as the growth rate of potential gross state product for calendar year 2021 is not more than 3.6%.

B. For calendar years 2022 and beyond, the health care cost growth benchmark must be equal to the growth rate of potential gross state product.

C. Prior to making any recommended modification to the health care cost growth benchmark under this subsection, the commission shall hold a public hearing on the recommended modification. The public hearing must be based on the data submitted by the Maine Health Data Organization comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year, any other data provided by the organization and such other pertinent information or data as may be available to the commission. The hearing must examine health care provider, provider organization and private and public health care payor costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the State's health care system, and whether, based on the testimony, information and data, a modification in the health care cost growth benchmark is appropriate. The commission shall provide public notice, including notice to the Legislature, of the hearing at least 45 days prior to the date of the hearing. The commission shall solicit the participation as witnesses for the public hearing of a representative sample of providers, provider organizations, payors and such other interested parties as the commission may determine. Other interested parties may testify at the hearing.

D. A recommendation of the commission to modify the health care cost growth benchmark under this subsection must be approved by a 2/3 vote of the board.

4. Health care entities. The commission shall provide notice to all health care entities that have been identified as exceeding the health care cost growth benchmark for

any given year. The notice must state that, based on the commission's cost growth analysis of individual health care entities, beginning in calendar year 2024, the commission may require certain actions, as established in this section, from health care entities so identified. For the purposes of this section, "health care entity" means a clinic, hospital, ambulatory surgical center, physician organization, accountable care organization or payor; except that a health care entity with a patient panel of 5,000 or fewer or that represents providers who collectively receive less than $10,000,000 in annual net patient service revenue from carriers is exempt.

A. For calendar year 2023, if the commission finds, based on the commission's annual report, the commission's annual cost trend hearings or any other pertinent information, that the average percentage change in cumulative total health care expenditures from 2021 to 2022 exceeded the average health care cost growth benchmark from 2021 to 2022, and in order to support the State's efforts to meet future health care cost growth benchmarks, the commission shall establish procedures to assist health care entities to improve efficiency and reduce cost growth by requiring certain health care entities to file and implement a performance improvement plan.

B. Beginning in calendar year 2024, if the commission finds, based on the commission's annual report, the commission's annual cost trend hearings or any other pertinent information, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, and in order to support the State's efforts to meet future health care cost growth benchmarks, the commission shall establish procedures to assist health care entities to improve efficiency and reduce cost growth by requiring certain health care entities to file and implement a performance improvement plan.

C. In addition to the notice provided under this subsection, the commission may require a health care entity that is identified as exceeding the health care cost growth benchmark established under this section to file a performance improvement plan with the commission. The commission shall provide written notice to the health care entity that it is required to file a performance improvement plan. Within 45 days of receipt of the written notice, the health care entity shall either:

(1) File a performance improvement plan with the commission; or

(2) File an application with the commission to waive or extend the requirement to file a performance improvement plan.

D. The health care entity may file any documentation or supporting evidence with the commission to support the health care entity's application to waive or extend the requirement to file a performance improvement plan under paragraph C. The commission shall require the health care entity to submit any other relevant information it determines necessary in considering the waiver or extension application; the information may be made public at the discretion of the commission.

E. The commission may waive or extend the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under paragraph C in light of all information received from the health care entity, based on consideration of the following factors:

(1) The costs, price and utilization trends of the health care entity over time, and any demonstrated improvement to reduce total medical expenses;

(2) Any ongoing strategies or investments that the health care entity is implementing to improve long-term efficiency and reduce cost growth;

(3) Whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity. Such factors may include, but are not limited to, age and other health status adjusted factors and other cost inputs such as pharmaceutical expenses and medical device expenses;

(4) The overall financial condition of the health care entity;

(5) A significant difference between the growth rate of potential gross state product and the growth rate of actual gross state product; and

(6) Any other factors the commission considers relevant.

F. If the commission declines to waive or extend the requirement for the health care entity to file a performance improvement plan in response to a waiver or extension request filed under paragraph C, the commission shall provide written notice to the health care entity that its application for a waiver or extension was denied, and the health care entity shall file a performance improvement plan.

G. A health care entity shall file a performance improvement plan:

(1) Within 45 days of receipt of a notice under this subsection;

(2) If the health care entity has requested a waiver or extension under paragraph C, within 45 days of receipt of a notice that the waiver or extension has been denied; or

(3) If the health care entity is granted an extension, on the date given on the extension.

The performance improvement plan must be generated by the health care entity and identify the causes of the entity's cost growth and must include, but is not limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve cost performance. The performance improvement plan must include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan may not exceed 18 months.

H. The commission shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable likelihood of successful implementation.

I. If the board determines that the performance improvement plan is unacceptable or incomplete, the commission may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 days, for resubmission; however, all aspects of the performance improvement plan must be proposed by the health care entity and the commission may not require specific elements for approval.

J. Upon approval of a performance improvement plan under paragraph H, the commission shall notify the health care entity to begin immediate implementation of

the performance improvement plan. Public notice that the health care entity is implementing a performance improvement plan must be provided by the commission on its publicly accessible website. A health care entity implementing an approved performance improvement plan is subject to additional reporting requirements and compliance monitoring as determined by the commission. The commission shall provide assistance to the health care entity in the implementation of its performance improvement plan.

K. A health care entity shall, in good faith, work to implement its performance improvement plan. At any point during the implementation of the performance improvement plan the health care entity may file amendments to the performance improvement plan, subject to approval of the commission.

L. At the conclusion of the timetable established in the performance improvement plan under paragraph C, the health care entity shall report to the commission regarding the outcome of the performance improvement plan. If the performance improvement plan was found to be unsuccessful, the commission shall:

(1) Extend the implementation timetable of the performance improvement plan;

(2) Approve amendments to the performance improvement plan as proposed by the health care entity;

(3) Require the health care entity to submit a new performance improvement plan under this subsection; or

(4) Waive or extend the requirement to file any additional performance improvement plans.

M. Upon the successful completion of its performance improvement plan, the identity of the health care entity must be removed from the commission's publicly accessible website.

N. The commission may submit a recommendation for proposed legislation to the joint standing committee of the Legislature having jurisdiction over health care financing matters if the commission determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this chapter, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section.

O. The commission may assess a civil penalty to a health care entity of not more than $500,000 if the commission determines that the health care entity has:

(1) Willfully neglected to file a performance improvement plan with the commission within 45 days as required under paragraph C;

(2) Failed to file an acceptable performance improvement plan in good faith with the commission;

(3) Failed to implement the performance improvement plan in good faith; or

(4) Knowingly failed to provide information required by this section to the commission or knowingly falsified the same.

The commission shall seek to promote compliance with this section and may impose a civil penalty only as a last resort.

5. Health care quality measures and targets. The commission shall develop health care quality measures and targets across all public and private payors in the State beginning in calendar year 2023. In developing the health care quality targets, the commission shall review data from health care providers, health insurance carriers, public payors, the Maine Health Data Organization and national organizations, including a national quality assurance organization and the federal Department of Health and Human Services, Centers for Disease Control and Prevention. The commission shall develop baseline quality measures and targets beginning for calendar year 2023, including targets for emergency department use, opioid overdose deaths and risk factors and cardiovascular health.

§7711. Health care spending and prescription drug spending targets for public payors

1. Health care spending targets; definition. The board has the following powers and duties. The board shall:

A. Beginning with targets for the year 2021 and in consultation with the advisory council established under section 7709, determine annual health care spending targets for public payors based upon a 10-year rolling average of the medical care services component of the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index plus a reasonable percentage for inflation and minus a spending target determined by the board for cost savings including spending targets for prescription drugs as a subset of the overall health care spending targets;

B. Determine spending targets on specific prescription drugs or health care services or procedures that may cause affordability challenges to enrollees in a public payor health plan; and

C. Determine which public payors are likely to exceed the spending targets determined under paragraph A.

For the purposes of this section, "public payor" means any division of state, county or municipal government that administers a health plan for employees of that division of state, county or municipal government or an association of state, county or municipal employers that administers a health plan for its employees, except for the MaineCare program.

2. Health care spending data. The board may consider the following data to accomplish its duties under this section:

A. A public payor's health care spending data, which the 3rd-party administrator or insurer for the public payor's health plan shall provide to the board on behalf of the public payor upon request notwithstanding any provision of law to the contrary, including:

(1) Expenditures and utilization data for health care spending for each plan offered by a public payor including spending for prescription drugs as a subset of the overall health care spending;

(2) Administrative expenses for each health plan offered by a public payor; and

(3) Health plan premiums and enrollee cost sharing for each plan offered by a public payor; and

B. Data compiled by the Maine Health Data Organization under Title 22, chapter 1683.

Health care spending data provided to the board under this subsection is confidential to the same extent it is confidential while in the custody of the entity that provided the data to the board.

3. Recommendations; prescription drug spending. Based upon the prescription drug spending data received under subsection 2, the board, in consultation with a representative of each public payor identified under subsection 1, shall determine methods for the public payor to meet the spending targets established under subsection 1. The board shall determine whether the following methods reduce costs to individuals purchasing prescription drugs through a public payor and allow public payors to meet the spending targets established under subsection 1:

A. Negotiating specific rebate amounts on the prescription drugs that contribute most to spending that exceeds the spending targets;

B. Changing a formulary when sufficient rebates cannot be secured under paragraph A;

C. Changing a formulary with respect to all of the prescription drugs of a manufacturer within a formulary when sufficient rebates cannot be secured under paragraph A;

D. Establishing a common prescription drug formulary for all public payors;

E. Prohibiting health insurance carriers in the State from offering on their formularies a prescription drug or any of the prescription drugs manufactured by a particular manufacturer when the method described in paragraph B or C is implemented;

F. Purchasing prescription drugs in bulk or through a single purchasing agreement for use among public payors;

G. Collaborating with other states and state prescription drug purchasing consortia to purchase prescription drugs in bulk or to jointly negotiate rebates;

H. Allowing health insurance carriers providing coverage to small businesses and individuals in the State to participate in a public payor prescription drug benefit for a fee;

I. Procuring common expert services for public payors, including but not limited to pharmacy benefit management services and actuarial services; and

J. Any other method the board may determine.

4. Recommendations; health care spending. Based upon the health care spending data received under subsection 2, the board shall determine methods for a public payor to meet the health care spending targets established under subsection 1. The board shall determine whether the following methods reduce costs to individuals covered through a public payor and allow public payors to meet the spending targets established under subsection 1 and make recommendations for their use:

A. Changing health plan design among public payors to lower premiums and cost sharing;

B. Establishing a global budget among public payors;

C. Implementing reference-based pricing for use among public payors;

D. Implementing value-based purchasing for use among public payors;

E. Consolidating public payor health plans;

F. Purchasing health care through a single purchasing agreement for use among public payors;

G. Collaborating with other states for the purchase of certain health care services or to jointly negotiate with health care providers;

H. Procuring common expert services for public payors related to the administration of health plans; and

I. Any other method the board may determine.

5. Report. The board shall report its recommendations, including health care and prescription drug spending targets, and the progress of implementing those recommendations to the joint standing committee of the Legislature having jurisdiction over health coverage and insurance matters no later than October 1, 2020 and on January 30th annually thereafter. The joint standing committee may report out legislation based upon the report.

§7712. Rules

The commission may adopt rules as necessary to implement this chapter. Rules adopted in accordance with this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 6. Transition. The following provisions apply to the establishment of the Maine Commission on Affordable Health Care pursuant to the Maine Revised Statutes, Title 24-A, chapter 97.

1. Board appointed. Within 30 days of the effective date of this Act, the Governor, the President of the Senate and the Speaker of the House of Representatives shall post nominations for the appointment of the members of the Board of Directors of the Maine Commission on Affordable Health Care. As soon as practicable after Senate confirmation of board members, the board shall appoint the executive director pursuant to Title 24-A, section 7707.

2. Initial staffing; Bureau of Insurance. Upon request from the Board of Directors of the Maine Commission on Affordable Health Care, the Department of Professional and Financial Regulation, Bureau of Insurance shall provide initial staffing assistance to the commission in the initial phases of its operations until the appointment of the executive director. The executive director of the Maine Commission on Affordable Health Care shall hire staff and contract for services to implement this Act.

Sec. 7. Staggered terms; Board of Directors of the Maine Commission on Affordable Health Care. Notwithstanding the Maine Revised Statutes, Title 24-A, section 7703, subsection 2, of the members initially appointed to the Board of Directors of the Maine Commission on Affordable Health Care, 4 members must be appointed to serve initial terms of 2 years, 3 members must be appointed to serve initial terms of 3 years and 2 members must be appointed to serve initial terms of 4 years.

Sec. 8. Appropriations and allocations. The following appropriations and allocations are made.

MAINE COMMISSION ON AFFORDABLE HEALTH CARE

Maine Commission on Affordable Health Care N340

Initiative: Establishes one Public Service Executive II position and one Comprehensive Health Planner II position starting August 1, 2020.

GENERAL FUND	**2019-20**	**2020-21**
POSITIONS - LEGISLATIVE COUNT	0.000	2.000
Personal Services	$0	$195,345
GENERAL FUND TOTAL	$0	$195,345

SUMMARY

This bill establishes the Maine Commission on Affordable Health Care to monitor health care spending growth in the State and also set health care quality benchmarks. The bill also requires the commission to establish health care spending targets for public payors, including separate targets for prescription drugs.