119th MAINE LEGISLATURE

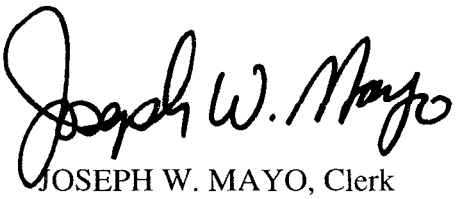
FIRST REGULAR SESSION-1999

Legislative Document **No. 1241**

H.P. 884 House of Representatives, February 11, 1999

An Act to Create a Single-payor System for Universal Health Care.

Reference to the Committee on Banking and Insurance suggested and ordered printed.



JOSEPH W. MAYO, Clerk

Presented by Representative TWOMEY of Biddeford.
Cosponsored by Representatives: AHEARNE of Madawaska, DUPLESSIE of Westbrook, POVICH of Ellsworth, SAXL of Portland, SHIAH of Bowdoinham, SOCTOMAH of the Passamaquoddy Tribe, VOLENIK of Brooklin, Senator: RAND of Cumberland.

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

PART A

Sec. A-1. 22 MRSA c. 1687 is enacted to read:

CHAPTER 1687

THE MAINE HEALTH CARE PLAN

§9801. Definitions

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

1. Administrator. "Administrator" means the entity designated by the board pursuant to section 9807 to administer the Maine Health Care Plan.

2. Authority. "Authority" means the Maine Health Care Authority established by section 9802.

3. Board. "Board" means the board of directors of the Maine Health Care Authority established by section 9802, subsection 1.

4. Carrier "Carrier" means an insurer, health maintenance organization or nonprofit hospital or medical service organization licensed to do business in this State.

5. Fund. "Fund" means the Maine Health Care Trust Fund established by section 9815.

6. Global budget. "Global budget" means a statewide aggregate amount budgeted for the provision of all health care services pursuant to section 9810.

7. Federally sponsored health plan. "Federally sponsored health plan" means health care coverage provided pursuant to federally sponsored programs, including the Medicare program, administered under the United States Social Security Act, Title XVIII; the Medicaid program, administered under the United States Social Security Act, Title V and Title XIX; the civilian health and medical program of the uniformed services; the health and medical program for veterans of the uniformed services; and the Federal Employee Health Benefit Plan.

8. Organization. "Organization" means the Maine Health Data Organization established pursuant to chapter 1683.

9. Participating provider. "Participating provider" means a provider agreeing to deliver health care services under the terms of the health plan as provided in sections 9806 and 9808.

10. Plan. "Plan" means the Maine Health Care Plan established by section 9804.

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

12. Quality improvement foundation. "Quality improvement foundation" means the quality improvement foundation designated by the Maine Health Data Organization pursuant to chapter 1683.

13. Resident. "Resident" means a person who has met the residency requirements as defined by rules adopted by the board pursuant to section 9805.

14. State health resource plan. "State health resource plan" means the state health resource plan adopted by the board pursuant to section 9809.

§9802. Maine Health Care Authority established

The Maine Health Care Authority is established as an independent executive agency. The authority has broad powers to carry out the purposes of this chapter.

1. Board of directors. The authority operates under the supervision of a board of directors that consists of 10 members.

A. Seven members are appointed jointly by the Governor, the President of the Senate and the Speaker of the House of Representatives, subject to review by the joint standing committee of the Legislature having jurisdiction over insurance matters and confirmation by the Legislature, as follows:

(1) Two members must be providers;

(2) Two members must be business representatives; and

(3) Three members must be consumer representatives. For the purposes of this subparagraph, "consumer" means an individual who is not affiliated with or employed by

a 3rd-party payor or provider or an association representing those providers.

B. Three members serve ex officio as follows:

(1) The commissioner or the commissioner's designee;

(2) The Commissioner of Mental Health and Mental Retardation or the commissioner's designee; and

(3) The Director of the State Planning Office or the director's designee.

C. Individuals eligible for appointment to the board must be knowledgeable about the organization, delivery and financing of health care.

D. An individual may not be a board member if that individual or a member of that individual's household is currently employed as or by or is a consultant for, is a member of the board of directors of, is affiliated with, is an agent or a representative of or otherwise has a personal financial interest in a person or entity having a direct financial interest in board decisions distinct from the interest of the general public. Board members may not accept gifts or any other financial gain from any of these persons or entities. Notwithstanding this paragraph, the 2 provider members of the board may negotiate with and contract for payment from the administrator for medical services provided under the plan.

2. Terms of office. The terms of the appointed members are staggered. Of the initial appointees, 2 must be appointed for one year, 2 for 2 years and 3 for 3 years. Two representatives from the same group may not be appointed for coextensive terms. All subsequent appointments are for 3-year terms, except that a member appointed to fill a vacancy in an unexpired term serves only for the remainder of that term. Members hold office until the appointment and confirmation of their successors.

3. Voting; chair. The 7 appointed members of the board may vote on all matters before the board. The 3 ex officio members do not have voting privileges. Four appointed board members constitute a quorum. The board may take action only by an affirmative vote of at least 4 appointed members. The voting members of the board shall elect a chair from among the board members.

4. Powers and duties. The board has the powers and duties regarding operation of the authority set forth in section 9803.

§9803. Powers and duties of the board

In addition to the powers granted to the board elsewhere in this chapter, the board is authorized to act as necessary to carry out the purposes of this chapter, including, but not limited to, the following.

1. Universal access. The board shall establish and maintain a system of universal access to medical care for all residents, as required by this chapter.

2. Administration. The board shall:

A. Solicit bids, negotiate contract terms and enter into contracts with the administrator as provided in section 9807;

B. Ensure that the administrator administers the plan in consistency with the requirements of this chapter;

C. Coordinate its activities with the activities of the administrator to ensure the most efficient and effective use of resources in meeting the requirements of this chapter;

D. Develop a global budget and health resource plan as required in sections 9809 and 9810;

E. Consistent with section 9804, determine the health services covered under the plan. The board may implement cost containment strategies, including, but not limited to, managed care techniques and utilization review;

F. Adopt quality assurance measures as required under section 9811 to monitor and improve the quality of health care delivered in the State;

G. Consistent with section 9805, establish standards and procedures for determining eligibility and enrollment under the plan;

H. Collect data consistent with the requirements of section 9812. To the extent permitted by federal law, the board shall implement standardized claims and reporting methods;

I. Employ an executive director to perform those duties delegated to the executive director by the board. The executive director serves at the pleasure of the board. The executive director may employ other staff as needed to administer the authority, subject to the personnel policies set by the board;

J. Institute a system to coordinate the activities of the authority, the plan and the administrator with the health care programs of the federal, state and municipal governments; and

K. In cooperation with health care providers and plan members, institute a complaint resolution system to handle the complaints of health care providers and plan members.

3. Advisory committees. The board may appoint advisory committees to advise and assist the board. Members of those committees serve without compensation but may be reimbursed by the authority for necessary expenses while on official business of the committee.

4. Fees. The board may charge and retain fees to recover the reasonable costs incurred in reproducing and distributing reports, studies and other publications in responding to requests for information.

5. Studies and analyses. The board may conduct studies and analyses related to the provision of health care, health care costs and other matters it considers appropriate.

6. Contracts. The board may contract with anyone for services necessary to carry out the activities of the authority. Without the specific written authorization of the board, a party entering into a contract with the authority may not release, publish or otherwise use information made available to it under contracted responsibilities.

7. Audits. During normal business hours and upon reasonable notification, the authority may audit, examine and inspect the records of any provider, the administrator or any other contractor to the extent necessary to carry out its responsibilities.

8. Funding. The board shall determine the level of funding required to carry out the purposes of this chapter. It shall submit biennially to the Legislature for approval a proposed budget with levels of assessments and taxes to be collected in the fund. Funding for the authority's budget approved by the Legislature must be paid from the fund.

9. Reports. On or before January 1st of each year, the authority shall submit to the Governor and the Legislature an annual report of its operations and activities during the previous year. The report must include the funding, tax and budget requirements under the global budget for the health plan

established pursuant to section 9810. The report must include facts, suggestions and policy recommendations that the board considers necessary and must report on access to health care under the plan, the economic impact of the plan on the State's gross state product, employment and per capita income and the quality of health care offered under the plan, with comparative statistics from comparable states. The authority may publish and disseminate information helpful to the residents of this State in making informed choices in obtaining health care, including the results of studies or analyses undertaken by the authority.

10. Grants. The board may solicit, receive and accept gifts, grants, payments and other funds and advances from any person and enter into agreements with respect to those gifts, grants, payments and other funds and advances, including agreements that involve the undertaking of studies, plans, demonstrations and projects, except that the board may not accept grants from any person or entity that has a financial interest in the decisions of the board distinct from the interest of the general public.

11. Legal action. The board may sue or be sued, including taking any action necessary for securing legal remedies for, on behalf of or against the authority, any board member or other parties subject to this chapter.

12. Rulemaking. The board may adopt, amend and repeal rules as necessary for the proper administration and enforcement of this chapter. Rules adopted pursuant to this chapter are routine technical rules in accordance with Title 5, chapter 375, subchapter II-A.

13. Other powers. The board may exercise all powers reasonably necessary to carry out the powers granted and responsibilities imposed by this chapter.

§9804. Maine Health Care Plan established

The Maine Health Care Plan is established to provide health benefits to residents of the State as provided under this chapter beginning July 1, 2000.

1. Services covered. If necessary or appropriate for prevention, diagnosis or treatment of or maintenance or rehabilitation following injury, disability or disease, the plan must provide coverage for the following health care services:

A. Inpatient services, including:

(1) Medical, surgical, intensive and emergency care, including organ transplants that improve patient clinical status as measured by medical condition, survival rates and other variables;

(2) Rehabilitation for disease or injury but excluding long-term, inpatient rehabilitation; and

(3) Skilled nursing facility care required for continued recovery after an acute inpatient hospitalization but excluding supportive activities of daily living care;

B. Outpatient and ambulatory services, including coverage of diagnostic, surgical and emergency care and excluding:

(1) Nonemergent emergency room care;

(2) Ambulance services determined not medically necessary; and

(3) Random health screenings for specific conditions for which no risk factors or indicators exist;

C. Professional services at all sites, including all medically necessary professional services delivered by any licensed, certified or registered health care practitioner within the practitioner's legal scope of practice, with the following exclusions:

(1) Speech and occupational therapy for persons 5 years of age or older for chronic conditions;

(2) Physical, occupational and speech therapy for nonacute rehabilitation;

(3) Vision care services other than the treatment of disease or injury;

(4) Counseling and health education services other than those integral to the care of an individual as a result of illness, injury or other health condition;

(5) Chiropractic services provided as nonacute care;

(6) Podiatry services other than the equivalents to those provided by Medicare;

(7) Accredited Christian Science facilities' services other than the equivalents to those provided by Medicare;

(8) Acupuncture services provided as nonacute care; and

(9) Massage therapy services provided as nonacute care;

D. Mental health and substance abuse services, both inpatient and outpatient, including detoxification and rehabilitation;

E. Preventive services as follows:

(1) Preventive medical services for both children and adults in accordance with the United States Task Force on Preventive Services Guidelines, except that screening mammograms must be provided in accordance with the guidelines of the American Cancer Society;

(2) Dental services for persons under 21 years of age, including examinations, cleanings, fluoride treatments, sealants and education at 6-month intervals and radiographs on an annual basis; and

(3) Dental services for persons 21 years of age and older, including examinations, sealants, fluoride treatments, cleaning and education covered on an annual basis;

F. Reproductive services, including coverage of prenatal, delivery and postpartum care, the diagnosis and treatment of sexually transmitted disease and birth control procedures, including sterilization, birth control devices and abortion;

G. Laboratory, radiology and special diagnostic procedures when medically necessary and appropriate, including electromyograms, nerve conduction studies, nuclear medicine procedures, pulmonary function studies and electrophysiology studies;

H. Hospice and palliative care only when medically necessary and appropriate, including medical supplies, drugs and medications, equipment and care for pain control and symptom management in the last 6 months of life;

I. Supplemental services as follows:

(1) Prosthetic devices when medically necessary and appropriate;

(2) Durable medical equipment when medically necessary and appropriate, including rental or purchase of durable medical equipment for therapeutic use, oxygen equipment and hearing aids; and

(3) Medical transportation, as appropriate, to the nearest facility that can render necessary and appropriate emergency medical treatment; and

J. Prescription drugs, including prescription legend drugs, prescribed nonlegend drugs, insulin and diabetic syringes but excluding:

(1) Experimental and investigational drugs unless prescribed as part of an established clinical trial and drugs prescribed as part of that trial that are covered by another financing mechanism; and

(2) Hair growth supplements, smoking deterrent agents, weight control drugs, nonroutine immunization agents, infertility treatments and nonprescription legend vitamins with the exception of those used to supplement the diets of pregnant women.

2. Excluded services. In addition to those exclusions in subsection 1, the following benefits are excluded from coverage under the plan:

A. Experimental diagnostic and treatment services other than those provided as part of an established clinical trial and services provided as part of that trial that are covered by another party;

B. Infertility diagnosis and treatment and reversal of sterilization;

C. Cosmetic surgery except for congenital anomalies and repair of injury resulting from an accident;

D. Nonacute ventilator support provided solely for the purpose of prolonging life;

E. Personal comfort items; and

F. Private rooms, except when medically necessary.

3. Expansion or substitution of covered services. The board may expand benefits beyond those in subsection 1 upon finding that the cost of the benefit is justified based

upon the improvement in patient health resulting from the benefit and finding that there are sufficient funds to cover the cost of providing the additional benefit. The board may substitute any service or benefit not previously covered under the plan for a listed service if the board determines that it is of equivalent therapeutic value or is a less costly treatment alternative to the listed service and that the service or benefit is delivered by a health care practitioner acting within the practitioner's scope of practice. In making a substitution or expansion under this subsection, the board shall consider the impact that the substitution or expansion will have on the public health goals of the Bureau of Health.

4. Delivery of services. Covered health care services must be provided to plan members by participating providers. The delivery of covered health care services to plan members is subject to the provisions of this subsection. The board shall adopt rules regarding benefit delivery by the plan that include but are not limited to the following provisions.

A. An eligible person may choose to receive services under the plan from any participating provider.

B. An eligible person may not be required to meet a deductible or copayment as a condition for receiving health care services covered by the plan that are provided by a participating provider, except that the eligible person may be required to make a copayment in an amount not to exceed $5 for each generic prescription drug and $10 for each nongeneric prescription drug.

C. The plan must cover health care services provided to plan members while they are out of the State. The plan member must have been out of the State temporarily for reasons other than to obtain health care services, or the member must have obtained the health care services out of the State for compelling reasons related to the suitability of the services, the nature of the condition and personal circumstances. The board shall establish and operate a plan to pay for health care services provided to plan members while they are outside the State. The payments must be made at the rates established by the board for comparable services provided by the plan in the State. Charges in excess of the payment rates established in accordance with this paragraph are the responsibility of the plan member. The board may establish rules governing out-of-state referrals, including, but not limited to, requirements for preauthorization.

D. The plan must cover cash benefits paid to a participating provider or to a plan member for a reasonable amount charged for medically necessary emergency health care services obtained by a plan member from a provider who is not a participating provider.

§9805. Eligibility; enrollment

Subject to the provisions of this section, all persons are eligible to receive the benefits specified in section 9804. The board shall adopt rules regarding application for a plan card and membership in the plan. The rules must provide for at least the following.

1. Residency requirement. A person not already covered under a federally sponsored health plan who is a resident of this State for at least one month at the time of enrollment is eligible to receive health care under the plan and may enroll in the plan. A dependent member of an eligible person's household is also eligible.

2. Nonresidents. A person who is not a resident of the State who maintains significant contact with the State, including employment or self-employment within the State or attendance at a college, university or other institution of higher education in the State, is eligible to receive health care under the plan. Eligibility extends to a person qualifying under this subsection and to that person's spouse and dependents. The board shall adopt rules establishing criteria for eligibility for nonresidents and determine the premium to be paid and the method of payment.

3. Continued participation. A plan member who ceases to be eligible for the plan may elect, within 60 days of losing eligibility, to continue participation in the plan for up to 18 months. The board shall ensure that plan members who become ineligible for enrollment in the plan are promptly notified of the provisions of this subsection. The board shall adopt rules establishing the premium to be paid by persons eligible under this subsection and the method of payment.

4. Plan card. To establish eligibility, each person must apply for a plan card and satisfy the application requirements established by the board. The board shall ensure that the applicant is issued a plan card within 30 days of receipt of a completed application or provided a written explanation for denial of the card or any restrictions placed on the applicant's participation. If good cause exists to believe that the applicant does not meet the eligibility requirements in this

section, the board may extend the time period in this section for an additional 30 days.

5. Presumed eligibility. A person is presumed eligible if:

A. The person is unconscious, comatose or otherwise unable because of a physical or mental condition to document eligibility or to act in the person's own behalf;

B. The person is a minor; or

C. The person is involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds.

A participating provider shall provide care to a person presumed eligible as if the person were eligible. In the event that the person does not otherwise meet the eligibility standards established pursuant to this section, the board shall pay that provider for services provided and shall seek reimbursement from the person served.

6. Enrollment. The board shall establish an enrollment procedure to ensure that all eligible persons are aware of their right to health care and are formally enrolled.

§9806. Provider participation

1. Participation; charges. A provider may participate in the plan if the provider is licensed, certified or registered to provide services covered under the plan, has agreed to accept no reimbursement for services offered under the plan other than the reimbursement set pursuant to section 9808 and has agreed to accept other terms of participation established pursuant to section 9808. A participating provider may not charge a plan member or a 3rd-party for covered health services. The provider shall charge persons not eligible for enrollment in the plan at the same reimbursement levels established pursuant to section 9808, except for services reimbursed by federally sponsored health plans other than the Federal Employees Health Benefit Plan.

2. Reimbursement. The board shall ensure that the administrator establishes a reimbursement system to promptly and appropriately reimburse participating providers for services rendered.

3. Association; representation. The board shall recognize professional associations to represent categories of licensed, certified or registered health care professionals in negotiations with the administrator. Pursuant to rules established by the

board, the professional association must be chosen by majority vote of the appropriate category of providers.

4. Discrimination. A participating provider may not refuse to provide services to a plan member on the basis of race, religious creed, color, national origin, ancestry, physical or mental disability, health status, medical condition, marital status, gender, sexual orientation, age, wealth or any other basis prohibited by the laws of this State. This subsection may not be construed to require a provider to perform a particular service if the particular service is outside the provider's scope of practice or if the provider asserts a religious or conscientious objection to providing the particular service.

5. Provision of information by participating provider. A participating provider shall make information available to the board and permit examination of the provider's records by the board as necessary for the purposes of this chapter.

6. Nonparticipating providers. Except as provided in section 9804, providers not participating in the plan may not be reimbursed by the plan.

§9807. Health plan administrator

Pursuant to rules adopted by the board, the board shall solicit bids from companies or nonprofit organizations to act as the administrator for the plan. The board shall select the administrator based on the price and quality of the administrator's proposal, including the administrator's ability to implement the health plan in accordance with the requirements of this chapter. The board may not enter into a contract with the administrator for a term longer than 5 years.

1. Duties. Consistent with the requirements of this chapter, the administrator has the following duties:

A. To administer the health plan for all claims for services covered under the plan;

B. To provide for timely payments to participating providers as required under this chapter;

C. To solicit bids for prescription drug contracts in order to achieve the lowest possible cost for drugs covered under the plan;

D. To negotiate with providers and provider associations to set reimbursement levels and other terms of participation in the plan;

E. When appropriate, to implement reimbursement schedules based upon the federal resource-based, relative-value scale, augmented as necessary to meet the needs of the plan; and

F. To fulfill all other duties delegated to it pursuant to its contract with the authority.

2. Audit. For each year of the contract with the authority, the administrator shall prepare a report on the operations of the administrator, including an annual internal and independent audit and an accounting of all revenues received and disbursed. The administrator shall submit the report to the authority, the Governor, the joint standing committee of the Legislature having jurisdiction over insurance matters and the State Auditor no later than January 15th of each year.

3. Administrative costs. The administrator's administrative budget is a matter of contract negotiated by the authority and the administrator.

§9808. Reimbursement for participating providers

In accordance with this section, the administrator shall impose standards for participation by providers and negotiate with providers to establish reimbursement levels for services provided under the plan.

1. Goals and strategies. Based on the state health resource plan, the global budget and the cost containment and quality assurance goals adopted by the authority, and subject to the board's advice and approval, the administrator shall:

A. Establish sector-wide budgets for appropriate categories of providers;

B. Develop reimbursement strategies to promote desirable utilization and practice patterns;

C. Develop reimbursement strategies to promote access for underserved populations;

D. Develop incentive programs to promote desirable capital expenditures; and

E. Establish standards of quality that must be met by providers wishing to participate in the plan.

2. Negotiation with providers. Negotiations between the administrator and providers are subject to the provisions of this subsection.

A. The administrator shall negotiate with providers or provider associations to determine reimbursement rates for services covered under the plan. As appropriate, the administrator shall use the federal resource-based, relative-value scale as a fee schedule, adjusted as appropriate for the plan. The administrator may not agree to reimburse participating providers at a rate that, based upon projections approved by the authority, would cause health care expenditures to exceed the global budget set by the authority pursuant to section 9810;

B. All professional provider associations may participate in reimbursement negotiations. All providers within a category are bound by the results of the negotiations between the administrator and the association representing that category of provider recognized by the authority pursuant to section 9806; and

C. In the event that negotiations with providers are not concluded in a timely manner, the authority may set rates, fees and prices for services reimbursed under the plan. A provider aggrieved by a rate, fee or price set by the authority pursuant to this subsection, upon the production of credible evidence that the rate, fee or price is confiscatory, is entitled to a hearing as provided under section 9813.

3. Caps on reimbursement. Notwithstanding the provisions of subsection 2, the administrator shall establish a limit on the aggregate annual payment to an individual participating provider. An individual provider whose billing volume or distribution suggests the possibility of impropriety is subject to investigation by the administrator or the board and may be subject to exclusion or other penalties.

4. Prior year expenditures. The administrator shall reduce total reimbursement to participating providers by the amount that the prior year's total expenditures exceeded the global budget or increase total reimbursement to participating providers by the amount that the prior year's total expenditures were less than the global budget. For the purposes of this subsection, "prior year" means the most recent year for which the board can determine total expenditures. The administrator may reduce or increase reimbursement pursuant to this section on a sector-by-sector basis, as appropriate.

§9809. State health resource plan

Before January 15, 2000 and every 2nd year thereafter, the board shall adopt a state health resource plan in accordance with the United States Public Health Services Act. The plan must identify the health care, facility and human resource needs in the State, the resources available to meet those needs and priorities for addressing those needs on a statewide basis.

1. Data; supporting information. In developing the state health resource plan, the board shall use the best and most recent data describing the current supply and distribution of health care, facility and human resources. The board shall consult with relevant state agencies and may establish advisory committees that include consumer groups, health care providers, insurance and health benefit carriers and other 3rd-party payors, as considered necessary to carry out the purposes of this chapter.

2. Plan components. The state health resource plan must include:

A. A statement of principles used in the allocation of resources and in establishing priorities for health services;

B. Identification of the current supply and distribution of hospital, nursing home and other inpatient services; home health and mental health services; treatment services for alcohol and substance abuse; emergency care; ambulatory care services, including primary care resources; human resources; major medical equipment; and health screening and early intervention;

C. A determination of the appropriate supply and distribution of resources and services identified in paragraph B and mechanisms that encourage the appropriate integration of these services on a local or regional basis. In making this determination, the board shall consider the following factors: the needs of the population on a statewide basis; the needs of particular geographic areas of the State; the use of facilities in this State by out-of-state residents; the use of out-of-state facilities by residents of this State; the needs of populations with special health care needs; the desirability of providing high-quality services in an economical and efficient manner, including the appropriate use of mid-level practitioners; and the cost impact of these factors on health care expenditures; and

D. A component that addresses health promotion and disease prevention prepared by the Bureau of Health in a format established by the board.

3. Public hearings. Prior to adopting the state health resource plan, the board shall conduct public hearings in different regions of the State on the proposed state health resource plan. Interested persons must be given the opportunity to submit oral and written testimony. Not less than 30 days before each hearing, the board shall publish in a newspaper of general circulation in the region the time and place of the hearing, the place where interested persons may review the state health resource plan in advance of the hearing and the place to which and period during which written comments may be directed to the board.

4. Funds. The board is authorized to accept and expend federal funds allotted or otherwise made available to states under the United States Public Health Services Act for the purposes of that Act and in accordance with that Act and applicable state laws, rules and fiscal policies or practices.

5. Health workforce forum. The board shall convene at least annually a health workforce forum to discuss health workforce issues. The forum must include representatives from health professionals and health education programs. The forum shall:

A. Develop an inventory of present health workforce and education programs;

B. Develop research and analytical methods for understanding population-based health care needs on an ongoing basis; and

C. Determine the appropriateness of forming a federation of licensing boards to facilitate communication across medical disciplines.

Through the forum, the board shall serve as a clearinghouse for information relating to health workforce issues. The board shall use the information gathered through the forum to form its health policy and planning decisions authorized under this chapter.

§9810. Global budget

Before January 1st of each year, the board shall prepare a global budget for all health care expenditures under the plan. The global budget must include the cost of all services and benefits provided under the plan, administrative costs, data

gathering and other activities and revenue deposited in the fund. The board shall determine an appropriate rate of increase for the global budget based upon the quality of care under the plan, access to care under the plan, the economic impact of the plan on gross state product, employment and per capita income and the projected revenues to be deposited in the fund. Beginning January 1, 2000 and through December 31, 2001, the board shall allow a rate of increase for the global budget not to exceed the rate of increase in the gross state product plus 2 percent.

§9811. High-quality, affordable health care

In coordination with the administrator, the board shall ensure that the health plan members receive high-quality, affordable health services.

1. Quality assurance. The board shall develop methods of quality analysis for analyzing the data to determine the quality and cost-effectiveness of the care provided by participating providers. The board may consult the quality improvement foundation designated by the Maine Health Data Organization pursuant to section 8704, to assist it in this process.

2. Cost containment. In order to control costs and ensure that funds are used for maximum service delivery, to the maximum extent feasible the board shall:

A. Eliminate administrative and other costs that do not contribute to health care;

B. Identify and eliminate wasteful and unnecessary care that is of no benefit to patients receiving that care;

C. Identify and foster those measures that prevent disease and maintain health;

D. Identify and implement managed care techniques that contain costs and improve the quality of care; and

E. Take other steps as necessary to ensure that the rate of increase allowed by the global budget is not exceeded.

§9812. Data collection and monitoring

1. Data collection. The board shall advise and assist the data collection activities of the Maine Health Data Organization under chapter 1683.

2. Analysis of data. The board shall analyze data necessary for the functioning of the plan, including, but not

limited to, the review of access to care; the quality, efficiency and appropriateness of care and services; provider participation; population-based health outcomes; and geographic distribution of health care resources.

3. Standard measurements. In cooperation with the Maine Health Data Organization, the board shall establish a standard set of indicators and methods to be used to assess the effectiveness of the plan in implementing and fulfilling the requirements of this chapter.

§9813. Proceedings generally

1. Actions before the board. Pursuant to this section, a person or entity aggrieved by an act or decision of the administrator or the authority may seek redress before the board. Proceedings before the board are subject to the Maine Administrative Procedure Act and any further rules established by the board consistent with the Maine Administrative Procedure Act. In actions arising under this chapter, the burden of proof is upon the party seeking to set aside any determination, requirement, direction or order of the board.

2. Appeals. A person aggrieved by a final determination of the board may appeal to the Superior Court in accordance with the Maine Administrative Procedure Act.

§9814. Private insurance

1. Duplicate benefits prohibited. A person, insurer, health maintenance organization or nonprofit hospital or medical service organization may not sell or offer for sale in this State a health insurance policy or contract or a health care contract or plan that offers benefits that duplicate the health care benefits offered by the plan. A violation of this section constitutes an unfair and deceptive trade practice under Title 24-A, section 2152.

2. Supplemental benefits authorized. A licensed insurer, health maintenance organization or nonprofit hospital or medical service organization may sell or offer for sale in this State a health insurance policy or contract or a health care contract or plan that offers coverage and benefits that are supplemental to and do not duplicate covered health care benefits offered by the plan.

3. Effective date; application. This section takes effect on July 1, 2000 and applies to all policies, contracts and plans executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2000. For purposes of this

section, all policies, contracts and plans are deemed renewed no later than the next yearly anniversary of the contract date.

4. Other insurance types authorized. This chapter may not be construed to prohibit the following types of insurance: accident, disability, credit, long-term care or nursing home care, Medicare supplement, specified disease, vision, coverage issued as a supplement to liability insurance, workers' compensation, automobile medical payment or insurance under which benefits are payable with or without regard to fault and that is required by statute to be contained in any liability insurance policy or equivalent self-insurance.

5. Persons not covered by plan. This chapter may not be construed to prohibit the sale of insurance to persons not covered by the plan.

§9815. Maine Health Care Trust Fund

1. Establishment of the fund. The Maine Health Care Trust Fund is established to finance the plan pursuant to this chapter. Deposits to the fund must be made pursuant to this section and to rules adopted by the board to carry out the purposes of this chapter. All money in the fund is commingled and undivided. The fund consists of:

A. All payments collected under this section;

B. Interest earned upon any money in the fund;

C. Property or securities acquired through the use of money belonging to the fund and all earnings of the property or securities; and

D. All other money received for the fund from any other source.

The fund does not lapse but carries forward from one fiscal year to the next.

2. Use of the fund. All revenue paid into the fund is available to the board and must be expended solely for the purpose of defraying the cost of administering the plan, including, but not limited to, payments to the administrator for administering the plan. The board shall adopt rules setting the requirements for expenditures from the fund. The board shall perform quarterly reviews of expenditures within the plan to determine whether expenditures are within the global budget.

3. Payment to the fund. Payments are deposited to the fund from the following sources:

A. Payments equal to 9.14% of the state liquor tax collected pursuant to Title 28-A, section 1651;

B. Payments equal to 50% of the excise tax on malt liquor, low-alcohol spirit products, fortified wines and wine collected pursuant to Title 28-A, section 1652;

C. Payments of the sales tax collected pursuant to Title 36, section 1811, as follows:

(1) An amount equal to 34.88% of the sales tax on the value of liquor sold in licensed establishments;

(2) An amount equal to 28.2% of the sales tax on the value of rental of living quarters in a hotel, rooming house or tourist or trailer camp;

(3) An amount equal to 23.03% of the sales tax collected on the value of rental for a period of less than one year of an automobile;

(4) An amount equal to 24.8% of the sales tax collected on the value of prepared food sold in establishments that are licensed for on-premises consumption of liquor; and

(5) An amount equal to 38.46% of the sales tax on the value of the all other tangible personal property and taxable services;

D. Payment equal to 65% of the personal income tax collected pursuant to Title 36, section 5111; and

E. Payment equal to 30% of the corporate income tax collected pursuant to Title 36, section 5200.

Sec. A-2. Effective date. Unless otherwise indicated, this Part takes effect January 1, 2000.

PART B

Sec. B-1. Waivers for Medicaid and Medicare. The Department of Human Services and the Maine Health Care Authority shall conduct a joint study of the provision of health care services under the Medicaid and Medicare programs to determine the best method of coordinating benefit delivery and compensation under

those programs and the reorganization of State Government necessary to achieve the objectives of the authority, and any other changes in law needed to carry out the purposes of the Maine Revised Statutes, Title 22, chapter 1683. The Department of Human Services shall apply for all waivers necessary to allow the State to incorporate the Medicaid program into the Maine Health Care Plan to the maximum degree possible. The Maine Health Care Authority shall apply for all waivers required to coordinate the benefits of the Maine Health Care Plan and the Medicare program. The Department of Human Services and the Maine Health Care Authority shall report their actions taken pursuant to this section to the Legislature no later than January 1, 2000 and shall include necessary legislation in the report.

Sec. B-2. Effective date. This Part takes effect October 1, 1999.

PART C

Sec. C-1. 22 MRSA §253, as amended by PL 1997, c. 689, Pt. A, §2 and affected by Pt. C, §2, is repealed.

Sec. C-2. 22 MRSA c. 103, as amended, is repealed.

Sec. C-3. Effective date. This Part takes effect October 1, 1999.

PART D

Sec. D-1. 5 MRSA §12004-G, sub-§14-C is enacted to read:

14-C. Health	Maine Health Care Authority	Expenses Only	22 MRSA §9802

PART E

Sec. E-1. 5 MRSA §285, as amended by PL 1997, c. 763, §1 and affected by §7, is repealed.

Sec. E-2. 5 MRSA §286, as amended by PL 1991, c. 780, Pt. Y, §§26 and 27, is repealed.

Sec. E-3. 5 MRSA §286-A, as amended by PL 1991, c. 780, Pt. Y, §28, is repealed.

Sec. E-4. Effective date. This Part takes effect October 1, 1999.

PART F

Sec. F-1. Transition. The following provisions apply to the implementation of the Maine Health Care Plan as it relates to insurance regulation under the Maine Revised Statutes, Title 24 and Title 24-A. The Maine Health Care Authority and the Superintendent of Insurance shall study the coordination of the delivery of health benefits under the Maine Health Care Plan and the regulation of insurers, health maintenance organizations and nonprofit hospital and medical organizations. The study must consider the repeal of unnecessary statutes and regulations and the elimination of unnecessary functions within the Bureau of Insurance. By January 1, 2000, the Maine Health Care Authority, with the assistance of the Superintendent of Insurance, shall submit to the Legislature all legislation necessary to coordinate the functions of the Bureau of Insurance with the implementation of the Maine Health Care Plan, including amendments of statutes, reallocation of funds and transitional language, as needed.

Sec. F-2. Effective date. This Part takes effect October 1, 1999.

PART G

Sec. G-1. Submission of legislation. By October 1, 1999, the Department of Human Services shall submit to the Legislature legislation to amend the statutes to correct cross-references and make any other technical changes necessitated by this Act.

SUMMARY

Part A of the bill establishes the Maine Health Care Authority to administer the Maine Health Care Plan, a universal health care plan for all Maine residents. Part A requires the authority to contract with an administrator for the administration of the Maine Health Care Plan. It also assigns to the Maine Health Care Authority the tasks of creating a comprehensive state health resource plan, establishing a global budget and ensuring the quality and affordability of health care in the State.

Part B requires the Maine Health Care Authority and the Department of Human Services to coordinate the Maine Health Care Plan with the health benefits provided under the Medicaid and

Medicare programs. The department is required to apply for all waivers necessary to integrate the Medicaid program with the Maine Health Care Plan, and the authority is required to apply for all waivers necessary to coordinate the benefits of the Maine Health Care Plan and the Medicare program.

Part C eliminates the requirement for the Department of Human Services to create a health resource plan. This Part also repeals the certificate of need program.

Part D allows the members of the board of the Maine Health Care Authority to be paid for expenses incurred by them.

Part E repeals the statutes creating the State Employee Health Commission and the Health Insurance Plan for State Employees. State employees will be insured under the Maine Health Care Plan.

Part F requires the Bureau of Insurance and the Maine Health Care Authority to study the statutes and regulations enforced by the bureau and report to the Legislature regarding any statutory changes needed to coordinate the role of the bureau with the implementation of the Maine Health Care Plan.

Part G requires the Department of Human Services to submit legislation to make technical corrections to the statutes necessitated by this Act, including cross-references.