121st MAINE LEGISLATURE

FIRST REGULAR SESSION-2003

Legislative Document **No. 889**

H.P. 666 House of Representatives, February 20, 2003

An Act To Establish a State Single-payor Health Insurance Plan

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

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative EDER of Portland.
Cosponsored by Representative LERMAN of Augusta and
Representatives: DUDLEY of Portland, LAVERRIERE-BOUCHER of Biddeford, PINEAU of Jay, PINGREE of North Haven, WALCOTT of Lewiston.

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

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

14-D. Health Security	Health Security Board	Expenses Only	24-A MRSA §6903

Sec. 2. 24-A MRSA c. 87 is enacted to read:

CHAPTER 87

MAINE SINGLE-PAYOR HEALTH CARE PLAN

SUBCHAPTER 1

GENERAL PROVISIONS

§6901. Maine Single-payor Health Care Plan established

There is established the Maine Single-payor Health Care Plan to provide health care coverage to all citizens of this State through a plan that emphasizes quality, cost containment, choice of provider and access to comprehensive, preventive and long-term care.

§6902. Definitions

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

1. Agency. "Agency" means the Agency of Health Security, established in section 6921.

2. Board. "Board" means the Health Security Board, established in Title 5, section 12004-G, subsection 14-D.

3. Fund. "Fund" means the Maine Health Care Plan Fund, established in section 6922.

4. Plan. "Plan" means the Maine Single-payor Health Care Plan, established in section 6901.

5. Plan enrollee. "Plan enrollee" means a person enrolled in the plan.

6. Provider. "Provider" means any person, organization, corporation or association that provides health care services and products and is authorized to provide those services and products under the laws of this State. "Provider" includes persons and

entities that provide treatment and care at least as inclusive as Medicaid coverage.

7. Resident. "Resident" means a person who resides within the State, as defined by rules adopted by the board.

§6903. Health Security Board

1. Board established. The Health Security Board, as established in Title 5, section 12004-G, subsection 14-D, consists of 19 members as follows:

A. The commissioner or the commissioner's designee;

B. The Executive Director of the Bureau of Health or the executive director's designee;

C. The Executive Director of the Bureau of Revenue Services or the executive director's designee;

D. The Senate chair of the joint standing committee of the Legislature having jurisdiction over health and human services matters;

E. The House chair of the joint standing committee of the Legislature having jurisdiction over health and human services matters; and

F. A representative of each of the following, appointed by the Governor and confirmed by the Legislature:

(1) A statewide organization that advocates universal health care;

(2) A statewide organization that represents Maine senior citizens;

(3) A statewide organization that defends the rights of children;

(4) An organization that provides services to low-income clients;

(5) A statewide labor organization;

(6) An organization representing health care economists;

(7) A statewide organization of physicians;

(8) A statewide organization of nurses;

(9) A statewide organization of health care providers;

(10) A statewide organization of hospitals;

(11) A statewide organization of long-term care facilities;

(12) The business community;

(13) An organization representing the self-employed; and

(14) The public.

2. Duties of board. The duties of the board include: implementing this chapter; promoting the purposes of the plan; setting reimbursement rates for participating providers; adopting rules necessary to implement the plan; establishing systems for enrollment, registration of providers for participation, rate setting and contracts with providers of services and pharmaceuticals; developing budgets with hospitals and institutional providers; establishing a certificate of need; administering the revenues of the plan; employing staff as necessary to implement this chapter; developing plans and funding for training and assistance for workers in the health care sector displaced by moving to a single-payor health care system; and conducting public hearings annually or more frequently regarding resource allocation, revenues and services.

The board shall stress prevention of disease and maintenance of health in the implementation of this plan and shall retain and strengthen existing health facilities whenever possible.

§6904. Rulemaking

The board shall adopt rules necessary to implement this chapter and negotiate reimbursement rates with providers. Rules adopted pursuant to this chapter are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

SUBCHAPTER 2

ELIGIBILITY AND COVERED HEALTH CARE SERVICES

§6911. Eligibility and covered health care services

1. Eligibility. Residents are eligible to receive covered health care services under the plan in accordance with this

section and must apply for an identification card to enroll in the plan.

A. The board is responsible for collecting information and documentation from individuals and insurance companies and reimbursing providers in the State.

A person who is unable to provide information or documentation of health care plan eligibility because of a health care condition is covered for the period in which that person is unable to provide the information.

2. Covered health care services. The plan must provide coverage for health care services from a provider within this State if those services are determined medically necessary by the provider for the patient, except that the plan may not provide cosmetic services. Copayments may be charged only as charged under current Medicaid coverage. Deductibles may not be charged to plan enrollees. The plan must be at least as inclusive as Medicaid coverage. This subsection does not preclude supplementary benefit insurance for services that are not medically necessary. Covered health care must include all services and providers for which coverage is mandated under this Title and must include all coverage offered by the Medicaid program.

3. Service delivery. Covered health care services are governed by this subsection.

A. Covered health care services must be provided to plan enrollees by participating providers who are located within the State and who are chosen by the plan enrollees.

B. The plan must pay for health care services provided to a plan enrollee while the enrollee is temporarily outside the State. The maximum period of time a plan enrollee may be covered while out of state is 90 days per year. A plan enrollee may qualify to begin services out of state but, in order to receive continued treatment, may be required to receive treatment within the State. Reimbursement for services rendered out of state must be at rates set by the board.

C. A participating provider may not charge plan enrollees or 3rd parties for covered health care services in excess of the amount reimbursed to that provider by the plan.

D. A participating provider may not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color,

creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status.

4. Role of other health care programs. Until the board determines otherwise, the plan is supplemental to all coverage available to a plan enrollee from another health care program, including, but not limited to, the following programs:

A. The Medicare program of the Social Security Act, Title XVIII;

B. The Medicaid program of the Social Security Act, Title XIX;

C. The civilian health and medical program as referred to in 10 United States Code, Sections 1071 to 1106;

D. The federal Indian Health Care Improvement Act, 25 United States Code, Sections 1601 to 1682;

E. Other 3rd-party payor programs that may be billable for health care services; and

F. Any state and local health programs, including, but not limited to, workers' compensation and employers' liability insurance pursuant to former Title 39 and Title 39-A.

Health care services billed to 3rd-party payors must be paid for by those programs. Coverage under the plan is supplemental to that coverage.

SUBCHAPTER 3

AGENCY OF HEALTH SECURITY

§6921. Administration

The Agency of Health Security is established to administer the plan. The agency operates as an independent agency of the State.

§6922. Maine Health Care Plan Fund

1. Fund established. The Maine Health Care Plan Fund is established to finance the plan.

A. Deposits into the fund and expenditures from the fund must be made pursuant to this section and to rules adopted by the board to carry out the purposes of this section. Payments into the fund may include premiums charged to plan

enrollees, payments from other governmental units, payments from 3rd-party payors, payments under agreements of cooperation and coordination for plan enrollees in other insurance or health benefit programs and payments under any system of revenue or taxation imposed by the Legislature to fund the plan.

B. All income generated pursuant to this chapter must be deposited into the fund, which may not lapse but must be carried forward from one fiscal year to the next.

C. All funds remaining in the fund at the end of the fiscal year must be reported to the Legislature by January 1st of the following year and may be used, by vote of the Legislature, to expand the coverage of services paid for by the plan.

D. Expenditures from the fund are authorized for payments to participating providers for health care services rendered and payments for administration of the fund, the plan and the agency.

2. Budget. The annual administrative costs for the agency and for all administrative aspects of the plan may not exceed 5% of the total annual budget for the fund. The board shall implement cost-control measures to reduce administrative costs and eliminate unnecessary health care. Cost-control measures may not be implemented to limit necessary health care.

3. Funding. Funding must be provided from a combination of sources, including:

A. Payments from other government sources, including federal, state and other government health and aid programs;

B. Payments from workers' compensation, pension and health insurance employee benefit plans and programs as provided by this chapter and the rules adopted to implement this chapter;

C. Payments from state, county and municipal governmental units for coverage provided to employees of those units;

D. Payments from any taxes or fees imposed by the Legislature to fund the plan, which may include but are not limited to corporate and individual income taxes; sales taxes; payroll taxes dedicated to the health care plan; any additional taxes to be determined by a feasibility study of economic impacts to individuals and businesses of payment options, including but not limited to corporate and individual income tax rate increases; sales tax rate

increases; elimination of sales tax exemptions and exclusions; establishment of a payroll or other tax dedicated to funding the plan; and other options proposed by the board or the Legislature; and

E. Payments by tobacco product manufacturers to the State in settlement of claims brought against them by the State.

§6923. Reports

1. Annual report. By January 1st of each year, the board shall submit to the Governor and to the Legislature an annual report of the agency's operations and activities during the previous year and the funding, tax and budget status of the plan.

2. Public information. The board may publish and disseminate information helpful to the citizens of this State in making informed choices in obtaining health care in conjunction with the Bureau of Health.

Sec. 3. Report. By January 1, 2004, the Health Security Board shall report to the joint standing committee of the Legislature having jurisdiction over human services matters on options for coordination of the Maine Single-payor Health Care Plan with other health care plans and options for the Maine Single-payor Health Care Plan to take over coverage of some persons on those other health care plans, with the plans to take effect January 1, 2005.

SUMMARY

This bill establishes the Maine Single-payor Health Care Plan. It establishes the Agency of Health Security as an independent agency to administer the plan. Under the plan, enrollees choose their own health care providers and the plan pays their bills. Coverage under the plan is supplemental to other coverage. The bill requires a report from the Health Security Board to the joint standing committee of the Legislature having jurisdiction over human services matters on the options for coordination of the plan with other health care plans and for the plan to take over coverage of some persons covered by those health care plans. The bill requires an annual report from the board to the Governor and the Legislature on the operation and activities of the plan.