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H.P. 913 House of Representatives, March 6, 2003

An Act Concerning Universal Health Insurance

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

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative O'NEIL of Saco.
Cosponsored by Senator LaFOUNTAIN of York and
Representatives: Speaker COLWELL of Gardiner, DUPLESSIE of Westbrook, RICHARDSON of Brunswick, Senators: President DAGGETT of Kennebec, GAGNON of Kennebec, MAYO of Sagadahoc, TREAT of Kennebec.

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

PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§8-A is enacted to read:

8-A. Primary health care policy. All carriers offering individual health plans in this State shall offer a primary health care policy, referred to in this subsection as "the policy." The superintendent shall adopt rules that define the benefit design for the policy in accordance with the following.

A. The policy must provide coverage that emphasizes primary and preventive care, including, but not limited to, well-adult and well-child visits and health screenings.

B. The annual maximum limit payable on the policy must be determined as follows:

(1) For an individual whose income is between 100% and 200% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $2,000 per individual covered under the policy;

(2) For an individual whose income is between 200% and 300% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $5,000 per individual covered under the policy;

(3) For an individual whose income is between 300% and 400% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $10,000 per individual covered under the policy; and

(4) For an individual whose income is above 400% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $20,000 per individual covered under the policy.

C. The policy must meet the requirements for mandated benefits under this Title applicable to individual health plans.

D. Notwithstanding subsection 2, paragraph D, a carrier may offer an additional discount of up to 20% of the premium rate for the policy based on an individual's weight or adherence to a recommended schedule for regular physicals. With respect to weight and regular physicals, the discount must be based on the individual's compliance with the

Centers for Disease Control and Prevention guidelines in effect on the year of issuance or renewal of the policy.

E. If approved by the superintendent, the policy may include provisions with financial incentives encouraging a policyholder to receive health care services at a center of excellence or other high-quality provider designated by the carrier based on objective quality indicators.

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

Sec. A-2. 24-A MRSA §2808-B, sub-§8-A is enacted to read:

8-A. Primary health care policy. All carriers offering small group health plans in this State shall offer a primary health care policy, referred to in this subsection as "the policy". The superintendent shall adopt rules that define the benefit design for the policy in accordance with the following.

A. The policy must provide coverage that emphasizes primary and preventive care, including, but not limited to, well-adult and well-child visits and health screenings.

B. The annual maximum limit payable on the policy per member covered under the small group health plan, including dependents, must be determined as follows:

(1) For a member whose income is between 100% and 200% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $2,000 per member covered under the policy;

(2) For a member whose income is between 200% and 300% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $5,000 per member covered under the policy;

(3) For a member whose income is between 300% and 400% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $10,000 per member covered under the policy; and

(4) For a member whose income is above 400% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $25,000 per member covered under the policy.

C. The policy must meet the requirements for mandated benefits under this Title applicable to small group health plans.

D. Notwithstanding subsection 2, paragraph D, a carrier may offer an additional discount of up to 20% of the premium rate for the policy based on an individual's weight or adherence to a recommended schedule for regular physicals. With respect to weight and regular physicals, the discount must be based on the individual's compliance with the Centers for Disease Control and Prevention guidelines in effect on the year of issuance or renewal of the policy.

E. If approved by the superintendent, the policy may include provisions with financial incentives encouraging a policyholder to receive health care services at a center of excellence or other high-quality provider designated by the carrier based on objective quality indicators.

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

Sec. A-3. 24-A MRSA §4315 is enacted to read:

§4315. Primary health care policy

1. Mandatory offer. A carrier offering a health plan in this State shall offer and actively market a primary health care policy, referred to in this section as "the policy," to individuals and groups regardless of size. The superintendent shall adopt rules that define the benefit design for the policy in accordance with the following.

A. The policy must provide coverage that emphasizes primary and preventive care, including, but not limited to, well-adult and well-child visits and health screenings.

B. The annual maximum limit payable on the policy per individual covered under the health plan, including dependents, must be determined as follows:

(1) For an individual whose income is between 100% and 200% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $2,000 per individual covered under the policy;

(2) For an individual whose income is between 200% and 300% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $5,000 per individual covered under the policy;

(3) For an individual whose income is between 300% and 400% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $10,000 per individual covered under the policy; and

(4) For an individual whose income is above 400% of the federal nonfarm income federal poverty level, the annual maximum limit payable on the policy is $20,000 per individual covered under the policy.

C. The policy must meet the requirements for mandated benefits under this Title applicable to the policyholder.

D. A carrier may offer an additional discount of up to 20% of the premium rate for the policy based on an individual's weight or adherence to a recommended schedule for regular physicals. With respect to weight and regular physicals, the discount must be based on the individual's compliance with the Centers for Disease Control and Prevention guidelines in effect on the year of issuance or renewal of the policy.

E. If approved by the superintendent, the policy may include provisions with financial incentives encouraging a policyholder to receive health care services at a center of excellence or other high-quality provider designated by the carrier based on objective quality indicators.

Notwithstanding section 4309, rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-4. 24-A MRSA c. 55-A is enacted to read:

CHAPTER 55-A

MAINE UNIVERSAL HEALTH CARE COVERAGE ACT

§4161. Short title

This chapter may be known and cited as "the Maine Universal Health Care Coverage Act."

§4162. Definitions

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

1. Agency. "Agency" means the Maine Universal Health Care Agency established in section 4164.

2. Carrier. "Carrier" has the same meaning as in section 4301, subsection 1.

3. Enrollee. "Enrollee" means a person enrolled in the plan.

4. Fund. "Fund" means the Maine Universal Health Care Fund.

5. Plan. "Plan" means the Maine Universal Health Care 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.

7. Resident. "Resident" means a person who resides within the State.

§4163. Maine Universal Health Care Plan established

The Maine Universal Health Care Plan is established to provide universal access to high-quality, affordable health care for the people of this State. The plan must offer health care coverage beginning January 1, 2004 and be administered and overseen by the agency in accordance with this chapter that includes the purchase of reinsurance or stop loss coverage from a reinsurer licensed to do business in this State. The plan may be administered through a self-insured arrangement or through a contract with a carrier licensed to do business in this State.

1. Eligibility. Residents of the State are eligible to receive covered health care services under the plan in accordance with the requirements of this section. The agency shall adopt rules regarding certification of eligibility for the plan, application for a plan card and membership in the plan. The rules must provide for at least the following.

A. Each resident of the State is eligible and may become an enrollee if the agency certifies that the resident has provided evidence of coverage under a primary health care policy offered pursuant to section 2736-C, subsection 8-A, section 2808-B, subsection 8-A and section 4315 and approved by the superintendent or under a medical savings account established pursuant to federal or state law.

B. Eligibility may extend to an enrollee's spouse and dependents if the evidence of coverage under a primary health care policy demonstrates coverage for the enrollee's spouse and dependents.

C. Eligibility may not be extended to an enrollee unless the evidence of coverage demonstrates that the enrollee has had coverage under a primary health care policy or other approved health insurance policy within 180 days before the date the enrollee applies for eligibility under the plan.

2. Plan benefits. As provided in this subsection, the plan must provide coverage to enrollees through one standard benefit plan. Benefits for covered health care services may not be provided to an enrollee until the enrollee has reached the maximum amount payable for coverage under that enrollee's primary health care policy. Covered health care services must be provided if those services are medically necessary or appropriate for the prevention, diagnosis or treatment of, or maintenance or rehabilitation following, injury, disability or disease. Covered health care must include all services and providers for which coverage is mandated under this Title. After consultation with the bureau, the agency shall adopt rules regarding the standard benefit design for the plan. This subsection does not preclude supplementary benefit insurance for services that are not medically necessary.

3. Delivery of health care services. This subsection governs the delivery of covered health care services.

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

B. The plan must pay for health care services provided to an enrollee while the enrollee is temporarily outside the State. The maximum period of time an enrollee may be covered and receive services while out-of-state is 90 days per year. An enrollee may qualify to begin services outside the State but, in order to receive continued treatment, may be required to receive treatment within the State.

C. A participating provider may not charge 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 an 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. Participating carriers; contracts. The plan may contract with one or more participating carriers to provide coverage to

enrollees. The plan shall develop objective criteria for the selection of participating carriers and provide adequate notice of the application process to permit all carriers a reasonable and fair opportunity to participate. The selection of participating carriers must be based on the criteria developed by the plan.

5. Reinsurance; contracts. The plan may contract with one or more carriers to provide reinsurance or stop loss insurance for coverage provided to eligible enrollees. The plan shall develop objective criteria for the selection of participating reinsurers or stop loss insurers and provide adequate notice of the application process to permit all reinsurers a reasonable and fair opportunity to participate. The selection of participating carriers must be based on the criteria developed by the plan.

6. Coordination with Medicaid. The plan shall maximize the use of federal funds available through the Medicaid program to provide health care coverage to all individuals enrolled in the plan who are or could become eligible for Medicaid pursuant to 42 United States Code, Section 1396a(r)(2), 1396u-1 or 1397bb. For enrollees and dependents eligible for Medicaid, health services provided by Medicaid must continue to be provided in coordination with health services covered under the plan. The Department of Human Services shall apply for any necessary federal Medicaid waivers to provide health care coverage through the plan under this section.

7. Licensing; regulation. Carriers, including reinsurance carriers, that contract with the plan must be licensed pursuant to this Title. Health plans offered by participating carriers must comply with all applicable provisions of this Title and rules adopted pursuant to this Title.

§4164. Maine Universal Health Care Agency

1. Administration. The Maine Universal Health Care Agency is established to administer and oversee the Maine Universal Health Care Plan established in section 4163. The agency operates as an independent agency of the State within the Executive Department.

2. Executive Director. The Executive Director of the Maine Universal Health Care Agency is appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and to confirmation by the Legislature, and serves at the pleasure of the Governor. The executive director must have experience in the organization, financing and delivery of health care.

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

A. The agency may employ necessary staff to administer this chapter, subject to the Civil Service Law.

B. The agency may enter into contracts with qualified 3rd parties for any service necessary to carry out the purposes of this chapter.

C. The agency may solicit, receive and accept gifts, grants, payments and other funds and advances from any person and enter into agreements with respect to those grants, gifts, payments and other funds and advances, including agreements that involve the undertaking of studies, plans, demonstrations and projects. The agency may charge and retain fees to recover the reasonable costs incurred in reproducing and distributing reports, studies and other publications and in responding to requests for information.

D. The agency may borrow any necessary funds to support initial operating expenses in administering this chapter.

E. The agency may conduct studies and analyses related to the provision of health care, health care costs and matters the agency considers appropriate.

F. The agency may establish a financial relationship directly with producers licensed pursuant to chapter 16 to market and service health coverage offered through the agency.

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

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

6. Technical assistance from bureau. The agency shall coordinate its activities to the extent possible with the bureau.

The bureau shall provide technical assistance and expertise to the agency in the development of the agency's rules for eligibility, benefit plan design and other aspects of the plan.

7. Coordination with federal, state and local health care systems. The agency shall institute a system to coordinate the activities of the agency and the plan with the health care programs of the Federal Government and state and municipal governments.

8. Reports. On or before January 1st of each year, the agency shall submit to the Governor and the Legislature an annual report of its operations and activities during the previous year. This report must include facts, suggestions and policy recommendations that the agency considers necessary. As it determines appropriate, the agency shall publish and disseminate information helpful to the citizens of this State in making informed choices in obtaining health care, including the results of studies or analyses undertaken by the agency.

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

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

11. Seal. The agency may have a seal bearing the words "Maine Universal Health Care Agency."

§4165. Maine Universal Health Care Fund

1. Fund established. The Maine Universal Health Care 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 agency to carry out the purposes of this chapter. Payments into the fund may include payments from other governmental units, payments from 3rd-party payors, payments under agreements of cooperation and coordination for 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, payments to enrollees from the Enrollee Hardship Fund established in subsection 2 and payments for administration of the fund, the plan and the agency.

2. Enrollee Hardship Fund. The Enrollee Hardship Fund is established as part of the fund to provide financial assistance to enrollees for whom the premium for a primary health care policy is a hardship based on income. The agency shall adopt rules for income eligibility of enrollees, the amount of financial assistance available and the application process for enrollees.

3. 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 agency 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.

PART B

Sec. B-1. 24 MRSA c. 19-A is enacted to read:

CHAPTER 19-A

MAINE NONPROFIT HEALTH INSURANCE COMPANY

§2381. Purpose

The Maine Nonprofit Health Insurance Company, referred to in this chapter as "the company," is established to provide health insurance coverage to residents of this State and to promote competition in the State's health insurance marketplace.

§2382. Establishment

1. Nonprofit hospital and medical service organization. The Maine Nonprofit Health Insurance Company is a nonprofit hospital and medical service organization subject to all the requirements and standards of this Title and Title 24-A that are applicable to health insurers and health maintenance organizations. The company shall offer individual and group health insurance coverage beginning January 1, 2004.

2. Health care coverage. The company shall provide individual and group health insurance to residents and employers in this State, including primary health care policies as required by Title 24-A, section 2736-C, subsection 8-A; section 2808-B, subsection 8-A; and section 4315. The company may not provide health insurance to out-of-state residents or employers.

3. Incorporation. The company must be incorporated pursuant to the provisions of chapter 19. The incorporators must be appointed by the Governor subject to review and approval by the joint standing committee of the Legislature having jurisdiction over health insurance matters. The appointments must be made within 10 days after the effective date of this subsection. The joint standing committee shall complete its review and vote on the approval of the appointments of the Governor within 10 days of the Governor's written notice of the appointments. If the joint standing committee fails to act within the required 10 days, then the appointees put forward by the Governor become the required incorporators. Upon appointment, the incorporators shall execute a certificate of organization as required by this Title and immediately pursue a certificate of authority for a nonprofit hospital and medical service organization.

4. Composition of board. The company is governed by a board of directors that consists of at least 14 members. Nine members must be policyholders who purchase health insurance coverage from the company, except that the initial appointment may include members who have purchased coverage from other carriers licensed in this State. Three members must be persons who represent the public interest of the company. Members who are policyholders and members who represent the public interest must be appointed by the Governor within 30 days after a new board member is authorized or a vacancy occurs, subject to review and approval by the joint standing committee of the Legislature having jurisdiction over health insurance matters. The joint standing committee shall complete its review and vote on approval of the appointments of the Governor within 15 days of the Governor's written notice of appointment. If the joint standing committee fails to act within the required 15 days, then the appointees put forward by the Governor become the required board members. One member must be an at-large policyholder member

elected by the board. The remaining board member is the president and chief executive officer, who shall serve on the board of directors while employed as president and chief executive officer.

5. Terms. Of the initial policyholder board members, 3 serve 3-year terms, 3 serve 2-year terms and 3 serve one-year terms. Of the initial public interest members, one serves a 3-year term, one serves a 2-year term and one serves a one-year term. A full term is 3 years. An individual may not serve more than 2 full terms as a director. All members shall serve for the terms provided and until their successors are appointed or elected and qualified.

6. Corporate governance. The initial board of directors shall, at the organizational meeting of the company to complete organization, adopt bylaws. The bylaws must provide a schedule of meetings and rules specifically relating to the conduct of meetings and voting procedures.

7. Annual report. In addition to any other reports required by this Title, the company shall submit an annual report to the Governor and to the joint standing committee of the Legislature having jurisdiction over health insurance matters that discloses the business transacted by the company during the previous year and states the resources and liabilities of the company together with other pertinent information considered appropriate by the board. The report must contain, at a minimum, a summary of the latest annual statement filing required to be filed under this Title with the Superintendent of Insurance prepared on a basis of statutory accounting precepts. Any variations between the annual statement and the annual report must be reconciled to clearly show variances and the basis for any different values.

§2383. Authority of board; powers and duties

1. General authority. The board may perform all acts necessary or convenient in the exercise of any power, authority or jurisdiction over the company, either in the administration of the company or in connection with the business of the company to fulfill the purposes of this chapter and chapter 19. The company has the powers otherwise granted to a nonprofit hospital and medical service organization.

2. Standard of performance. The board shall discharge its duties with the same care, skill, prudence and diligence as that of prudent directors acting in a similar enterprise and with a similar purpose.

3. Personal liability. The members of the board and officers or employees of the company are not liable personally, either jointly or severally, for any debt or obligation created or incurred by the company.

§2384. Plan of operation

1. Plan of operation. The company shall develop and file with the Superintendent of Insurance for review and approval a plan of operation and any amendments to a plan of operation necessary or suitable to ensure the fair, reasonable and equitable administration of the company.

2. Initial funding. The company may obtain initial start-up funds by:

A. Borrowing from any public or private source; and

B. The sale of private activity bonds through an allocation of the state ceiling on private activity bonds to the company pursuant to Title 10, section 363.

§2385. President and chief executive officer

1. Appointment. The board shall appoint a president who serves as chief executive officer and who is responsible for the operation of the company. The president must be qualified by education and experience to manage an organization with financial and operational obligations to its policyholders and claimants.

2. Term. The president serves at the will of the board.

3. Compensation. The president is entitled to compensation as established by the board and is subject to any reasonable requirements, including bonding, established by the board.

4. Board member. The president is a member of the board but may not be the chair of the board.

5. Duties. The board, as part of its plan of operation, shall designate the powers and duties of the president. The president may, with direction from the board, assist in the development of the plan of operation and other start-up functions.

§2386. Nonstate agency

The company is not considered a state agency or instrumentality of the State for any purpose. The State may not borrow or otherwise appropriate funds from the company.

PART C

Sec. C-1. 36 MRSA c. 370-A is enacted to read:

CHAPTER 370-A

PAYROLL TAX

§2831. Payroll tax on wages and earnings

1. Tax levied. Every taxpayer constituting an employing unit in this State shall pay a tax of 5% on all gross earnings of that employing unit's employees. Every taxpayer who is self-employed shall pay a tax of 5% on all gross earnings of that taxpayer's wages and earnings.

2. Payment of tax; returns. Every taxpayer subject to the tax imposed by this section shall, on or before the last day of each April, the last day of each June and the last day of each October, file with the assessor on forms prescribed by the assessor a return for the quarter ending the last day of the preceding month, except for the month of June, which is for the quarter ending June 30th. The final return and payment must be filed on or before March 15th covering the prior calendar year. At the time of filing such returns, each taxpayer shall pay to the assessor the amount of tax shown due. A taxpayer with annual tax liability not exceeding $500 may with approval of the assessor file an annual return with payment on or before March 15th covering the prior calendar year.

3. Maine Universal Health Care Fund. The assessor shall pay taxes collected under this section to the Maine Universal Health Care Fund established in Title 24-A, section 4165.

SUMMARY

In Part A, this bill establishes the Maine Universal Health Care Plan. It establishes the Maine Universal Health Care Agency as an independent agency to administer the plan. Under the plan, enrollees are provided health care coverage after the policy limits of their primary health care policy have been reached. Coverage under the plan is contingent upon the enrollee's having secured coverage for primary and preventive care either individually or through the enrollee's employer. The primary health care policy must be approved by the Bureau of Insurance.

In Part B, the bill establishes a new nonprofit hospital and medical service organization to compete with other carriers in Maine's health insurance market. The bill requires that the organization be organized in accordance with the Maine Revised Statutes, Title 24.

In Part C, the bill establishes a 5% payroll tax on wages and earnings, including self-employed earnings, and dedicates that tax revenue to the Maine Universal Health Care Fund.