124th MAINE LEGISLATURE

FIRST REGULAR SESSION-2009

Legislative Document **No. 1365**

H.P. 955 House of Representatives, April 2, 2009

An Act To Establish a Single-payer Health Care System

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

Millicent M. MacFarland
MILLICENT M. MacFARLAND
Clerk

Presented by Representative PRIEST of Brunswick.
Cosponsored by Senator BOWMAN of York and
Representatives: AYOTTE of Caswell, BEAUDOIN of Biddeford, BRYANT of Windham, CAIN of Orono, EATON of Sullivan, GOODE of Bangor, HASKELL of Portland, LEGG of Kennebunk, MARTIN of Eagle Lake, MILLER of Somerville, MORRISON of South Portland, Speaker PINGREE of North Haven, STEVENS of Bangor, STUCKEY of Portland, TREAT of Hallowell, TUTTLE of Sanford, WEBSTER of Freeport, Senators: BLISS of Cumberland, CRAVEN of Androscoggin, GERZOFSKY of Cumberland.

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

PART A

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

CHAPTER 106

ACCESS TO AFFORDABLE HEALTH CARE

SUBCHAPTER 1

GENERAL PROVISIONS

§371. Definitions

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

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

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

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

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

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

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

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

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

9. Provider. "Provider" means any 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 United States Social Security Act, Title XVIII and permitted under state law.

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

11. Small Business Hardship Fund. "Small Business Hardship Fund" means the fund created by section 374, subsection 1, paragraph A as part of the Maine Health Care Trust Fund.

SUBCHAPTER 2

ENSURING ACCESS TO HEALTH CARE

§372. Maine Health Care Plan

The Maine Health Care Plan is established to provide security through high-quality, affordable health care for the people of the State. The plan becomes effective and binding upon the State when substantially similar legislation has been enacted into law by any 2 states from among the states of New England. By common action, it is the policy of each of the states to provide for the mutual development, execution and cooperation in the delivery of health care to its residents. The plan must offer health care services beginning 6 months after the plan becomes effective and the agency shall administer and oversee the plan in accordance with this chapter.

1. Goals of Maine Health Care Plan. The goals of the plan are:

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

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

C. To reduce waste and inefficiency in the administration of health care services and health insurance;

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

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

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

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

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

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

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

2. Eligibility for Maine Health Care Plan. In accordance with this subsection, residents and nonresidents are eligible to receive covered health care services from participating providers under the plan within this State if the service is necessary or appropriate for the prevention, diagnosis or treatment of, or maintenance or rehabilitation

following, injury, disability or disease. The agency shall adopt rules regarding payment of premiums, application for a plan card and membership in the plan. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The rules must meet the criteria of this subsection.

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

B. A nonresident 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 paragraph and to that person's spouse and dependents. The agency shall adopt rules establishing criteria for eligibility for nonresidents and determine the premium to be paid by them and the method of payment.

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

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

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

A. Hospital services;

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

C. Laboratory tests and imaging procedures;

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

E. Rehabilitative services for persons receiving therapeutic care;

F. Prescription drugs and devices. Unless the prescribing practitioner certifies that a more expensive drug is medically necessary, the plan may cover only part of the cost of a drug dispensed in a package or form of dosage or administration when the

agency determines that a less expensive package or form of dosage or administration is available that is pharmaceutically equivalent in its therapeutic effect. If a plan member chooses to purchase a more expensive drug under this paragraph, the plan member is responsible for paying the amount not covered by the plan;

G. Mental health services;

H. Substance abuse treatment;

I. Primary and acute dental services;

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

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

L. Hospice care; and

M. Health care services payable pursuant to Title 39-A for all employees whose date of injury is on or after July 1, 2010.

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

4. Benefit delivery. Covered health care services must be provided to plan members by the participating providers of their choice through organized delivery systems or the open plan. The delivery of covered health care services to plan members is subject to the provisions of this subsection. The agency shall adopt rules regarding benefit delivery by the plan that meet the criteria of this subsection.

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

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

C. The plan must pay for health care services provided to a plan member while the plan member is out of the State. The plan member must have been out of the State temporarily for reasons other than to obtain the health care services, or the plan 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 agency shall establish and operate a plan to pay for health care services provided to a plan member while the plan member is out of the State. The payments must be made at the rates established by the agency 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.

D. The plan must pay cash benefits to a provider of health care services 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.

E. Copayments or deductibles do not apply to health care services provided through the plan, except that, to encourage the use of the most appropriate and cost-effective mode of service, an organized delivery system may require reasonable payments by a

plan member if payment is approved by the agency and does not substantially interfere with access to needed health care services.

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

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

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

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

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

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

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

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

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

8. Role of other health care programs. Until the agency determines otherwise, the plan is supplemental to all coverage available to a plan member from another health care program, including, but not limited to, the Medicare program of the United States Social Security Act, Title XVIII; the Medicaid program of the United States Social Security Act, Title XIX; the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Sections 1071 to 1106; the federal Indian Health Care Improvement Act, 25 United States Code, Sections 1601 to 1682; the statewide plan provided through the Dirigo Health Program pursuant to Title 24-A, chapter 87; other 3rd-party payors who may be billable for health care services; and any state and local health care 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 other than the plan must be paid for by those programs, and coverage under the plan is supplemental to that coverage. A plan member who receives health care services under another health care program or from a 3rd-party payor to which the plan is supplemental shall pay a premium to the fund in proportion to the health care benefits available to the plan member under the plan.

SUBCHAPTER 3

ENSURING THE QUALITY, AFFORDABILITY AND EFFICIENCY OF HEALTH CARE

§373. Quality; affordability; efficiency; health planning

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

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

A. Operation of the plan;

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

C. Evaluation of the performance of participating providers;

D. Standards and continuity of care;

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

F. Access to information and data for the agency;

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

H. Plan member involvement in policy decisions; and

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

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

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

B. Operation of the Small Business Hardship Fund to assist employers for which the plan constitutes a hardship;

C. Maintenance of a prescription drug formulary; and

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

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

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

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

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

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

D. A health planning program; and

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

SUBCHAPTER 4

FINANCING OF THE MAINE HEALTH CARE PLAN

§374. Financing of Maine Health Care Plan

Financing of the plan is accomplished by the fund.

1. Maine Health Care Trust Fund. The Maine Health Care Trust Fund is established to finance the plan. 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 section. All income generated pursuant to this chapter must be deposited in the fund, which does not lapse but carries forward from one fiscal year to the next. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

A. The Small Business Hardship Fund is established as a part of the fund to assist self-employed persons and employers for which participation in the plan constitutes a hardship.

B. Payments are deposited into the fund from:

(1) Payroll taxes transferred pursuant to Title 36, chapter 370-A;

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

(3) Payments appropriated from the General Fund;

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

(5) Other payments made pursuant to law.

C. Expenditures from the fund are authorized for the purposes in this paragraph:

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

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

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

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

(5) Payments to the Small Business Hardship Fund;

(6) Payments for administration of the fund and the plan;

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

(8) Other payments made pursuant to law.

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

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

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

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

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

SUBCHAPTER 5

MAINE HEALTH CARE AGENCY

§375. Establishment

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

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

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

3. Maine Health Care Trust Fund. Administer and oversee the Maine Health Care Trust Fund.

§376. General powers

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.

1. 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 subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

2. Executive director and staff. The agency shall employ an executive director, who must have had experience in the organization, financing or delivery of health care and who shall perform the duties delegated by the agency. The agency may delegate to the executive director any of its functions and duties except the adoption of rules, the establishment of a global budget for health care for the State under section 373, subsection 4 and the review of certificate of need applications under chapter 103-A. The executive director is an unclassified employee and serves at the pleasure of the council. The executive director, at the direction of the agency, shall hire personnel to administer this chapter, subject to the Civil Service Law and within the budget set by the agency.

3. Receipt of gifts, grants and payments; fees. 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.

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

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

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

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

8. Data collection. The agency shall institute a data collection system to acquire and analyze information on the provision of health care and health care costs. All data released by the agency must protect the confidentiality of the health care provider and the plan member and, whenever possible, must be released as aggregate data.

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

10. 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 premiums and assessments and taxes under Title 36, section 4365. Funding for the agency budget approved by the Legislature is paid from the fund.

11. 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, state and municipal governments.

12. Reports. By January 1st of each year, the agency shall submit to the Governor and the Legislature a report of its operations and activities during the previous year, including its operations and activity with respect to the funding, tax and budget requirements pursuant to subsection 10. This report must include facts and 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.

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

14. 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.

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

§377. Maine Health Care Council

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

1. Membership. The council is composed of 3 members, appointed by the Governor and, within 30 days after authorization, subject to review by the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters and to confirmation by the Legislature.

Persons eligible for appointment to the council must have had experience in the organization, delivery or financing of health care. At least one member of the council must be an individual with experience in the delivery and organization of primary and preventive care and public health services. At least one member of the council must be an individual who is not a health care provider and has not worked for a health care provider or health insurer. Members of the council shall devote full time to their duties.

2. Terms. All appointments are for 5-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. Chair; voting. The Governor shall designate one member of the council as chair. The chair shall preside at meetings of the council, is responsible for the expedient organization of the agency's work and may vote on all matters before the council. Two council members constitute a quorum. The council may take action only by an affirmative vote of at least 2 members.

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

Sec. A-2. Working capital advance. The State Controller shall transfer a $400,000 working capital advance to the dedicated account of the Maine Health Care Trust Fund on the effective date of this Part. The Maine Health Care Agency shall repay this working capital advance by June 30, 2012.

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

Sec. A-4. Effective date. This Part takes effect July 1, 2010.

PART B

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

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

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

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

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

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

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

2. Duties. The committee shall hold public hearings, solicit public comments and advise the Maine Health Care Council for the purposes of planning the transition to the Maine Health Care Plan established in the Maine Revised Statutes, Title 22, section 372 and recommending legislative changes to accomplish the purposes of Title 22, chapter 106.

3. Staffing and funding. The Maine Health Care Council shall provide staffing and funding for the committee.

4. Compensation. Members of the committee serve without compensation. They are entitled to reimbursement from the Maine Health Care Council for travel and other necessary expenses incurred in the performance of their duties on the committee.

5. Reports. Every 6 months beginning July 1, 2010, the committee shall report to the Maine Health Care Council, the Governor and the Legislature.

6. Completion of duties. The committee shall complete its duties when the Maine Health Care Plan becomes effective pursuant to the Maine Revised Statutes, Title 22, section 372.

Sec. B-2. Effective date. This Part takes effect January 1, 2010.

PART C

Sec. C-1. 2 MRSA §6-F is enacted to read:

§6-F. Salaries of members of the Maine Health Care Council and executive director of the Maine Health Care Agency

Notwithstanding any other provision of law, the salaries of members of the Maine Health Care Council, as established in Title 22, section 377, and of certain employees of the Maine Health Care Agency, as established in Title 22, section 375, are set out in this section.

1. Members; Maine Health Care Council. The salaries of the members of the Maine Health Care Council, as established in Title 22, section 377, are within salary range 91.

2. Executive director; Maine Health Care Agency. The salary of the executive director of the Maine Health Care Agency, as established in Title 22, section 375, is within salary range 91.

Sec. C-2. Effective date. This Part takes effect July 1, 2010.

PART D

Sec. D-1. 24-A MRSA §2185-A is enacted to read:

§2185-A. Benefits that duplicate health care benefits of the Maine Health Care Plan

Health insurance policies and contracts and health care contracts and plans are subject to the provisions of this section.

1. Prohibited conduct. 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 Maine Health Care Plan under Title 22, section 372, subsection 3 unless that person, insurer, health maintenance organization or nonprofit hospital or medical service organization has been authorized as

an organized delivery system by the Maine Health Care Agency pursuant to Title 22, section 372, subsection 4, paragraph A. A violation of this section constitutes an unfair and deceptive trade practice under section 2152.

2. Allowed conduct. A person, insurer, health maintenance organization or nonprofit hospital or medical service organization may sell or offer for sale in the 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 Maine Health Care Plan under Title 22, section 372, subsection 3.

PART E

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

Sec. E-2. Delivery of long-term health care services. The Maine Health Care Agency, as established in the Maine Revised Statutes, Title 22, section 375, shall study the delivery of long-term health care services to Maine Health Care Plan members under Title 22, chapter 106. The study must address the best and most efficient manner of delivery of health care services to individuals needing long-term care and funding sources for long-term care. In undertaking the study, the agency shall consult with the Maine Health Care Plan Transition Advisory Committee established in Part B of this Act, representatives of consumers and potential consumers of long-term care services, representatives of providers of long-term care services and representatives of employers, employees and the public. The agency shall report to the Legislature on or before January 1, 2012 and may include suggested legislation in the report.

Sec. E-3. Provision of health care services. The Maine Health Care Agency, as established in the Maine Revised Statutes, Title 22, section 375, shall study the provision of health care services under the MaineCare and Medicare programs. The study must consider the waivers necessary to coordinate the MaineCare and Medicare programs with the Maine Health Care Plan established in Title 22, section 372; the method of coordination of benefit delivery and compensation; reorganization of State Government necessary to achieve the objectives of the agency; and any other changes in law needed to carry out the purposes of Title 22, chapter 106. The agency shall apply for all waivers required to coordinate the benefits of the Maine Health Care Plan and the MaineCare and Medicare programs. The agency shall report to the Legislature on or before March 1, 2011 and may include suggested legislation in the report.

PART F

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

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

PART G

Sec. G-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 7.5% on all gross earnings of that employing unit's employees. Every taxpayer who is self-employed shall pay a tax of 7.5% 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 Health Care Trust Fund. The assessor shall pay taxes collected under this section to the Maine Health Care Trust Fund established in Title 22, section 374.

SUMMARY

This bill establishes a universal access health care system that offers a choice of coverage through organized delivery systems or through a managed care system operated by the Maine Health Care Agency and channels all health care dollars through a dedicated trust fund.

1. Part A of the bill does the following.

It establishes the Maine Health Care Plan to provide security through high-quality, affordable health care for the people of the State. The plan becomes effective when 2 other New England states enact substantially similar legislation. All residents and nonresidents who maintain significant contact with the State are eligible for covered health care services through the Maine Health Care Plan. The plan is funded by the Maine Health Care Trust Fund, a dedicated fund receiving payments from payroll taxes and payments from the General Fund or any other sources. The Maine Health Care Plan provides a range of benefits, including hospital services, health care services from participating providers, laboratory and imaging procedures, home health services, rehabilitative services, prescription drugs and devices, mental health services, substance abuse treatment services, dental services, vision appliances, medical supplies and equipment and hospice care. Health care services under the Maine Health Care Plan are

provided by participating providers in organized delivery systems and through the open plan, which is available to all providers. The plan is supplemental to other health care programs that may be available to plan members, such as MaineCare, Medicare, the Dirigo Health Program, the federal Civilian Health and Medical Program of the Uniformed Services, the federal Indian Health Care Improvement Act and workers' compensation.

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

It directs the Maine Health Care Agency to establish programs to ensure quality, affordability, efficiency of care and health planning. The agency health planning program includes the establishment of global budgets for health care expenditures for the State and for institutions and hospitals. The health planning program also encompasses the certificate of need responsibilities of the agency pursuant to the Maine Revised Statutes, Title 22, chapter 103-A and the health planning responsibilities pursuant to Title 2, chapter 5. The agency is also required to contract with a 3rd-party administrator for claims processing and data collection services.

It requires the State Controller to advance $400,000 to the Maine Health Care Trust Fund on the effective date of the Part, July 1, 2010. This amount must be repaid by the Maine Health Care Agency by June 30, 2012.

2. Part B of the bill establishes the Maine Health Care Plan Transition Advisory Committee. Composed of 20 members, appointed and subject to confirmation, the committee is charged with holding public hearings, soliciting public comments and advising the Maine Health Care Council on the transition from the current health care system to the Maine Health Care Plan. Members of the committee serve without compensation but may be reimbursed for their expenses. The committee is directed to report to the Governor and to the Legislature every 6 months beginning July 1, 2010. The committee completes its work when the Maine Health Care Plan becomes effective.

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

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

5. Part E of the bill directs the Maine Health Care Agency to ensure employment retraining for administrative workers employed by insurers and providers who are displaced by the transition to the Maine Health Care Plan. It directs the Maine Health Care Agency to study the delivery and financing of long-term care services to plan members. Consultation is required with the Maine Health Care Plan Transition Advisory Committee, representatives of consumers and potential consumers of long-term care

services and representatives of providers of long-term care services, employers, employees and the public. A report by the agency to the Legislature is due January 1, 2012.

The Maine Health Care Agency is directed to study the provision of health care services under the MaineCare and Medicare programs, waivers, coordination of benefit delivery and compensation, reorganization of State Government necessary to accomplish the objectives of the Maine Health Care Agency and legislation needed to carry out the purposes of the bill. The agency is directed to apply for all waivers required to coordinate the benefits of the Maine Health Care Plan and the MaineCare and Medicare programs. A report by the agency is due to the Legislature by March 1, 2011.

6. Part F of the bill clarifies that, throughout the Maine Revised Statutes, the words "payer" and "payor" may be used interchangeably and have the same meaning.

7. Part G of the bill establishes a 7.5% payroll tax on wages and earnings, including self-employed earnings, and dedicates that tax revenue to the Maine Health Care Trust Fund.