125th MAINE LEGISLATURE

FIRST REGULAR SESSION-2011

Legislative Document **No. 1397**

H.P. 1026 House of Representatives, April 4, 2011

An Act To Establish a Single-payor Health Care System To Be Effective in 2017

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

HEATHER J.R. PRIEST
Clerk

Presented by Representative PRIEST of Brunswick.
Cosponsored by Senator GERZOFSKY of Cumberland and
Representatives: BEAUDOIN of Biddeford, BERRY of Bowdoinham, BOLAND of Sanford, BRIGGS of Mexico, BRYANT of Windham, CAIN of Orono, CASAVANT of Biddeford, CHAPMAN of Brooksville, CLARK of Millinocket, CLARKE of Bath, CORNELL du HOUX of Brunswick, DION of Portland, DRISCOLL of Westbrook, DUCHESNE of Hudson, EVES of North Berwick, FLEMINGS of Bar Harbor, GILBERT of Jay, GOODE of Bangor, GRAHAM of North Yarmouth, HASKELL of Portland, HAYES of Buckfield, HINCK of Portland, HOGAN of Old Orchard Beach, KENT of Woolwich, KRUGER of Thomaston, KUMIEGA of Deer Isle, LONGSTAFF of Waterville, LOVEJOY of Portland, MacDONALD of Boothbay, MARTIN of Eagle Lake, MAZUREK of Rockland, McCABE of Skowhegan, MITCHELL of the Penobscot Nation, MORRISON of South Portland, PEOPLES of Westbrook, PETERSON of Rumford, PILON of Saco, RANKIN of Hiram, ROCHELO of Biddeford, ROTUNDO of Lewiston, RUSSELL of Portland, SANBORN of Gorham, STUCKEY of Portland, TREAT of Hallowell, TUTTLE of Sanford, WAGNER of Lewiston, WEBSTER of Freeport, WELSH of Rockport, Senators: ALFOND of Cumberland, BLISS of Cumberland, BRANNIGAN of Cumberland, CRAVEN of Androscoggin, JACKSON of Aroostook, PATRICK of Oxford.

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, paragraph B.

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, paragraph A.

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. Plan card. "Plan card" means a card to authenticate patient identity, which, consistent with privacy and security standards established by the agency, enables a health care professional or provider to access patient records and facilitate payment for services.

10. Premium. "Premium" means the required payment by a Maine resident and eligible nonresident into the fund as required by Title 36, chapter 379.

11. 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 federal Social Security Act, Title XVIII and permitted under state law.

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

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 approval of a state waiver from the Secretary of the United States Department of Health and Human Services pursuant to Section 1332 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The plan must offer health care services no later than 10 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 plan has the following goals:

A. To provide uniform access to health care for every resident of this State;

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

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

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

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

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

G. 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;

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

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

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

K. 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 provide for at least the following.

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.

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 federal 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, a person must apply for a plan card, pay to the fund the premium determined applicable pursuant to section 374, subsection 1, paragraph A 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 nominal 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 the effective date of this section.

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 include, but are not limited to, the following.

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 care 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 federal Social Security Act, Title XVIII; the Medicaid program of the federal 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. The plan may require 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 to 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 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. A 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. Rates of payment for durable and nondurable medical devices, supplies and related items;

C. Rates of payment for medical tests to detect or evaluate disease and to determine treatment, including, but not limited to, blood tests, computerized tomography scans, DNA testing, electrocardiogram screening, HIV screening, magnetic resonance imaging and positron emission tomography scans and ultrasounds;

D. Maintenance of a prescription drug formulary; and

E. 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 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 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 located in this State to provide 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 subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

A. Payments are deposited into the fund from the following sources:

(1) Dedicated premium assessments paid by residents and eligible nonresidents based on adjusted gross income pursuant to Title 36, chapter 379;

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

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

(4) Other payments made pursuant to law.

B. Expenditures from the fund are authorized for the following purposes:

(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 for administration of the fund and the plan;

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

(7) 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 the 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 has 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. 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 and analysis. The agency shall institute a data collection system to acquire and analyze information on the provision of health care and health care costs. The agency shall coordinate with existing medical information centers that currently provide such services to the State. 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 under Title 36, section 2897 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 federal, state and municipal governments.

12. Reports. By March 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 5 members who serve full time, appointed by the Governor and, within 30 days after appointment, 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 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.

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. Three council members constitute a quorum. The council may take action only by an affirmative vote of at least 3 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 $600,000 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, 2018.

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 2 years, 2 for 3 years and 2 for 5 years.

Sec. A-4. Effective date. This Part takes effect January 1, 2017.

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 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, 2017, 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 Title 22, section 372.

Sec. B-2. Effective date. This Part takes effect January 1, 2017.

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 January 1, 2017.

PART D

Sec. D-1. 24-A MRSA §2188, is enacted to read:

§2188. 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.

Sec. D-2. Effective date. This Part takes effect January 1, 2017.

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, 2018 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, 2017 and may include suggested legislation in the report.

Sec. E-4. Effective date. This Part takes effect January 1, 2017.

PART F

Sec. F-1. Waiver for state innovation. The Maine Health Care Agency shall submit a request for waiver to the Secretary of the United States Department of Health and Human Services pursuant to Section 1332 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The waiver request must be submitted no later than March 1, 2017.

Sec. F-2. Effective date. This Part takes effect January 1, 2017.

PART G

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

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

PART H

Sec. H-1. 36 MRSA c. 379 is enacted to read:

CHAPTER 379

HEALTH CARE PREMIUM ASSESSMENT

§2897. Health care premium assessment

1. Premium assessment established. Residents of this State and eligible nonresidents as described in Title 22, section 372, subsection 2, paragraph B shall pay premium assessments in accordance with this subsection to the Maine Health Care Trust Fund established in Title 22, section 374, subsection 1 to finance the Maine Health Care Plan established in Title 22, section 372.

A. A resident or eligible nonresident shall pay 9% of federal adjusted gross income except those residents or nonresidents with a federal adjusted gross income at or under 300% of the federal poverty level as provided in paragraph B.

B. The premium assessment paid by a resident or eligible nonresident with a federal adjusted gross income at or under 300% of the federal poverty level is determined as follows:

(1) The premium assessment for an individual with federal adjusted gross income from 300% to 276% of the federal poverty level is 8%;

(2) The premium assessment for an individual with federal adjusted gross income from 275% to 251% of the federal poverty level is 7%;

(3) The premium assessment for an individual with federal adjusted gross income from 250% to 226% of the federal poverty level is 6%;

(4) The premium assessment for an individual with federal adjusted gross income from 225% to 201% of the federal poverty level is 5%;

(5) The premium assessment for an individual with federal adjusted gross income from 200% to 176% of the federal poverty level is 4%;

(6) The premium assessment for an individual with federal adjusted gross income from 175% to 151% of the federal poverty level is 3%;

(7) The premium assessment for an individual with federal adjusted gross income from 150% to 133% of the federal poverty level is 2%; and

(8) The premium assessment for an individual with federal adjusted gross income at or under 132% of the federal poverty level is zero.

2. Premium adjustment. The Maine Health Care Agency established in Title 22, section 375 may submit legislation to adjust the premium assessment established in this section if the agency determines the adjustment is necessary to the operation of the Maine Health Care Plan established in Title 22, section 372 in a fiscally responsible manner. A proposal to adjust the premium assessment may not exceed 1% per year and may not exceed 13% of a resident's or eligible nonresident's adjusted gross income.

3. Payment of premium assessment; returns. Premium assessments are paid in the following manner.

A. If a resident or eligible nonresident is employed by an employer in the State, the employer shall deduct the premium assessment from the employee's wages and forward the assessment to the assessor. An employer may pay the premium assessment on behalf of an employee for a period of 5 years after the Maine Health Care Plan becomes effective and treat any amount used for that purpose as a business expense on the employer's tax return.

B. An employee may receive employer-sponsored health care coverage for a period of 5 years after the Maine Health Care Plan becomes effective.

C. For a resident or eligible nonresident who is not employed by an employer in this State, that resident or eligible nonresident, including a self-employed person, shall submit the premium assessment required under this section and quarterly income statements to the assessor on forms approved by the assessor. The premium assessment and quarterly income statement must be submitted on or before the last day of April, June and October in each calendar year, and the final income statement and premium assessment payment for a calendar year are due on March 15th of the succeeding calendar year. With the approval of the assessor, a resident or eligible nonresident with an annual liability for a premium assessment not exceeding $500 may file an annual income statement with the premium assessment payment on or before March 15th for the prior calendar year.

4. Transfer to Maine Health Care Trust Fund. The assessor shall transfer premium assessments collected under this section to the Maine Health Care Trust Fund established in Title 22, section 374.

Sec. H-2. Effective date. This Part takes effect January 1, 2017.

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. The system becomes effective January 1, 2017 and is contingent on the approval of a waiver from the United States Department of Health and Human Services in accordance with the federal Patient Protection and Affordable Care Act.

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 will become effective and binding on the State upon the approval of a waiver from the United States Department of Health and Human Services. 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 employers, individuals and plan members. The Maine Health Care Plan must conform to the minimum essential benefits required under federal law, but may require additional benefits within existing resources. 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 Medicare, Medicaid. 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.

It contains a directive to the State Controller to advance $600,000 to the Maine Health Care Trust Fund on the effective date, January 1, 2017. This amount must be repaid by the Maine Health Care Agency by June 30, 2018.

2. Part B of the bill establishes the Maine Health Care Plan Transition Advisory Committee. Composed of 20 members, appointed by the Governor, President of the Senate and Speaker of the House of Representatives and subject to confirmation by the Legislature, the committee is charged with holding public hearings, soliciting public comments and advising the Maine Health Care Agency 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, 2017. 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 care 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 committee to the Legislature is due January 1, 2018.

The Maine Health Care Agency is directed to study the provision of health care services under the MaineCare, Medicaid 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 Medicaid and Medicare programs. A report by the agency is due to the Legislature by March 1, 2017.

6. Part F of the bill requires the Maine Health Care Agency to submit a request for a state waiver pursuant to federal law no later than March 1, 2017.

7. Part G clarifies that throughout the Maine Revised Statutes, the words "payer" and "payor" have the same meaning.

8. Part H establishes a 9% premium assessment on a resident's or eligible nonresident's federal adjusted gross income and dedicates that revenue to the Maine

Health Care Trust Fund, except that those persons with federal adjusted gross incomes at or under 300% of the federal poverty level pay progressively lower premium assessments. Part H also defines a process for premium adjustment requests by the agency in order to operate in a fiscally responsible manner.