

MAINE STATE LEGISLATURE

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127th MAINE LEGISLATURE

FIRST REGULAR SESSION-2015

Legislative Document

No. 815

S.P. 289

In Senate, March 10, 2015

An Act To Establish a Unified-payor, Universal Health Care System

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

A handwritten signature in cursive script, reading "Heather J.R. Priest".

HEATHER J.R. PRIEST
Secretary of the Senate

Presented by Senator GRATWICK of Penobscot.
Cosponsored by Representatives: BROOKS of Lewiston, TUCKER of Brunswick,
Representative SANBORN of Gorham and
Senators: ALFOND of Cumberland, JOHNSON of Lincoln, MIRAMANT of Knox,
Representatives: BURSTEIN of Lincolnville, HYMANSON of York.

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

2 **PART A**

3 **Sec. A-1. 2 MRSA §6, sub-§1**, as amended by PL 2011, c. 657, Pt. Y, §1, is
4 further amended to read:

5 **1. Range 91.** The salaries of the following state officials and employees are within
6 salary range 91:

- 7 Commissioner of Transportation;
- 8 Commissioner of Agriculture, Conservation and Forestry;
- 9 Commissioner of Administrative and Financial Services;
- 10 Commissioner of Education;
- 11 Commissioner of Environmental Protection;
- 12 Executive Director of Dirigo Health;
- 13 Commissioner of Public Safety;
- 14 Commissioner of Professional and Financial Regulation;
- 15 Commissioner of Labor;
- 16 Commissioner of Inland Fisheries and Wildlife;
- 17 Commissioner of Marine Resources;
- 18 Commissioner of Corrections;
- 19 Commissioner of Economic and Community Development;
- 20 Commissioner of Defense, Veterans and Emergency Management; ~~and~~
- 21 Executive Director, Workers' Compensation Board; and
- 22 Executive Director, Maine Health Benefit Marketplace.

23 **Sec. A-2. 24-A MRSA c. 93** is enacted to read:

24 **CHAPTER 93**

25 **MAINE HEALTH BENEFIT MARKETPLACE ACT**

26 **§7201. Short title**

27 This chapter may be known and cited as "the Maine Health Benefit Marketplace
28 Act."

29 **§7202. Definitions**

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

1 **1. Commissioner.** "Commissioner" means the Commissioner of Professional and
2 Financial Regulation.

3 **2. Educated health care consumer.** "Educated health care consumer" means an
4 individual who is knowledgeable about the health care system, who has no financial
5 interest in the delivery of health care services or sale of health insurance and has a
6 background or experience in making informed decisions regarding health, medical or
7 scientific matters.

8 **3. Health benefit plan.** "Health benefit plan" means a policy, contract, certificate or
9 agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or
10 reimburse any of the costs of health care services.

11 A. "Health benefit plan" does not include:

12 (1) Coverage only for accident and disability income insurance or any
13 combination of accident and disability income insurance;

14 (2) Coverage issued as a supplement to liability insurance;

15 (3) Liability insurance, including general liability insurance and automobile
16 liability insurance;

17 (4) Workers' compensation or similar insurance;

18 (5) Automobile medical payment insurance;

19 (6) Credit-only insurance;

20 (7) Coverage for on-site medical clinics; or

21 (8) Insurance coverage similar to any coverage listed in subparagraphs (1) to (7),
22 as specified in federal regulations issued pursuant to the federal Health Insurance
23 Portability and Accountability Act of 1996, Public Law 104-191, under which
24 benefits for health care services are secondary or incidental to other insurance
25 benefits.

26 B. "Health benefit plan" does not include the following benefits if the benefits are
27 provided under a separate policy, certificate or contract of insurance or are otherwise
28 not an integral part of the plan:

29 (1) Limited-scope dental or vision benefits;

30 (2) Benefits for long-term care, nursing home care, home health care,
31 community-based care or any combination of those benefits; or

32 (3) Limited benefits similar to benefits listed in subparagraphs (1) and (2) as
33 specified in federal regulations issued pursuant to the federal Health Insurance
34 Portability and Accountability Act of 1996, Public Law 104-191.

35 C. "Health benefit plan" does not include the following benefits if the benefits are
36 provided under a separate policy, certificate or contract of insurance, there is no
37 coordination between the provision of the benefits and any exclusion of benefits
38 under any group health plan maintained by the same plan sponsor and the benefits are
39 paid with respect to an event without regard to whether benefits are provided with

1 respect to such an event under any group health plan maintained by the same plan
2 sponsor:

3 (1) Coverage only for a specified disease or illness; or

4 (2) Hospital indemnity or other fixed indemnity insurance.

5 D. "Health benefit plan" does not include the following if offered as a separate
6 policy, certificate or contract of insurance:

7 (1) Medicare supplemental health insurance as defined under the United States
8 Social Security Act, Section 1882(g)(1);

9 (2) Coverage supplemental to the coverage provided under 10 United States
10 Code, Chapter 55; or

11 (3) Supplemental coverage similar to coverage listed in subparagraphs (1) and
12 (2) provided under a group health plan.

13 **4. Health carrier.** "Health carrier" or "carrier" means:

14 A. An insurance company licensed in accordance with this Title to provide health
15 insurance;

16 B. A health maintenance organization licensed pursuant to chapter 56;

17 C. A preferred provider arrangement administrator registered pursuant to chapter 32;

18 D. A nonprofit hospital or medical service organization or health benefit plan
19 licensed pursuant to Title 24; or

20 E. An employee benefit excess insurance company licensed in accordance with this
21 Title to provide property and casualty insurance that provides employee benefit
22 excess insurance pursuant to section 707, subsection 1, paragraph C-1.

23 **5. Marketplace.** "Marketplace" means the Maine Health Benefit Marketplace
24 established in section 7203 pursuant to Section 1311 of the federal Affordable Care Act.

25 **6. Qualified employer.** "Qualified employer" means a small employer that elects to
26 make its full-time employees and, at the option of the employer, some or all of its part-
27 time employees eligible for one or more qualified health plans or qualified stand-alone
28 dental benefit plans offered through the SHOP exchange and that:

29 A. Has its principal place of business in this State and elects to provide coverage
30 through the SHOP exchange to all of its eligible employees, wherever employed; or

31 B. Elects to provide coverage through the SHOP exchange to all of its eligible
32 employees who are principally employed in this State.

33 **7. Qualified health plan.** "Qualified health plan" means a health benefit plan that
34 has in effect a certification that the plan meets the criteria for certification described in
35 Section 1311(c) of the federal Affordable Care Act and this chapter.

36 **8. Qualified individual.** "Qualified individual" means an individual, including a
37 minor, who:

1 A. Is seeking to enroll in a qualified health plan or qualified stand-alone dental
2 benefit plan offered to individuals through the marketplace;

3 B. Resides in this State within the meaning of the federal Affordable Care Act;

4 C. At the time of enrollment, is not incarcerated, other than incarceration pending the
5 disposition of charges; and

6 D. Is, and is reasonably expected to be, for the entire period for which enrollment is
7 sought, a citizen or national of the United States or an alien lawfully present in the
8 United States.

9 **9. Qualified stand-alone dental benefit plan.** "Qualified stand-alone dental benefit
10 plan" means a stand-alone dental benefit plan that has been certified in accordance with
11 section 7208, subsection 5.

12 **10. Secretary.** "Secretary" means the Secretary of the United States Department of
13 Health and Human Services.

14 **11. SHOP exchange.** "SHOP exchange" means the Small Business Health Options
15 Program established pursuant to section 7203.

16 **12. Small employer.** "Small employer" means an employer that employed an
17 average of not more than 100 employees during the preceding calendar year except that,
18 for plan years beginning before January 1, 2018, "small employer" means an employer
19 that employed an average of not more than 50 employees during the preceding calendar
20 year. For purposes of this subsection:

21 A. All persons treated as a single employer under 26 United States Code, Section
22 414(b), (c), (m) or (o) must be treated as a single employer;

23 B. A successor employer and a predecessor employer must be treated as a single
24 employer;

25 C. All employees must be counted, including part-time employees and employees
26 who are not eligible for coverage through the employer;

27 D. If an employer was not in existence throughout the preceding calendar year, the
28 determination of whether that employer is a small employer must be based on the
29 average number of employees reasonably expected to be employed by that employer
30 on business days in the current calendar year; and

31 E. An employer that makes enrollment in qualified health plans or qualified
32 stand-alone dental benefit plans available to its employees through the SHOP
33 exchange, and would cease to be a small employer by reason of an increase in the
34 number of its employees, must continue to be treated as a small employer for
35 purposes of this chapter as long as the employer continuously makes enrollment
36 through the SHOP exchange available to its employees.

37 **13. Stand-alone dental benefit plan.** "Stand-alone dental benefit plan" means a
38 policy, contract, certificate or agreement offered or issued by a carrier to provide, deliver,
39 arrange for, pay for or reimburse any of the costs of limited-scope dental benefits meeting
40 the requirements of Section 9832(c)(2)(A) of the federal Internal Revenue Code of 1986.

1 **§7203. Maine Health Benefit Marketplace established; declaration of necessity**

2 **1. Marketplace established.** The Commissioner of Professional and Financial
3 Regulation shall establish the Maine Health Benefit Marketplace to provide, pursuant to
4 the federal Affordable Care Act, for the establishment of a health benefit exchange to
5 facilitate the purchase and sale of qualified health plans and qualified stand-alone dental
6 benefit plans in the individual market in this State and for the establishment of the SHOP
7 exchange to assist qualified employers in this State in facilitating the enrollment of their
8 employees in qualified health plans and qualified stand-alone dental benefit plans offered
9 in the small group market. The intent of the marketplace is to reduce the number of
10 uninsured individuals, provide a transparent marketplace and consumer education and
11 assist individuals with access to programs, premium tax credits and cost-sharing
12 reductions. It is also the intent of the marketplace to maximize the receipt of federal
13 funds, including those available pursuant to the federal Affordable Care Act, and to be the
14 foundation for a universal health care system in the State through the Maine Health Care
15 Plan pursuant to Title 22, chapter 106. The exercise by the Maine Health Benefit
16 Marketplace of the powers conferred by this chapter is deemed and held to be the
17 performance of an essential government function.

18 **2. Contracting authority.** The marketplace may contract with an eligible entity for
19 any of its functions described in this chapter. For the purposes of this subsection, "eligible
20 entity" includes, but is not limited to, the federally facilitated marketplace, any entity
21 under contract with the federally facilitated marketplace, the MaineCare program or any
22 entity that has experience in individual and small group health insurance or benefit
23 administration or other experience relevant to the responsibilities to be assumed by the
24 entity, except that a health carrier or an affiliate of a health carrier is not an eligible entity.

25 **3. Information sharing.** The marketplace may enter into information-sharing
26 agreements with federal and state agencies and other states' exchanges to carry out its
27 responsibilities under this chapter; such agreements must include adequate protections
28 with respect to the confidentiality of the information to be shared and comply with all
29 state and federal laws, rules and regulations.

30 **§7204. Records**

31 Except as provided in subsections 1 and 2, information obtained by the marketplace
32 under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter
33 1.

34 **1. Financial information.** Any personally identifiable financial information,
35 supporting data or tax return of any person obtained by the marketplace under this chapter
36 is confidential and not open to public inspection.

37 **2. Health information.** Health information obtained by the marketplace under this
38 chapter that is covered by the federal Health Insurance Portability and Accountability Act
39 of 1996, Public Law 104-191 or information covered by chapter 24 or Title 22, section
40 1711-C is confidential and not open to public inspection.

1 **§7205. Executive director**

2 **1. Appointed position.** The commissioner shall appoint an executive director, who
3 serves at the pleasure of the commissioner.

4 **2. Duties of executive director.** The executive director appointed under subsection
5 1 shall:

6 A. Serve as the liaison between the commissioner and the marketplace;

7 B. Manage the marketplace's programs and services;

8 C. Employ or contract on behalf of the marketplace for professional and
9 nonprofessional personnel or services. Employees of the marketplace are subject to
10 the Civil Service Law;

11 D. Approve all accounts for salaries, per diems or allowable expenses of the
12 marketplace or of any employee or consultant of the marketplace and expenses
13 incidental to the operation of the marketplace; and

14 E. Perform other duties as necessary to carry out the functions of this chapter.

15 **§7206. Availability of coverage**

16 **1. Coverage.** The marketplace shall make qualified health plans and qualified
17 stand-alone dental benefit plans available to qualified individuals and qualified employers
18 no later than January 1, 2017. The marketplace may enroll qualified individuals and
19 qualified employers beginning on or after October 15, 2016.

20 **2. Other eligible populations.** To the extent allowable under federal law, the
21 marketplace may make qualified health plans and qualified stand-alone dental benefit
22 plans available to other populations in addition to those eligible under the federal
23 Affordable Care Act, including:

24 A. To individuals and employers who are not qualified individuals or qualified
25 employers as defined by this chapter and by the federal Affordable Care Act;

26 B. To individuals who are eligible for Medicaid benefits, upon approval by the
27 federal Centers for Medicare and Medicaid Services, as long as including these
28 individuals in the marketplace will not reduce their Medicaid benefits;

29 C. To individuals who are eligible for Medicare benefits, upon approval by the
30 federal Centers for Medicare and Medicaid Services, as long as including these
31 individuals in the marketplace will not reduce their Medicare benefits;

32 D. To state employees and municipal employees, including teachers; and

33 E. To the extent allowable under federal law, to employees for injuries arising out of
34 or in the course of employment in lieu of medical benefits provided pursuant to Title
35 39-A.

36 **3. Qualified plan required.** The marketplace may not make available any health
37 benefit plan that is not a qualified health plan or any stand-alone dental benefit plan that
38 is not a qualified stand-alone dental benefit plan.

1 **4. Dental benefits.** The marketplace shall allow a health carrier to offer a qualified
2 stand-alone dental benefit plan through the marketplace, either separately or in
3 conjunction with a qualified health plan, if the plan provides pediatric dental benefits
4 meeting the requirements of Section 1302(b)(1)(J) of the federal Affordable Care Act.
5 This subsection does not prohibit a carrier from offering other dental benefit plans
6 consistent with the requirements of section 7208, subsections 5 and 6.

7 **5. No fee or penalty for termination of coverage.** The marketplace or a carrier
8 offering qualified health plans or qualified stand-alone dental benefit plans through the
9 marketplace may not charge an individual a fee or penalty for termination of coverage if
10 the individual enrolls in another type of minimum essential coverage because the
11 individual has become newly eligible for that coverage or because the individual's
12 employer-sponsored coverage has become affordable under the standards of Section 1401
13 of the federal Affordable Care Act.

14 **6. Standardized plans.** The marketplace may standardize qualified health plans to
15 be offered through the marketplace.

16 **§7207. Powers and duties of the Maine Health Benefit Marketplace**

17 **1. Powers.** Subject to any limitations contained in this chapter or in any other law,
18 the marketplace may:

19 A. Take any legal actions that are necessary for the proper administration of the
20 marketplace;

21 B. Make and alter bylaws, not inconsistent with this chapter or with the laws of this
22 State, for the administration and regulation of the activities of the marketplace;

23 C. Have and exercise all powers necessary or convenient to effect the purposes for
24 which the marketplace is organized or to further the activities in which the
25 marketplace may lawfully be engaged, including the establishment of the
26 marketplace;

27 D. Engage in legislative liaison activities, including gathering information regarding
28 legislation, analyzing the effect of legislation, communicating with Legislators and
29 attending and giving testimony at legislative sessions, public hearings or committee
30 hearings;

31 E. Enter into contracts with qualified 3rd parties both private and public for any
32 service necessary to carry out the purposes of this chapter;

33 F. Apply for and receive funds, grants or contracts from public and private sources;
34 and

35 G. In accordance with the limitations and restrictions of this chapter, cause any of its
36 powers or duties to be carried out by one or more organizations organized, created or
37 operated under the laws of this State.

38 **2. Duties.** The marketplace shall:

39 A. Implement procedures for the certification, recertification and decertification,
40 consistent with guidelines developed by the secretary under Section 1311(c) of the

- 1 federal Affordable Care Act and pursuant to section 7208, of health benefit plans as
2 qualified health plans and of stand-alone dental benefit plans as qualified stand-alone
3 dental benefit plans;
- 4 B. Provide for the operation of a toll-free telephone hotline to respond to requests for
5 assistance except that the hotline may not be automated unless the hotline provides
6 the opportunity for live customer service;
- 7 C. Provide for enrollment periods as provided under Section 1311(c)(6) of the
8 federal Affordable Care Act;
- 9 D. Maintain a publicly accessible website through which enrollees and prospective
10 enrollees of qualified health plans and qualified stand-alone dental benefit plans may
11 obtain standardized comparative information on such plans;
- 12 E. Assign a rating to each qualified health plan offered through the marketplace in
13 accordance with the criteria developed by the secretary under Section 1311(c)(3) of
14 the federal Affordable Care Act and determine each qualified health plan's level of
15 coverage in accordance with regulations issued by the secretary under Section
16 1302(d)(2)(A) of the federal Affordable Care Act;
- 17 F. Use a standardized format for presenting health and dental benefit options in the
18 marketplace, including the use of the uniform outline of coverage established under
19 the federal Public Health Service Act, 42 United States Code, Section 300gg-15
20 (2010);
- 21 G. In accordance with Section 1413 of the federal Affordable Care Act, inform
22 individuals of eligibility requirements for the Medicaid program under the United
23 States Social Security Act, Title XIX or the State Children's Health Insurance
24 Program under the United States Social Security Act, Title XXI or under any
25 applicable state or local public program and if, through screening of an application by
26 the marketplace, the marketplace determines that an individual is eligible for any
27 such program, enroll the individual in that program;
- 28 H. Determine the criteria and process for eligibility, enrollment and disenrollment of
29 enrollees and potential enrollees in the marketplace and coordinate that process with
30 the state and local government entities administering other health care coverage
31 programs, including the MaineCare program and the basic health program, if
32 established by paragraph O, in order to ensure consistent eligibility and enrollment
33 processes and seamless transitions between coverages. To the extent possible, the
34 executive director shall encourage the use of existing infrastructure and capacity from
35 other state agencies;
- 36 I. Determine the minimum requirements a carrier must meet to be considered for
37 participation in the marketplace and the standards and criteria for selecting qualified
38 health plans to be offered through the marketplace that are in the best interests of
39 qualified individuals and qualified employers. The executive director shall
40 consistently and uniformly apply these requirements, standards and criteria to all
41 carriers offering qualified health plans through the marketplace and, if relevant, shall
42 apply those requirements, standards and criteria to carriers offering qualified stand-
43 alone dental benefit plans or other dental benefit plans through the marketplace. In
44 the course of selectively contracting for health care coverage offered to qualified

1 individuals and qualified employers through the marketplace, the executive director
2 shall seek to contract with carriers so as to provide health care coverage choices that
3 offer the optimal combination of choice, value, quality and service. In evaluating the
4 quality of health care coverage offered by a carrier, the executive director shall
5 consider comparative health care quality information and assessments developed by
6 the Maine Quality Forum, as established in section 6951;

7 J. Provide, in each region of the State, a choice of qualified health plans at each of
8 the 5 levels of coverage contained in Section 1302(d) and (e) of the federal
9 Affordable Care Act;

10 K. Require, as a condition of participation in the marketplace, carriers to fairly and
11 affirmatively offer, market and sell in the marketplace at least one product within
12 each of the 5 levels of coverage contained in Section 1302(d) and (e) of the federal
13 Affordable Care Act. The executive director may require carriers to offer additional
14 products within each of those 5 levels of coverage. This paragraph does not apply to a
15 carrier that solely offers supplemental coverage in the marketplace or that solely
16 offers a qualified stand-alone dental benefit plan;

17 L. Require, as a condition of participation in the marketplace, carriers that sell any
18 products outside the marketplace to:

19 (1) Fairly and affirmatively offer, market and sell all products made available to
20 individuals in the marketplace to individuals purchasing coverage outside the
21 marketplace; and

22 (2) Fairly and affirmatively offer, market and sell all products made available to
23 small employers in the marketplace to small employers purchasing coverage
24 outside the marketplace;

25 M. Establish and make available by electronic means and by a toll-free telephone
26 number a calculator to determine the actual cost of coverage after application of any
27 premium tax credit under Section 1401 of the federal Affordable Care Act and any
28 cost-sharing reduction under Section 1402 of the federal Affordable Care Act;

29 N. Establish a SHOP exchange through which qualified employers may access
30 coverage for their employees, enabling any qualified employer to specify a level of
31 coverage or amount of contribution toward coverage so that any of its employees may
32 enroll in any qualified health plan or qualified stand-alone dental benefit plan offered
33 through the SHOP exchange at the specified level of coverage;

34 O. Consider, in consultation with the Department of Health and Human Services and
35 the MaineCare Advisory Committee, establishing a basic health program for eligible
36 individuals in accordance with Section 1331 of the federal Affordable Care Act in
37 order to ensure continuity of care and that families previously enrolled in Medicaid
38 remain in the same plan. On or before April 1, 2016, the executive director shall
39 submit the executive director's recommendation on whether to establish a basic health
40 plan in accordance with this paragraph for review by the joint standing committee of
41 the Legislature having jurisdiction over insurance matters;

42 P. Subject to Section 1411 of the federal Affordable Care Act, issue a certification
43 attesting that, for purposes of the individual responsibility penalty under 26 United

1 States Code, Section 5000A, an individual is exempt from the individual
2 responsibility requirement or from the penalty because:

3 (1) There is no affordable qualified health plan available through the
4 marketplace, or the individual's employer, covering the individual; or

5 (2) The individual meets the requirements for any other exemption from the
6 individual responsibility requirement or penalty;

7 Q. Transfer to the United States Secretary of the Treasury the following:

8 (1) A list of the individuals who are issued a certification under paragraph P,
9 including the name and taxpayer identification number of each individual;

10 (2) The name and taxpayer identification number of each individual who was an
11 employee of an employer but who was determined to be eligible for the premium
12 tax credit under Section 1401 of the federal Affordable Care Act because:

13 (a) The employer did not provide the minimum essential coverage; or

14 (b) The employer provided the minimum essential coverage, but it was
15 determined under Section 1401 of the federal Affordable Care Act to either
16 be unaffordable to the employee or not provide the required minimum
17 actuarial value; and

18 (3) The name and taxpayer identification number of:

19 (a) Each individual who notifies the marketplace under Section 1411(b)(4)
20 of the federal Affordable Care Act that the individual has changed
21 employers; and

22 (b) Each individual who ceases coverage under a qualified health plan
23 during a plan year and the effective date of that cessation;

24 R. Provide to each employer the name of each employee of the employer described
25 in paragraph Q, subparagraph (3) who ceases coverage under a qualified health plan
26 during a plan year and the effective date of the cessation;

27 S. Perform duties required of the marketplace by the secretary and the United States
28 Secretary of the Treasury related to determining eligibility for premium tax credits,
29 reduced cost sharing and individual responsibility requirement exemptions;

30 T. Select entities qualified to serve as navigators in accordance with section 7209,
31 Section 1311(i) of the federal Affordable Care Act and standards developed by the
32 secretary and award grants to enable navigators to:

33 (1) Conduct public education activities to raise awareness of the availability of
34 qualified health plans and qualified stand-alone dental benefit plans;

35 (2) Distribute fair and impartial information concerning enrollment in qualified
36 health plans and qualified stand-alone dental benefit plans and the availability of
37 premium tax credits under Section 1401 of the federal Affordable Care Act and
38 cost-sharing reductions under Section 1402 of the federal Affordable Care Act;

39 (3) Facilitate enrollment in qualified health plans and qualified stand-alone
40 dental benefit plans;

1 (4) Provide referrals to any applicable office of health insurance consumer
2 assistance or health insurance ombudsman established under the federal Public
3 Health Service Act, 42 United States Code, Section 300gg-93 (2010), or any
4 other appropriate state agency, for an enrollee with a grievance, complaint or
5 question regarding a health benefit plan or stand-alone dental benefit plan or
6 coverage or a determination under that plan or coverage; and

7 (5) Provide information in a manner that is culturally and linguistically
8 appropriate to the needs of the population being served by the marketplace.

9 An individual licensed as an insurance producer pursuant to chapter 16 may serve as
10 a navigator to qualified individuals in the marketplace and in the SHOP exchange in
11 accordance with Section 1311(i) of the federal Affordable Care Act;

12 U. Review the rate of premium growth within the marketplace and outside the
13 marketplace and consider the information in developing recommendations on
14 whether to continue limiting qualified employer status to small employers;

15 V. Credit the amount of any free choice voucher to the monthly premium of the
16 health benefit plan in which an employee is enrolled, in accordance with Section
17 10108 of the federal Affordable Care Act, and collect the amount credited from the
18 offering qualified employer;

19 W. Consult with stakeholders regarding carrying out the activities required under this
20 chapter, including, but not limited to:

21 (1) Educated health care consumers who are enrollees in qualified health plans
22 and qualified stand-alone dental benefit plans;

23 (2) Individuals and entities with experience in facilitating enrollment in qualified
24 health plans and qualified stand-alone dental benefit plans;

25 (3) Representatives of small businesses and self-employed individuals;

26 (4) Representatives of the MaineCare program; and

27 (5) Advocates for enrolling hard-to-reach populations;

28 X. Keep an accurate accounting of all activities, receipts and expenditures and
29 annually submit to the secretary, the Governor, the superintendent and the Legislature
30 a report concerning such accountings; and

31 Y. Fully cooperate with any investigation conducted by the secretary pursuant to the
32 secretary's authority under the federal Affordable Care Act and allow the secretary, in
33 coordination with the Inspector General of the United States Department of Health
34 and Human Services, to:

35 (1) Investigate the affairs of the marketplace;

36 (2) Examine the properties and records of the marketplace; and

37 (3) Require periodic reports of the marketplace in relation to the activities
38 undertaken by the marketplace.

39 The marketplace may not use any funds intended for the administrative and operational
40 expenses of the marketplace for staff retreats, promotional giveaways, excessive

1 executive compensation or promotion of federal or state legislative and regulatory
2 modifications.

3 **3. Budget.** The revenues and expenditures of the marketplace are subject to
4 legislative approval in the biennial budget process. The executive director shall prepare
5 the budget for the administration and operation of the marketplace in accordance with the
6 provisions of law that apply to departments of State Government.

7 **4. Audit.** The marketplace must be audited annually by the State Auditor. The
8 executive director may, in the executive director's discretion, arrange for an independent
9 audit to be conducted. A copy of any audit must be provided to the State Controller, the
10 superintendent, the joint standing committee of the Legislature having jurisdiction over
11 appropriations and financial affairs, the joint standing committee of the Legislature
12 having jurisdiction over insurance and financial services matters and the joint standing
13 committee of the Legislature having jurisdiction over health and human services matters.

14 **5. Rulemaking.** The marketplace may adopt rules as necessary for the proper
15 administration and enforcement of this chapter pursuant to the Maine Administrative
16 Procedure Act. Unless otherwise specified, rules adopted pursuant to this subsection are
17 routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Rules adopted
18 pursuant to this subsection may not conflict with or prevent the application of regulations
19 promulgated by the secretary under the federal Affordable Care Act.

20 **6. Annual report.** Beginning February 1, 2017, and annually thereafter, the
21 executive director shall report on the operation of the marketplace to the Governor, the
22 joint standing committee of the Legislature having jurisdiction over appropriations and
23 financial affairs, the joint standing committee of the Legislature having jurisdiction over
24 insurance and financial services matters and the joint standing committee of the
25 Legislature having jurisdiction over health and human services matters.

26 **7. Technical assistance from other state agencies.** Other state agencies, including,
27 but not limited to, the bureau; the Department of Health and Human Services; the
28 Department of Administrative and Financial Services, Maine Revenue Services; and the
29 Maine Health Data Organization, shall provide technical assistance and expertise to the
30 marketplace upon request.

31 **8. Legal counsel.** The Attorney General, when requested, shall furnish any legal
32 assistance, counsel or advice the marketplace requires in the discharge of its duties.

33 **9. Coordination with federal, state and local health care programs.** The
34 marketplace shall institute a system to coordinate the activities of the marketplace with
35 the health care programs of the Federal Government and state and municipal
36 governments.

37 **10. Advisory committees.** The executive director may appoint advisory committees
38 to advise and assist the executive director in discharging the executive director's
39 responsibilities under this chapter. Members of an advisory committee serve without
40 compensation but may be reimbursed by the marketplace for necessary expenses while on
41 official business of the advisory committee.

1 **11. Publication of costs.** The marketplace shall publish the average costs of
2 licensing, regulatory fees and any other payments required by the marketplace, and the
3 administrative costs of the marketplace, on a publicly accessible website to educate
4 consumers on such costs. This information must include information on money lost to
5 waste, fraud and abuse.

6 **§7208. Health benefit plan certification**

7 **1. Certification.** The marketplace shall certify a health benefit plan as a qualified
8 health plan if:

9 A. The health benefit plan provides the essential health benefits package described in
10 Section 1302(a) of the federal Affordable Care Act, except that the plan is not
11 required to provide essential benefits that duplicate the minimum benefits of qualified
12 stand-alone dental benefit plans, as provided in subsection 5, if:

13 (1) The marketplace has determined that at least one qualified stand-alone dental
14 benefit plan is available to supplement the plan's coverage; and

15 (2) The carrier makes prominent disclosure at the time it offers the plan, in a
16 form approved by the marketplace, that the plan does not provide the full range
17 of essential pediatric dental benefits and that qualified stand-alone dental benefit
18 plans providing those benefits and other dental benefits not covered by the plan
19 are offered through the marketplace;

20 B. The premium rates and contract language have been approved by the
21 superintendent;

22 C. The health benefit plan provides at least a bronze level of coverage, as determined
23 pursuant to Section 1302(d)(1)(A) of the federal Affordable Care Act for catastrophic
24 plans, and will be offered only to individuals eligible for catastrophic coverage;

25 D. The health benefit plan's cost-sharing requirements do not exceed the limits
26 established under Section 1302(c)(1) of the federal Affordable Care Act and, if the
27 plan is offered through the SHOP exchange, the plan's deductible does not exceed the
28 limits established under Section 1302(c)(2) of the federal Affordable Care Act;

29 E. The health carrier offering the health benefit plan:

30 (1) Is licensed and in good standing to offer health insurance coverage in this
31 State;

32 (2) Offers at least one qualified health plan in the silver level and at least one
33 plan in the gold level as described in Section 1302(d)(1)(B) and (d)(1)(C) of the
34 federal Affordable Care Act through each component of the marketplace in
35 which the carrier participates. As used in this subparagraph, "component" means
36 the SHOP exchange and the marketplace;

37 (3) Offers at least one qualified health plan that provides the essential health
38 benefits package described in Section 1302(a) of the federal Affordable Care Act
39 without benefits that duplicate the minimum dental benefits of stand-alone dental
40 benefit plans, if the marketplace has determined that at least one qualified stand-

1 alone dental benefit plan is available through the marketplace to supplement the
2 qualified health plan's coverage;

3 (4) Charges the same premium rate for each qualified health plan without regard
4 to whether the plan is offered through the marketplace and without regard to
5 whether the plan is offered directly from the carrier or through an insurance
6 producer;

7 (5) Does not charge any fees or penalties for termination of coverage in violation
8 of section 7206, subsection 5; and

9 (6) Complies with the regulations developed by the secretary under Section
10 1311(c) of the federal Affordable Care Act and such other requirements as the
11 marketplace may establish;

12 F. The health benefit plan meets the requirements of certification as adopted by rules
13 pursuant to section 7207, subsection 5 and by regulations promulgated by the
14 secretary under Section 1311(c) of the federal Affordable Care Act that include, but
15 are not limited to, minimum standards in the areas of marketing practices, network
16 adequacy, essential community providers in underserved areas, accreditation, quality
17 improvement, uniform enrollment forms and descriptions of coverage and
18 information on quality measures for health benefit plan performance; and

19 G. The marketplace determines that making the health benefit plan available through
20 the marketplace is in the interest of qualified individuals and qualified employers.

21 **2. Authority to exclude health benefit plans.** The marketplace may not exclude a
22 health benefit plan:

23 A. On the basis that the health benefit plan is a fee-for-service plan;

24 B. Through the imposition of premium price controls by the marketplace; or

25 C. On the basis that the health benefit plan provides treatments necessary to prevent
26 patients' deaths in circumstances in which the marketplace determines the treatments
27 are inappropriate or too costly.

28 **3. Carrier requirements.** The marketplace shall require each health carrier seeking
29 certification of a health benefit plan as a qualified health plan to:

30 A. Submit a justification for any premium rate increase before implementation of
31 that increase. The carrier shall prominently post the information concerning the
32 justification on its publicly accessible website. The marketplace shall take this
33 information, along with the information and the recommendations provided to the
34 marketplace by the superintendent under the federal Public Health Service Act, 42
35 United States Code, Section 300gg-94 (2010), into consideration when determining
36 whether to allow the carrier to make health benefit plans available through the
37 marketplace;

38 B. Make available to the public and submit to the marketplace, the secretary and the
39 superintendent accurate, transparent and timely disclosure of the following:

40 (1) Claims payment policies and practices;

- 1 (2) Periodic financial disclosures;
- 2 (3) Data on enrollment;
- 3 (4) Data on disenrollment;
- 4 (5) Data on the number of claims that are denied;
- 5 (6) Data on rating practices;
- 6 (7) Information on cost sharing and payments with respect to any out-of-network
- 7 coverage;
- 8 (8) Information on enrollee and participant rights under Title I of the federal
- 9 Affordable Care Act; and
- 10 (9) Other information as determined appropriate by the secretary.

11 The information required in this paragraph must be provided in plain language, as
12 that term is defined in Section 1311(e)(3)(B) of the federal Affordable Care Act;

13 C. Make available to an individual, in a timely manner upon the request of the
14 individual, the amount of cost sharing, including deductibles, copayments and
15 coinsurance, under the individual's plan or coverage that the individual would be
16 responsible for paying with respect to the furnishing of a specific item or service by a
17 participating provider. At a minimum, this information must be made available to the
18 individual through a publicly accessible website and through other means for an
19 individual without access to the Internet; and

20 D. Make a separate disclosure of the price of pediatric dental benefits if the plan
21 provides a comprehensive essential health benefits package described in Section
22 1302(a) of the federal Affordable Care Act, as long as the carrier is not required to
23 offer the pediatric dental benefit for sale on the marketplace on a stand-alone basis.

24 **4. No exemption from licensing or solvency requirements.** The marketplace may
25 not exempt any health carrier seeking certification of a qualified health plan, regardless of
26 the type or size of the carrier, from state licensure or solvency requirements.

27 **5. Application to qualified stand-alone dental benefit plans.** The provisions of
28 this chapter that are applicable to qualified health plans also apply to the extent relevant
29 to qualified stand-alone dental benefit plans except as provided in this subsection or by
30 rules adopted by the marketplace.

31 A. The marketplace may certify a stand-alone dental benefit plan as a qualified
32 stand-alone dental benefit plan if the carrier offering the plan:

33 (1) Is licensed and in good standing to offer dental coverage in this State. The
34 carrier need not be licensed to offer other health benefits;

35 (2) Offers at least one stand-alone dental benefit plan that includes only the
36 essential pediatric dental benefit requirement of Section 1302(b)(1)(J) of the
37 federal Affordable Care Act, as long as this requirement does not limit a carrier
38 from providing other stand-alone dental benefit plans that are certified by the
39 marketplace;

1 (3) Charges the same premium rate for each stand-alone dental benefit plan
2 without regard to whether the plan is offered through the marketplace and
3 without regard to whether the plan is offered directly from the carrier or through
4 an insurance producer;

5 (4) Submits the premium rates and contract language to the superintendent for
6 approval;

7 (5) Does not charge any fees or penalties for termination of coverage in violation
8 of section 7206, subsection 5; and

9 (6) Complies with any regulations adopted by the secretary under Section
10 1311(d) of the federal Affordable Care Act and any rules adopted by the
11 marketplace pursuant to this chapter.

12 B. The qualified stand-alone dental benefit plan must be limited to dental and oral
13 health benefits, without substantially duplicating the benefits typically offered by
14 health benefit plans without dental coverage, and must meet the requirements for
15 essential pediatric dental benefits prescribed by the secretary pursuant to Section
16 1302(b)(1)(J) of the federal Affordable Care Act and such other dental benefits as the
17 marketplace or the secretary may specify by rule or regulation.

18 C. Carriers may jointly offer a comprehensive plan through the marketplace in which
19 the dental benefits are provided by a carrier through a qualified stand-alone dental
20 benefit plan and the other benefits are provided by a carrier through a qualified health
21 plan, if the plans are priced separately and are also made available for purchase
22 separately at the same prices.

23 D. The marketplace may not exclude a stand-alone dental benefit plan on the basis
24 that the plan is a fee-for-service plan or through the imposition of premium price
25 controls by the marketplace.

26 **6. Other stand-alone dental benefit plans.** In addition to the certification of a
27 qualified stand-alone dental benefit plan pursuant to this section, the marketplace may
28 certify other stand-alone dental benefit plans, either as part of a qualified health plan or
29 separately, in accordance with this section and any rules adopted by the marketplace.

30 The marketplace shall apply the criteria of this section in a manner that ensures
31 fairness between or among health carriers participating in the marketplace.

32 **§7209. Navigators**

33 **1. Navigator grant program.** The marketplace shall establish a navigator grant
34 program to award grants to entities qualified to serve as navigators, in accordance with
35 this section, Section 1311(i) of the federal Affordable Care Act and standards developed
36 by the secretary, to enable navigators to perform the activities described in section 7207,
37 subsection 2, paragraph T.

38 **2. Selection of navigators.** The executive director shall, in the executive director's
39 sole discretion, select as a navigator and award a navigator grant to an eligible entity
40 described in subsection 3 that demonstrates to the satisfaction of the executive director
41 that it has the capacity and experience to effectively reach out to individuals, including

1 uninsured individuals, underinsured individuals, low-income individuals and self-
2 employed individuals, and small employers and their employees likely to be qualified to
3 enroll in a qualified health plan or qualified stand-alone dental benefit plan. In awarding a
4 grant to an eligible entity, the executive director shall ensure that the entity is able to
5 address the needs of individuals and small employers and their employees in all
6 geographic regions of the State in a manner that is culturally and linguistically
7 appropriate to the needs of the population being served.

8 **3. Eligible entities.** The executive director may award navigator grants in
9 accordance with subsection 1 to any of the following eligible entities:

- 10 A. A trade, industry or professional association;
- 11 B. A community-focused and consumer-focused nonprofit group;
- 12 C. A chamber of commerce;
- 13 D. A labor union;
- 14 E. A small business development center; or
- 15 F. An insurance producer or broker licensed in this State.

16 A navigator may not be a carrier or receive any consideration directly or indirectly from
17 any carrier in connection with the enrollment of any qualified individual or employees of
18 a qualified employer in a qualified health plan.

19 **4. Compliance.** A navigator shall comply with all applicable provisions of the
20 federal Affordable Care Act, regulations adopted thereunder and federal guidance issued
21 pursuant to the federal Affordable Care Act.

22 **5. Information standards.** The marketplace shall collaborate with the secretary to
23 develop standards to ensure that the information distributed and provided by navigators is
24 fair and accurate.

25 **6. Performance standards; accountability.** The marketplace shall establish
26 performance standards, accountability requirements and maximum grant amounts for
27 navigators.

28 **7. Antisteering provisions; participation of insurance producers.** The
29 marketplace shall prohibit an insurance producer, as a condition of that insurance
30 producer's participation as a navigator, from steering, directly or indirectly, a qualified
31 individual or an employee of a qualified employer to any particular qualified health plan
32 or qualified stand-alone dental benefit plan.

33 **§7210. Carrier participation**

34 **1. Required levels of coverage.** Beginning January 1, 2016, a carrier shall, with
35 respect to health benefit plans, fairly and affirmatively offer, market and sell only the 5
36 levels of coverage contained in Section 1302(d) and (e) of the federal Affordable Care
37 Act, except that a carrier that does not participate in the marketplace shall, with respect to
38 health benefit plans, fairly and affirmatively offer, market and sell only the 4 levels of
39 coverage contained in Section 1302(d) of the federal Affordable Care Act.

1 **2. Standardized products.** Beginning January 1, 2016, a carrier that does not
2 participate in the marketplace shall, with respect to health benefit plans, fairly and
3 affirmatively offer at least one standardized health benefit plan that has been designated
4 by the marketplace in each of the 4 levels of coverage contained in Section 1302(d) of the
5 federal Affordable Care Act. This subsection applies only if the executive director
6 exercises the executive director's authority under section 7207, subsection 2, paragraph K.
7 This subsection may not be construed to:

8 A. Require a carrier that does not participate in the marketplace to offer standardized
9 health benefit plans in the small group market if the carrier sells health benefit plans
10 only in the individual market;

11 B. Require a carrier that does not participate in the marketplace to offer standardized
12 health benefit plans in the individual market if the carrier sells health benefit plans
13 only in the small group market; or

14 C. Prohibit a carrier from offering other health benefit plans as long as the carrier
15 complies with the required levels of coverage described in subsection 1.

16 **§7211. The Maine Health Benefit Marketplace Enterprise Fund**

17 The Maine Health Benefit Marketplace Enterprise Fund is created as an enterprise
18 fund for the deposit of any funds advanced for initial operating expenses, payments made
19 by employers and individuals, federal funds and any funds received from any public or
20 private source. The fund may not lapse, but must be carried forward to carry out the
21 purposes of this chapter.

22 **§7212. Relation to other laws**

23 This chapter, and any action taken by the marketplace pursuant to this chapter, may
24 not be construed to preempt or supersede the authority of the superintendent to regulate
25 the business of insurance within this State. Except as expressly provided to the contrary
26 in this chapter, all health carriers offering qualified health plans or qualified stand-alone
27 dental benefit plans in this State shall comply fully with all applicable health insurance
28 laws of this State and rules adopted and orders issued by the superintendent.

29 **§7213. Suspension of operations**

30 The marketplace shall suspend its operations pursuant to this chapter upon the
31 issuance of a waiver by the secretary pursuant to Section 1332 of the federal Affordable
32 Care Act.

33 **Sec. A-3. Declaration of intent to establish state-based exchange.** No later
34 than November 18, 2015, the Executive Director of the Maine Health Benefit
35 Marketplace shall submit a declaration of intent to establish a state-based exchange to the
36 Secretary of the United States Department of Health and Human Services, together with
37 any necessary supporting documentation as required by the secretary, pursuant to the
38 federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by
39 the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152
40 and any rules adopted by the secretary.

1 **Sec. A-4. Transition.** The following provisions apply to the establishment of the
2 Maine Health Benefit Marketplace pursuant to the Maine Revised Statutes, Title 24-A,
3 chapter 93.

4 **1. Appointment of executive director; hiring of staff.** As soon as practicable but
5 no later than 30 days following the effective date of this Act, the Commissioner of
6 Professional and Financial Regulation shall appoint the Executive Director of the Maine
7 Health Benefit Marketplace. The Executive Director of the Maine Health Benefit
8 Marketplace shall hire staff and contract for services to implement this Act. In hiring and
9 contracting, the Executive Director of the Maine Health Benefit Marketplace may give
10 preference to state employees and other contractors who are employed by the State.

11 **2. Grant funding.** As soon as practicable, the Executive Director of the Maine
12 Health Benefit Marketplace shall submit an application to the Secretary of the United
13 States Department of Health and Human Services for any grant funding made available to
14 states for exchange planning and implementation pursuant to the federal Patient
15 Protection and Affordable Care Act, Public Law 111-148, as amended by the federal
16 Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

17 **3. Report.** Beginning 90 days after the effective date of this Act and until June 30,
18 2017, the Executive Director of the Maine Health Benefit Marketplace shall report on a
19 quarterly basis to the joint standing committee of the Legislature having jurisdiction over
20 insurance and financial services matters on the initial operations of the Maine Health
21 Benefit Marketplace.

22 **Sec. A-5. Maine Health Benefit Marketplace funding mechanism; report.**
23 The Executive Director of the Maine Health Benefit Marketplace shall consider how to
24 ensure that the marketplace is financially sustainable by 2018 as required by federal law,
25 including, but not limited to:

26 1. A recommended plan for the budget of the marketplace; and

27 2. The funding mechanism recommended by the marketplace to fund its operations.
28 Any funding mechanism recommended by the marketplace must be broad-based, may not
29 disadvantage health benefit plans offered inside the marketplace and must minimize
30 adverse selection.

31 On or before February 1, 2017, the Executive Director of the Maine Health Benefit
32 Marketplace shall submit a report, including suggested legislation, with its recommended
33 funding mechanism to the joint standing committee of the Legislature having jurisdiction
34 over insurance matters. The joint standing committee of the Legislature having
35 jurisdiction over insurance matters may submit a bill based on the report to the First
36 Regular Session of the 128th Legislature.

37 **Sec. A-6. Impact of adverse selection on the Maine Health Benefit**
38 **Marketplace; report.** The Executive Director of the Maine Health Benefit
39 Marketplace, in consultation with any stakeholders, shall study and make
40 recommendations regarding rules under which health benefit plans should be offered

1 inside and outside the marketplace in order to mitigate adverse selection and encourage
2 enrollment in the marketplace, including:

3 1. Whether any benefits should be required of qualified health plans beyond those
4 mandated by the federal Patient Protection and Affordable Care Act, Public Law 111-
5 148, as amended by the federal Health Care and Education Reconciliation Act of 2010,
6 Public Law 111-152, and whether any such additional benefits should be required of
7 health benefit plans offered outside the marketplace; and

8 2. Whether carriers offering health benefit plans outside the marketplace should be
9 required to offer either all the same health benefit plans inside the marketplace or,
10 alternatively, at least one health benefit plan inside the marketplace.

11 On or before April 1, 2016, the Executive Director of the Maine Health Benefit
12 Marketplace shall submit a report, including any suggested legislation, with the executive
13 director's recommendations to the Joint Standing Committee on Insurance and Financial
14 Services. The joint standing committee may submit a bill based on the report to the
15 Second Regular Session of the 127th Legislature.

16 **PART B**

17 **Sec. B-1. 22 MRSA c. 106** is enacted to read:

18 **CHAPTER 106**

19 **ACCESS TO AFFORDABLE HEALTH CARE**

20 **§371. Definitions**

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

23 **1. Agency.** "Agency" means the Maine Health Care Agency established by section
24 376.

25 **2. Council.** "Council" means the Maine Health Care Council established by section
26 378.

27 **3. Federal Affordable Care Act.** "Federal Affordable Care Act" has the same
28 meaning as in Title 24-A, section 14.

29 **4. Fund.** "Fund" means the Maine Health Care Trust Fund established by section
30 375, subsection 1.

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

33 **6. Open plan.** "Open plan" means the benefit delivery system for the Maine Health
34 Care Plan that is open to all plan members and all participating providers, as described in
35 section 372, subsection 4, paragraph B.

1 **7. Organized delivery system.** "Organized delivery system" means an organization
2 that provides or enters into a contract with another person to provide for a complete range
3 of health care services to plan members, as described in section 372, subsection 4,
4 paragraph A.

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

7 **9. Plan.** "Plan" means the Maine Health Care Plan established by section 372.

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

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

16 **12. Resident.** "Resident" means a person who resides within the State as defined by
17 rules adopted by the agency pursuant to section 377, subsection 1.

18 **§372. Maine Health Care Plan**

19 The Maine Health Care Plan is established to provide security through high-quality,
20 affordable health care for the people of the State and to include federal funds to the
21 maximum extent allowable under federal law and waivers from federal law. The plan
22 becomes effective and binding upon the approval of a state waiver from the Secretary of
23 the United States Department of Health and Human Services pursuant to Section 1332 of
24 the federal Affordable Care Act. The plan must offer health care services no later than 10
25 months after the plan becomes effective, and the agency shall administer and oversee the
26 plan in accordance with this chapter.

27 **1. Goals of Maine Health Care Plan.** The plan has the following goals:

28 A. To provide uniform access to health care for every resident;

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

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

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

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

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

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

- 1 H. To distribute the costs of health care fairly and equitably;
- 2 I. To simplify the health care system for consumers, businesses and providers;
- 3 J. To ensure providers the clinical freedom to treat patients based on health care
4 needs and criteria; and
- 5 K. To ensure accountability in all aspects of the health care system to promote public
6 confidence and control of costs.

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

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

14 B. A nonresident who maintains significant contact with the State, including
15 employment or self-employment within the State or attendance at a college,
16 university or other institution of higher education in the State, is eligible to receive
17 health care under the plan. Eligibility extends to a person qualifying under this
18 paragraph and to that person's spouse and dependents. The agency shall adopt rules
19 establishing criteria for eligibility for nonresidents.

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

29 D. To establish membership eligibility, a person must apply for a plan card and
30 satisfy the application requirements established by the agency.

31 **3. Coverage of health care services.** As provided in this subsection, the plan must
32 provide coverage for health care services from participating providers within this State if
33 those services are necessary or appropriate for the prevention, diagnosis or treatment of,
34 or maintenance or rehabilitation following, injury, disability or disease. The plan must
35 provide coverage for the following covered health care services:

- 36 A. Hospital services;
- 37 B. Medical and other professional services furnished by participating providers;
- 38 C. Laboratory tests and imaging procedures;
- 39 D. Home health care for persons requiring services performed by or under the
40 supervision of professional or technical personnel, including, but not limited to, home
41 care for acute illness, personal care attendant services and the medical component of

1 home care for chronic illness. Notwithstanding any other provision of law, the plan
2 may use nominal copayments for permanent care services;

3 E. Rehabilitative services for persons receiving therapeutic care;

4 F. Prescription drugs and devices. Unless the prescriber certifies that a more
5 expensive package or form of dosage or administration of a drug is medically
6 necessary, the plan may cover only part of the cost of a drug dispensed in a package
7 or form of dosage or administration when the agency determines that a less expensive
8 package or form of dosage or administration that is pharmaceutically equivalent in its
9 therapeutic effect is available. If a plan member chooses to purchase a more
10 expensive package or form of dosage or administration of a drug under this
11 paragraph, the plan member is responsible for paying the amount not covered by the
12 plan;

13 G. Mental health services;

14 H. Substance abuse treatment;

15 I. Primary and acute dental services;

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

18 K. Medical supplies, durable medical equipment and selected assistive devices;

19 L. Hospice care; and

20 M. Health care services the costs of which are payable pursuant to Title 39-A for all
21 employees whose date of injury is on or after the effective date of this section.

22 **4. Benefit delivery.** Covered health care services must be provided to plan members
23 by the participating providers of their choice through organized delivery systems or the
24 open plan. The delivery of covered health care services to plan members is subject to the
25 provisions of this subsection.

26 A. Organized delivery systems authorized by the agency may provide a complete
27 range of health care services to plan members.

28 B. The open plan is available to all plan members and to all participating providers
29 approved by the plan.

30 C. The plan must pay for health care services provided to a plan member while the
31 plan member is out of the State. The plan member must have been out of the State
32 temporarily for reasons other than to obtain the health care services, or the plan
33 member must have obtained the health care services out of the State for compelling
34 reasons related to the suitability of the services, the nature of the condition and
35 personal circumstances. The agency shall establish and operate a plan to pay for
36 health care services provided to a plan member while the plan member is out of the
37 State. The payments must be made at the rates established by the agency for
38 comparable services provided by the plan in the State. Charges in excess of the
39 payment rates established in accordance with this paragraph are the responsibility of
40 the plan member.

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

4 E. Copayments or deductibles may not be charged for health care services provided
5 through the plan, except that, to encourage the use of the most appropriate and cost-
6 effective mode of service, an organized delivery system may require reasonable
7 copayments or deductibles by a plan member if copayments or deductibles are
8 approved by the agency and do not substantially interfere with access to needed
9 health care services.

10 F. The plan must ensure accountability to the public of the open plan and organized
11 delivery systems in order to promote public confidence in the plan and awareness of
12 the costs of care.

13 G. The plan must provide flexible enrollment and transfer processes that preserve
14 plan member confidence and ensure that health care needs are met.

15 H. The plan must provide an opportunity for negotiation of fair rates of
16 compensation with participating providers in the open plan and organized delivery
17 systems and negotiation with pharmaceutical companies for similarly classified
18 pharmaceuticals.

19 I. The plan must establish a program to expand services to underserved rural and
20 low-income communities.

21 J. The plan must develop mechanisms to provide incentives to participating
22 providers in the open plan and to organized delivery systems for additional savings
23 that do not compromise the quality of health care.

24 **5. Participating provider requirements.** Except as provided in subsection 4,
25 paragraph E, participating providers, the open plan and organized delivery systems may
26 not charge a plan member or a 3rd party for covered health care services and may not
27 charge rates in excess of the reimbursement levels set by the agency. A participating
28 provider, the open plan and organized delivery systems may not refuse to provide
29 services to a plan member on the basis of health status, medical condition, previous
30 insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual
31 orientation, disability, marital status or arrest record except as appropriate to the
32 provider's professional specialization or in other medically appropriate circumstances.

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

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

38 **8. Role of other health care programs.** Until the agency determines otherwise, the
39 plan is supplemental to all coverage available to a plan member from another health care
40 program, including, but not limited to, the Medicare program of the federal Social
41 Security Act, Title XVIII; the Medicaid program of the federal Social Security Act, Title
42 XIX; the federal TRICARE program, 10 United States Code, Chapter 55; the federal

1 Indian Health Care Improvement Act, 25 United States Code, Sections 1601 to 1683;
2 other 3rd-party payors who may be billable for health care services; and any state and
3 local health care programs, including, but not limited to, workers' compensation and
4 employers' liability insurance, pursuant to former Title 39 and Title 39-A. Health care
5 services billed to another health care program or a 3rd-party payor other than the plan
6 must be paid for by that program or 3rd-party payor, and coverage under the plan is
7 supplemental to that coverage. The plan may require a plan member who receives health
8 care services under another health care program or from a 3rd-party payor to which the
9 plan is supplemental to pay a premium to the fund in proportion to the health care
10 benefits available to the plan member under the plan.

11 **§373. Implementation; waiver**

12 **1. Implementation.** The plan must be implemented 90 days following the last to
13 occur of:

14 A. Receipt of a waiver under Section 1332 of the federal Affordable Care Act
15 pursuant to subsection 2;

16 B. Enactment of a law establishing the financing for the plan;

17 C. Initial approval by the agency of the plan;

18 D. Initial appropriations of funds for the plan; and

19 E. A determination by the agency that each of the following conditions will be met:

20 (1) Each resident covered by the plan will receive benefits with an actuarial
21 value of 80% or greater;

22 (2) When implemented, the plan will not have a negative aggregate impact on
23 the State's economy;

24 (3) The financing for the plan is sustainable;

25 (4) Administrative expenses will be reduced;

26 (5) Plan cost-containment efforts will result in a reduction in the rate of growth
27 in the State's per capita health care spending; and

28 (6) Health care professionals will be reimbursed at levels sufficient to allow the
29 State to recruit and retain high-quality health care professionals.

30 **2. Waiver; suspension of marketplace.** As soon as allowed under federal law, the
31 agency shall seek a waiver to allow the State to suspend operation of the Maine Health
32 Benefit Marketplace and to enable the State to receive the appropriate federal fund
33 contribution in lieu of the federal premium tax credits, cost-sharing subsidies and small
34 business tax credits provided in the federal Affordable Care Act. The agency may seek a
35 waiver from other provisions of the federal Affordable Care Act as necessary to ensure
36 the operation of the plan.

1 **§374. Quality; affordability; efficiency; health care planning**

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

4 **1. Quality of care.** The agency shall establish a quality assurance program. At a
5 minimum, the program must provide for:

6 A. Operation of the plan;

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

9 C. Evaluation of the performance of participating providers;

10 D. Standards and continuity of care;

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

12 F. Access to information and data for the agency;

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

15 H. Plan member involvement in policy decisions; and

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

18 **2. Affordability of health care.** The agency shall establish an affordability
19 assurance program. The program must include, but is not limited to:

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

22 B. Rates of payment for durable and nondurable medical devices, supplies and
23 related items;

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

28 D. Maintenance of a prescription drug formulary; and

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

34 **3. Efficiency of health care.** The agency shall establish an efficiency of health care
35 program. The agency shall review health care malpractice insurance costs and work with
36 organized delivery systems, participating providers and carriers to ensure that the
37 resources of the fund are used for best possible service delivery. The agency shall
38 contract with a 3rd-party administrator located in this State to provide claims handling

1 and data collection services, including, but not limited to, uniform billing procedures to
2 facilitate the exchange of information and communication between the agency and
3 participating providers.

4 **4. Health care planning.** The agency shall establish a health care planning
5 program. The agency shall consider health care planning in light of the programs on
6 quality, affordability and efficiency established under subsections 1 to 3. The program
7 must include, but is not limited to:

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

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

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

16 D. Data collection regarding health care needs, resources and expenditures.

17 **§375. Financing of Maine Health Care Plan**

18 Financing of the plan is accomplished by the fund.

19 **1. Maine Health Care Trust Fund.** The Maine Health Care Trust Fund is
20 established to finance the plan. Deposits into the fund and expenditures from the fund
21 must be made pursuant to this section and to rules adopted pursuant to section 377,
22 subsection 1 by the agency to carry out the purposes of this section. All income generated
23 pursuant to this chapter must be deposited in the fund, which does not lapse but carries
24 forward from one fiscal year to the next.

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

26 (1) Authorized transfers or appropriations from the General Fund;

27 (2) If authorized by a waiver from federal law, federal funds for Medicaid,
28 Medicare and the Maine Health Benefit Marketplace established in Title 24-A,
29 chapter 93; and

30 (3) The proceeds from grants, donations, contributions, taxes and any other
31 sources of revenue.

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

33 (1) The administration and delivery of health care services covered by the plan
34 as provided in this chapter;

35 (2) Expenses related to the duties and operation of the plan; and

36 (3) Other payments made pursuant to law.

1 **§376. Maine Health Care Agency; establishment**

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

3 **1. Maine Health Care Plan.** Administer and oversee the plan;

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

5 **3. Maine Health Care Trust Fund.** Administer and oversee the fund.

6 **§377. Maine Health Care Agency; general powers**

7 In addition to the powers granted to the agency elsewhere in this chapter, the agency
8 is authorized to act as necessary to carry out the purposes of this chapter.

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

13 **2. Executive director and staff.** The agency shall employ an executive director
14 who has experience in the organization, financing or delivery of health care and who shall
15 perform the duties delegated by the agency. The agency may delegate to the executive
16 director any of its functions and duties except the adoption of rules and the establishment
17 of a global budget for health care for the State under section 374, subsection 4. The
18 executive director is an unclassified employee and serves at the pleasure of the council.
19 The executive director, at the direction of the agency, shall hire personnel to administer
20 this chapter, subject to the Civil Service Law and within the budget set by the agency.

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

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

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

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

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

5 **8. Data collection and analysis.** The agency shall institute a data collection system
6 to acquire and analyze information on the provision of health care and health care costs.
7 The agency shall coordinate with existing medical information centers that currently
8 provide such services to the State. All data released by the agency must protect the
9 confidentiality of the participating provider and the plan member and, whenever possible,
10 must be released as aggregate data.

11 **9. Complaint resolution.** In cooperation with participating providers and plan
12 members, the agency shall institute a complaint resolution system to handle the
13 complaints of participating providers and plan members.

14 **10. Funding.** The agency shall determine the level of funding required to carry out
15 the purposes of this chapter. The agency shall submit biennially to the Legislature for
16 approval a proposed budget. Funding for the agency budget approved by the Legislature
17 is paid from the fund.

18 **11. Coordination with federal, state and local health care programs.** The agency
19 shall institute a system to coordinate the activities of the agency and the plan with the
20 health care programs of federal, state and municipal governments.

21 **12. Reports.** By March 1st of each year, the agency shall submit to the Governor
22 and the Legislature a report of its operations and activities during the previous year,
23 including its operations and activities with respect to the funding, tax and budget
24 requirements pursuant to subsection 10. This report must include facts and suggestions
25 and policy recommendations that the agency considers necessary. As it determines
26 appropriate, the agency shall publish and disseminate information helpful to the citizens
27 of this State in making informed choices in obtaining health care, including the results of
28 studies or analyses undertaken by the agency.

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

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

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

37 **§378. Maine Health Care Council**

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

1 number of members in the Senate, and 2 must be appointed by the Speaker of the
2 House of Representatives, one from each of the 2 political parties having the largest
3 number of members in the House.

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

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

14 The appointing authorities shall notify the Executive Director of the Legislative Council
15 upon making their appointments. All appointments must be made within 30 days of the
16 effective date of this Act. Within the following 30 days, the appointments must be
17 reviewed and approved by the joint standing committee of the Legislature having
18 jurisdiction over insurance and financial services matters and the joint standing
19 committee of the Legislature having jurisdiction over health and human services matters
20 and must be confirmed by the Legislature.

21 When appointment of all members of the committee is completed, the chair of the
22 Legislative Council shall call the first meeting of the committee. The first meeting must
23 be held within 90 days of the effective date of this Act. The members of the committee
24 shall elect a chair from among the members.

25 **2. Duties.** The committee shall hold public hearings, solicit public comments and
26 advise the Maine Health Care Council for the purposes of planning the transition to the
27 Maine Health Care Plan established in the Maine Revised Statutes, Title 22, section 372
28 and recommending legislative changes to accomplish the purposes of Title 22, chapter
29 106.

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

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

35 **5. Reports.** Every 6 months beginning July 1, 2019, the committee shall report to
36 the Maine Health Care Council, the Governor and the Legislature on planning for the
37 transition to the Maine Health Care Plan and any recommended legislative changes.

38 **6. Completion of duties.** The duties of the committee are considered complete and
39 the committee is dissolved when the Maine Health Care Plan becomes effective.

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PART D

Sec. D-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 the members of the Maine Health Care Council, as established in Title 22, section 378, and the salary of the executive director of the Maine Health Care Agency, as established in Title 22, section 376, are within salary range 91.

PART E

Sec. E-1. 24-A MRSA §2189 is enacted to read:

§2189. 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 covered 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 subsection constitutes an unfair or deceptive act or 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 F

Sec. F-1. Financing plan. The Maine Health Care Agency, as established in the Maine Revised Statutes, Title 22, section 376, shall recommend 2 plans for sustainable financing to the Legislature no later than January 15, 2018.

1. One plan must recommend the amounts and necessary mechanisms to finance any initiatives in order to provide coverage to all Maine residents in the absence of a waiver from certain federal health care reform provisions established in 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.

1 2. The 2nd plan must recommend the amounts and necessary mechanisms to finance
2 the Maine Health Care Plan and any systems improvements needed to achieve a public-
3 private universal health care system. The agency shall recommend whether nonresidents
4 employed by Maine businesses should be eligible for the Maine Health Care Plan and
5 solutions to other cross-border issues.

6 3. In developing both financing plans, the agency shall consider the following:

7 A. All financing sources, including adjustments to the income tax, a payroll tax,
8 consumption taxes, provider and employer assessments, other new or existing taxes
9 and additional options as determined by the agency;

10 B. The impacts of the various financing sources, including levels of deductibility of
11 any tax or assessment system;

12 C. Issues involving federal law and taxation;

13 D. The impact of tax system changes:

14 (1) On individuals, households, businesses, public sector entities and the
15 nonprofit community, including the circumstances under which a particular tax
16 change may result in the potential for double payments, such as double payments
17 of premiums and tax obligations;

18 (2) Over time, on changing revenue needs; and

19 (3) For a transitional period, while the tax system and health care cost structure
20 are changing;

21 E. Growth in health care spending relative to consumer needs and capacity to pay;

22 F. Anticipated federal funds that may be used for health care services and how to
23 maximize the amount of federal funding available for this purpose;

24 G. The amounts required to maintain existing state insurance benefit requirements
25 and other appropriate considerations in order to determine the state contribution
26 toward federal premium tax credits available in the Maine Health Benefit
27 Marketplace under the Maine Revised Statutes, Title 24-A, chapter 93 pursuant to the
28 federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended
29 by the federal Health Care and Education Reconciliation Act of 2010, Public Law
30 111-152;

31 H. Additional funds needed to support recruitment and retention programs for high-
32 quality health care professionals in order to address the shortage of primary care
33 professionals and other specialty care professionals in this State;

34 I. Additional funds needed to provide coverage for the uninsured who are eligible for
35 public coverage and the Maine Health Benefit Marketplace;

36 J. Funding mechanisms to ensure that operations of both the Maine Health Benefit
37 Marketplace and Maine Health Care Plan are self-sustaining;

38 K. How to maximize the flow of federal funds to the State for individuals eligible for
39 Medicare, such as enrolling eligible individuals in Medicare and paying or
40 supplementing the cost-sharing requirements on behalf of those individuals;

1 L. The use of financial or other incentives to encourage healthy lifestyles and patient
2 self-management for individuals enrolled in the Maine Health Care Plan;

3 M. Preserving retirement health benefits while enabling retirees to participate in the
4 Maine Health Care Plan;

5 N. The implications of the Maine Health Care Plan regarding funds set aside to pay
6 for future retiree health benefits; and

7 O. Changes in federal health care funding through reduced payments to health care
8 professionals or through limitations or restrictions on the availability of grant funding
9 or federal matching funds available to states through the Medicaid program.

10 4. In developing the financing plan for the Maine Health Care Plan, the agency shall
11 consult with interested stakeholders, including health care professionals, employers and
12 members of the public, to determine the potential impact of various financing sources on
13 Maine businesses and on the State's economy and economic climate.

14 5. In addition to the consultation required by this section, in developing the financing
15 plan for the Maine Health Care Plan, the agency shall solicit input from interested
16 stakeholders, including health care professionals, employers and members of the public,
17 and shall provide opportunities for public engagement in the design of the financing plan.

18 6. The agency shall consider strategies to address individuals who receive health care
19 coverage through the United States Department of Veterans Affairs, the federal
20 TRICARE program under 10 United States Code, Chapter 55, the Federal Employees
21 Health Benefits Program or the government of a foreign nation or from another federal
22 governmental or foreign source.

23 **Sec. F-2. Employment retraining.** The Maine Health Care Agency, as
24 established in the Maine Revised Statutes, Title 22, section 376, shall coordinate with the
25 Department of Economic and Community Development, the Department of Labor and
26 private industry councils to ensure that employment retraining services are available for
27 administrative workers employed by insurers and health care service providers who are
28 displaced due to the transition to the Maine Health Care Plan established in Title 22,
29 section 372.

30 **Sec. F-3. Delivery of long-term health care services.** The Maine Health Care
31 Agency, as established in the Maine Revised Statutes, Title 22, section 376, shall study
32 the delivery of long-term health care services to Maine Health Care Plan members under
33 Title 22, chapter 106. The study must address the best and most efficient manner of
34 delivery of health care services to individuals needing long-term health care and funding
35 sources for long-term health care. In undertaking the study, the agency shall consult with
36 the Maine Health Care Plan Transition Advisory Committee established in this Act,
37 representatives of consumers and potential consumers of long-term health care services,
38 representatives of providers of long-term health care services and representatives of
39 employers, employees and the public. The agency shall report to the Legislature on or
40 before January 1, 2020 and may include suggested legislation in the report.

1 Part B also directs the Maine Health Care Agency to establish programs to ensure
2 quality, affordability, efficiency of care and health care planning. The agency health care
3 planning program includes the establishment of global budgets for health care
4 expenditures for the State and for institutions and hospitals. The health care planning
5 program also encompasses the certificate of need responsibilities of the agency pursuant
6 to the Maine Revised Statutes, Title 22, chapter 103-A.

7 The bill contains a directive to the State Controller to advance \$600,000 to the Maine
8 Health Care Trust Fund. This amount must be repaid by the Maine Health Care Agency
9 by June 30, 2020.

10 Part C of the bill establishes the Maine Health Care Plan Transition Advisory
11 Committee. Composed of 20 members, appointed by the Governor, President of the
12 Senate and Speaker of the House of Representatives and subject to confirmation by the
13 Legislature, the committee is charged with holding public hearings, soliciting public
14 comments and advising the Maine Health Care Council on the transition from the current
15 health care system to the Maine Health Care Plan. Members of the committee serve
16 without compensation but may be reimbursed for their expenses. The committee is
17 directed to report to the Governor and to the Legislature every 6 months beginning July 1,
18 2019. The committee completes its work when the Maine Health Care Plan becomes
19 effective.

20 Part D of the bill establishes the salaries of the members of the Maine Health Care
21 Council and the executive director of the Maine Health Care Agency.

22 Part E of the bill prohibits the sale on the commercial market of health insurance
23 policies and contracts that duplicate the coverage provided by the Maine Health Care
24 Plan. It allows the sale of health care policies and contracts that do not duplicate and are
25 supplemental to the coverage of the Maine Health Care Plan.

26 Part F of the bill directs the Maine Health Care Agency to submit 2 financing plans to
27 the Legislature by January 15, 2018. Part F also directs the Maine Health Care Agency to
28 ensure employment retraining for administrative workers employed by insurers and
29 providers who are displaced by the transition to the Maine Health Care Plan. It directs the
30 Maine Health Care Agency to study the delivery and financing of long-term care services
31 to plan members. Consultation is required with the Maine Health Care Plan Transition
32 Advisory Committee, representatives of consumers and potential consumers of long-term
33 care services and representatives of providers of long-term care services, employers,
34 employees and the public. A report by the agency to the Legislature is due January 1,
35 2020.

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