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.

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.

Printed on recycled paper

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

PART A

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

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

Commissioner of Transportation;

Commissioner of Agriculture, Conservation and Forestry;

Commissioner of Administrative and Financial Services;

Commissioner of Education;

Commissioner of Environmental Protection;

Executive Director of Dirigo Health;

Commissioner of Public Safety;

Commissioner of Professional and Financial Regulation;

Commissioner of Labor;

Commissioner of Inland Fisheries and Wildlife;

Commissioner of Marine Resources;

Commissioner of Corrections;

Commissioner of Economic and Community Development;

Commissioner of Defense, Veterans and Emergency Management; ~~and~~

Executive Director, Workers' Compensation Board~~.~~; and

Executive Director, Maine Health Benefit Marketplace.

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

CHAPTER 93

MAINE HEALTH BENEFIT MARKETPLACE ACT

§7201. Short title

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

§7202. Definitions

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

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

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

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

A. "Health benefit plan" does not include:

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

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

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

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

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

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

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

(1) Limited-scope dental or vision benefits;

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

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

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

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

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

(2) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. Stand-alone dental benefit plan. "Stand-alone dental benefit plan" means a policy, contract, certificate or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of limited-scope dental benefits meeting 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.

§7205. Executive director

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

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

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

B. Manage the marketplace's programs and services;

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

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

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

§7206. Availability of coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Duties. The marketplace shall:

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

federal Affordable Care Act and pursuant to section 7208, of health benefit plans as qualified health plans and of stand-alone dental benefit plans as qualified stand-alone dental benefit plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance except that the hotline may not be automated unless the hotline provides the opportunity for live customer service;

C. Provide for enrollment periods as provided under Section 1311(c)(6) of the federal Affordable Care Act;

D. Maintain a publicly accessible website through which enrollees and prospective enrollees of qualified health plans and qualified stand-alone dental benefit plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the marketplace in accordance with the criteria developed by the secretary under Section 1311(c)(3) of the federal Affordable Care Act and determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under Section 1302(d)(2)(A) of the federal Affordable Care Act;

F. Use a standardized format for presenting health and dental benefit options in the marketplace, including the use of the uniform outline of coverage established under the federal Public Health Service Act, 42 United States Code, Section 300gg-15 (2010);

G. In accordance with Section 1413 of the federal Affordable Care Act, inform individuals of eligibility requirements for the Medicaid program under the United States Social Security Act, Title XIX or the State Children's Health Insurance Program under the United States Social Security Act, Title XXI or under any applicable state or local public program and if, through screening of an application by the marketplace, the marketplace determines that an individual is eligible for any such program, enroll the individual in that program;

H. Determine the criteria and process for eligibility, enrollment and disenrollment of enrollees and potential enrollees in the marketplace and coordinate that process with the state and local government entities administering other health care coverage programs, including the MaineCare program and the basic health program, if established by paragraph O, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverages. To the extent possible, the executive director shall encourage the use of existing infrastructure and capacity from other state agencies;

I. Determine the minimum requirements a carrier must meet to be considered for participation in the marketplace and the standards and criteria for selecting qualified health plans to be offered through the marketplace that are in the best interests of qualified individuals and qualified employers. The executive director shall consistently and uniformly apply these requirements, standards and criteria to all carriers offering qualified health plans through the marketplace and, if relevant, shall apply those requirements, standards and criteria to carriers offering qualified stand-alone dental benefit plans or other dental benefit plans through the marketplace. In the course of selectively contracting for health care coverage offered to qualified

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

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

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

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

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

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

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

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

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

P. Subject to Section 1411 of the federal Affordable Care Act, issue a certification 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;

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

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

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

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

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

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

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

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

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

(4) Representatives of the MaineCare program; and

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

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

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

(1) Investigate the affairs of the marketplace;

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

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

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

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

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

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

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

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

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

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

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

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

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

§7208. Health benefit plan certification

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

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

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

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

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

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

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

E. The health carrier offering the health benefit plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

(7) Information on cost sharing and payments with respect to any out-of-network coverage;

(8) Information on enrollee and participant rights under Title I of the federal Affordable Care Act; and

(9) Other information as determined appropriate by the secretary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§7209. Navigators

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

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

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

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

A. A trade, industry or professional association;

B. A community-focused and consumer-focused nonprofit group;

C. A chamber of commerce;

D. A labor union;

E. A small business development center; or

F. An insurance producer or broker licensed in this State.

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

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

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

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

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

§7210. Carrier participation

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

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

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

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

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

§7211. The Maine Health Benefit Marketplace Enterprise Fund

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

§7212. Relation to other laws

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

§7213. Suspension of operations

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

Sec. A-3. Declaration of intent to establish state-based exchange. No later than November 18, 2015, the Executive Director of the Maine Health Benefit Marketplace shall submit a declaration of intent to establish a state-based exchange to the Secretary of the United States Department of Health and Human Services, together with any necessary supporting documentation as required by the secretary, pursuant to 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 and any rules adopted by the secretary.

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

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

2. Grant funding. As soon as practicable, the Executive Director of the Maine Health Benefit Marketplace shall submit an application to the Secretary of the United States Department of Health and Human Services for any grant funding made available to states for exchange planning and implementation pursuant to 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.

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

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

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

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

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

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

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

1. Whether any benefits should be required of qualified health plans beyond those mandated by 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, and whether any such additional benefits should be required of health benefit plans offered outside the marketplace; and

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

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

PART B

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

CHAPTER 106

ACCESS TO AFFORDABLE HEALTH CARE

§371. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

§372. Maine Health Care Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Hospital services;

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

C. Laboratory tests and imaging procedures;

D. Home health care for persons requiring services performed by or under the supervision of professional or technical personnel, including, but not limited to, home care for acute illness, personal care attendant services and the medical component of

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

E. Rehabilitative services for persons receiving therapeutic care;

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

G. Mental health services;

H. Substance abuse treatment;

I. Primary and acute dental services;

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

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

L. Hospice care; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§373. Implementation; waiver

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

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

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

C. Initial approval by the agency of the plan;

D. Initial appropriations of funds for the plan; and

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

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

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

(3) The financing for the plan is sustainable;

(4) Administrative expenses will be reduced;

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

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

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

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

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

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

A. Operation of the plan;

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

C. Evaluation of the performance of participating providers;

D. Standards and continuity of care;

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

F. Access to information and data for the agency;

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

H. Plan member involvement in policy decisions; and

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

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

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

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

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

D. Maintenance of a prescription drug formulary; and

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

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

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

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

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

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

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

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

§375. Financing of Maine Health Care Plan

Financing of the plan is accomplished by the fund.

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

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

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

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

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

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

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

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

(3) Other payments made pursuant to law.

§376. Maine Health Care Agency; establishment

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

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

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

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

§377. Maine Health Care Agency; general powers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§378. Maine Health Care Council

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

1. Membership. The council is composed of 5 members who serve full-time, are appointed by the Governor and, within 30 days after appointment, are subject to review by the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters and to confirmation by the Legislature.

In order to be eligible for appointment to the council, a person must have experience in the organization, delivery or financing of health care. At least one member of the council must be an individual with experience in the delivery and organization of primary and preventive care and public health services. At least one member of the council must be an individual who is not a provider and has not worked for a provider or health insurer.

2. Terms. All appointments are for 5-year terms, except that a member appointed to fill a vacancy in an unexpired term serves only for the remainder of that term. Members hold office until the appointment and confirmation of their successors.

3. Chair; voting. The Governor shall designate one member of the council as chair. The chair shall preside at meetings of the council, is responsible for the expedient organization of the council's work and may vote on all matters before the council. Three council members constitute a quorum. The council may take action only by an affirmative vote of at least 3 members.

4. Duties. The council shall direct, administer and oversee the agency in the performance of its duties under this chapter. The council has broad authority to carry out the purposes of this chapter.

Sec. B-2. Working capital advance. The State Controller shall transfer a $600,000 working capital advance to the dedicated account of the Maine Health Care Trust Fund, established pursuant to the Maine Revised Statutes, Title 22, section 375, on or before January 1, 2017. The Maine Health Care Agency, established pursuant to Title 22, section 376, shall repay this working capital advance by June 30, 2020.

Sec. B-3. Initial appointees of Maine Health Care Council; staggered terms. The terms of the members of the Maine Health Care Council, established in the Maine Revised Statutes, Title 22, section 378 are staggered. Of the initial appointees, one must be appointed for 2 years, 2 for 3 years and 2 for 5 years.

PART C

Sec. C-1. Maine Health Care Plan Transition Advisory Committee. The Maine Health Care Plan Transition Advisory Committee, referred to in this section as "the committee," is established to advise the members of the Maine Health Care Council as established in the Maine Revised Statutes, Title 22, section 378.

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

A. Four members must be Legislators. Two of those members must be appointed by the President of the Senate, one from each of the 2 political parties having the largest

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

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

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

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

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

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

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

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

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

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

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.

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

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

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

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

C. Issues involving federal law and taxation;

D. The impact of tax system changes:

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

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

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

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

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

G. The amounts required to maintain existing state insurance benefit requirements and other appropriate considerations in order to determine the state contribution toward federal premium tax credits available in the Maine Health Benefit Marketplace under the Maine Revised Statutes, Title 24-A, chapter 93 pursuant to 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;

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. F-4. Provision of health care services. The Maine Health Care Agency, as established in the Maine Revised Statutes, Title 22, section 376, shall study the provision of health care services under the MaineCare and Medicare programs. The study must consider the waivers necessary to coordinate the MaineCare and Medicare programs with the Maine Health Care Plan established in Title 22, section 372; the method of coordination of benefit delivery and compensation; reorganization of State Government necessary to achieve the objectives of the agency; and any other changes in law needed to carry out the purposes of Title 22, chapter 106. The agency shall apply for all waivers required to coordinate the benefits of the Maine Health Care Plan and the MaineCare and Medicare programs. The agency shall report to the Legislature on or before March 1, 2019 and may include suggested legislation in the report.

PART G

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

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

SUMMARY

Part A of the bill establishes the Maine Health Benefit Marketplace as the State's health benefit exchange as authorized by the federal Patient Protection and Affordable Care Act to facilitate the purchase of health care coverage by individuals and small businesses. The Maine Health Benefit Marketplace is established within the Department of Professional and Financial Regulation. The bill requires coverage to be available through the state-based marketplace no later than January 1, 2017 and requires the Executive Director of the Maine Health Benefit Marketplace to submit a declaration of intent to establish a state-based exchange under federal law to the federal Department of Health and Human Services no later than November 18, 2015. The bill also requires the executive director to submit applications for any available federal grant funding to support planning and implementation of the exchange as soon as practicable.

Part B of the bill establishes the Maine Health Care Plan to provide security through high-quality, affordable health care for the people of the State. The plan will become effective and binding on the State upon the approval of a waiver from the United States Department of Health and Human Services. All residents and nonresidents who maintain significant contact with the State are eligible for covered health care services through the Maine Health Care Plan. The Maine Health Care Plan must conform to the minimum essential benefits required under federal law, but may require additional benefits within existing resources. Health care services under the Maine Health Care Plan are provided by participating providers in organized delivery systems and through the open plan, which is available to all providers. It establishes the Maine Health Care Agency to administer and oversee the Maine Health Care Plan, to act under the direction of the Maine Health Care Council and to administer and oversee the Maine Health Care Trust Fund. The Maine Health Care Council is the decision-making and directing council for the agency and is composed of 5 full-time appointees.

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

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

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

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

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

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

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