L.D. 758

(Filing No. H-643)

STATE OF MAINE
HOUSE OF REPRESENTATIVES
114TH LEGISLATURE
FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 560, L.D. 758, Bill, "An Act to Amend the Preferred Provider Arrangement Act of 1986"

Amend the bill by striking out all of the title and inserting in its place the following:

'An Act Relating to Health Insurance'

Further amend the bill by inserting after the title and before the enacting clause the following:

'**Emergency preamble. Whereas,** Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation permits the Joint Standing Committee on Banking and Insurance to request that the Mandated Benefits Advisory Commission formed in Part A of this Act perform studies on various issues and report to the Legislature. The committee intends to request the studies be performed by the fall of 1989; and

Whereas, in order for the studies to go forward in a timely manner, it is necessary for the members of the commission to be appointed and to begin work as soon as possible after enactement of this legislation; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,'

COMMITTEE AMENDMENT "A" to H.P. 560, L.D. 758

Further amend the bill by striking out everything after the enacting clause and before the statement of fact and inserting in its place the following:

'PART A

Sec. 1. 5 MRSA §12004-I, sub-§50, as enacted by PL 1987, c. 786, §5, is repealed and the following enacted in its place:

50. Insurance	Mandated Benefits Advisory Commission	Legislative Per Diem and Expenses	24-A MRSA §2325-B

Sec. 2. 24 MRSA §2325-B, as enacted by PL 1987, c. 480, §3 is repealed and the following enacted in its place:

§2325-B. Mandated Benefits Advisory Commission

1. Appointment; membership. The Mandated Benefits Advisory Commission, as established by Title 5, section 12004-I, subsection 50, shall be composed of 19 members.

A. The following members shall be appointed by the President of the Senate and the Speaker of the House of Representatives:

(1) Two health insurance consumers who are not otherwise affiliated with the provision or financing of health care;

(2) One representative of a labor organization;

(3) Three Legislators, 2 of whom shall be members of the joint standing committee having jurisdiction over insurance matters and one of whom shall be a member of the joint standing committee having jurisdiction over human resource matters;

(4) One chiropractor; and

(5) One representative of a statewide association of public health professionals.

Initial appointments shall be made no later than 30 days after the effective date of this section.

B. The following members shall be appointed by the Governor:

(1) Two health insurance consumers who are not otherwise affiliated with the provision or financing of health care;

(2) One representative of a labor organization;

(3) One representative of a commercial health insurance company;

(4) One representative of a nonprofit hospital or medical service organization;

(5) One representative of a licensed alcohol and substance abuse treatment program;

(6) One representative of a licensed mental health treatment program;

(7) One representative of small business;

(8) One representative of a major industry and business trade association;

(9) One physician, provided that the Governor shall alternately appoint an allopathic and an osteopathic physician ; and

(10) One representative of the hospital industry.

The Governor shall notify the President of the Senate, the Speaker of the House of Representatives and the Executive Director of the Legislative Council of the appointments as soon as they are made. Initial appointments shall be made within 30 days of the effective date of this section.

2. Terms. Except for initial appointees, members shall serve for 3-year terms. The appointing authority shall determine the terms of initial appointees so that 1/3 of the appointments made by the authority shall serve 3-year terms, 1/3 serve 2 year terms and 1/3 serve one-year terms.

3. Ex officio members. A representative of the Bureau of Insurance and a representative of the Bureau of Health shall serve on the committee as ex officio nonvoting members.

4. First meeting; commission chair. The Chair of the Legislative Council shall call the first meeting no later than September 1, 1989. The commission shall select a chair or cochairs, as determined by the membership, and shall make other decisions regarding the organization and structure of the commission as necessary in order to effectively carry out its duties under this section.

5. Commission responsibilities. The commission shall have the following responsibilities:

A. The commission shall develop and maintain, with the Bureau of Insurance, a system and program of data collection to assess the impact of mandated benefits, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers and other data as may be appropriate.

B. The commission shall advise and assist the Bureau of Insurance on matters relating to mandated insurance benefits regulations.

C. The commission shall perform assessments of proposed and existing mandated benefits and other studies of mandated benefits issues as requested by the Legislature pursuant to Title 24-A, section 2751.

D. The commission shall report annually on its activities to the joint standing committee of the Legislature having jurisdiction over insurance by March 30th of each year.

6. Staff. The Bureau of Insurance shall provide staffing assistance to the commission.

7. Compensation. Upon request to the Bureau of Insurance, commission members shall be compensated as provided in Title 5, chapter 379.

Sec. 3. 24 MRSA §2332-C is enacted to read:

§2332-C. Assessment of mandated benefits proposals

The requirements of Title 24-A, section 2751, shall apply to any legislative measure which proposes a mandated health benefit applicable to nonprofit hospital or medical services organizations, to the extent the requirement applies to proposals applicable to insurers governed by Title 24-A.

Sec. 4. 24-A MRSA §2701, sub-§2, as amended by PL 1985, c. 648, §9, is repealed and the following enacted in its place:

2. Any group or blanket policy, except that:

A. Sections 2736, 2736-A and 2736-B shall apply to group Medicare supplement policies as defined in chapter 67 and group nursing home care and long-term care insurance policies as defined in chapter 68; and

B. Section 2751 shall apply with respect to mandated benefits for group or blanket health policies.

Sec. 5. 24-A MRSA §2751 is enacted to read:

§2751. Assessment of mandated benefits proposals; studies of mandated benefits issues

1. Proposed mandatory health insurance benefits; impact assessment study. Whenever a legislative measure containing a mandated health benefit is proposed, the joint standing committee having jurisdiction over the proposal shall request that the Mandated Benefits Advisory Commission prepare and forward to the Governor and the Legislature, by a certain date, a study that assesses the social and financial effects and the medical efficacy of the proposed mandated benefit. The study may be conducted by the commission or pursuant to a contract with the commission and shall analyze information collected from a state data collection system, proponents of the new mandate, the Bureau of Insurance, health planning organizations and other appropriate data sources. For purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or for certain providers of health care services as part of individual or group health insurance policies. A mandated option is not a mandated benefit for purposes of this section.

The study shall include, at the minimum and to the extent that information is available, the following:

A. The social impact of mandating the benefit which shall include:

(1) The extent to which the treatment or service is utilized by a significant portion of the population;

(2) The extent to which the treatment or service is available to the population;

(3) The extent to which insurance coverage for this treatment or service is already available;

(4) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(5) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(6) The level of public demand and the level of demand from providers for the treatment or service;

(7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(8) The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;

(9) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(10) The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(11) The alternatives to meeting the identified need;

(12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance;

(13) The impact of any social stigma attached to the benefit upon the market;

(14) The impact of this benefit on the availability of other benefits currently being offered; and

(15) The impact of the benefit as it relates to employers shifting to self-insured plans;

B. The financial impact of mandating the benefit which shall include:

(1) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(2) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

(3) The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service;

(4) The methods which will be instituted to manage the utilization and costs of the proposed mandate;

(5) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years;

(6) The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(7) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(8) The impact of this coverage on the total cost of health care; and

(9) The effects on the cost of health care to employers and employees, including the financial impact on small employers, medium-sized employers and large employers;

C. The medical efficacy of mandating the benefit which shall include:

(1) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment of service compared to alternatives or not providing the treatment or service; and

(2) If the legislation seeks to mandate coverage of an additional class of practitioners:

(a) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

(b) The methods of the appropriate professional organization that assure clinical proficiency; and

D. The effects of balancing the social, economic and medical efficacy considerations which shall include:

(1) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders; and

(2) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders.

2. Studies of existing mandated benefits. The joint standing committee of the Legislature having jurisdiction over insurance matters shall request that the Mandated Benefits Advisory Commission assess the social and financial effects and the medical efficacy of existing mandated benefits laws. The committee shall submit a schedule of assessments to the commission by February 1, 1990, setting forth the dates by which particular laws shall be assessed by the commission. The assessments shall include information relative to the same issues as for an assessment of proposed mandates, except that the data to be included shall be existing data on the actual effects of the mandate, rather than predictions of likely effects of the mandate.

3. Studies of other issues. The joint standing committee of the Legislature having jurisdiction over insurance matters may request that the commission prepare and forward to the committee studies on other issues relating to mandated benefits, such as the applicability of mandates to various types of insurers, the application of managed care programs to mandated benefits and issues related to other alternative delivery systems. Requests to the commission shall be made in writing, signed by the chairs of the committee, and shall set forth the scope of the issue and a date by which the study shall be completed and forwarded to the Legislature.

Sec. 6. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Act.

	1989-90	1990-91
PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF		
Bureau of Insurance		
Personal Services	$12,540	$12,540
All Other	33,400	33,400
Provides funding for the per diem and expenses of the Mandated Benefits Advisory Commission. Includes funds for the expenses of the Bureau of Insurance to staff the commission.		
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION TOTAL	$45,940	$45,940

PART B

Sec. 1. 24-A MRSA §5051, sub-§1, as enacted by PL 1985, c. 648, §12, is amended to read:

1. Long-term care policy. "Long-term care policy" means a group or individual policy of health insurance ~~or~~, a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan or a life insurance rider which is advertised, marketed or designed primarily to provide coverage ~~or services for chronic or terminally ill care in either institutional or community based settings~~ for not less than 12 consecutive months for each covered person on an expense-incurred basis, indemnity basis, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. ~~That~~ The term does not include:

A. A policy or contract defined as Medicare supplement insurance pursuant to chapter 67;

B. A policy or contract issued prior to October 1, 1990, to one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or combination of both, or for members or former members, or combination of both, of the labor organizations;

C. A policy or contract issued prior to October 1, 1990, to any professional, trade or occupational association for its members, former members or retired members or combination of all members, if the association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least 2 years prior to the date of its initial offering of the policy or plan to its members; and

D. ~~Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when that group or individual policy or contract includes provisions which are inconsistent with the requirements of this chapter.~~ Individual policies or

contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when that group or individual policy or contract:

(1) Was issued prior to October 1, 1990; and

(2) Includes provisions which are inconsistent with the requirements of this chapter; and

E. A policy or contract offered primarily to provide basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection, accident only coverage, specified disease or specified accident coverage or limited benefit health coverage.

Sec. 2. 24-A MRSA §5051, sub-§§4 and 5 are enacted to read:

4. Home health care provider. "Home health care provider" has the same meaning as set forth in section 2745.

5. Home health care services. "Home health care services" has the same meaning as set forth in section 2745, subsections 1 and 2, except that the requirements of section 2745, subsection 1, paragraph A shall not apply.

Sec. 3. 24-A MRSA §§5051-A and 5051-B are enacted to read:

§5051-A. Required and prohibited provisions

1. Prohibited provisions. A long-term care policy may not:

A. Contain coverage for skilled nursing facilities only;

B. Exclude coverage for skilled, intermediate or custodial care received by a resident of a skilled nursing or intermediate care facility;

C. Require a prior hospital stay as a condition for any policy benefits;

D. Require a prior skilled nursing facility stay as a condition for intermediate care facility benefits; or

E. Require prior institutionalization as a condition of receipt of home health care benefits.

2. Required provisions. A long-term care policy must provide:

A. Custodial care benefits that are at least 50% of those provided for skilled nursing care in a nursing facility

provided that the benefits need not exceed usual, customary and reasonable charges;

B. Benefits for home health care services rendered by a home health care provider;

C. Home health care coverage for at least 90 visits in any continuous 12-month period during which coverage is in force; and

D. Per visit benefits for home health care services which are at least 50% of the daily benefit for skilled nursing facility confinement provided that the benefit need not exceed usual, customary and reasonable charges.

§5051-B. Alternative policies

1. Innovative long-term care products permitted. Notwithstanding section 5051-A, an insurer, organization or plan may offer a long-term care policy, within the meaning of section 5051, subsection 1, which does not meet one or more of the requirements of section 5051-A if the Superintendent of Insurance finds that:

A. For each requirement of section 5051-A which is not satisfied, there is a valid reason why that requirement is inappropriate for the policy design in question;

B. The total package of benefits provided is at least as comprehensive as that required by section 5051-A; and

C. Availability of the policy would be in the best interest of the public taking into consideration the following factors:

(1) Whether the policy accomplishes the goal of providing dependable benefits for long-term care; and

(2) Whether the plans for marketing the policy contain adequate safeguards to minimize any confusion that may be caused to consumers by the failure of the policy to fall within the established guidelines of this section.

2. Qualifications for tax incentives. If the superintendent finds that a policy meets the criteria of subsection 1, the superintendent, in determining whether to certify the policy for tax incentives under section 5054, shall consider the policy to comply with each of the requirements of section 5051-A.

Sec. 4. 24-A MRSA §§5054 and 5055 are enacted to read:

§5054. Certification by superintendent

1. Filing of form. Any insurer, nonprofit hospital or medical service organization, or nonprofit health care plan may, at the time it files a policy or contract for approval for issuance or delivery in the State, request that the superintendent certify the policy or contract as a long-term care policy within the meaning of section 5051.

Within 60 days of receipt of a request for certification, the superintendent shall:

A. Certify in writing that the policy or contract complies with this section;

B. Deny the request in writing, stating the reasons for denial; or

C. Notify the insurer or nonprofit hospital or medical service organization or nonprofit health care plan in writing that an insufficient basis exists for determining whether a certification should be made, indicating in what respects the request was insufficient.

2. Standards for compliance. The superintendent shall certify a policy or contract submitted for review under this section as a long-term care policy if the superintendent finds that the policy or contract:

A. Is a long-term care policy within the meaning of section 5051; and

B. Complies with all standards applicable to long-term care policies as set forth in this chapter and in chapters 27, 33 and 35 and in rules adopted pursuant to any of those chapters by the superintendent. Waivers granted under the rules shall be taken into consideration.

§5055. Tax incentives available

1. Reduced premium tax. Any insurance company choosing to offer an insurance policy which is certified by the superintendent as a long-term care policy shall qualify for the reduced tax on premiums collected under Title 36, section 2513.

2. Income tax reduction. Any person paying premiums for a policy or contract which is certified by the superintendent as a long-term care policy shall qualify for the income tax deduction provided for in Title 36, section 5122.

3. Credit for employers. An employer providing long-term care benefits to its employees may qualify for the tax credit provided by Title 36, section 2525 or 5217-B.

4. Life insurance riders. With respect to life insurance riders that qualify as long-term care policies, the tax incentives provided by this section shall apply only to that portion of the premium attributable to the rider.

5. Provision of records. Any person who holds a group long-term care policy pursuant to or under which premiums are paid in whole or in part by certificate holders or other 3rd parties shall provide to those certificate holders or 3rd parties adequate and timely records to enable those persons to have knowledge of the tax reduction to which they may be entitled under subsection 2 and under Title 36, section 5122.

Sec. 5. 36 MRSA §2513, as amended by PL 1985, c. 783, §11, is further amended by adding at the end a new paragraph to read:

Notwithstanding this section, for income tax years commencing on or after January 1, 1989, the tax imposed by this section upon all gross direct premiums collected or contracted for on long-term care policies, as certified by the superintendent pursuant to Title 24-A, section 5054, shall be at the rate of 1% a year.

Sec. 6. 36 MRSA §2525 is enacted to read:

§2525. Employer-provided long-term care benefits

1. Credit. A taxpayer under this chapter constituting an employing unit is allowed a credit against the tax imposed by this chapter for each taxable year equal to the lowest of the following:

A. Five thousand dollars;

B. Twenty percent of the costs incurred by the taxpayer in providing long-term care policy coverage as part of a benefit package; or

C. One hundred dollars for each employee covered by an employer-provided long-term care policy.

2. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Long-term care policy" has the same meaning as in Title 24-A, section 5051.

B. "Employing unit" has the same meaning as in Title 26, section 1043.

3. Limitation. The amount of the credit that may be used by a taxpayer for a taxable year may not exceed the amount of tax otherwise due under this chapter. Any unused credit may be carried over to the following year or years for a period not to exceed 15 years.

Sec. 7. 36 MRSA §5122, sub-§2, ¶C, as amended by PL 1987, c. 739, §§45 and 48, and by PL 1987, c. 772, §36, is repealed and the following enacted in its place:

C. Social security benefits and railroad retirement benefits paid by the United States, to the extent included in federal adjusted gross income;

Sec. 8. 36 MRSA §5122, sub-§2, ¶D, as amended by PL 1987, c. 739, §§46 and 48, is further amended to read:

D. For each of the taxable years ending in 1985 through 1987, 1/3 of the amount by which federal adjusted gross income was increased for the taxable year ending in 1984 under subsection 1, paragraph F; and

Sec. 9. 36 MRSA §5122, sub-§2, ¶E, as enacted by PL 1987, c. 739, §§47 and 48, is amended to read:

E. Pick-up contributions paid to the taxpayer by the Maine State Retirement System which have been previously taxed under this Part. ; and

Sec. 10. 36 MRSA §5122, sub-§2, ¶F is enacted to read:

F. For income tax years commencing on or after January 1, 1989, an amount equal to the total premiums spent for insurance policies for long-term care which have been certified by the Superintendent of Insurance as complying with Title 24-A, chapter 68.

Sec. 11. 36 MRSA §5217-B is enacted to read:

§5217-B. Employer-provided long-term care benefits

1. Credit. A taxpayer constituting an employing unit is allowed a credit against the tax imposed by this Part for each taxable year equal to the lowest of the following:

A. Five thousand dollars;

B. Twenty percent of the costs incurred by the taxpayer in providing long-term care policy coverage as part of a benefit package; or

C. One hundred dollars for each employee covered by an employer-provided long-term care policy.

2. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings:

A. "Long-term care policy" has the same meaning as in Title 24-A, section 5051.

B. "Employing unit" has the same meaning as in Title 26, section 1043.

3. Limitation. The amount of the credit that may be used by a taxpayer for a taxable year may not exceed the amount of tax otherwise due under this Part. Any unused credit may be carried over to the following year or years for a period not to exceed 15 years.

Sec. 12. Consumer education program. The Superintendent of Insurance shall establish a consumer education program concerning long-term care insurance. In particular, the superintendent shall review the Senior Health Insurance Benefit Advisors programs, or SHIBA, currently in operation in other states, and shall devise a strategy for implementing a similar SHIBA program in this State. The superintendent shall submit a report, together with any necessary implementing legislation to the Second Regular Session of the 114th Legislature no later than February 1, 1990, regarding progress on the implementation of a SHIBA program.

Sec. 13. Cost-benefit analysis for state employees. The Department of Administration shall conduct a cost-benefit analysis of providing a group long-term insurance benefit for state employees in addition to, or as an option to, current state employee benefits. The commissioner shall submit a report, together with any necessary implementing legislation, to the Second Regular Session of the 114th Legislature no later than February 1, 1990.

Sec. 14. Rulemaking for group long-term care policies. The Superintendent of Insurance shall, no later than February 1, 1990, review the existing rules relating to long-term care policies and, where appropriate, adopt modifications of the rules to make them consistent with this Act. The superintendent shall revise the rules as appropriate to reflect their applicability to group long-term care policies issued after October 1, 1990.

Sec. 15. Application. This Part shall apply to tax years beginning on or after the effective date of this part.

Sec. 16. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Part.

	1989-90
ADMINISTRATION, DEPARTMENT OF	
Accident, Sickness and Health Insurance	
All Other	$15,000
Provides funds for consulting fees to assist in the cost-benefit study of providing group long-term health insurance.	

PART C

Sec. 1. 24 MRSA c. 19, sub-c. II-A is enacted to read:

SUBCHAPTER II-A

LICENSURE OF MEDICAL UTILIZATION REVIEW ENTITIES

§2342. Review entities

1. Licensure. Any person, partnership or corporation, other than an insurer, nonprofit service organization, health maintenance organization, preferred provider organization or an employee of those exempt organizations that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators or employers, shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100. No person, partnership or corporation other than an insurer, nonprofit service organization, health maintenance organization or the employees of exempt organizations may perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

2. Listing. The Bureau of Insurance shall compile and maintain a current listing of persons, partnerships or corporations licensed pursuant to this section.

3. Information required. Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

A. The process by which the entity carries out its utilization review services, including the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State;

B. The process used by the entity for addressing beneficiary or provider complaints;

C. The types of utilization review programs offered by the entity, such as:

(1) Second opinion programs;

(2) Prehospital admission certification;

(3) Preinpatient service eligibility determination; or

(4) Concurrent hospital review to determine appropriate length of stay; and

D. The process chosen by the entity to preserve beneficiary confidentiality of medical information.

4. Transition for existing entities. Notwithstanding subsection 1, persons, partnerships or corporations performing utilization review services on the effective date of this section shall have 90 days from its effective date to submit an application to the superintendent. The superintendent shall act upon those applications within 6 months of the date of receipt of the application, during which time the review entities may continue to perform medical utilization review services.

§2343. Minimum standards

A utilization review program of the applicant must meet the following minimum standards.

1. Notification of adverse decisions. Notification of an adverse decision by the utilization review agent must be provided to the insured or other party designated by the insured within a time period to be determined by the superintendent through rulemaking.

2. Reconsideration of determination. All licensees shall maintain a procedure by which insureds, patients or providers may seek reconsideration of determinations of the licensee.

3. Accessibility of representatives. A representative of the licensee must be accessible by telephone to insureds, patients or providers and the superintendent may adopt standards of accessibility by rule.

4. Information materials; confidentiality. A copy of the materials designed to inform applicable patients of the requirements of the utilization plan and the responsibilities and rights of patients under the plan and an acknowledgment that all applicable state and federal laws to protect the confidentiality of individual medical records are followed must be filed with the bureau.

§2344. Utilization review services

As used in this subchapter, unless the context indicates otherwise, "utilization review services" or "medical utilization review services" means any program or process by which a person, partnership or corporation, on behalf of an insurer, nonprofit service organization, 3rd-party administrator or employer which is a payor for or which arranges for payment of medical services, seeks to review the utilization, appropriateness or quality of medical services provided to a person whose medical services are paid for, partially or entirely, by that insurer, nonprofit service organization, 3rd-party administrator or employer. The terms include these programs or processes whether they apply prospectively or retrospectively to medical services. Utilization review services include, but are not limited to, the following:

1. Second opinion programs. Second opinion programs;

2. Prehospital admission certification. Prehospital admission certification;

3. Preinpatient service eligibility certification. Preinpatient service eligibility certification; and

4. Concurrent hospital review. Concurrent hospital review to determine appropriate length of stay.

§2345. Enforcement

The following provisions govern enforcement of this chapter.

1. Periodic reviews. The superintendent may conduct periodic reviews of the operations of the entities licensed pursuant to this subchapter to ensure that they continue to meet

the minimum standards set forth in section 2343 and any applicable rules adopted by the superintendent. The superintendent may perform periodic telephone audits of licensees to determine if representatives of the licensee are reasonably accessible, as required by section 2343.

2. Action against licensee. The superintendent is authorized to take appropriate action against a licensee which fails to meet the standards of this subchapter or any rules adopted by the superintendent, or who fails to respond in a timely manner to corrective actions ordered by the superintendent. The superintendent may impose a civil penalty not to exceed $1,000 for each violation, as permitted by Title 24-A, section 12-A or may deny, suspend or revoke the license.

3. Opportunity to provide information and request hearing. Before taking the actions authorized by this section to deny, suspend or revoke the license, the superintendent shall provide the licensee with reasonable time to supply additional information demonstrating compliance with the requirements of this subchapter and the opportunity to request a hearing to be held consistent with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375.

4. Authority to adopt rules. The superintendent may adopt rules necessary to implement the provisions of this subchapter.

5. Rulings on appropriateness of medical judgments not authorized. Nothing in this subchapter requires or authorizes the superintendent to rule on the appropriateness of medical decisions or judgments rendered by review entities and their agents.

Sec. 2. 24-A MRSA c. 34 is enacted to read:

CHAPTER 34

LICENSURE OF MEDICAL UTILIZATION REVIEW ENTITIES

§2771. Review entities

1. Licensure. Any person, partnership or corporation, other than an insurer, nonprofit service organization, health maintenance organization, preferred provider organization or employee of those exempt organizations that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators or employers, shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100. No person, partnership or corporation other than an insurer, nonprofit service organization, health maintenance organization or the employees of

exempt organizations may perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

2. Listing. The Bureau of Insurance shall compile and maintain a current listing of persons, partnerships or corporations licensed pursuant to this section.

3. Information required. Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

A. The process by which the entity carries out its utilization review services, including the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State;

B. The process used by the entity for addressing beneficiary or provider complaints;

C. The types of utilization review programs offered by the entity, such as:

(1) Second opinion programs;

(2) Prehospital admission certification;

(3) Preinpatient service eligibility determination; or

(4) Concurrent hospital review to determine appropriate length of stay; and

D. The process chosen by the entity to preserve beneficiary confidentiality of medical information.

4. Transition for existing entities. Notwithstanding subsection 1, persons, partnerships or corporations performing utilization review services on the effective date of this section shall have 90 days from its effective date to submit an application to the superintendent. The superintendent shall act upon those applications within 6 months of the date of receipt of the application, during which time the review entities may continue to perform medical utilization review services.

§2772. Minimum standards

A utilization review program of the applicant must meet the following minimum standards.

1. Notification of adverse decisions. Notification of an adverse decision by the utilization review agent must be provided to the insured or other party designated by the insured within a time period to be determined by the superintendent through rulemaking.

2. Reconsideration of determinations. All licensees shall maintain a procedure by which insureds, patients or providers may seek reconsideration of determinations of the licensee.

3. Accessibility of representatives. A representative of the licensee must be accessible by telephone to insureds, patients or providers and the superintendent may adopt standards of accessability by rule.

4. Information materials; confidentiality. A copy of the materials designed to inform applicable patients of the requirements of the utilization plan and the responsibilities and rights of patients under the plan and an acknowledgment that all applicable state and federal laws to protect the confidentiality of individual medical records are followed must be filed with the bureau.

§2773. Utilization review services

As used in this chapter, unless the context indicates otherwise, "utilization review services" or "medical utilization review services" means any program or process by which a person, partnership or corporation, on behalf of an insurer, nonprofit service organization, 3rd-party administrator or employer which is a payor for or which arranges for payment of medical services, seeks to review the utilization, appropriateness or quality of medical services provided to a person whose medical services are paid for, partially or entirely, by that insurer, nonprofit service organization, 3rd-party administrator or employer. The terms include these programs or processes whether they apply prospectively or retrospectively to medical services. Utilization review services include, but are not limited to, the following:

1. Second opinion programs. Second opinion programs;

2. Prehospital admission certification. Prehospital admission certification;

3. Preinpatient service eligibility certification. Preinpatient service eligibility certification; and

4. Concurrent hospital review. Concurrent hospital review to determine appropriate length of stay.

§2774. Enforcement

The following provisions govern enforcement of this chapter.

1. Periodic reviews. The superintendent may conduct periodic reviews of the operations of the entities licensed pursuant to this chapter to ensure that they continue to meet the minimum standards set forth in section 2772 and any applicable rules adopted by the superintendent. The superintendent may perform periodic telephone audits of licensees to determine if representatives of the licensee are reasonably accessible, as required by section 2772.

2. Action against licensee. The superintendent is authorized to take appropriate action against a licensee which fails to meet the standards of this chapter or any rules adopted by the superintendent, or who fails to respond in a timely manner to corrective actions ordered by the superintendent. The superintendent may impose a civil penalty not to exceed $1,000 for each violation, as permitted by section 12-A, or may deny, suspend or revoke the license.

3. Opportunity to provide information and request hearing. Before taking the actions authorized by this section to deny, suspend or revoke the license, the superintendent shall provide the licensee with reasonable time to supply additional information demonstrating compliance with the requirements of this chapter and the opportunity to request a hearing to be held consistent with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375.

4. Authority to adopt rules. The superintendent may adopt rules necessary to implement the provisions of this chapter.

5. Rulings on appropriateness of medical judgments not authorized. Nothing in this chapter requires or authorizes the superintendent to rule on the appropriateness of medical decisions or judgments rendered by review entities and their agents.

Sec. 3. 24-A MRSA §2847 is enacted to read:

§2847. Utilization review data

1. Report required. On or before April 1st of each year, any insurer or 3rd-party administrator which issues or administers a program or contract in this State providing coverage for hospital care that contains a provision whereby in nonemergency cases the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening eligibility program or any

similar preutilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed or ordered by a duly licensed physician shall file a report on the results of that evaluation for the preceding year with the superintendent which shall contain the following:

A. The number and type of evaluations performed. For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service;

B. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or whether benefits paid for the service were reduced by the insurer;

C. The number and result of any appeals by the patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and

D. Any complaints filed in a court of competent jurisdiction and served upon an insurer filing under this section stating a cause of action against that insurer on the basis of damages to patients alleged to have been approximately caused by a delay, reduction or denial of medical benefits by the insurer, as determined through prospective evaluations, and the determination of liability or other disposition of the complaint.

2. Residents. This section is applicable to evaluations, appeals and complaints relating to residents of this State only.

3. Confidentiality. Any information provided pursuant to this section shall not identify the patients.

Sec. 4. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Part.

	1989-90	1990-91
PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF		
Bureau of Insurance		
Positions	(0.5)	(0.5)
Personal Services	$9,568	$13,082

All Other	750	1,000
Capital Expenditures	1,000	
Provides funds for a half-time Insurance Company Examiner to review applications, maintain records and adopt rules.		
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION TOTAL	$11,318	$14,082

PART D

Sec. 1. 24 MRSA §2317-A is enacted to read:

§2317-A. Explanation and notice to parent of minor

Title 24-A, sections 2713-A and 2823-A shall apply to nonprofit hospital corporations, nonprofit medical service corporations and nonprofit health care plans to the extent not inconsistent with this chapter and the reasonable implications of this chapter.

Sec. 2. 24-A MRSA §2713-A is enacted to read:

§2713-A. Explanation and notice to parent of minor

If the insured is a minor under 18 years of age, and if the insurer is so requested by a parent of the insured who is not paying the premiums on the policy, the insurer shall provide that parent with:

1. Payment or denial of claim. An explanation of the payment or denial of any claim filed on behalf of the insured minor;

2. Change in terms and conditions. An explanation of any proposed change in the terms and conditions of the policy; or

3. Notice of lapse. Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified.

In addition, any parent who is able to provide the information necessary for the insurer to process a claim shall be permitted to authorize the filing of any claims under the policy.

Sec. 3. 24-A MRSA §2823-A is enacted to read:

§2823-A. Explanation and notice to parent of minor

If the insured is a minor under 18 years of age, and if the insurer is so requested by either of the minor's parents, the insurer shall provide that parent with:

1. Payment or denial of claim. An explanation of the payment or denial of any claim filed on behalf of the insured minor;

2. Change in terms and conditions. An explanation of any proposed change in the terms and conditions of the policy; or

3. Notice of lapse. Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified.

In addition, any parent who is able to provide the information necessary for the insurer to process a claim shall be permitted to authorize the filing of any claims under the policy.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved, except that Parts B, C and D shall take effect 90 days after adjournment of the First Regular Session of the 114th Legislature.

FISCAL NOTE

PART A

Part A of the bill will have the following effect on revenues:

	1989-90	1990-91
Other Special Revenue Fund	$45,940	$45,940

The Bureau of Insurance within the Department of Professional and Financial Regulation will need to increase its annual assessment on insurers to cover the additional costs related to the Mandated Benefits Advisory Commission established in this bill.

Part B

Part B of the bill will require the Bureau of Insurance to review and certify long-term care policies and establish a consumer education program. The bureau will be able to meet these requirements within existing budgeted resources. The

Department of Administration, state employee health insurance program, has a sufficient balance of dedicated revenue to fund the cost-benefit study. An allocation to authorize the expenditures for the study is required.

In addition, because long-term health care insurance has not been widely available due primarily to its expense, it is expected that few individuals will avail themselves of this type of insurance. The expected loss of revenue, therefore, from the proposed income tax deduction and the lower insurance premium tax for these policies will not be significant in the 1990-91 biennium. The long-term General Fund revenue loss, however, could be significant.

PART C

Part C of the bill will have the following effect on revenues:

	1989-90	1990-91
Other Special Revenue Fund	$11,318	$14,082

The Bureau of Insurance will receive additional dedicated revenues from fees amounting to $6,000 and $1,500 in fiscal years 1989-90 and 1990-91, respectively. The additional costs in this Part of the bill above the increased revenue from fees will require an increase of the annual assessment on insurers.

PART D

The Bureau of Insurance within the Department of Professional and Financial Regulation will be able to absorb the potential cost of implementing Part D of the bill. This change will not significantly affect the cost of the state employee health insurance program.'

STATEMENT OF FACT

This amendment replaces the language of the bill with the language of 4 bills considered and amended by the Joint Standing Committee on Banking and Insurance: S.P. 253, L.D. 643, "An Act to Provide for the Social and Financial Assessment of Proposed Mandatory Health Insurance Benefits"; S.P. 367, L.D. 984, "An Act Related to Improving Access to Long-term Health Care Insurance"; S.P. 374, L.D. 998, "An Act to Register 3rd-party Medical Reimbursement Review Entities"; and H.P. 928, L.D. 1294, "An Act to Require Health Insurance Carriers to Inform Parents of Benefit and Other Information."

Part A of the amendment relates to L.D. 643, providing for assessment of mandated health insurance benefits. The amendment directs joint standing committees having jurisdiction over mandated health insurance benefits to request an assessment of the proposal by the Mandated Benefits Advisory Commission. The assessment would include consideration of the financial and social effects of the proposal and the medical efficacy of the proposal.

The amendment also reforms the existing Mandated Benefits Advisory Commission to include representation of the entities currently on the commission, and to add representatives to be appointed by legislative leadership, including Legislators and representatives of consumers, labor organizations, chiropractors and public health professionals. An ex officio representative of the Bureau of Health is also added. The amendment adds to the duties of the commission by requiring the commission to perform studies of proposed mandated benefits when requested by committees, to study existing mandated benefits on a schedule to be determined by the Joint Standing Committee on Banking and Insurance and to perform studies of particular issues related to mandated benefits when requested by the Joint Standing Committee on Banking and Insurance.

Part B of the amendment relates to L.D. 984, long-term health care insurance. The amendment includes criteria for long-term health care insurance; subjected group policies to regulation beginning October 1, 1990; includes life insurance policy riders in the category of policies which may qualify as long-term care policies; creates an income tax deduction for individuals who purchase long-term health care insurance and an income tax credit for businesses that offer the insurance to their employees and pay part of the premium; and reduces the tax in premiums received by insurers from long-term policies. The amendment also requires the Superintendent of Insurance to establish a consumer education program concerning long-term care insurance and requires the Department of Administration to conduct a cost-benefit study of providing long-term health care insurance to state employees.

Part C of the amendment related to L.D. 998, regarding 3rd-party medical reimbursement review entities, requires all entities which review medical utilization to be licensed by the Bureau of Insurance. This includes entities that perform 2nd opinion programs, prehospital admission certification, preinpatient service eligibility determinations and concurrent hospital review. The amendment also provides specific standards which these review entities would be required to meet, including requirements that an adverse decision by the reviewer must be provided to the insured within a time period to be specified by the superintendent; that licensees must have a procedure for insureds to seek reconsideration of determinations; that

representation of the licensee must be accessible to insureds; and that review entities meet the requirement for state and federal laws relating to confidentiality of medical records.

The superintendent would be authorized to conduct periodic reviews of entities to assure that they continue to comply with rules adopted under the law and the superintendent is authorized to impose penalties for noncompliance, including imposition of civil penalties and revocation of licenses.

Part D of the amendment relates to L.D. 1294, providing information on health insurance benefits to the parents of minors. The amendment requires insurers to provide explanations to the nonpolicyholder parent of a minor when that parent asks for information about a particular claim denial or payment or about a change in the terms and conditions of a policy. The insurer would also be required to provide advance notice to those parents that a policy is about to lapse, provided that the parent has given the insurer an address at which to notify the parent. Finally, the amendment permits a nonpolicyholder parent to file a claim for benefits under the policy, as long as they have the information necessary for the insurer to process the claim, such as the policy number.

Reported by the Committee on Banking and Insurance
Reproduced and distributed under the direction of the Clerk of the House
6/20/89

(Filing No. H-643)