L.D. 1322

(Filing No. S-390)

STATE OF MAINE
SENATE
114TH LEGISLATURE
FIRST REGULAR SESSION

SENATE AMENDMENT " B" to COMMITTEE AMENDMENT "A" to H.P. 954, L.D. 1322, Bill, "An Act to Improve Access to Health Care and Relieve Hospital Costs Due to Charity and Bad Debt Care Which are Currently Shifted to Third-party Payors"

Amend the amendment by striking out everything after the title and before the statement of fact and inserting in its place the following:

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

'**Sec. 1. 22 MRSA §396-F, first ¶,** as enacted by PL 1983, c. 579, §10, is amended to read:

In establishing revenue limits for ~~individual hospitals~~ an individual hospital, the commission shall make provision for revenue deductions ~~in the following categories~~ determined in accordance with subsections 1 to 3, offset as appropriate by any distributions the hospital will receive in the same payment year from the fund established in subsection 5.

Sec. 2. 22 MRSA §396-F, sub-§4, as enacted by PL 1987, c. 847, §2, is repealed.

Sec. 3. 22 MRSA §396-F, sub-§5 is enacted to read:

5. Hospital payments fund. There is established the Hospital Uncompensated Care and Governmental Payment Shortfall Fund, which may be referred to as the "hospital payments fund," administered by the commission. The assets of this fund shall be derived from any appropriation that the Legislature may make or from any portion of the approved gross patient service revenue of each hospital designated as hospital payments fund revenue pursuant to section 396-I, subsection 1, or from both of these sources.

A. The hospital payments fund shall be administered as follows.

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(1) Except as otherwise provided, the Treasurer of State shall be the custodian of the hospital payments fund. Upon receipt of vouchers signed by a person or persons designated by the commission, the State Controller shall draw a warrant on the Treasurer of State for the amount authorized. A duly attested copy of the resolution of the commission designating these persons and bearing on its face specimen signatures of these persons shall be filed with the State Controller as authority for making payments upon these vouchers.

(2) The commission may cause funds to be invested and reinvested subject to its periodic approval of the investment program.

(3) The commission shall publish annually, for each fiscal year, a report showing fiscal transactions of funds for the fiscal year and the assets and liabilities of the funds at the end of the fiscal year.

B. The commission shall disburse amounts from the hospital payments fund to those hospitals most affected by bad debts, charity care and shortfalls in governmental payments. The commission shall develop standards for the distribution of the funds to individual hospitals. The standards shall address the following factors:

(1) The impact of the proportion of Medicare and Medicaid payments;

(2) The special disadvantages of the Medicare payment system for rural hospitals;

(3) The proportion of charges to nonpaying patients;

(4) The efficiency of the hospital; and

(5) The financial distress of the hospital and the plan of the hospital to relieve that distress.

Sec. 4. 22 MRSA §396-H, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

§396-H. Establishment and adjustment of gross patient service revenue limits

The commission shall establish a gross patient service revenue limit for each hospital for each payment year commencing on or after October 1, 1984. This limit shall be established as follows.

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1. General computation. The gross patient service revenue limit shall be computed to allow the hospital to charge an amount calculated to recover its payment year financial requirements, offset by its available resources pursuant to section 396-E, taking into consideration the revenue deductions determined pursuant to section 396-F.

2. Hospital payments fund adjustment. For payment years or partial payment years on or after October 1, 1990, the commission may include in the gross patient service revenue limit an adjustment, based on a uniform percentage to be applied to all hospitals, to provide revenue to be transmitted to the hospital payments fund in accordance with section 396-I, subsections 1 and 6. The adjustment shall not exceed .75% of net patient service revenues annually.

Sec. 5. 22 MRSA §396-I, sub-§1, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

1. Components of revenue limits. The commission shall, for each payment year, apportion each hospital's approved revenue limit into the following components, as applicable.

A. One component shall be designated "management fund revenue" and shall be equal to the adjustment, if any, for management support services determined under section 396-D, subsection 9, paragraph A.

B. One component shall be designated "hospital retained revenue" and shall be equal to the approved gross patient service revenue limit less the "management fund revenue" and "hospital payments fund revenue."

C. One component shall be designated "hospital payments fund revenue" and shall be equal to the adjustment, if any, determined under section 396-H, subsection 2, for the support of the hospital payments fund.

Sec. 6. 22 MRSA §396-I, sub-§6 is enacted to read:

6. Transmittal of hospital payments fund revenue. No later than 30 days following the close of each quarter of each fiscal year, each hospital shall transmit to the hospital payments fund, established in section 396-F, that portion of its revenues that corresponds to the hospital payments fund revenue determined under subsection 1.

Sec. 7. 22 MRSA §§3189 to 3191 are enacted to read:

§3189. The Maine Health Program

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

A. "Department" means the Department of Human Services.

B. "Federal poverty level" means the federal poverty level established as required by the United States Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, Sections 652 and 673(2).

C. "Household income" means the income of a person or group of persons determined according to rules adopted by the department in accordance with subsection 6, provided that the rules do not include, in the definition of a household, persons other than those who reside together and among whom there is legal responsibility for support.

D. "Program" means the Maine Health Program described in this section.

2. Program created; eligibility and benefits. There is created the Maine Health Program. Any person residing in Maine whose household income is 100% or less of the federal poverty level who is not eligible for the benefits provided by Medicaid and who meets the other criteria established under this section shall be eligible to participate in the program. Participants in the program are entitled to receive benefits in accordance with this section.

Benefits under the program are subject to the limit of the funds appropriated for the program. The department will promulgate rules in accordance with subsection 6 to determine how benefits shall be allocated among participants in the program within the limits of the appropriation.

3. Program development and administration. The department shall develop and administer the program in accordance with this section.

A. The department, by rule adopted in accordance with subsection 6, shall determine the scope and amount of medical assistance to be provided to participants in the program provided that the rules meet the following criteria.

(1) The scope and amount of medical assistance shall be the same as the medical assistance received by persons eligible for Medicaid, except that pregnancy-related services and nursing home benefits covered under Medicaid shall not be offered as services under the program.

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(2) The medical assistance to be provided shall not require the participant to make out-of-pocket expenditures, such as requiring deductibles or copayments for any service covered, except to the extent out-of-pocket expenditures are required under state Medicaid rules.

B. The department shall develop plans to ensure appropriate utilization of services. The department's consideration shall include, but not be limited to, preadmission screening, managed care, use of preferred providers and 2nd surgical opinions.

C. No contribution may be required to be paid on behalf of those persons participating in the program.

D. The department shall adopt rules in accordance with subsection 6 to establish guidelines on:

(1) Provider eligibility for reimbursement for services under this section, provided that the criteria for providers shall be no more stringent than those established in the state Medicaid rules; and

(2) Service provider fees, provided that the fees shall be no less than service provider fees established in the Medicaid fee schedule for the applicable program year.

E. The department shall maximize the use of federal funds by establishing procedures to identify participants in the program who become eligible for Medicaid. Any person eligible for benefits under Medicaid or the United States Family Support Act of 1988, Public Law 100-482, is ineligible to receive those benefits under the program. This paragraph authorizes the department to take advantage of any Medicaid options that become available to cover persons eligible for the program.

F. The department shall make available applications for participation in the program and shall assist persons in completing them. The department shall review those forms and notify persons of eligibility within 45 days of receipt of the form.

The department shall treat any application for aid to families with dependent children or for any medical assistance program administered by the department as an application for the program. If the applicant is not eligible for Medicaid, the department shall review the application for eligibility for the program. The department shall review and determine eligibility for the program of

any person whose eligibility for Medicaid or any other medical services program is being terminated.

G. The department shall implement this section and commence coverage of eligible persons in the program no later than July 1, 1990.

4. Coordination with other payors. The program shall be a secondary payor to all other payors to the extent permitted by federal and state law.

The department shall adopt rules in accordance with subsection 6 to implement this subsection.

5. Transition period for participants losing eligibility. Any participant who ceases to be eligible to participate in the program because of household income exceeding 100% of the federal poverty level shall be entitled to continue to participate in the program for a period of 2 years following loss of eligibility, provided the participant pays a premium established for such persons by the department by rule adopted in accordance with subsection 6.

6. Procedures for adopting rules. The commissioner or the department may adopt rules as necessary pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, to implement the provisions of this section.

§3190. Community Health Program grants

1. Grants. The Community Health Program is created to expand health and medical resources available to local communities through a grant program while encouraging the development of greater efficiency in care for low-income persons. Grants shall be awarded according to the terms of this section in the amounts specified and to the persons and organizations selected by the Department of Human Services.

2. Primary health care grants. Grants shall be used only as specified and shall be awarded to directly provide or arrange access to primary and preventive services, referral to specialty and inpatient care, prescription drugs, ancillary services, health education, case finding and outreach to bring people into the system. Funds for this program are to be targeted to primary and preventive care and shall not be used to subsidize inpatient care.

Grants shall be awarded to local health care providers, or to new organizations where existing providers are unwilling or unable to participate, who demonstrate the capacity to provide an organized system of primary care. Eligible grantees include, but are not limited to, groups of physicians, primary health care centers,

health maintenance organizations and hospital outpatient departments, provided they meet the following criteria:

A. Arrangements for services 24 hours a day, 7 days a week;

B. Full hospital privileges for all primary care physicians or arrangements to refer patients for inpatient hospital care and specialist services. Arrangements must be in writing or the provider must be able to demonstrate that patients are being accepted and treated;

C. Provisions for follow-up care from the hospital or specialist to the patient's primary care provider;

D. Access to ancillary services including laboratory, pharmacy and radiology;

E. Linkage to the Women, Infants and Children Special Supplemental Food Program of the United States Child Nutrition Act of 1966, nutritional counseling, social and other support services;

F. Acceptance without limits of Medicaid and Maine Health Program patients and uninsured persons, including public notice of appropriate sliding fee scales;

G. A medical record system with arrangements for the transfer of records to the hospital, the specialist and their return to the primary care physician;

H. Quality assurance mechanisms to evaluate the quality and appropriateness of patient care; and

I. Evidence of community-wide input into the design and provision of health services to be funded by the grant.

3. Health promotion and health education grants. Notwithstanding the criteria set forth in subsection 2, grants may be made for health promotion and health education programs. To qualify for a health promotion or health education grant, the applicant must demonstrate an ability to coordinate services and programmatic efforts with local primary care providers and provide a plan for follow-up care for their consumers.

4. Application for grants. Applications for grants awarded under this section shall be submitted to and reviewed by the Department of Human Services.

5. Selection of recipients; amounts of awards. The Department of Human Services shall designate the recipients of the grants and the amount of the grants. Recipients and amounts shall be based on:

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A. Documented health status needs;

B. Documented financial hardship such as area unemployment;

C. Evidence of problems of access to health care services;

D. Evidence of local commitment to the health program; and

E. Other criteria the Department of Human Services establishes by rule.

6. Grants renewable. Grants may be awarded for a period of up to 3 years and, if awarded for less than 3 years, may be renewed provided the total term of the grant does not exceed 3 years. After receiving grants for 3 years, a previous grant recipient may apply for an additional grant provided the Department of Human Services evaluates the application with other grant applicants in an open competitive bidding process.

7. Rulemaking. The Department of Human Services shall adopt rules necessary to implement this section in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375.

8. Commencement of grants. The Department of Human Services shall complete its rulemaking and begin to make grants under this section no later than July 1, 1990.

§3191. Hospital Uncompensated Care and Governmental Payment Shortfall Fund report

The Department of Human Services and the Maine Health Care Finance Commission shall jointly submit a report to the President of the Senate and the Speaker of the House of Representatives, on or before December 1, 1991, and every 2 years thereafter, setting forth the manner in which the Hospital Uncompensated Care and Governmental Payment Shortfall Fund, established in section 396-F, subsection 5, has been administered.

Sec. 8. 24 MRSA §2336, as enacted by PL 1985, c. 704, §2, is repealed and the following enacted in its place:

§2336. Contracts; agreements or arrangements with incentives or limits on reimbursement authorized

1. Arrangements with preferred providers permitted. Subject to this section and to the approval of the superintendent, nonprofit service organizations may:

A. Enter into agreements with certain providers of their choice relating to health care services which may be rendered to subscribers of the nonprofit service

organizations, including agreements relating to the amounts to be charged by the provider to the subscriber for services rendered and amounts to be paid by the nonprofit service organization for services rendered; or

B. Issue or administer programs or contracts in this State that include incentives for the subscriber to use the services of a provider who has entered into an agreement with the nonprofit service organization pursuant to paragraph A. When such a program or contract is offered to an employee group, employees shall have the option annually of participating in any other health insurance program or health care plan sponsored by their employer.

2. Terms restricting access or availability prohibited. Contracts, agreements or arrangements issued under this Act may not contain terms or conditions that will operate unreasonably to restrict the access and availability of health care services. The superintendent shall adopt rules setting forth criteria for determining when a term or condition operates unreasonably to restrict access and availability of health care services. The rules shall include criteria for evaluating the reasonableness of the distance to be travelled by subscribers for particular services and may prohibit the nonprofit service organization from applying the benefit level differential to individual subscribers who must travel an unreasonable distance to obtain the service. The criteria shall also include the effect of the arrangement on nonsubscribers in the communities affected by the arrangement, including, but not limited to, the ability of nonpreferred providers to continue to provide health care services if all nonemergency services were provided by a preferred provider.

3. Length of contract; contracting process. Contracts for preferred provider arrangements shall not exceed a term of 3 years. A preferred provider arrangement for all subscribers of a nonprofit services organization must be awarded on the basis of an open bidding process after invitation to all providers of that service in the State. Each preferred provider arrangement affecting all subscribers must be bid and contracted for as separate services. Each service on the list set forth in section 2339 shall constitute a separate service.

Sec. 9. 24 MRSA §2337, as enacted by PL 1985, c. 704, §2, is amended to read:

§2337. Filing for approval; disclosure

~~**1. Disclosure.** Any nonprofit service organization which proposes to offer a preferred provider arrangement authorized by this chapter shall disclose in a report to the Superintendent of Insurance, at least 30 days prior to its initial offering and prior to any change thereafter, the following:~~

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~~A. The name which the arrangement intends to use and its business address;~~

~~B. The name, address and nature of any separate organization which administers the arrangement on the behalf of the nonprofit service organization; and~~

~~C. The names and addresses of all providers designated by the nonprofit service organizations under this section and the terms of the agreements with designated health care providers.~~

~~The superintendent shall maintain a record of arrangements proposed under this section, including a record of any complaints submitted relative to the arrangements.~~

1-A. Approval of arrangements. A nonprofit services organization that proposes to offer a preferred provider arrangement authorized by this chapter shall file proposed agreements, rates and other materials relevant to the proposed arrangement, in the time period and the manner established by rule by the superintendent. No arrangement may be offered until the superintendent has approved the arrangement. The superintendent shall include in the rules the number of days within which the superintendent must approve or disapprove a proposed arrangement.

A. The superintendent shall disapprove any arrangement if it contains any unjust, unfair or inequitable provisions or fails to meet the standards set forth in section 2336, or those set forth in rules adopted pursuant to section 2336. The superintendent shall also adopt rules setting forth the criteria to be used in determining what constitutes an unjust, unfair or inequitable provision.

B. Within 10 days of receipt of a report of a proposed preferred provider arrangement, the superintendent shall mail notice of the proposal to all persons who have requested notice of preferred provider arrangement proposals in advance from the superintendent.

C. The superintendent may hold a public hearing on approval of a preferred provider arrangement and shall hold a public hearing if an interested person requests a public hearing and the request meets the criteria set forth in this section and in the rules adopted under this section. The superintendent shall hold a public hearing upon request of an interested person when:

(1) The interested person makes a written request to the superintendent:

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(a) Within the time period established by rule by the superintendent;

(b) Stating briefly the respects in which that person is interested or affected; and

(c) Stating the grounds on which that person will rely for the relief to be demanded at the hearing;

(2) The superintendent finds that:

(a) The request is timely and made in good faith; and

(b) The interested person would be aggrieved if the stated grounds were established and the grounds otherwise justify the hearing; and

(3) The request meets other criteria established by the superintendent by rule.

The superintendent shall adopt rules to implement the hearing requirement, including rules setting forth the time period within which a public hearing may be held on the superintendent's initiative and the time period within which an interested person may file a request for a public hearing. If the superintendent finds that a public hearing is justified at the request of an interested person, the public hearing shall be held within 30 days after the filing of the request by an interested person, unless the hearing is postponed by consent of the interested person, the superintendent and the nonprofit service organization filing the arrangement. The hearing shall be held in accordance with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375, including the provision permitting intervention of interested persons.

2. Certain arrangements with incentives or limits on reimbursement; disclosure. If a nonprofit service organization offers an arrangement with incentives or limits on reimbursement consistent with this subchapter as part of a group health insurance contract or policy, the forms shall disclose to subscribers:

A. Those providers with which agreements or arrangements have been made to provide health care services to the subscribers and a source for the subscribers to contact regarding changes in those providers;

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B. The extent of coverage as well as any limitations or exclusions of health care services under the policy or contract;

C. The circumstances under which reimbursement will be made to a subscriber unable to use the services of a preferred provider;

D. A description of the process for addressing a complaint under the policy or contract;

E. Deductible and coinsurance amounts charged to any person receiving health care services from a preferred provider; and

F. The rate of payment when health care services are provided by a nonpreferred provider.

~~3. Disapproval of arrangements. The superintendent shall disapprove any arrangement if it contains any unjust, unfair or inequitable provisions.~~

Sec. 10. 24 MRSA §2338, as enacted by PL 1985, c. 704, §2, is amended to read:

§2338. Risk sharing

Preferred provider arrangements may embody risk sharing by providers. ~~Any nonprofit service organization having formed a preferred provider arrangement by employing a prepaid capitation rate shall file applicable provider agreements, rates and other relevant material with the Superintendent of Insurance for approval. The superintendent shall disapprove any rates which are excessive, inadequate or unfairly discriminatory.~~

~~If the superintendent has not taken any action on the forms filed within 30 days of receipt, the arrangement shall be deemed approved. The superintendent may extend, by not more than an additional 30 days, the period within which he may affirmatively approve or disapprove any form, by giving notice to the nonprofit service organization before expiration of the initial 30-day period. At the expiration of any extension, if the superintendent has not acted on the forms, the arrangement shall be deemed approved. The superintendent may at any time, after hearing and for cause shown, withdraw any such approval.~~

Sec. 11. 24 MRSA §2339, as amended by PL 1987, c. 34, §1, is repealed and the following enacted in its place:

§2339. Alternative health care benefits

A nonprofit service organization that makes a preferred provider arrangement available shall provide for payment of

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covered health care services rendered by providers who are not preferred providers.

1. Benefit level. Except as provided in this section, the benefit level differential between services rendered by preferred providers and nonpreferred providers may not exceed 20% of the allowable charge for the service rendered. Prior to July 1, 1993, the benefit level differential for the purchases and services listed in subsection 2 may exceed 20% but may not exceed 50% of the allowable charge for the service. The benefit level differential for all services rendered after June 30, 1993, shall be limited to 20% of the allowable charge. Any contract entered into prior to July 1, 1993, that provides a benefit level differential in excess of 20% for the services and purchases listed in subsection 2, shall include a provision reducing the benefit level differential to not more than the maximum benefit level differential permitted by law for services and purchases provided on or after July 1, 1993.

2. Fifty percent benefit level differential. The following purchases and services, when rendered prior to July 1, 1993, on an outpatient basis, in a nonemergency case, may be subject to a 50% benefit level differential subject to the limitations of subsection 1:

A. Radiology services, except x rays of extremities, screening and diagnostic chest x rays, maxillofacial x rays, screening cervical, thoracic and lumbar spine x rays, posttrauma x rays such as x rays of skull and ribs, flat plate abdomen x rays and other radiology services to be determined by rule by the superintendent;

B. Laboratory services provided by medical laboratories licensed in accordance with the Maine Medical Laboratory Commission, licensed by an equivalent out-of-state licensing authority or by a hospital, excluding those licensed laboratories owned by a community health center, a physician or group of physicians where the laboratory services are offered solely to the patients of the center, the physician or group of physicians;

C. Pathology services;

D. Magnetic resonance imaging services;

E. Computerized tomography services;

F. Mammography services;

G. Ultrasonography services;

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H. Cardiac diagnostic services including electrocardiograph stress testing, physiologic diagnostic procedures, cardiac catheterization and angiography, but excluding electrocardiograms;

I. Lithotripsy services unless approved under the Maine Certificate of Need Act of 1978;

J. Services provided by free standing ambulatory surgery facilities certified to participate in the Medicare program;

K. Purchases of durable medical equipment; and

L. Any other service performed in an outpatient setting requiring the purchase of new equipment costing $500,000 or more or for which the charge per unit of service is $250 or more.

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

A. "Allowable charge" means the amount which would be payable for services under the preferred provider arrangement prior to the application of any deductible and coinsurance.

B. "Nonemergency case" means a case other than one involving accidental bodily injury or sudden and unexpected onset of a critical condition requiring medical or surgical care for which a person seeks immediate medical attention within 24 hours of the onset.

Sec. 12. 24 MRSA §2340-A is enacted to read:

§2340-A. Annual report

In addition to the utilization reports required by section 2340, each nonprofit services organization shall file a report with the joint standing committee of the Legislature having jurisdiction over insurance matters by January 1st of each year, setting forth its activities for the past year with respect to preferred provider arrangements, its plans to develop arrangements in the future, the effects of the preferred provider arrangements on insurance costs and services and subscriber and employer satisfaction with the arrangement. The superintendent shall also file a report with the committee by January 1st of each year on the activities of nonprofit services organizations with respect to preferred provider arrangements, any complaints received by the Bureau of Insurance concerning these arrangements and the effects of preferred provider arrangements.

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Sec. 13. 24-A MRSA §2673, as enacted by PL 1985, c. 704, §4, is repealed and the following enacted in its place:

§2673. Policies, agreements or arrangements with incentives or limits on reimbursement authorized

1. Arrangements with preferred providers permitted. Subject to this section and to the approval of the superintendent, an insurer or administrator may enter into agreements with certain providers of the insurer's or administrator's choice relating to health care services that may be rendered to insureds of the insurer or beneficiaries of the administrator, including agreements relating to the amounts to be charged by the provider to the insured or beneficiary for services rendered and amounts to be paid by the insurer or administrator.

A. An administrator may market and otherwise make available preferred provider arrangements to licensed health maintenance organizations, insurance companies, health service corporations, fraternal benefit societies, self-insuring employers or health and welfare trust funds and their subscribers provided that, in performing these functions, the administrator shall provide administrative services only and shall not accept underwriting risk in the form of a premium or capitation payment for services rendered. In performing functions consistent with this chapter, an administrator shall not accept any underwriting risk in the form of premium or capitation payment for services rendered.

B. An insurer may issue policies in this State or an administrator may administer programs in this State that include incentives for the insured or beneficiary to use the services of a provider who has entered into an agreement with the insurer or administrator pursuant to subsection 2. When such a program or policy is offered to an employee group annually, employees shall have the option of participating in any other health insurance program or health care plan sponsored by their employer. Policies, agreements or arrangements issued under this chapter may not contain terms or conditions that will operate unreasonably to restrict the access and availability of health care services.

2. Terms restricting access or availability prohibited. Policies, agreements or arrangements issued under this chapter may not contain terms or conditions that will operate unreasonably to restrict the access and availability of health care services. The superintendent shall adopt rules setting forth criteria for determining when a term or condition operates unreasonably to restrict access and availability of health care

services. The rules shall include criteria for evaluating the reasonableness of the distance to be travelled by insureds or beneficiaries for particular services and may prohibit the insurer or administrator from applying the benefit level differential to individual insureds or beneficiaries who must travel an unreasonable distance to obtain the service. The criteria shall also include the effect of the arrangement on noninsureds and nonbeneficiaries in the communities affected by the arrangement, including, but not limited to, the ability of nonpreferred providers to continue to provide health care services if all nonemergency services were provided by a preferred provider.

3. Length of contract; contracting process. Contracts for preferred provider arrangements shall not exceed a term of 3 years. A preferred provider arrangement for all insured or beneficiaries of an insurer must be awarded on the basis of an open bidding process after invitation to all providers of that service in the State. Each preferred provider arrangement affecting all insureds and beneficiaries must be bid and contracted for as separate services. Each service on the list set forth in section 2677 shall constitute a separate service.

Sec. 14. 24-A MRSA §2675, sub-§1, as enacted by PL 1985, c. 704, §4, is repealed.

Sec. 15. 24-A MRSA §2675, sub-§1-A is enacted to read:

1-A. Approval of arrangements. An insurer which proposes to offer a preferred provider arrangement authorized by this chapter shall file with the superintendent proposed agreements, rates and other materials relevant to the proposed arrangement, in the time period and the manner established by rule by the superintendent. No arrangement may be offered until the superintendent has approved the arrangement. The superintendent shall include in the rules the number of days within which the superintendent must approve or disapprove a proposed arrangement.

A. The superintendent shall disapprove any arrangement if it contains any unjust, unfair or inequitable provisions or fails to meet the standards set forth in section 2673, or those set forth in rules adopted pursuant to section 2673. The superintendent shall also adopt rules setting forth the criteria to be used in determining what constitutes an unjust, unfair or inequitable provision.

B. Within 10 days of receipt of a report of a proposed preferred provider arrangement, the superintendent shall mail notice of the proposal to all persons who have requested notice of preferred provider arrangement proposals in advance from the superintendent.

C. The superintendent may hold a public hearing on approval of a preferred provider arrangement and shall hold a public hearing if an interested person requests a public hearing and the request meets the criteria set forth in this section and in the rules adopted under this section. The superintendent shall hold a public hearing upon request of an interested person when:

(1) The interested person makes a written request to the superintendent:

(a) Within the time period established by rule by the superintendent;

(b) Stating briefly the respects in which that person is interested or affected; and

(c) Stating the grounds on which that person will rely for the relief to be demanded at the hearing;

(2) The superintendent finds that:

(a) The request is timely and made in good faith; and

(b) The interested person would be aggrieved if the stated grounds were established and the grounds otherwise justify the hearing; and

(3) The request meets other criteria established by the superintendent by rule.

The superintendent shall adopt rules to implement the hearing requirement, including rules setting forth the time period within which a public hearing will be held on the superintendent's initiative and the time period within which an interested person must file a request for a public hearing. If the superintendent finds that a public hearing is justified at the request of an interested person, the public hearing shall be held within 30 days after the filing of the request by an interested person, unless the hearing is postponed by consent of the interested person, the superintendent and the nonprofit service organization filing the arrangement. The hearing shall be held in accordance with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375, including the provision permitting intervention of interested persons.

Sec. 16. 24-A MRSA §2675. sub-§3. as enacted by PL 1985, c. 704, §4, is repealed.

Sec. 17. 24-A MRSA §2676, as enacted by PL 1985, c. 704, §4, is repealed and the following enacted in its place:

§2676. Risk sharing

Preferred provider arrangements may embody risk sharing by providers.

Sec. 18. 24-A MRSA §2677, as amended by PL 1987, c. 34, §2, is repealed and the following enacted in its place:

§2677. Alternative health care benefits

An insurer or administrator who makes a preferred provider arrangement available shall provide for payment of covered health care services rendered by providers who are not preferred providers.

1. Benefit level. Except as provided in this section, the benefit level differential between services rendered by preferred providers and nonpreferred providers may not exceed 20% of the allowable charge for the service rendered. Prior to July 1, 1993, the benefit level differential for the services and purchases listed in this subsection may exceed 20% but may not exceed 50% of the allowable charge for the service. The benefit level differential for all services rendered after June 30, 1993, shall be limited to 20% of the allowable charge. Any contract entered into prior to July 1, 1993, that provides a benefit level differential in excess of 20% for the services and purchases listed in subsection 2, shall include a provision reducing the benefit level differential to not more than the maximum benefit level differential permitted by law for services provided on or after July 1, 1993.

2. Fifty percent benefit level differential. The following purchases and services, when rendered prior July 1, 1993, on an outpatient basis in a nonemergency case, may be subject to a 50% benefit level differential subject to the limitations of subsection 1:

A. Radiology services, except x rays of extremities, screening and diagnostic chest x rays, maxillofacial x rays, screening cervical, thoracic and lumbar spine x rays, posttrauma x rays such as x rays of skull and ribs, flat plate abdomen x rays and other radiology services to be determined by rule by the superintendent;

B. Laboratory services provided by medical laboratories licensed in accordance with the Maine Medical Laboratory Commission, licensed by an equivalent out-of-state licensing authority or by a hospital, excluding those licensed laboratories owned by a community health center, a physician

or group of physicians where the laboratory services are offered solely to the patients of the center, the physician or group of physicians;

C. Pathology services;

D. Magnetic resonance imaging services;

E. Computerized tomography services;

F. Mammography services;

G. Ultrasonography services;

H. Cardiac diagnostic services including electrocardiograph stress testing, physiologic diagnostic procedures, cardiac catheterization and angiography, but excluding electrocardiograms;

I. Lithotripsy services unless approved under the Maine Certificate of Need Act of 1978;

J. Services provided by free standing ambulatory surgery facilities certified to participate in the Medicare program;

K. Purchases of durable medical equipment; and

L. Any other service performed in an outpatient setting requiring the purchase of new equipment costing $500,000 or more or for which the charge per unit of service is $250 or more.

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

A. "Allowable charge" means the amount which would be payable for services under the preferred provider arrangement prior to the application of any deductible and coinsurance.

B. "Nonemergency case" means a case other than one involving accidental bodily injury or sudden and unexpected onset of a critical condition requiring medical or surgical care for which a person seeks immediate medical attention within 24 hours of the onset.

Sec. 19. 24-A MRSA §2678-A is enacted to read:

§2678-A. Annual report

SENATE AMENDMENT "B" to COMMITTEE AMENDMENT "A" to H.P. 954, L.D. 1322

In addition to the utilization reports required by section 2678, each insurer shall file a report with the joint standing committee of the Legislature having jurisdiction over insurance matters by January 1st of each year, setting forth its activities for the past year with respect to preferred provider arrangements, its plans to develop arrangements in the future, the effects of the preferred provider arrangements on insurance costs and services and insured and employer satisfaction with the arrangement. The superintendent shall also file a report by January 1st of each year on the activities of insurers with respect to preferred provider arrangements, any complaints received by the Bureau of Insurance concerning these arrangements and the effects of preferred provider arrangements.

Sec. 20. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1989-90	1990-91
HUMAN SERVICES, DEPARTMENT OF		
Community Health Program		
All Other		$2,000,000
Provides funds for the Community Health Program grants to be awarded beginning July 1, 1990.		
Bureau of Medical Services		
Positions	(0.5)	(2)
Personal Services	$16,000	$250,000
All Other	14,000	18,479,017
Capital Expenditures		50,000
TOTAL	$30,000	$18,779,017
Provides funds for the Maine Health Program to insure all persons whose household income is 100% or less of the federal poverty level.		
Medical Care - Payments to Providers		
All Other	$115,168	$334,245

Provides state funds for the expansion of Medicaid eligibility under the Sixth Omnibus Budget Reconciliation Act option to children 5 to 7 year old to 100% of the federal poverty level.		
Medical Care - Payments to Providers		
All Other	$500,000	$500,000
Provides state funds for an increase in Medicaid reimbursement to physicians.		
Income Maintenance - Regional		
Positions		(27)
Personal Services		$692,705
All Other		65,501
Capital Expenditures		21,600
TOTAL		$779,806
Provides state funds to carry out the eligibility functions of the Maine Health Program.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$645,168	$22,393,068
MAINE HEALTH CARE FINANCE COMMISSION		
Hospital Uncompensated Care and Governmental Payment Shortfall Fund		
All Other		$5,000,000
MAINE HEALTH CARE FINANCE COMMISSION TOTAL		$5,000,000
TOTAL APPROPRIATIONS	$645,168	$27,393,068

Sec. 21. Allocation. The following funds are allocated from Federal Expenditures funds to carry out the purposes of this Act.

SENATE AMENDMENT "B" to COMMITTEE AMENDMENT "A" to H.P. 954, L.D. 1322

	1989-90	1990-91
HUMAN SERVICES, DEPARTMENT OF		
Medical Care - Payments to Providers		
All Other	$219,332	$601,755
Allocates federal Medicaid matching funds for the expansion of Medicaid eligibility under the Sixth Omnibus Budget Reconciliation Act option to children 5 to 7 year old in households with income at or below the federal poverty level.		
Medical Care - Payments to Providers		
All Other	$952,220	$900,170
Allocates federal Medicaid matching funds to provide an increase in physician reimbursement.		
Income Maintenance - Regional		
Positions		(27)
Personal Services		$685,092
All Other		55,502
Capital Expenditures		21,600
TOTAL		$762,194
Allocates federal Medicaid matching funds for eligibility determination services in the Maine Health Program.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$1,171,552	$2,264,119

SENATE AMENDMENT "B" to COMMITTEE AMENDMENT "A" to H.P. 954, L.D. 1322

Sec. 22. 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		
All Other	$4,000	$3,000
Allocates funds for hearings, rulemaking and annual reports with respect to preferred provider arrangements.		
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION TOTAL	$4,000	$3,000

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved, except that sections 8 through 19 shall take effect 90 days after adjournment of the First Regular Session of the 114th Legislature.' '

STATEMENT OF FACT

This amendment makes the following changes to the committee amendment.

1. Eligibility for the Maine Health Program is restricted to persons residing in a household with income of 100% or less of the federal poverty level. The provision to establish the Maine Health Program Council is eliminated.

2. The Community Health Program grants are retained as originally proposed.

3. Funding for the Hospital Uncompensated Care and Governmental Payment Shortfall Fund is $5,000,000 in fiscal year 1990-91.

4. This amendment appropriates funds and allocates federal matching funds, totaling $334,500 in fiscal year 1989-90 and $936,000 in fiscal year 1990-91, for the expansion of Medicaid eligibility under the so-called Sixth Omnibus Budget

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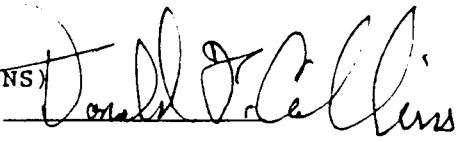
SENATE AMENDMENT " B " to COMMITTEE AMENDMENT "A" to H.P. 954, L.D. 1322

Reconciliation Act to children 5 to 7 years old in households with incomes at or below the federal poverty level.

5. This amendment appropriates funds and allocates federal matching funds to increase Medicaid reimbursement specifically to physicians by slightly more than $1,400,000 in each year of the biennium.

(Senator COLLINS)
SPONSORED BY: 

COUNTY: Aroostook

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