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1 L.D. 1322

3 (Filing No. H-644)

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7 **STATE OF MAINE**
HOUSE OF REPRESENTATIVES
9 **114TH LEGISLATURE**
FIRST REGULAR SESSION

11

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

17

Amend the bill by striking out everything after the title
19 and inserting in its place the following:

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

25 **Whereas,** over 130,000 people in Maine lack health insurance and considerably more face other barriers to access to health
27 care; and

29 **Whereas,** this legislation creates several programs designed to provide health care, or to improve access to health care for
31 persons who are currently inadequately cared for; and

33 **Whereas,** the programs in this legislation which provide coverage of health care costs for those who are currently unable
35 to pay those costs will lessen the burden on 3rd-party payors of health care costs caused by bad debt and charity care; and

37

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

43

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

45

Sec. 1. 5 MRSA §12004-I, sub-§35-A is enacted to read:

47

35-A. Human Services	Maine Health Program Council	Expenses Only	22 MRSA §3189

49

Sec. 2. 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Sec. 3. 22 MRSA §396-F, sub-§4, as enacted by PL 1987, c. 847, §2, is repealed.

Sec. 4. 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.

(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. 5. 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.

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. 6. 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.

1 A. One component shall be designated "management fund revenue" and shall be equal to the adjustment, if any, for
3 management support services determined under section 396-D, subsection 9, paragraph A.
5
B. One component shall be designated "hospital retained
7 revenue" and shall be equal to the approved gross patient service revenue limit less the "management fund revenue" and
9 "hospital payments fund revenue."

11 C. One component shall be designated "hospital payments fund revenue" and shall be equal to the adjustment, if any,
13 determined under section 396-H, subsection 2, for the support of the hospital payments fund.
15
Sec. 7. 22 MRSA §396-I, sub-§6 is enacted to read:
17
6. Transmittal of hospital payments fund revenue. No later
19 than 30 days following the close of each quarter of each fiscal year, each hospital shall transmit to the hospital payments fund,
21 established in section 396-F, that portion of its revenues that corresponds to the hospital payments fund revenue determined
23 under subsection 1.

25 **Sec. 8. 22 MRSA §§3189 to 3191** are enacted to read:

27 **§3189. The Maine Health Program**

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

33 A. "Applicable premium" means the amount that a person is required to pay to participate in the Maine Health Program,
35 as determined under subsection 4.

37 B. "Council" means the Maine Health Program Council created in subsection 3.
39
C. "Department" means the Department of Human Services.
41
D. "Federal poverty level" means the federal poverty level
43 established as required by the United States Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, Sections 652
45 and 673(2).

47 E. "Household income" means the income of a person or group of persons determined according to rules adopted by the
49 department in accordance with subsection 8, provided that the rules do not include, in the definition of a household,
51 persons other than those who reside together and among whom there is legal responsibility for support.

F. "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 whose household income is 150% or less of the federal poverty level who is not eligible for all 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.

3. Maine Health Program Council. There is created the Maine Health Program Council, as established in Title 5, section 12004-I, subsection 35-A. The council shall be composed of 13 members, as follows: one representative of hospitals, to be appointed taking into account the recommendation of the Maine Hospital Association; one representative of physicians, to be appointed taking into account a joint recommendation of the Maine Osteopathic Association and the Maine Medical Association; one representative of community health centers, to be appointed taking into account the recommendation of the Maine Ambulatory Care Coalition; one representative of providers of mental health, substance abuse or chiropractic services, to be appointed taking into account recommendations of statewide organizations representing those providers; one representative of the Medicaid Advisory Committee created pursuant to 42 Code of Federal Regulations, Section 431.12; 3 representatives of health care consumers; one representative of the academic disciplines related to health policy, to be appointed taking into account the recommendation of the Maine Public Health Association; and one representative of the Special Select Commission on Access to Health Care created by Title 24-A, section 6071. The Director of the Bureau of Medical Services, the Director of the Bureau of Income Maintenance and the Superintendent of the Bureau of Insurance shall serve as ex officio nonvoting members of the council. These directors may designate alternative representatives of their bureaus. No person may be appointed as a representative of consumers of health care if that person has within 12 months preceding the appointment been engaged for compensation in the provision of health care, or the provision of health research, instruction or insurance. Except for the ex officio members from the bureaus, members of the council shall be appointed jointly by the President of the Senate and the Speaker of the House of Representatives. Appointments shall be made no later than October 1, 1989.

A. The council has the following powers and duties.

(1) The council shall advise the department on an ongoing basis with respect to the development and administration of the program.

(2) The council shall participate in the process of making rules for the program as described in subsection 8.

(3) The council may accept grants to be used for the council's purposes under this section.

B. The council shall study what asset limits, if any, are appropriate to determine eligibility for benefits under the program. The study shall include consideration of:

(1) The treatment of assets in other federal and state medical programs serving the population with greater income than the Medicaid program, including the Hill-Burton program of hospital community care described in United States Code, Title 42, Chapter 6-A, Subchapter IV; the Medicaid expansion under the United States Omnibus Budget Reconciliation Act of 1986, Public Law 99-509; the United States Family Support Act of 1988, Public Law 100-482; and the treatment of assets under the charity care income guidelines adopted pursuant to section 396-F, subsection 1;

(2) The needs of working and nonworking participants for funds to pay transportation and other work-related costs, noncovered medical costs and other emergencies and reasonable incentives for savings; and

(3) Program administrative costs.

The council shall recommend a policy on assets to the department for review, revision and adoption of any necessary rule, in accordance with subsection 8.

C. The Chair of the Legislative Council shall call the first meeting of the council no later than 30 days after all members of the council have been appointed. At the first meeting, members of the council shall elect a chair from among the council members. Thereafter, the council shall meet at the call of the chair of the council or at the call of at least 1/4 of the members of the council. A majority of the council members shall constitute a quorum for the purpose of conducting business of the council and exercising all the powers of the council. A vote of the majority of the members present shall be sufficient for all actions of the council.

1 D. Each member of the council shall be compensated according to the provisions of Title 5, chapter 379.

3

E. The department shall supply staff and other assistance to
5 the council.

7 **4. Program development and administration.** The department shall develop and administer the program in consultation with the
9 council and in accordance with this section.

11 A. The department, by rule adopted in accordance with subsection 8, shall determine the scope and amount of
13 medical assistance to be provided to participants in the program provided that the rules meet the following criteria.
15

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

23 (2) The medical assistance to be provided shall not require the participant to make out-of-pocket
25 expenditures, such as requiring deductibles or copayments for any service covered, except to the
27 extent out-of-pocket expenditures are required under state Medicaid rules.
29

B. The department, in consultation with the council, shall
31 develop plans to ensure appropriate utilization of services. The department's consideration shall include, but
33 not be limited to, preadmission screening, managed care, use of preferred providers and 2nd surgical opinions.
35

C. The department shall adopt rules in accordance with
37 subsection 8, setting forth a sliding scale of premiums to be paid by persons eligible for the program provided that
39 the rules shall meet the following criteria.

41 (1) The premium for a household whose household income does not exceed 100% of the federal poverty level shall
43 be zero.

45 (2) The premium for a household whose household income exceeds 100% of the federal poverty level but does not
47 exceed 150% of the federal poverty level shall not exceed 3% of that household income.
49

D. The department shall adopt rules in accordance with
51 subsection 8 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 and the amount of premium due 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. At least one month prior to termination, 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.

5. Use of available health coverage. To receive any benefits under the program, a person who is eligible to be covered by a medical plan for which an employer contributes to the cost shall, unless exempted in this subsection, enroll in the employer-supported plan.

A. If the person is required to contribute toward the cost of the employer-supported plan, the person shall pay only the amount the person would be required to pay as an applicable premium to be covered by the program. The department shall promptly pay the remainder of the person's

required contribution to the employer-supported plan to the person's employer or directly to the insurer.

B. Any person who has enrolled in an available employer-supported plan but whose plan does not provide all of the benefits or the same level of benefits as provided by the program, shall be entitled to receive the remaining benefits from the program. The person shall be required to pay toward the program only the difference, if any, between any premium paid by the person for the employer-supported health plan and the applicable premium for the program.

C. If the department determines that the employer-supported plan is not a cost-effective use of state funds to provide the services offered, the person need not enroll in that employer-supported plan as a condition of eligibility for the program and the department shall not be obligated to contribute toward the premium as a benefit of the program.

D. The department shall adopt rules in accordance with subsection 8 to implement this subsection.

6. **Coordination of benefits.** Any participant who is covered by an employer-supported plan in addition to the program shall file with the department the name, address and group policy number of the employer-supported plan. The department may request, from the insurer that provides the group policy, information sufficient to permit the department to coordinate benefits between the program and the employer-supported plan. An insurer shall respond to the request from the department within 30 days. The department may also require the employer or the insurer to provide notice to the department of any changes in coverage and to provide notice to the department of any termination of the policy. 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 8 to implement this subsection.

7. **Transition period for participants losing eligibility.** Any participant who ceases to be eligible to participate in the program because of household income exceeding 150% 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 8.

8. **Procedures for adopting rules.** In adopting, amending or repealing any rule required or authorized by this section, the department shall comply with the Maine Administrative Procedure

Act, Title 5, chapter 375, and with the additional requirements of this subsection.

A. The council shall develop proposed rules necessary to implement this section no later than February 1, 1990, and shall submit the proposed rules to the department. The department shall hold a public hearing on the proposed rules and shall take all other steps required under the Maine Administrative Procedure Act, Title 5, chapter 375.

B. At the public hearing on the rules, members of the council shall be permitted to conduct reasonable questioning and comments shall be taken from the public on the proposed rules. Following the public hearing, the department shall adopt such rules as it determines appropriate, provided that for each difference between the department rules and the council's proposed rules, the department shall provide a written explanation of why the council's proposed rule was not adopted.

C. Following adoption of a set of rules addressing each aspect necessary to implement this section, the department may propose and adopt rules provided that, before the department begins the process of adopting rules under the Maine Administrative Procedure Act, Title 5, chapter 375, the department shall consult with the council on any rules to be proposed. The department shall also permit members of the council to conduct reasonable questioning at any public hearing on the proposed rules.

9. Limitation on number of participants. Except as provided in this subsection, the number of participants in the program at any time may not exceed:

A. Five thousand, six hundred twenty persons above the age of 5 but below the age of 21, whose household income is below 100% of the federal poverty level;

B. Eleven thousand, eight hundred eighty-four persons above the age of 20 but below the age of 65, whose household income is below 100% of the federal poverty level;

C. Four thousand, eight hundred seventy-two persons at or above the age of one but below the age of 21, whose household income is at or above 100% of the federal poverty level and who are not covered under an employer-supported health insurance plan;

D. Seven thousand, two hundred forty persons at or above the age of one but below the age of 21, whose household income is at or above 100% of the federal poverty level, and

who are covered under an employer-supported health insurance plan;

E. Seven thousand, four hundred twenty-two persons above the age of 20 but below the age of 65 whose household income is at or above 100% of the federal poverty level and who are not covered under an employer-supported health insurance plan;

F. Eleven thousand twenty-seven persons above the age of 20 but below the age of 65 whose household income is at or above 100% of the federal poverty level and who are covered under an employer-supported health insurance plan;

G. Three thousand, six hundred sixty-nine persons above the age of 64, regardless of household income; and

H. One thousand, three hundred ninety-nine persons who have a physical or mental defect, illness or impairment which substantially reduces or eliminates their ability to support or care for themselves or their families, as determined under rules adopted by the department.

Notwithstanding these limits, the department may not terminate the coverage of a participant solely because the participant is reclassified in a category in which the maximum number of participants has been reached. The department shall adopt rules for reallocating positions among the categories when necessary to permit continued coverage of reclassified participants, provided that the total number of participants may not exceed 53,133. For purposes of this subsection, persons participating in the program pursuant to subsection 7 shall not be included in counting the number of participants in the program.

10. Phase-in of participation. Notwithstanding subsection 9, the number of participants in the first year of the program shall be limited as provided in this subsection. In the first month of the first year, the number of participants in each category shall be limited to 30% of the limits set forth in subsection 9. For each susequent month of the first year, the percentage of the limits to be used in determining the maximum number of participants shall be increased by 6.375.

§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:

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. Funding of the Hospital Uncompensated Care and Governmental Payment Shortfall Fund

1. Purpose. This section provides for appropriations to the Hospital Uncompensated Care and Governmental Payment Shortfall Fund to provide a coordinated response to the overall problem of health care access; appropriate, affordable coverage to citizens who are not otherwise able to pay for existing

coverage; and direct relief to businesses, 3rd-party payors and individuals by limiting the adverse impact on hospital charges and health insurance premiums of charity care, bad debts and governmental payment shortfalls.

2. Legislative intent for appropriations. Consistent with subsection 1, it is the intent of the Legislature that, with respect to appropriations from the General Fund for bienniums beginning on and after July 1, 1989, appropriations shall be carried out so that the appropriation for the Hospital Uncompensated Care and Governmental Payment Shortfall Fund, established pursuant to section 396-F, subsection 5, shall be the amount estimated by the Maine Health Care Finance Commission to be the financial impact on Maine hospitals of the Medicaid shortfall, including Medicaid's share of bad debt and charity care, but no more than 1/2 the amount appropriated for the Maine Health Program created in section 3189. For the purposes of this section, the amount of the Medicaid shortfall for the biennium beginning July 1, 1989, is deemed to be $15,000,000 annually.

3. Budget requests. The Department of Human Services and the Maine Health Care Finance Commission shall coordinate in order that the budget request of the Governor submitted to the Legislature is prepared consistent with subsection 2.

4. 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 provisions of this section were carried out.

Sec. 9. 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. 10. 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:~~

~~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:

(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;

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. 11. 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. 12. 24 MRSA §2339, as amended by PL 1987, c. 34, §1, is repealed and the following enacted in its place:

<u>§2339. Alternative health care benefits</u>

<u>A nonprofit service organization that makes a preferred provider arrangement available shall provide for payment of covered health care services rendered by providers who are not preferred providers.</u>

<u>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</u>

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;

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. 13. 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.

Sec. 14. 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

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

9

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

23

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

37

2. Terms restricting access or availability prohibited.
39 Policies, agreements or arrangements issued under this chapter may not contain terms or conditions that will operate
41 unreasonably to restrict the access and availability of health care services. The superintendent shall adopt rules setting
43 forth criteria for determining when a term or condition operates unreasonably to restrict access and availability of health care
45 services. The rules shall include criteria for evaluating the reasonableness of the distance to be travelled by insureds or
47 beneficiaries for particular services and may prohibit the insurer or administrator from applying the benefit level
49 differential to individual insureds or beneficiaries who must travel an unreasonable distance to obtain the service. The
51 criteria shall also include the effect of the arrangement on noninsureds and nonbeneficiaries in the communities affected by

1 the arrangement, including, but not limited to, the ability of nonpreferred providers to continue to provide health care
3 services if all nonemergency services were provided by a preferred provider.
5

3. Length of contract; contracting process. Contracts for
7 preferred provider arrangements shall not exceed a term of 3 years. A preferred provider arrangement for all insured or
9 beneficiaries of an insurer must be awarded on the basis of an open bidding process after invitation to all providers of that
11 service in the State. Each preferred provider arrangement affecting all insureds and beneficiaries must be bid and
13 contracted for as separate services. Each service on the list set forth in section 2677 shall constitute a separate service.
15

Sec. 15. 24-A MRSA §2675, sub-§1, as enacted by PL 1985, c.
17 704, §4, is repealed.

19 **Sec. 16. 24-A MRSA §2675, sub-§1-A** is enacted to read:

21 1-A. Approval of arrangements. An insurer which proposes to offer a preferred provider arrangement authorized by this
23 chapter shall file with the superintendent proposed agreements, rates and other materials relevant to the proposed arrangement,
25 in the time period and the manner established by rule by the superintendent. No arrangement may be offered until the
27 superintendent has approved the arrangement. The superintendent shall include in the rules the number of days within which the
29 superintendent must approve or disapprove a proposed arrangement.

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

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

45 C. The superintendent may hold a public hearing on approval of a preferred provider arrangement and shall hold a public
47 hearing if an interested person requests a public hearing and the request meets the criteria set forth in this section
49 and in the rules adopted under this section. The superintendent shall hold a public hearing upon request of
51 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. 17. 24-A MRSA §2675, sub-§3, as enacted by PL 1985, c. 704, §4, is repealed.

Sec. 18. 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. 19. 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. 20. 24-A MRSA §2678-A is enacted to read:

§2678-A. Annual report

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

1 January 1st of each year on the activities of insurers with respect to preferred provider arrangements, any complaints
3 received by the Bureau of Insurance concerning these arrangements and the effects of preferred provider arrangements.
5

Sec. 21. Appropriation. The following funds are appropriated
7 from the General Fund to carry out the purposes of this Act.

		1989-90	1990-91
9			
11	**HUMAN SERVICES, DEPARTMENT OF**		
13	**Bureau of Health**		
15	All Other		$2,000,000
17	Provides funds for community health program grants to be		
19	awarded beginning July 1, 1990.		
21	**Medical Care - Payments to Providers**		
23			
	All Other		$1,000,000
25			
	Provides funds for an		
27	increase in Medicaid reimbursement to providers to		
29	increase access to health care for Medicaid recipients.		
31			
33	**Maine Health Program**		
35	All Other		$25,717,137
37	Provides funds for the Maine Health Program.		
39	**Medical Care Administration**		
41			
	Positions	(2)	(19)
43	Personal Services	$52,927	$449,061
	All Other	95,893	353,845
45	Capital Expenditures	1,180	11,203
47	TOTAL	$150,000	$814,109
49	Provides funds for the development and		
51	administration of the Maine		

1 Health Program and expenses for the Maine Health Program
3 Council.

5 **Income Maintenance - Regional**

7 Positions		(47)
Personal Services		$1,125,745
9 All Other		78,984
Capital Expenditures		30,973
11		
TOTAL		$1,235,702

13

Provides funds for additional
15 staff and related expenses to
implement and administer the
17 provisions of the Maine
Health Program.

19

21 **DEPARTMENT OF HUMAN SERVICES TOTAL**	$150,000	$30,766,948

23

25 **MAINE HEALTH CARE FINANCE COMMISSION**

27 **Health Care Finance Commission**

29 All Other		$15,000,000

31 Provides funds for the
Hospital Uncompensated Care
33 and Governmental Payment
Shortfall Fund.

35

37 **MAINE HEALTH CARE FINANCE COMMISSION TOTAL**		$15,000,000
39		
TOTAL APPROPRIATIONS	$150,000	$45,766,948

41

Sec. 22. Allocation. The following funds are allocated from
43 Federal Expenditures funds to carry out the purposes of this Act.

45 **1990-91**

47 **HUMAN SERVICES, DEPARTMENT OF**

49 **Medical Care - Payments to Providers**

51 All Other	$1,800,336

Allocates federal matching funds for a provider fee increase.

Income Maintenance - Regional

Positions	(47)
Personal Services	$1,125,745
All Other	78,984
Capital Expenditures	30,973
TOTAL	$1,235,702

Allocates federal matching funds for additional staff and related expenses.

DEPARTMENT OF HUMAN SERVICES TOTAL	$3,036,038

Sec. 23. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Act.

	1989-90	**1990-91**
HUMAN SERVICES, DEPARTMENT OF		
Maine Health Program		
All Other		$3,358,200
Allocates participant contributions toward cost of health program.		
DEPARTMENT OF HUMAN SERVICES TOTAL		$3,358,200
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
TOTAL ALLOCATIONS	$4,000	$3,361,200

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved except that sections 9 to 20 shall take effect 90 days after adjournment of the First Regular Session of the 114th Legislature.

FISCAL NOTE

The estimated future costs of the Maine Health Program, including administrative costs, will be approximately $49,000,000 in fiscal year 1991-92 and is expected to increase by nearly $5,000,000 each year thereafter. The projected increase in cost is due to the fact that the phase-in provisions apply to the first year of the program only.

There is a potential for cost savings to some programs which currently provide medical services for individuals, as these individuals may become eligible for participation in the Maine Health Program. The amount of these savings cannot be determined at this time.

The Bureau of Insurance will increase dedicated revenue $4,000 in fiscal year 1989-90, and $3,000 in fiscal year 1990-91, through the annual assessment on insurers to cover the additional costs to the bureau.'

STATEMENT OF FACT

This amendment contains the Maine Health Program and the Community Health Program grants essentially in the same form as proposed in the original bill. The amendment adds one member to the Maine Health Program Council to represent substance abuse, mental health and chiropractic care providers and authorizes the Department of Human Services to maximize the use of federal funds by taking advantage of Medicaid options for persons eligible for the Maine Health Program. With respect to the Community Health Program grants, the amendment provides for a starting date of July 1, 1990 instead of January 1, 1990. The Maine Health Program and the Community Health Program grants are created in section 8 of the amendment.

The amendment does not include the Subsidized Excess Insurance Program and the small employer tax credit which were proposed in Legislative Document 1322.

1 Sections 2 to 7 of the amendment provide for a new Hospital Uncompensated Care and Governmental Payment Shortfall Fund funded
3 both from appropriations from the General Fund and from all hospitals on an equal percentage basis recoverable in revenues.
5
The amendment adds the Hospital Uncompensated Care and
7 Governmental Payment Shortfall Fund and appropriates $15,000,000 for the 2nd year of the biennium to the fund. The Maine Revised
9 Statutes, Title 22, section 3191, created in section 8 of the amendment sets forth the funding mechanism for the Maine Hospital
11 Uncompensated Care and Governmental Payment Shortfall Fund. Title 22, section 3191, subsection 1 describes the purposes of
13 the funding mechanism. Title 22, section 3191, subsection 2 sets forth the legislative intent with respect to appropriations to
15 the fund. For bienniums beginning on and after July 1, 1989, the amount appropriated to the Hospital Uncompensated Care and
17 Governmental Payment Shortfall Fund shall be the amount projected by the Maine Health Care Finance Commission to be the impact on
19 Maine hospitals of the Medicaid shortfall, but no more than 1/2 the amount appropriated for the Maine Health Program. Title 22,
21 section 3191, subsection 3 describes the budget process. Title 22, section 3191, subsection 4 calls upon the Department of Human
23 Services and the Health Care Finance Commission to file a report with the President of the Senate and the Speaker of the House of
25 Representatives setting forth the manner in which purposes of this section have been fulfilled.
27
Sections 9 to 20 of the amendment revise laws relating to
29 preferred provider arrangements. The amendment requires that all preferred provider arrangements be approved by the superintendent
31 before being offered and provides a mechanism for interested persons to request a public hearing on approval of a preferred
33 provider arrangement.

35 The amendment requires the superintendent to adopt rules clarifying the standards which will be used in determining
37 whether to approve a preferred provider arrangement. To be approved, a preferred provider arrangement must not contain terms
39 that will operate unreasonably to restrict access and availability of health care services for all persons, whether or
41 not they are subject to the preferred provider arrangement. In addition, the preferred provider arrangement must not contain any
43 unjust, unfair or inequitable provisions. The superintendent is required to adopt rules setting forth the criteria to be used in
45 evaluating proposed preferred provider arrangements under these standards.
47
The amendment provides a larger benefit level differential
49 for certain services set forth in the amendment, but only for services provided prior to July 1, 1993. The benefit level
51 differential is the amount an insurer is permitted to reduce payment that would otherwise be made to an insured or subscriber

1 when the person obtains services from a nonpreferred provider. For services such as mammography, computerized tomography
3 services and others listed in sections 12 and 19 of the amendment, the benefit level differential may be up to 50% of the
5 amount that would be payable to the insured or beneficiary if the insured or beneficiary obtained the service from a preferred
7 provider. Under current law, for all services, the benefit level differential is limited to 20%. Any preferred provider
9 arrangement contract providing for a 50% benefit level differential must include specific provisions indicating that the
11 differential for services at the 50% level will not apply to services provided after June 30, 1993.

13

The amendment provides that preferred provider arrangements
15 which will apply to all subscribers or insureds in the State must be awarded on an open bidding process and may only be bid one
17 service at a time.

19 The amendment appropriates $1,000,000 of state funds to increase Medicaid reimbursement fees to health care providers.
21 This appropriation of state funds will draw a federal match of $1,800,000 for Medicaid reimbursement.

23

The amendment adds a fiscal note to the bill.

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-644)