Amendment

L.D. 1322

(Filing No. H-702)

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

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

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

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

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

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

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

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

PART A

Sec. 1. 3 MRSA §507, sub-§8, ¶A, as repealed and replaced by PL 1985, c. 763, Pt. A, §4, is amended to read:

A. Unless continued or modified by law, the following Group D-1 independent agencies shall terminate, not including the grace period, no later than June 30, 1986:

(1) Maine Arts Commission; and

(2) Maine State Museum; and

(3) Maine Health Care Finance Commission.

Sec. 2. 5 MRSA §12004-I, sub-§35-A is enacted to read:

35-A. Human Services	Maine Health Program Advisory Committee	Legislative Per Diem for Legislative Members Only; Expenses Only for Other Members	22 MRSA §3189

Sec. 3. 22 MRSA §304-D, sub-§1, ¶B, as enacted by PL 1985, c. 661, §2, is repealed.

Sec. 4. 22 MRSA §304-D, sub-§4, as enacted by PL 1985, c. 661, §2, is repealed.

Sec. 5. 22 MRSA §382, sub-§1-A is enacted to read:

1-A. Border hospital. "Border hospital" means a hospital located in this State within 10 miles of the New Hampshire border.

Sec. 6. 22 MRSA §382, sub-§16-A is enacted to read:

16-A. Revenue limit. "Revenue limit" means the revenue per case, the rate per unit of outpatient service, the total outpatient revenue or the total revenue approved by the commission under section 396.

Sec. 7. 22 MRSA §388, sub-§1, ¶A, as amended by PL 1987, c. 73, is further amended to read:

A. Prior to January 1st, the commission shall prepare and transmit to the Governor and to the Legislature a report of its operations and activities during the previous year. This report shall include such facts, suggestions and policy recommendations as the commission considers necessary. The report shall include:

(1) Data citations, to the extent possible, to support the factual statements in the report;

(2) The administrative requirements for compliance with the system by hospitals to the extent possible;

(3) The commission's view of the likely future impact on the health care financing system of trends in the use or financing of hospital care, including federal reimbursement policies, demographic changes, technological advances and competition from other providers;

(4) The commission's view of likely changes in apportionment of revenues among classes of payers and purchasers as a result of trends set out in subparagraph (3);

(5) The relationship of the advisory committees to the commission;

(6) Comparisons of the impact of the hospital care financing system with relevant regional and national data, to the extent that such data is available; and

(7) To the extent available, information on trends in utilization. ; and

(8) Demonstration projects considered or approved by the commission.

Sec. 8. 22 MRSA §388, sub-§5 is enacted to read:

5. Review of exception threshold and variable adjustment factor. The basis for, and the commission's experience with, the threshold on exception requests in section 396-D, subsection 12, and the variable adjustment factor in section 396-D, subsection 1-A, shall be reviewed after these provisions have been in operation for 2 years. By October 1, 1993, the commission shall recommend to the Legislature how these factors should be established and what the factors should be in light of the current status of hospital care.

Sec. 9. 22 MRSA §396, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

§396. Establishment of revenue limits and apportionment methods

1. Authority. The commission may establish and approve revenue limits and apportionment methods for individual hospitals.

2. Criteria. Subject to more specific provisions contained in this subchapter, the revenue limits and apportionment methods established by the commission shall ensure that:

A. The financial requirements of a hospital are reasonably related to its total services;

B. A hospital's patient service revenues are reasonably related to its financial requirements; and

C. Rates are set equitably among all payors, purchasers or classes of purchasers of health care services without undue discrimination or preference.

3. Average revenue per case payment system. The commission shall establish an average revenue per case payment system.

The per case system shall have 2 components.

A. The commission shall establish and approve limits on the average revenue per case mix adjusted inpatient admission.

B. For payment years beginning or deemed to begin on or after October 1, 1992, the commission shall regulate outpatient services by setting the rate per unit of service by department. For payment years beginning or deemed to begin before October 1, 1992, the commission shall establish revenue limits for outpatient services using methods consistent with those used in setting gross patient service revenue limits for payment years beginning prior to October 1, 1990. Nothing in this paragraph prohibits the commission from refining or modifying the method of adjusting for outpatient volume.

4. Total revenue system. The commission shall establish a total revenue system, which may be chosen by hospitals that are in relatively self-contained catchment areas, are not in direct competition with other hospitals and that meet certain criteria developed by the commission.

A. Criteria shall include, but not be limited to:

(1) Distance of the hospital in miles and travel time from the nearest other hospital; and

(2) Utilization of existing hospital services by patients within the catchment area.

B. The commission shall establish a procedure by which, and time limits within which, an eligible hospital may initially elect to participate in the total revenue system. The commission shall also establish the procedures and conditions under which an eligible hospital may choose to be regulated under the per case or total revenue system after the period provided for the initial election. These

conditions may include, but are not limited to, reasonable limits on the frequency with which an eligible hospital may choose to transfer from one regulatory system to the other.

C. A hospital that is not eligible to choose to participate in the total revenue system may request the commission's approval to participate in the total revenue system for a period of no more than 2 years. The commission may approve the request if it determines that the hospital is experiencing significant financial problems and is in the process of making a transition to a different scope or type of service. The commission shall require the hospital to establish that the approval of its request to participate in the total revenue system would be consistent with the orderly and economic development of the health care system.

D. The commission shall establish the total gross patient service revenue limit for inpatient and outpatient services for hospitals that apply for this system and meet the established criteria.

5. Excess charges prohibited. No hospital may charge for services at rates that are inconsistent with the revenue limits approved by the commission.

6. Specialty hospitals. The commission shall provide alternative regulatory options for hospitals defined by the commission as being specialty hospitals.

7. Return on investment. The revenue limits established by the commission under this chapter shall, in the case of a proprietary, for-profit hospital, be established in a manner that provides a reasonable opportunity for the hospital to earn an amount that will provide a fair return to owners based on their investment in hospital resources.

Sec. 10. 22 MRSA §396-D, sub-§1, as enacted by PL 1983, c. 579, §10, is amended to read:

1. Economic trend factor. In determining payment year financial requirements, the commission shall include an adjustment for the projected impact of inflation on the prices paid by hospitals for the goods and services required to provide patient care. In order to measure and project the impact of inflation, the commission shall establish and use the following data:

A. Homogeneous classifications of hospital costs for goods and services and of capital costs, which shall be called "cost components;"

B. Estimates or determinations of the proportion of hospital costs in each cost component; and

C. Identification or development of proxies which measure the reasonable increase in prices, by cost component, which the hospitals would be expected to pay for goods and services.

The proxy or proxies chosen by the commission to measure the reasonable increase in employee compensation shall reflect the experience of workers in the Northeast and regions of this State who are reasonably representative of professional medical personnel and other hospital workers.

~~It~~ The commission may also consider the discrepancies, if any, between the projected and actual inflation experience of noncompensation proxies in preceding payment years.

The commission may, from time to time during the course of a payment year, in accordance with duly promulgated regulations, make further adjustments in the event it obtains substantial evidence that its initial projections for the current payment year will be in error.

Sec. 11. 22 MRSA §396-D, sub-§1-A is enacted to read:

1-A. Variable adjustment factor. In determining payment year financial requirements, the commission shall include an adjustment based upon a factor, fixed by the commission between 0.5% and 2.0%, which shall be added to the percentage adjustment for inflation determined pursuant to subsection 1. This factor shall reflect the following:

A. Changes in technology not covered by certificate of need projects, including changes in drugs and supplies;

B. Changes in medical practice;

C. Increased severity of illness not accounted for by the case mix system and the aging of the population; and

D. Other changes specified by the commission that are expected to affect a substantial number of Maine hospitals.

Sec. 12. 22 MRSA §396-D, sub-§2, ¶B, as enacted by PL 1983, c. 579, §10, is amended to read:

B. The commission may, for hospitals regulated under the total revenue system, from time to time during the course of a payment year, in accordance with duly promulgated regulations, make further adjustments, on an interim or final basis, in the event of discrepancies, if any, between

projected and actual case mix changes in the preceding payment years or in the event it obtains substantial evidence that its initial projections for the current payment year will be in error. In making such further adjustments, the commission shall consider the special needs and circumstances of small hospitals.

Sec. 13. 22 MRSA §396-D, sub-§2, ¶C is enacted to read:

C. The commission shall consider changes in case mix for hospitals regulated under the per case system and shall make prospective adjustments in years subsequent to the first payment year in which the hospital is subject to the per case system, using a marginal cost factor in the range of 60% to 90%, giving consideration to the characteristics of inpatient and outpatient services and hospital size. This paragraph is repealed effective October 1, 1991.

Sec. 14. 22 MRSA §396-D, sub-§3, ¶A, as amended by PL 1985, c. 661, §7, is further amended to read:

A. An allowance for the cost of facilities and fixed equipment shall include: allowances for straight line depreciation and interest expense, less interest income on debt service reserve funds available to the hospital.

~~(1) Debt service requirements associated with the hospital's facilities and fixed equipment; and~~

~~(2) Annual contributions to a sinking fund sufficient to provide a down payment on replacement facilities and fixed equipment. The sinking fund shall be required to be maintained by each hospital and the commission may include in it price level depreciation on fixed equipment or a portion of price level depreciation on facilities.~~

In determining payment year financial requirements, the commission shall include an adjustment in the allowance for facilities and fixed equipment to reflect changes in ~~debt service~~ interest expense and to reflect any new increases or decreases in capital costs which result from the acquisition, replacement or disposition of facilities or fixed equipment and which are not related to projects for which an adjustment is required to be made under subsection 5 ~~or subsection 9, paragraph D~~. Any positive adjustments made to reflect such increases in capital costs shall not be effective until the facilities or fixed equipment have been put into use and the associated expenses would be eligible for reimbursement under the Medicare program.

Sec. 15. 22 MRSA §396-D, sub-§3, ¶B, as enacted by PL 1983, c. 579, §10, is amended to read:

B. An allowance for the cost of movable equipment shall be calculated on the basis of ~~price-level~~ straight line depreciation and interest consistent with paragraph A. ~~The commission shall promulgate rules to define the manner in which price level depreciation is to be computed and adjustments are to be made to reflect changes from year to year. Funding of this depreciation shall be required as specified by the commission.~~

Sec. 16. 22 MRSA §396-D, sub-§3, ¶C is enacted to read:

C. Hospitals shall fund depreciation and use their funded depreciation as a first source of funds for payment for capital projects, proportional to the ratio between the capital cost of the new project and the gross book value of the hospital assets.

Sec. 17. 22 MRSA §396-D, sub-§4, ¶C, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 18. 22 MRSA §396-D, sub-§4, ¶D, as enacted by PL 1983, c. 579, §10, is amended is to read:

D. The commission may, for hospitals regulated under the total revenue system, from time to time during the course of a payment year, in accordance with duly promulgated regulations, make such further adjustments as may be necessary in the event of discrepancies, if any, between projected and actual volume changes in preceding payment years or in the event it obtains substantial evidence that its initial projections for the current payment year will be in error. In making such further adjustments, the commission shall consider the special needs and circumstances of small hospitals.

Sec. 19. 22 MRSA §396-D, sub-§4, ¶E is enacted to read:

E. The commission shall consider changes in volume of services for hospitals regulated according to the per case system and shall make prospective volume adjustments in years subsequent to the first payment year in which the hospital is subject to the per case system using a marginal cost factor in the range of 60% to 90%, giving consideration to the characteristics of inpatient and outpatient services and hospital size. This paragraph is repealed effective October 1, 1991.

Sec. 20. 22 MRSA §396-D, sub-§6, as repealed and replaced by PL 1987, c. 440, §2, is repealed.

Sec. 21. 22 MRSA §396-D, sub-§6-A is enacted to read:

6-A. Standard component. For payment years commencing on or after October 1, 1990, but no later than October 1, 1991, the commission shall establish reasonable standards of financial requirements or costs per case for hospitals. In determining financial requirements for payment years to which the standards apply, the commission shall include an adjustment to incorporate the standards into financial requirements as otherwise determined under this section.

A. The adjustment under this subsection shall apply to noncapital financial requirements and to the allowance for capital costs of movable equipment but shall exclude the allowance for the capital costs of facilities and fixed equipment determined under subsection 3.

B. The commission may exclude certain categories of operating costs in order to permit reasonable comparisons among hospitals.

C. The commission may exclude financial requirements associated with outpatient services from the adjustment under this subsection, either for all payment years or for some portion of the 5-year phase-in period.

D. The adjustment under this subsection shall be phased in over a 5-year period, distributed as equally over the 5 years as is practicable. At the end of the 5-year period, the standard component may not exceed 50% of those financial requirements to which the adjustment is applied.

E. The commission may waive or modify the standard component adjustment for a border hospital or a hospital regulated under the total revenue system if the commission finds that including the standard component in the hospital's financial requirements would impair the capacity of the hospital to provide needed services at acceptable levels of quality and the hospital could not avoid this impairment by management action.

Sec. 22. 22 MRSA §396-D, sub-§9, ¶B, as amended by PL 1987, c. 811, §12, is repealed.

Sec. 23. 22 MRSA §396-D, sub-§9, ¶D, as repealed and replaced by PL 1987, c. 402, Pt. A, §136, is repealed.

Sec. 24. 22 MRSA §396-D, sub-§9, ¶F, as amended by PL 1987, c. 542, Pt. H, §2 and as repealed and replaced by PL 1987, c. 777, §§1 and 6, is repealed.

Sec. 25. 22 MRSA §396-D, sub-§9, ¶¶F-1 and F-2 are enacted to read:

F-1. In determining payment year financial requirements, the commission shall include an adjustment to reflect the actual costs of the hospital's participation in the Health Occupations Training Project, Title 26, chapter 31. These costs shall be limited to actual payments made to lenders under the program. The commission shall make an adjustment under this paragraph only to the extent that the costs found to be reasonable are not otherwise included in financial requirements.

F-2. In determining payment year financial requirements, the commission shall include an adjustment for the hospital's assessment by the Maine High-risk Insurance Organization, pursuant to Title 24-A, section 6052, subsection 2.

Sec. 26. 22 MRSA §396-D, sub-§9, ¶G, as enacted by PL 1987, c. 769, Pt. A, §65, is repealed.

Sec. 27. 22 MRSA §396-D, sub-§9, ¶H, as enacted by PL 1987, c. 847, §1, is amended to read:

H. In determining payment year financial requirements, the commission shall include an adjustment for the hospital's assessment under Title 36, section ~~3800~~ 2801.

Sec. 28. 22 MRSA §396-D, sub-§11, ¶B, as enacted by PL 1983, c. 579, §10, is amended to read:

B. Adjustments made for a payment year for working capital, management support and those new regulatory costs specified in subsection 9, paragraph C, subparagraphs (1) and (2), shall not be considered part of base year or payment year financial requirements for purposes of computing payment year financial requirements pursuant to section 396-C for a subsequent payment year. The ~~commission may determine from the nature of the unforeseen circumstances whether that adjustment is to be included in~~ payment year ~~financial requirements for purposes of computing financial requirements for a subsequent payment year~~ or years to which an adjustment for an exception request applies shall be determined in accordance with subsection 12, paragraph C.

Sec. 29. 22 MRSA §396-D, sub-§12 is enacted to read:

12. Exception requests. The commission shall provide for a special exception adjustment whereby a hospital may request an adjustment to its financial requirements to reflect major,

reasonable changes in expenses for which no adequate adjustment is otherwise provided under this chapter.

A. In determining whether and to what extent such an adjustment should be granted, the commission shall consider the following in addition to any more specific criteria that the commission may establish by rule:

(1) The nature and reasonableness of the changes in expenses for which an adjustment is under consideration, including any offsetting expense changes;

(2) The reasonableness and necessity of the hospital's total acute care operating expenses;

(3) The hospital's efficiency and its costs in comparison to other hospitals; and

(4) The effects on patients, purchasers and payors of any change in charges that would result from granting the adjustment.

After review of an exception request made pursuant to this subsection, the commission may, on the basis of the facts found, either increase or decrease the total financial requirements of a hospital.

B. A request that meets the requirements of paragraph A, but that would result in a positive adjustment equal to less than 1.5% of a hospital's financial requirements for the previous year or $1,000,000, whichever is less, shall not be granted, unless the applicant establishes either of the following:

(1) That the applicant's failure to receive the adjustment will immediately, seriously and irreparably impair its financial capacity to continue providing hospital services and that no alternative means of providing those services is available; or

(2) That denial of the adjustment would result in a groundless difference in regulatory treatment of similarly situated hospitals seeking relief under this subsection on the basis of essentially the same facts.

C. Except as provided in subparagraph (1), an adjustment pursuant to this subsection shall be included in a hospital's financial requirements only for periods of operation after the date on which the application for interim adjustment is deemed complete or the commencement of the payment year for which a timely notice of contest, requesting an adjustment under this subsection and

containing supporting information specified by the commission, has been filed.

(1) An interim adjustment under this subsection may be applied to all or part of the period between the beginning of the payment year during which an application was filed and the date that the application was deemed complete if the commission finds that:

(a) The hospital would otherwise be unable to meet its cash requirements as a consequence of events beyond its control; or

(b) Such relief is consistent with the public interest.

(2) The commission may determine from the nature of the expenses for which the adjustment is made whether it shall become a part of financial requirements for purposes of computing financial requirements for subsequent payment years.

Sec. 30. 22 MRSA §396-F, first ¶, as enacted by PL 1983, c. 579, §10, is amended to read:

In establishing revenue limits for an individual ~~hospitals~~ hospital, the commission shall make provision for the revenue deductions ~~in the following categories~~ determined in accordance with subsections 1 to 3, offset as appropriate by any distributions that the hospital will receive in the same payment year from the fund established in subsection 4.

Sec. 31. 22 MRSA §396-F, sub-§4, as enacted by PL 1987, c. 847, §2, is repealed and the following enacted in its place:

4. 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. 32. 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 or limits 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 or limits 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 and the payment system applicable to the hospital.

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. 33. 22 MRSA §396-I, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

§396-I. Payments to hospitals

1. Components of revenue limits. The commission shall, for each payment year, apportion each hospital's approved revenue limit or limits 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.

2. Apportionment among payors and purchasers. Based on historical or projected utilization data, the commission shall apportion, for each revenue center specified by the hospital subject to subsection 6, and for the hospital as a whole, the hospital's approved gross patient service revenue among the following categories:

A. Major 3rd-party payors, each of whom shall be a separate category; and

B. All purchasers and payors, other than major 3rd-party payors, which shall together constitute one category.

3. Payments by payors and purchasers. Payments by payors and purchasers shall be determined as follows.

R of S.

HOUSE AMENDMENT "A" to H.P. 954, L.D. 1322

A. Payments made by major 3rd-party payors shall be made in accordance with the following procedures.

(1) The commission shall require major 3rd-party payors to make biweekly periodic interim payments to hospitals, provided that any such payor may, on its own initiative, make more frequent payments.

(2) After the close of each payment year, the commission shall adjust the apportionment of payments among major 3rd-party payors based on actual utilization data for that year. Final settlement shall be made within 30 days of that determination.

B. For hospitals regulated according to the total revenue system, payments made by payors, other than major 3rd-party payors, and by purchasers shall be made in accordance with the following procedures.

(1) Payors, other than major 3rd-party payors, and purchasers shall pay on the basis of charges established by hospitals, to which approved differentials are applied. Hospitals shall establish these charges at levels which will reasonably ensure that its total charges, for each revenue center, or, at the discretion of the commission for groups of revenue centers and for the hospital as a whole, are equal to the portion of the gross patient service revenue apportioned to persons other than major 3rd-party payors.

(2) Except as otherwise provided in this subparagraph, subsequent to the close of a payment year, the commission shall determine the amount of overcharges or undercharges, if any, made to payors, other than major 3rd-party payors, and to purchasers and shall adjust, by the percentage amount of the overcharges or undercharges, the portion of the succeeding year's gross patient service revenue limit that would otherwise have been allocated to purchasers and payors other than major 3rd-party payors. Adjustments to the succeeding year's gross patient service revenue limit shall not be made for undercharges if the undercharges resulted from an affirmative decision by the hospital's governing body to undercharge. Any such decision to undercharge must be disclosed to the commission in order that it may be taken into account in the apportionment of the hospital's approved gross patient service revenue among all payors and purchasers, including major 3rd-party payors.

C. Payments to hospitals on the per case system shall be made on the basis of charges established consistent with limits set by the commission under that system. The commission shall establish by rule the necessary adjustments to approved revenues in subsequent payment years for hospitals determined to have overcharged or undercharged purchasers and payors other than major 3rd-party payors.

D. In addition to any reductions in payments to hospitals under paragraphs A, B and C, if a hospital exceeds any revenue limit by an amount in excess of a margin equal to 5% for small hospitals and 3% for all other hospitals, the commission may impose a penalty equal to 120% of the amount in excess of the margin times the rate of inflation. The amount of any penalty imposed shall be applied prospectively, and in accordance with methods prescribed by the commission, to reduce charges applicable to the class or classes of payors or purchasers which were overcharged. In determining whether to impose a penalty on a hospital regulated according to the total revenue system, the commission shall consider whether the revenues received by a hospital met its approved financial requirements.

4. Negotiated discounts. As of March 1, 1991, any hospital that is participating, or has chosen to participate or must participate, in the rate per case system, may negotiate discounts to charges with payors. Between March 1, 1991 and September 30, 1991, negotiated discounts may not exceed 5% of the hospital's established charges for inpatient services or 7% of its established charges for outpatient services. There shall be no limit on the magnitude of negotiated discounts after September 30, 1991. Hospitals in the total revenue system may negotiate discounts with the approval of the commission according to standards adopted by rule of the commission. The revenue losses resulting from negotiated discounts shall not be reflected in the computation of a hospital's revenue limit.

5. Transmittal of management fund revenue. No later than 30 days after receipt of each payment, each hospital shall transmit to the Management Support Fund, established pursuant to section 396-J, the portion, if any, of the payment which corresponds to the management fund revenue.

6. Review of allocations. Notwithstanding the provisions of subsection 2, the commission shall review the allocation of revenues to revenue centers specified by each hospital and shall ensure that such allocation, to the extent it results in internal departmental subsidies, is reasonable and does not result in undue price discrimination.

7. 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 which corresponds to the hospital payments fund revenue determined under subsection 1.

Sec. 34. 22 MRSA §396-K, sub-§3, ¶B, as repealed and replaced by PL 1985, c. 661, §10, is repealed.

Sec. 35. 22 MRSA §396-K, sub-§3, ¶B-1 is enacted to read:

B-1. On the basis of additional information received after an annual credit is established pursuant to paragraph A, including information provided by the department concerning the State Health Plan or projects then under review, the commission may by rule increase or decrease the amount of the annual credit during the course of the payment year cycle to which it applies. The commission may not act under this paragraph to decrease the credit below the amount that would, in combination with any amounts carried over from prior years, equal the total of any debits associated with projects approved on or before the date that the commission notifies the department of a proposed rule that would decrease the credit. For any payment year cycle in which the annual credit is apportioned to "statewide" and "individual hospital" components, the increase or decrease authorized by this paragraph shall apply solely to the "statewide" component of the credit.

Sec. 36. 22 MRSA §396-K, sub-§3, ¶C, as repealed and replaced by PL 1985, c. 661, §10, is amended to read:

C. The commission shall approve an adjustment to a hospital's financial requirements under section 396-D, subsection 5, paragraph A, for a major or minor project if:

(1) The project was approved by the department under the Maine Certificate of Need Act; and

(2) The associated incremental annual capital and operating costs do not exceed the amount remaining in the ~~statewide component of the~~ Hospital Development Account as of the date of approval of the project by the department, after accounting for previously approved projects.

Sec. 37. 22 MRSA §396-K, sub-§3, ¶D, as repealed and replaced by PL 1985, c. 661, §10, is repealed.

Sec. 38. 22 MRSA §396-K, sub-§3, ¶E, as enacted by PL 1985, c. 661, §10, is repealed.

R of S

Sec. 39. 22 MRSA §396-K, sub-§3, ¶F, as enacted by PL 1985, c. 661, §10, is amended to read:

F. Debits and carry-overs shall be determined as follows.

(1) Except as provided in subparagraph (2), the commission shall debit against the ~~statewide component of the~~ Hospital Development Account the full amount of the incremental annual capital and operating costs associated with each project for which an adjustment is approved under paragraph C. Incremental annual capital and operating costs shall be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 5, for the 3rd fiscal year of implementation of the project.

(2) In the case of a project which is approved under paragraph C and which involves extraordinary incremental annual capital and operating costs, the commission may, in accordance with duly promulgated rules, defer the debiting of a portion of the annual costs associated with the project until a subsequent payment year cycle or cycles.

~~(3) The commission shall debit against a hospital's individual development account the full amount of the incremental annual capital and operating costs associated with each proposal of the hospital for which an adjustment is approved under paragraph E. Incremental annual capital and operating costs shall be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 9, paragraph D, for the 3rd fiscal year of implementation of the proposal.~~

(4) Amounts credited to the ~~statewide component of the~~ Hospital Development Account for which there are no debits shall be carried forward to subsequent payment year cycles as a credit ~~to the statewide component. Amounts credited to an individual hospital account for which there are no debits shall be carried forward to subsequent payment year cycles as a credit to that account.~~

Sec. 40. 22 MRSA §396-K, sub-§4, as repealed and replaced by PL 1985, c. 661, §10, is repealed.

Sec. 41. 22 MRSA §396-O, as enacted by PL 1983, c. 579, §10, is amended by inserting at the end a new paragraph to read:

<u>The commission may waive any statutory requirements for hospital demonstration projects which further the goals described</u>

in section 381. The commission shall review hospitals with approved demonstration projects and may collect data to monitor performance, and require compliance adjustments if the conditions of the demonstration are contravened. The commission may terminate a demonstration if it determines that the hospital has not substantially complied with the terms of the demonstration project.

Sec. 42. 22 MRSA §400, as enacted by PL 1987, c. 440, §4, is repealed.

Sec. 43. 22 MRSA §§3189 to 3191 are enacted to read:

§3189. The Maine Health Program

1. Program created; intent. The Maine Health Program is created to expand access of Maine citizens to basic health care services. The Maine Health Program is intended to meet, to the extent of available funds, the health care needs of uninsured Maine residents with the highest priority being those needs of residents who are financially needy and under the age of 18.

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

A. "Applicable premium" means the amount that a person is required to pay to participate in the Maine Health Program, as determined under subsection 5.

B. "Committee" means the Maine Health Program Advisory Committee created in subsection 4.

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

D. "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).

E. "Household income" means the income of a person or group of persons determined according to rules adopted by the department in accordance with subsection 9, 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.

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

3. Eligibility. This subsection sets forth eligibility criteria for the program.

A. Except as provided in subsection 5 and in paragraph B of this subsection, the following persons are eligible to participate in the program and to receive benefits in accordance with this section:

(1) Any person who is under 18 years of age and whose household income is 125% or less of the federal poverty level;

(2) Any person who is age 18 or older and whose household income is 95% or less of the federal poverty level; and

(3) Beginning July 1, 1992, any person who is age 18 or older and whose household income is 100% or less of the federal poverty level.

B. Notwithstanding paragraph A, the following persons shall not be eligible to participate in the program:

(1) Persons eligible for the full scope of Maine medical assistance program benefits;

(2) Persons who are confined to state correctional facilities, county jails or local or county detention centers or who reside in institutions operated by the Department of Mental Health and Mental Retardation; and

(3) Persons who fail to meet other criteria established by this section.

4. Maine Health Program Advisory Committee. There is created the Maine Health Program Advisory Committee, as established in Title 5, section 12004-I, subsection 35-A.

A. The committee shall be composed of 12 members. The Governor shall appoint the following members: one representative of hospitals, to be appointed taking into account the recommendation of the Maine Hospital Association; one representative of providers of mental health, substance abuse or chiropractic services, to be appointed taking into account the recommendations of statewide organizations representing those providers; one representative of physicians, to be appointed taking into account a joint recommendation of the Maine Osteopathic Association and the Maine Medical Association; one health policy researcher, to be appointed taking into account the recommendations of the Maine Public Health Association; and one representative of the nursing profession, taking into account the recommendation of the Maine State Nurses' Association and the Maine Nursing Organization, a coalition

of nursing organizations. The following members shall be appointed jointly by the President of the Senate and the Speaker of the House of Representatives: 2 representatives of health care consumers; one representative of the Special Select Commission on Access to Health Care created by Title 24-A, section 6071; and one representative of community health centers, to be appointed taking into account the recommendation of the Maine Ambulatory Care Coalition. The President of the Senate shall appoint one Senator and the Speaker of the House of Representatives shall appoint one member of the House of Representatives to serve on the committee. The Superintendent of Insurance or the superintendent's designee shall also serve on the committee.

B. No person may be appointed as a representative of consumers of health care if that persons 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. Appointments shall be made no later than October 1, 1989.

C. Except for the initial appointees, members shall serve 2-year terms. The Governor shall appoint one half of the initial group of members to serve a one-year term and one half to serve a 2-year term. The President of the Senate and the Speaker of the House of Representatives shall appoint one half of the initial group of members to serve a one-year term and one half to serve 2-year terms.

D. The committee has the following powers and duties.

(1) The committee shall advise the department on an ongoing basis with respect to the development and administration of the program, including reasonable opportunity for review and comment on proposed rules by the committee prior to the department's issuance of public notice of rulemaking.

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

E. The committee may study issues relating to implementation of the program as it deems advisable. The committee shall study what asset limits, if any, are appropriate to determine eligibility for benefits under the program. The study of asset limits 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 committee shall recommend a policy on assets to the department for review.

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

G. Each member of the committee shall be compensated according to the provisions of Title 5, chapter 379.

H. The department shall supply staff and other assistance to the committee.

5. Program development and administration. The department shall develop and administer the program with advice from the committee and in accordance with this section.

A. The department, by rule adopted in accordance with subsection 9, 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.

(2) Notwithstanding the requirements of this paragraph, if the department determines that available funds are inadequate to continue to provide the full scope and amount of medical assistance, the department, in accordance with paragraph G, may restrict the scope and amount of medical assistance to be provided to participants in the program by adoption of rules in accordance with subsection 9.

(3) The medical assistance to be provided shall not require participants with household income below 100% of the federal poverty level 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. The department may study, in consultation with the committee, whether to require copayments from participants with household income above 100% of the federal poverty level. Copayments may be required of those persons only to the extent that the study finds that implementation of the proposed copayment will not significantly reduce access to necessary services, and will achieve appropriate reduction in the utilization of services and the cost of the program.

B. The department, in consultation with the council, 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. The department shall adopt rules in accordance with subsection 9, setting forth a sliding scale of premiums to be paid by persons eligible for the program provided that the rules shall meet the following criteria.

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

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

The department may, by rule, reduce or waive premiums for persons below the age of 18 years whose household income does not exceed 125% of the federal poverty level.

D. The department shall adopt rules in accordance with subsection 9 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. In each year of operation, the program's maintenance, reduction or expansion shall be determined by the availability of funds. The department, in accordance with paragraphs F and G, shall adjust program criteria in order to keep costs within yearly appropriations.

The department shall make annual recommendations to the Governor and the Governor shall make annual recommendations to the Legislature to maintain, reduce or expand the program after consideration of expenditures and available projected revenues. In addition, the department shall make an annual report to the Governor and the Legislature regarding experience of the program.

F. Notwithstanding subsection 3, provided funds are available, the department may, by rule, provide for coverage of persons whose household income exceeds the income limits set forth in subsection 3, in accordance with statutory provisions, including section 3191, subsection 2.

G. Notwithstanding subsection 3, if at any time during the fiscal year the department determines that the funds available for the program are inadequate to continue the program pursuant to the requirements of subsection 3, the department, in accordance with this subsection and subsection 9, may take action to limit the program for the full or partial fiscal year for which the department determines funding is inadequate. The priority of making reductions shall be as follows:

(1) With regard to new applicants only, the income limit for persons aged 18 or older may be reduced to such lower percentage of federal poverty level as the department determines appropriate;

(2) With regard to new applicants only, the income limits for all otherwise eligible persons may be reduced to such lower percentages of the federal poverty level as the department determines appropriate;

(3) With regard to all otherwise eligible persons, the department may restrict the scope and amount of medical assistance to be provided;

(4) With regard to new applicants only, no persons aged 18 or older may be found eligible for the program;

(5) No new applicants may be found eligible for the program.

Sixty days prior to the effective date of any proposed reduction of benefits or eligibility recommended pursuant to this paragraph, the department shall provide copies of the proposed rule together with a concise statement of the principal reason for the rule, including the balance remaining in the account for the program, an analysis of the proposed rule and the savings anticipated by the adoption of the proposed rule to the Governor and to each member of the joint standing committee of the Legislature having jurisdiction over insurance matters and appropriations matters.

H. 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.

I. 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. 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.

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

6. 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. If the person's contribution is smaller than the applicable premium, the person shall be required to make the contribution and pay the difference between the contribution and the applicable premium to the department.

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.

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 cost of the employer-supported plan as a benefit of the program.

D. The department shall adopt rules in accordance with subsection 9 to implement this subsection. The department may adopt rules reducing or waiving the requirements of this subsection for persons under the age of 18 when the person's parents or other responsible adults are not participants in the program.

7. 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 9 to implement this subsection.

8. Transition period for participants losing eligibility. Any participant who ceases to be eligible to participate in the program because of household income exceeding the applicable percentage 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's income does not exceed the applicable income eligibility standard by more than 50% and further provided the participant pays a premium established for such persons by the department by rule adopted in accordance with subsection 9.

9. 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 shall provide the committee a reasonable opportunity to review and comment on the proposed rules as a committee prior to the department giving public notice of rulemaking.

10. Fund balances. Any balances of funds appropriated for services under this section shall not lapse, but shall be carried forward from year to year to be expended for the same purpose.

11. Legislative intent. It is the intent of the Legislature to appropriate the same amount for the program in fiscal year 1992-93 as it appropriates for fiscal year 1991-92.

12. Repeal. This section is repealed effective June 30, 1993.

§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 May 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 4, 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. 44. 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 a 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. 45. 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. 46. 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. 47. 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 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;

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

HOUSE AMENDMENT "A" to H.P. 954, L.D. 1322

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. 48. 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. 49. 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.

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 this subsection. When such a program or policy 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. 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 a 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. 50. 24-A MRSA §2675, sub-§1, as enacted by PL 1985, c. 704, §4, is repealed.

Sec. 51. 24-A MRSA §2675, sub-§1-A is enacted to read:

1-A. Approval of arrangements. An insurer or administrator 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 insurer or administrator 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. 52. 24-A MRSA §2675, sub-§3, as enacted by PL 1985, c. 704, §4, is repealed.

Sec. 53. 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. 54. 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 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 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. 55. 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 and administrator 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. 56. Study. The Commission to Study the Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services is established.

1. **Scope.** The study commission shall study the following subjects.

A. The study commission shall review the provisions of Maine law relating to health services planning, including the certificate of need law and provisions of the health care finance law relating to the hospital development account and to affiliated interests. The study commission shall submit its report, including any necessary legislation to implement its recommendations, to the Joint Standing Committee on Human Resources by December 15, 1989.

B. The study commission shall study the current and potential impact of competitive market forces on outpatient volumes and the cost, quality and accessibility of ambulatory health services. Its study shall include an evaluation of the advisability of deregulating various outpatient services. The study commission shall submit its recommendations, including any necessary legislation to implement its recommendations, to the Joint Standing Committee on Human Resources by December 15, 1990. In the course of this study, the commission shall consider the likely impact of deregulating the charges made by hospitals for outpatient services and the elimination of any continuing restrictions on the establishment of preferred provider arrangements.

2. **Composition.** The study commission shall be composed of 13 members. The President of the Senate shall appoint one Senator, one hospital official and one consumer member representing business. The Speaker of the House of Representatives shall appoint 2 members of the House of Representatives and one consumer member. The Governor shall appoint one representative of the Department of Human Services, one hospital official, one physician, one representative of a 3rd-party payor other than the Department of Human Services, one representative of the Maine Health Policy Advisory Council who is not a health care provider or representative of a health care provider, and one consumer member representing labor. The chair of the Maine Health Care Finance Commission shall appoint one representative of the Maine Health Care Finance Commission. All appointments shall be made within 30 days of the effective date of this Act. The chair of the Legislative Council shall call the first meeting of the commission. The members of the commission shall elect a chair from among the members of the study commission.

3. **Staff.** The Maine Health Care Finance Commission shall provide staff to the commission for the duration of the study.

4. **Expenses.** The members of the commission who are Legislators shall receive the legislative per diem as defined in

the Maine Revised Statutes, Title 3, section 2, for each day's attendance at commission meetings. All members who do not represent state agencies shall receive expenses for attending meetings upon application to the Executive Director of the Legislative Council.

5. Sunset. This section is repealed December 15, 1990.

Sec. 57. Commission study and rule revisions. The Maine Health Care Finance Commission is directed to conduct studies and propose rules as follows.

1. Outpatient services. The commission shall conduct a study for the purpose of improving the method that it currently employs to adjust the financial requirements of hospitals for changes in the volume of outpatient services provided and developing a method of regulating outpatient revenues on the basis of rate per unit of service. On or before March 1, 1992, the commission shall release to the Joint Standing Committee on Human Resources, to hospitals subject to its jurisdiction and to the general public a report of the results of its study and an outline of the changes that it proposes to make. The commission shall propose new rules or amendments to its existing rules, in accordance with the requirements of the Maine Revised Statutes, the Maine Administrative Procedure Act, Title 5, chapter 375, for the purpose of implementing the results of its study for payment years beginning on and after October 1, 1992.

2. Marginal cost rates and volume corridors. The commission shall conduct a study to determine whether changes in the marginal cost percentages and volume corridors specified in its existing rules to implement adjustments for volume and case mix are reasonable and appropriate, taking into account the effects of those rules on hospitals with increasing, decreasing and stable volume, as well as the effects of those rules upon those who pay for hospital services. The commission shall release a report of the results of its study to the Joint Standing Committee on Human Resources, to all hospitals subject to its jurisdiction and to the general public on or before March 1, 1991. To the extent that the study concludes that changes in the marginal cost percentages or the volume corridors, or both, should be made, the commission shall propose amendments to its existing rules or new rules for the purpose of implementing those changes for payment years beginning on and after October 1, 1991.

3. Participation. In conducting the studies required by subsections 1 and 2, the commission shall seek comments and active participation from the advisory committees established by the Maine Revised Statutes, Title 22, section 396-P, and from other interested and affected hospitals, payors and members of the general public.

Sec. 58. Level of licensure review. The Department of Human Services shall review systems of licensure for health care facilities to determine what additional levels of licensure might be created to ease the problems of hospitals which are experiencing financial difficulty operating at the current level of licensure and which could continue to provide selected community health care services at a lower level of licensure. The department shall develop standards of licensure at lower levels and submit any legislation necessary to implement them to the Joint Standing Committee on Human Resources by February 1, 1990.

Sec. 59. Transition. The hospital care financing system, as amended by this Act, shall apply to hospital payment years beginning on or after October 1, 1990, except that section 35 of this Act shall apply to payment year cycles beginning on or after October 1, 1989.

The commission shall administer the hospital care financing system established by the Maine Revised Statutes, Title 22, chapter 107, as those provisions of law existed prior to the effective date of this Act, with respect to all hospital payment years beginning before October 1, 1990. The continuing authority provided by this section shall extend to the determination and enforcement of compliance with revenue limits for those earlier payment years and to the settlement of payments and adjustments of overcharges and undercharges for those years, in proceedings that may be commenced after the close of those years. Nothing in this Act may be construed to limit the authority of the commission to enforce compliance with or seek penalties for violation of any provision of Title 22, chapter 107, that was in effect at the time of the act, event or failure to act with respect to which enforcement action is taken or penalties are sought.

Sec. 60. Application. A preferred provider arrangement for which a disclosure report was filed with the Superintendent of Insurance prior to the effective date of sections 44 to 55 of this Act shall become subject to sections 44 to 55 of the Act on the first renewal date after January 1, 1991, of contracts or arrangements entered into pursuant to the arrangement. If the contract or agreement does not have a renewal date, the arrangement is subject to sections 44 to 55 of the Act 3 years from the effective date of those sections.

Sec. 61. 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		
Bureau of Health		
All Other	$500,000	$1,200,000
Provides funds for community health program grants to be awarded beginning May 1, 1990.		
Medical Care - Payments to Providers		
All Other	$675,000	$833,000
Provides funds for an increase in Medicaid reimbursement to providers to increase access to health care for Medicaid recipients.		
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 years old in households with income to 100% of the federal poverty level.		
Maine Health Program		
All Other		$9,946,885
Provides funds for the Maine Health Program.		
Medical Care Administration		
Positions	(1.5)	(9)
Personal Services	$53,000	$189,000
All Other	88,000	41,513
Capital Expenditures	9,000	48,000
TOTAL	$150,000	$278,513

Provides funds for the development and administration of the Maine Health Program and costs related to the Maine Health Program Advisory Committee.		
Income Maintenance - Regional		
Positions		(17)
Personal Services		$357,000
All Other		43,643
Capital Expenditures		22,100
TOTAL		$422,743
Provides funds for additional staff and related expenses to implement and administer the provisions of the Maine Health Program.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$1,440,168	$13,015,386
MAINE HEALTH CARE FINANCE COMMISSION		
Health Care Finance Commission		
All Other		$5,324,071
Provides funds for the Hospital Uncompensated Care and Governmental Payment Shortfall Fund.		
MAINE HEALTH CARE FINANCE COMMISSION TOTAL		$5,324,071
Commission to Study the Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services		
Personal Services	$1,485	$825
All Other	4,950	1,250
TOTAL	$6,435	$2,075

Provides funds for per diem for legislative members and expenses for other members of the study commission.		
TOTAL APPROPRIATIONS	**$1,446,603**	**$18,341,532**

Sec. 62. Allocation. The following funds are allocated from Federal Expenditures funds to carry out the purposes of this Act.

	1989-90	**1990-91**
HUMAN SERVICES, DEPARTMENT OF		
Medical Care - Payments to Providers		
All Other	$1,285,500	$1,499,680
Allocates federal matching funds for a provider fee increase.		
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 years old in households with income to 100% of the federal poverty level.		
Income Maintenance - Regional		
Positions		(17)
Personal Services		$357,000
All Other		43,643
Capital Expenditures		22,100
TOTAL		$422,743
Allocates federal matching funds for additional staff and related expenses.		

DEPARTMENT OF HUMAN SERVICES TOTAL	$1,504,832	$2,524,178

Sec. 63. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Act.

	1989-90	1990-91
MAINE HEALTH CARE FINANCE COMMISSION		
Health Care Finance Commission		
Positions	(5)	(5)
Personal Services	$97,562	$188,620
All Other	150,000	
Allocates funds for 2 Health Care Financial Analysts, one Planning and Research Associate II, one Programmer Analyst and one Staff Attorney and funds to carry out the required study.		
MAINE HEALTH CARE FINANCE COMMISSION TOTAL	$247,562	$188,620
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	$251,562	$191,620

PART B

Sec. 1. 36 MRSA §1752, sub-§5-B is enacted to read:

5-B. Liquor. "Liquor" has the same meaning as in Title 28-A, section 2, subsection 16.

Sec. 2. 36 MRSA §1811, first ¶, as repealed and replaced by PL 1987, c. 497, §40, is amended to read as follows:

A tax is imposed at the rate of 5% on the value of all tangible personal property, on telephone and telegraph service, on extended cable television service, on fabrication services and on custom computer programming sold at retail in this State and at the rate of 7% on the value of all other taxable services sold at retail in this State and at the rate of 10% on the value of liquor sold in licensed establishments as defined in Title 28-A, section 2, in accordance with Title 28-A, chapter 43. Value shall be measured by the sale price, except as otherwise provided.

Sec. 3. 36 MRSA §1812, sub-§1, ¶C is enacted to read:

C. If the tax rate is 10%:

Amount of Sale Price	Amount of Tax
$0.01 to $0.10, inclusive	0¢
.11 to .20, inclusive	2¢
.21 to .40, inclusive	4¢
.41 to .60, inclusive	6¢
.61 to .80, inclusive	8¢
.81 to 1.00, inclusive	10¢

Sec. 4. 36 MRSA §1812, sub-§2, as enacted by PL 1987, c. 402, Pt. A, §181, is amended to read:

2. Several items. When several purchases are made together and at the same time, the tax shall be computed on the total amount of the several items, except that purchases taxed at 5% and 7% and 10% shall be separately totaled.

PART C

Sec. 1. 12 MRSA §§7793-A to 7793-E are enacted to read:

§7793-A. Collection by commissioner

The commissioner or agents of the commissioner shall act on behalf of the State Tax Assessor to collect the use tax due under Title 36, chapters 211 to 225 in respect to any watercraft for

which an original registration is required under this Title at the time and place of registration of that watercraft.

Each official shall deduct and retain from the use taxes collected pursuant to this section a fee of $1.25 for each watercraft in respect to which a use tax certificate has been submitted in accordance with section 7793-C, even though the certificate indicated that no use tax was due in respect to the watercraft in question.

All fees so retained shall be transmitted forthwith to the Treasurer of State and treated as funds deposited pursuant to section 7074. All taxes collected pursuant to this section shall be transmitted forthwith to the Treasurer of State and shall be credited to the General Fund.

§7793-B. Original registration defined

"Original registration" shall mean any registration other than a renewal of registration by the same owner in sections 7793-A to 7793-E.

§7793-C. Payment of sales or use tax a prerequisite to registration

No application for registration shall be granted in respect to any watercraft whose sale or use may be subject to tax under Title 36, chapters 211 to 225, except in the case of a renewal of registration by the same owner, unless and until one of the following conditions has been satisfied:

1. Dealers' certificate. The applicant has submitted a dealers' certificate in a form prescribed by the State Tax Assessor, showing either that the sales tax due in respect to the watercraft in question has been collected by the dealer or that the sale of the vehicle is exempt from or otherwise not subject to tax under Title 36, chapters 211 to 225;

2. Use tax certificate. The applicant has properly executed and signed a use tax certificate in such form and manner as may be prescribed by the State Tax Assessor and paid the amount of tax shown therein to be due; or

3. Exemption. The applicant has properly executed and signed a use tax certificate in such form and manner as may be prescribed by the State Tax Assessor showing that the sale or use of the watercraft in question is exempt from or otherwise not subject to tax under Title 36, chapters 211 to 225.

§7793-D. Certificates to be forwarded to the State Tax Assessor

Upon receipt by the commissioner or the commissioner's agent of any certificate submitted in accordance with section 7793-C, that official shall promptly forward the certificate to the State Tax Assessor.

§7793-E. Collection by State Tax Assessor

The provisions of this section shall be construed as cumulative of other methods prescribed in Title 36, chapters 211 to 225, for the collection of the sales or use tax. Nothing herein shall be construed as precluding the State Tax Assessor from collecting the tax due in respect to any watercraft in accordance with such other methods as are prescribed in Title 36, chapters 211 to 225, for the collection of the sales or use tax.

Sec. 2. 36 MRSA §1752, sub-§23 is enacted to read:

23. Watercraft. "Watercraft" means a watercraft which is subject to excise tax under chapter 112, excluding commercial vessels as defined in that chapter.

Sec. 3. 36 MRSA §1764, as repealed and replaced by PL 1987, c. 769, Pt. A, §155, is amended to read:

§1764. Tax against certain isolated sales

The tax imposed by chapters 211 to 225 shall be levied upon all isolated transactions involving the sale of camper trailers, motor vehicles, special mobile equipment, livestock trailers, watercraft or aircraft excepting those sold for resale, and excepting an isolated transaction involving the sale of camper trailers, motor vehicles, special mobile equipment, livestock trailers, watercraft or aircraft to a corporation when the seller is the owner of a majority of the common stock of the corporation.

Sec. 4. 36 MRSA §1765, sub-§3, as repealed and replaced by PL 1987, c. 402, Pt. A, §180, is repealed and the following enacted in its place:

3. Watercraft. Watercraft;

Sec. 5. 36 MRSA §1952-A, as enacted by PL 1975, c. 702, §6, is amended to read:

§1952-A. Payment of tax on vehicles and watercraft

The tax imposed by chapters 211 to 225 on the sale or use of any vehicle or watercraft shall, except where the dealer thereof has collected such tax in full, be paid by the purchaser or other person seeking registration of the vehicle or watercraft at the time and place of registration of such vehicle or watercraft. The

In the case of vehicles, tax shall be collected by the Secretary of State and transmitted to the Treasurer of State as provided by Title 29, chapter 5, subchapter 1-A. In the case of watercraft, the tax shall be collected by the Commissioner of Inland Fisheries and Wildlife and transmitted to the Treasurer of State as provided by Title 12, sections 7793-A to 7793-E.

Sec. 6. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1990-91
FINANCE, DEPARTMENT OF	
Bureau of Taxation	
Positions	(1)
Personal Services	$13,021
All Other	4,557
Capital Expenditures	5,000
Provides funds for a Clerk Typist III and related equipment to provide billing services.	
DEPARTMENT OF FINANCE TOTAL	$22,578

PART D

Sec. 1. 36 MRSA §4365, as amended by PL 1985, c. 535, §9, is further amended to read:

§4365. Rate of tax

A tax is imposed on all cigarettes held in this State by any person for sale, the tax to be at the rate of ~~14~~ 15.5 mills for each cigarette ~~and the payment thereof to~~ beginning October 1, 1989; 16.5 mills for each cigarette beginning January 1, 1991; and 18.5 mills for each cigarette beginning July 1, 1991. Payment of the tax shall be evidenced by the affixing of stamps to the packages containing the cigarettes. If a federal program similar to that provided in Title 22, section 3185, becomes effective, this tax is reduced by one mill for each cigarette. The Governor shall determine by proclamation when the federal program has become effective. Nothing contained in this chapter shall be construed to impose a tax on any transaction, the taxation of which by this State is prohibited by the Constitution of the United States.

Each unclassified importer shall, within 24 hours after receipt of any unstamped cigarettes in this State, notify the State Tax Assessor of the number of cigarettes received, and the name and address of consignor. The State Tax Assessor thereupon shall notify the unclassified importer of the amount of the tax due thereon, which shall be at the same rate ~~of 14 mills per cigarette~~ as for cigarettes held in this State by any person for sale. Payment of the amount due the State shall be made within 10 days from mailing date of notice thereof.

Sec. 2. 36 MRSA §4365-A, as enacted by PL 1985, c. 535, §10, is amended to read:

§4365-A. Rate of tax after September 30, 1989

Cigarettes which have been stamped at the rate of ~~10~~ 14 mills for each cigarette which are held for resale by any person after September 30, ~~1985~~ 1989, shall be subject to tax at the rate of ~~14~~ 15.5 mills for each cigarette.

Any person holding cigarettes for resale shall be liable for the difference between the ~~14~~ 15.5 mills for each cigarette tax rate and the ~~10~~ 14 mills for each cigarette tax rate in effect prior to October 1, ~~1985~~ 1989. Stamps evidencing payment of the tax imposed by this section shall be affixed to all packages of cigarettes held as of October 1, ~~1985~~ 1989, for resale, except that cigarettes held in vending machines as of October 1, ~~1985~~ 1989, need not be so stamped.

Notwithstanding any other provision of this chapter, it is presumed that all cigarette vending machines are filled to capacity on October 1, ~~1985~~ 1989, and the tax imposed by this section shall be reported on that basis. A credit against this inventory tax shall be allowed for cigarettes stamped at the ~~14-mill~~ 15.5-mill rate placed in vending machines before October 1, ~~1985~~ 1989.

Payment of the tax imposed by this section shall be made to the State Tax Assessor before November 15, ~~1985~~ 1989, and it shall be accompanied by forms prescribed by the State Tax Assessor.

Sec. 3. 36 MRSA §§4365-B and 4365-C are enacted to read:

§4365-B. Rate of tax after December 31, 1990

Cigarettes which have been stamped at the rate of 15.5 mills for each cigarette which are held for resale by any person after December 31, 1990, shall be subject to tax at the rate of 16.5 mills for each cigarette.

Any person holding cigarettes for resale shall be liable for the difference between the 16.5 mills for each cigarette tax rate and the 15.5 mills for each cigarette tax rate in effect prior to January 1, 1991. Stamps evidencing payment of the tax imposed by this section shall be affixed to all packages of cigarettes held as of January 1, 1991, for resale, except that cigarettes held in vending machines as of January 1, 1991, need not be so stamped.

Notwithstanding any other provision of this chapter, it is presumed that all cigarette vending machines are filled to capacity on January 1, 1991, and the tax imposed by this section shall be reported on that basis. A credit against this inventory tax shall be allowed for cigarettes stamped at the 16.5-mill rate placed in vending machines before January 1, 1991.

Payment of the tax imposed by this section shall be made to the State Tax Assessor before February 15, 1991, and it shall be accompanied by forms prescribed by the State Tax Assessor.

§4365-C. Rate of tax after June 30, 1991

Cigarettes which have been stamped at the rate of 16.5 mills for each cigarette which are held for resale by any person after June 30, 1991, shall be subject to tax at the rate of 18.5 mills for each cigarette.

Any person holding cigarettes for resale shall be liable for the difference between the 18.5 mills for each cigarette tax rate and the 16.5 mills for each cigarette tax rate in effect prior to July 1, 1991. Stamps evidencing payment of the tax imposed by this section shall be affixed to all packages of cigarettes held as of July 1, 1991, for resale, except that cigarettes held in vending machines as of July 1, 1991, need not be so stamped.

Notwithstanding any other provision of this chapter, it is presumed that all cigarette vending machines are filled to capacity on July 1, 1991, and the tax imposed by this section shall be reported on that basis. A credit against this inventory tax shall be allowed for cigarettes stamped at the 18.5-mill rate placed in vending machines before July 1, 1991.

Payment of the tax imposed by this section shall be made to the State Tax Assessor before August 15, 1991, and it shall be accompanied by forms prescribed by the State Tax Assessor.

Sec. 4. 36 MRSA §4403, sub-§§1 and 2, as enacted by PL 1985, c. 783, §16, are amended to read:

1. Smokeless tobacco. A tax is imposed on all smokeless tobacco, including chewing tobacco and snuff, at the rate of ~~45%~~ 50% of the wholesale sales price beginning October 1, 1989; ~~55%~~

of the wholesale sales price beginning January 1, 1991; and 62% of the wholesale sales price beginning July 1, 1991.

2. Other tobacco. A tax is imposed on cigars, pipe tobacco and other tobacco intended for smoking at the rate of ~~12%~~ 13% of the wholesale sales price beginning October 1, 1989; 14% of the wholesale sales price beginning January 1, 1991; and 16% of the wholesale sales price beginning July 1, 1991.

Sec. 5. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1989-90	1990-91
FINANCE, DEPARTMENT OF		
Bureau of Taxation		
All Other	$100,000	$100,000
Provides funds to implement a heat-applied decal system for affixing cigarette tax indicia.		
DEPARTMENT OF FINANCE TOTAL	$100,000	$100,000

PART E

36 MRSA §1760, sub-§20 is repealed and the following enacted in its place:

20. Continuous residence; refunds and credits. Rental charged to any person who resides continuously for 28 days at any one hotel, rooming house, tourist or trailer camp if:

A. The person does not maintain a primary residence at some other location; or

B. The person is residing away from that person's primary residence in connection with employment or education.

Tax paid by such person to the retailer under section 1812 during the initial 28-day period shall be refunded by the retailer. Such tax reported and paid to the State by the retailer may be taken as a credit by the retailer on the report filed by the retailer covering the month in which refund was made to such tenant.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved, except that Part A, sections 3, 4 and 40 shall take effect October 1, 1990; Part B shall take effect December 1, 1989; Part C shall take effect October 1, 1989; Part D shall take effect October 1, 1989; and Part E shall take effect July 1, 1991.

FISCAL NOTE

The cost of the Maine Health Program in fiscal year 1990-91 is based upon a projected participation rate of 32.5%.

The estimated future costs of the programs in the bill, including administrative costs, will be approximately $28,000,000 in fiscal year 1991-92 and $47,000,000 in fiscal year 1992-93.

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.

Costs associated with the Department of Human Services' review of systems of licensure for health care facilities will be absorbed within existing resources.

Part B of this amendment is estimated to increase General Fund revenue by $4.4 million in fiscal year 1989-90 and $9 million in fiscal year 1990-91. The corresponding increase to the Local Government Fund would be $224,400 in fiscal year 1989-90 and $459,000 in fiscal year 1990-91.

Part C of this amendment is estimated to increase General Fund revenue by $500,000 in fiscal year 1989-90 and by $1.1 million in fiscal year 1990-91. The corresponding increase to the Local Government Fund would be $25,500 in fiscal year 1989-90 and $56,100 in fiscal year 1990-91.

Part D of this amendment is estimated to increase General Fund revenue by $2,375,000 in fiscal year 1989-90 and $3,400,000 in fiscal year 1990-91. This is a net increase after the appropriation for the purchase of heat stamps. There is also a significant increase in General Fund revenues in the next biennium due to the increase in the cigarette tax.

Part E will result in additional General Fund revenue beginning in the next biennium due to the elimination of the 28-day continuous residence sales tax exemption in some cases.'

STATEMENT OF FACT

Part A of this amendment contains the Maine Health Program, the Community Health Program grants, an appropriation to increase Medicaid reimbursement rates for providers and the contents of Legislative Document 920 which implements the recommendations of the Blue Ribbon Commission on the Regulation of Health Care Expenditures. The amendment does not include the Subsidized Excess Insurance Program or the small employer health insurance tax credit which was included in Legislative Document 1322. The amendment also contains revisions of the Preferred Provider Arrangement Act of 1986.

Children with household incomes below 125% of the federal poverty level and adults with household income below 95% of the federal poverty level would be eligible for medical assistance under the Maine Health Program. Beginning July 1, 1992, the income limit for adults would increase to 100% of the federal poverty level. The medical benefits to be provided by the program to eligible persons would be the same as those provided under the state Medicaid program.

The Department of Human Services, which administers the program, is required to adjust program criteria to keep costs of the program within yearly appropriations. The department is authorized to reduce the income eligibility level or to change the benefits to be provided if available funds are inadequate to fund the program at the full level of benefits for all eligible persons. Changes in the eligibility level would not affect persons who are already participating in the program, and would only be made after notice to legislative committees and through a public rule-making process.

The amendment states legislative intent to expand access to health care services for uninsured Maine residents, with first priority to financially needy children under the age of 18 years. If funds are available, the department is authorized to expand eligibility to persons not covered under the eligibility guidelines in the amendment.

Participants with household income over 100% of the federal poverty level are generally required to pay a sliding scale premium to participate in the program. All participants are required to take advantage of employer-supported health insurance for which they are eligible, and the Maine Health Program will wrap around that coverage to provide benefits not offered by the

employer's plan. The program will be a secondary payor to all other payors, to the extent permitted by state and federal law.

The amendment repeals the Maine Health Program effective June 30, 1993.

The Community Health Program grants contained in the amendment is essentially the same as set forth in Legislative Document 1322, except that the grants will begin during fiscal year 1989-90 rather than fiscal year 1990-91.

The amendment appropriates $675,000 in fiscal year 1989-90 and $833,000 in fiscal year 1990-91 to increase the reimbursement schedule for Medicaid providers. That appropriation of state money draws $1,285,500 and $1,499,680 in federal funds for fiscal year 1989-90 and 1990-91, respectively.

The contents of the Committee Amendment to Legislative Document 920, relating to regulation of hospital expenditures, are added to the amendment.

The amendment differs from Legislative Document 920 in the funding of the Hospital Uncompensated Care and Governmental Payment Shortfall Fund. In Legislative Document 920, $30,000,000 was provided in each fiscal year of the upcoming biennium for the fund. This amendment states legislative intent to appropriate the lesser of the Medicaid shortfall or 1/2 the amount appropriated for the Maine Health Program. For fiscal year 1990-91, $5,324,071 is appropriated to the fund.

The amendment revises the Preferred Provider Arrangement Act of 1986, under which insurers and administrators may enter into agreements with providers of health care services to send insureds and subscribers to that provider for services. If the policyholder under a preferred provider arrangement does not obtain services from the preferred provider, the insurer may reimburse at a lesser rate for the service. The difference between the reimbursement for a preferred provider and that for a nonpreferred provider is the "benefit level differential." Current law permits a 20% benefit level differential for all services. The amendment includes the following changes:

1. A requirement that all preferred provider arrangements be filed for approval by the Superintendent of Insurance, and that interested persons be notified that an arrangement has been filed and that they can request a public hearing on approval of the arrangement;

2. A benefit level differential of 50% for certain nonemergency, outpatient services listed in the amendment, with a sunset date of June 30, 1993; and

HOUSE AMENDMENT "A" to H.P. 954, L.D. 1322

3. Protections to assure that preferred provider arrangements do not restrict access to or availability of health care services.

Parts B, C, D and E add the tax changes necessary to fund the programs created in Part A. Part B increases the sales tax on beverages sold in bars and restaurants that have liquor licenses from 5% to 10%, beginning December 1, 1989.

Part C subjects isolated casual sales of boats and other watercraft to the 5% sales tax, beginning October 1, 1989. The tax would be collected either by the seller of the boat at the time of the sale, or by the Commissioner of Inland Fisheries and Wildlife, at the time the watercraft is registered. Payment of the tax would be required as a prerequisite to registration of the watercraft.

Part D increases the tax on cigarettes and other tobacco products. The tax on a package of cigarettes would increase by 3¢ on October 1, 1989, another 2¢ on January 1, 1991 and 4¢ on July 1, 1991. The tax on smokeless tobacco products would increase from 45% of the wholesale sales price to 50% on October 1, 1989; 55% on January 1, 1991; and 62% on July 1, 1991. Other tobacco products would increase from 12% of the wholesale sales price to 13% on October 1, 1989; 14% on January 1, 1991; and 16% on July 1, 1991.

Part E subjects long-term vacation rental of hotels, camps and rooming houses to sales tax, but retains the exemption from sales tax for residential rentals. A rental of 28 or more days is considered long-term rental.

This amendment changes the appropriations, the allocations and the fiscal note.

Filed by Rep. Rydell of Brunswick
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