L.D. 2251

(Filing No. S-602)

STATE OF MAINE
SENATE
115TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to S.P. 879, L.D. 2251, Bill, "An Act to Clarify the Enrollment Period for the 5-year Medical Liability Demonstration Project"

Amend the bill by striking out the title and substituting the following:

'**An Act to Clarify the Enrollment Period for the 5-year Medical Liability Demonstration Project and to Clarify Provisions of the Rural Medical Access Program**'

Further amend the bill by inserting after section 1 and before the emergency clause the following:

'**Sec. 2. 24-A MRSA §6302,** as enacted by PL 1989, c. 931, §5, is amended to read:

§6302. Purpose

The purpose of this chapter is to promote~~, through financial incentives to physicians who practice in underserved areas of the State, the availability of physicians who deliver babies in those~~ areas perinatal services in underserved areas of the State.

Sec. 3. 24-A MRSA §6303, sub-§2-A is enacted to read:

2-A. Program. "Program" means the Rural Medical Access Program.

Sec. 4. 24-A MRSA §6304, sub-§3, as enacted by PL 1989, c. 931, §5, is amended to read:

3. Assistance from boards and Department of Human Services; insure through other means. The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration shall assist the superintendent in identifying those physicians who insure against professional negligence by means other than through insurers defined in section 6303. The Department of Human Services~~, Division of Licensure and Certification~~, shall assist the superintendent in determining the

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insuring entity for any licensed hospital or physician's employer, ~~and~~ in identifying those hospitals and physician's employers that insure against professional negligence by means other than through insurers defined in section 6303 and in identifying the individual or entity who makes the insurance payment for each physician.

Sec. 5. 24-A MRSA §§6307, 6308 and 6309, as enacted by PL 1989, c. 931, §5, are amended to read:

§6307. Qualifications for premium assistance

1. Eligibility qualifications. A physician is a qualified physician eligible to ~~receive--professional--liability--premium assistance~~ participate in the program if that physician:

A. Is licensed to practice medicine in the State;

B. Accepts and serves Medicaid patients;

C. Provides complete obstetrical care for patients, including prenatal care and delivery, provided that physicians in an underserved area without a facility for obstetrical delivery are still eligible if they provide only prenatal care and have referral agreements for delivery with a physician meeting the requirements of paragraphs A and B; and

D. Practices at least 50% of the time in areas of the State that are underserved areas for obstetrical and prenatal medical services as determined by the Department of Human Services.

The Commissioner of Human Services shall determine those physicians who meet the requirements of this subsection. The commissioner shall adopt rules, pursuant to the Maine Administrative Procedure Act, determining underserved areas with respect to obstetrical and prenatal care. "Underserved areas" includes ~~Medically Underserved Areas~~ medically underserved areas, ~~Health Manpower Shortage Areas~~ health manpower shortage areas and other priority areas determined by the commissioner. The commissioner may adopt rules pursuant to the Maine Administrative Procedure Act defining the scope of services that must be provided to meet the requirements of paragraphs B and C and the method of prioritizing underserved areas for purposes of distribution of the ~~assistance~~ funds authorized by ~~this~~ section 6308.

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2. Ineligible if premium owed. Any physician or physician's employer who owes premiums to any insurer for any policy year prior to the year ~~for--which--assistance~~ that participation in the program is sought is not eligible ~~for~~ assistance to participate.

§6308. Funding of the program

The amount of ~~premium--assistance~~ funds available for the program is determined as follows.

1. Available funds. The amount available for ~~premium~~ assistance the program for policy years beginning on or after July 1, 1990, but before July 1, 1991, is 1/2 of the amount of the assessment determined under section 6305 for that year. For policy years beginning on or after July 1, 1991, ~~but-before-July 1,--1992,~~ the Bureau of Insurance shall determine the amount available ~~for-premium-assistance-is-the-remainder-of-the-amount determined-under-section-6305-that-is-not-used-in-the-first-year that-assistance-is-available-added-to-the-amount-of,~~ except that the amount may be no less than the assessment determined for that year. ~~--For--subsequent--policy--years--the--amount--available--for premium--assistance--is--the--amount--of--the--assessment--determined under-section-6305-for-that-year.~~

2. Determination of participants in the program. The superintendent shall apply the standards of prioritization adopted by the Commissioner of Human Services to determine the physicians who ~~will-receive-premium-assistance~~ are eligible for the program. ~~Each~~ The funding available for each qualified physician is ~~entitled--to--an--annual-premium-credit~~ the amount equal to the difference between the physician's medical malpractice insurance premiums with obstetrical care coverage and the physician's premiums without obstetrical care coverage; however, the ~~amount--of-premium--assistance~~ funding must be at least $5,000 but may not be more than $10,000 as determined by the superintendent. Program payments must be made to the individual or entity paying the medical malpractice premium for the qualified physician.

§6309. Intercorporate transfers

The superintendent may order intercorporate transfers of funds to balance assessments and ~~premium-credits~~ program payments on an equitable basis among insurers and to provide for ~~credits~~ payments to eligible self-insureds.'

Further amend the bill by inserting at the end before the statement of fact the following:

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FISCAL NOTE

The Bureau of Insurance, Board of Registration in Medicine and the Board of Osteopathic Examination and Registration will incur some minor additional administrative costs related to record keeping and updating the existing data base. These costs can be absorbed within the agencies' existing budgeted resources. The Bureau of Insurance can also absorb any costs associated with the modifications to the administration of the Rural Medical Access Program fund.'

STATEMENT OF FACT

This amendment clarifies certain provisions of the Rural Medical Access Program that was established at the same time as the Medical Liability Demonstration Project. This amendment addresses 3 concerns in the current law.

1. The current language requires payment of the assistance funds to the physician participating in the Rural Medical Access Program. In some situations, however, the physician's employer, a hospital or clinic for example, pays the medical malpractice insurance premium, not the physician. This amendment provides that the program payment go directly to the individual or entity that pays the premium. Language is added to ensure that the Department of Human Services can collect the necessary information to make that possible.

2. The terminology is changed from "premium assistance" to "participation in the program" to avoid confusion under federal law that requires certain types of assistance to be offset against expenses, thus reducing the federal money available to certain physicians. This was not the intent of the program, and the changes are designed to avoid that problem.

3. This amendment also changes the amount of money in the Rural Medical Access Program fund that is available to provide program payments to participating physicians. During the first year of the program, only 1/2 of the fund could be paid out. Current law provides that the remaining half from the first year and all of the assessment attributable in the 2nd year must be paid out in the 2nd year. This results in less being paid out in the 3rd year of the program, creating the problem of including some physicians in the program in the 2nd year only because the amount in the fund will be less in the 3rd year. This amendment provides that the Bureau of Insurance will determine the amount of the fund used for program payments each year, including the

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2nd year of the program, but at least the amount of the assessment collected for that year must be paid out. This leaves a small amount in the fund to help cover shortfalls in years that the assessment is less than the previous year's assessment.

The amendment also adds a fiscal note to the bill.

Reported by Senator Gauvreau for the Committee on Judiciary.
Reproduced and Distributed Pursuant to Senate Rule 12.
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