# 116th MAINE LEGISLATURE

## FIRST REGULAR SESSION-1993

**Legislative Document** **No. 182**

H.P. 137 House of Representatives, January 28, 1993

**An Act to Implement the Recommendations of the Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program.**

(EMERGENCY)

Reported by Representative RYDELL from the Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program.

Reference to the Joint Standing Committee on Banking and Insurance suggested and printing ordered under Joint Rule 19.

Joseph W. Mayo

JOSEPH W. MAYO, Clerk

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

**Whereas,** it is estimated that as many as 136,300 Maine citizens lack health insurance and that over 200,000 of the State's citizens are underinsured; and

**Whereas,** the State's health spending per capita increased 150% from 1980 to 1990, ranking Maine 5th highest in the nation for per capita health spending, and the State's per capita spending on health is expected to increase 2.3 times by the year 2000 if the current trend continues; and

**Whereas,** uncompensated care costs from the growing numbers of Maine's uninsured are being shifted onto a shrinking number of insured consumers, workers and businesses in Maine; and

**Whereas,** disproportionate segments of health insurance costs and health care costs are directly attributable to administrative inefficiency, burdening Maine businesses, providers and consumers with avoidable costs; and

**Whereas,** on quality indices, the State's health care for all its citizens scores below societies spending less and providing universal, comprehensive health insurance systems for all citizens; 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. A-1. 24-A MRSA §2808, sub-§1, ¶A,** as amended by PL 1987, c. 476, §4, is further amended to read:

A. The policyholder is a bona fide group ~~formed--for purposes-other-than-procurement-of-insurance~~;

**Sec. A-2. 24-A MRSA §2808, sub-§§5 and 6** are enacted to read:

5. A group formed pursuant to this section for the purpose of purchasing insurance is subject to section 2808-B.

6. Under this section a municipality may assist its residents in the formation of a group and in the administrative work necessary for the purchase of insurance.

## PART B

**Sec. B-1. 24-A MRSA §2736-C** is enacted to read:

**§2736-C. Community rating**

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

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

B. "Community rate" means the rate charged to all eligible individuals for health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D.

C. "Health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. "Health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment; or

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance.

D. "Premium rate" means the rate charged to an individual for a health plan.

**2. Rating practices.** The following requirements apply to the rating practices of carriers providing health plans.

A. A carrier issuing a health plan after the effective date of this section must file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent for informational purposes prior to issuance of any health plan.

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the individual.

C. A carrier may vary the premium rate due to family status, smoking status and participation in wellness programs.

D. A carrier may vary the premium rate due to age, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued

or renewed in this State between July 15, 1995 and July 14, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1996 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1997, the premium rate may not deviate from the community rate filed by the carrier.

Unless continued or modified by law, this paragraph is repealed on July 15, 1994.

**3. Guaranteed issuance and guaranteed renewal.** Carriers providing health plans must meet the following requirements on issuance and renewal.

A. Coverage must be guaranteed to all individuals.

B. Renewal must be guaranteed to all individuals except:

(1) For nonpayment of the required premiums by the policyholder or contract holder;

(2) For fraud or material misrepresentation by the policyholder or contract holder;

(3) For fraud or material misrepresentation on the part of the individual or the individual's representative; and

(4) When the carrier ceases providing health plans in compliance with subsection 4.

**4. Cessation of business.** Carriers that provide health plans after the effective date of this section that plan to cease doing business in the health plan market must comply with the following requirements.

A. Notice of the decision to cease doing business in the health plan market must be provided to the bureau and to the policyholder or contract holder 6 months prior to nonrenewal.

B. Carriers that cease to write new business in the health plan market continue to be governed by this section.

C. Carriers that cease to write new business in the health plan market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent.

**5. Fair marketing standards.** Carriers providing health plans must meet the following standards of fair marketing.

A. Each carrier must actively market health plan coverage to individuals in this State.

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

(1) Encouraging or directing individuals to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; or

(2) Encouraging or directing individuals to seek coverage from another carrier because of any of the rating factors listed in subsection 2.

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of a health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2.

D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2.

E. Denial by a carrier of an application for coverage from an individual must be in writing and must state the reason or reasons for the denial.

F. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of health plans in this State.

G. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice

under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier.

**6. Applicability.** This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

**Sec. B-2. 24-A MRSA §2808-B, sub-§1, ¶¶D and H,** as enacted by PL 1991, c. 861, §2, are amended to read:

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that during at least 50% of its working days in the preceding calendar quarter employed fewer than ~~25~~ 50 eligible employees, the majority of whom are employed within the State. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer. In the calculation of carrier percentage participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation.

H. "Subgroup" means an employer with fewer than ~~25~~ 50 employees within an association or a multiple employer trust or any similar subdivision of a larger group covered by a single group health policy or contract.

**Sec. B-3. 24-A MRSA §2808-B, sub-§2, ¶¶B and D,** as enacted by PL 1991, c. 861, §2, is amended to read:

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the eligible group or members of the group.

D. A carrier may vary the premium rate due to age, ~~gender,~~ occupation or industry, and geographic area only under the following schedule and within the listed percentage bands~~:~~.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and July 14, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1996 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1997, the premium rate may not deviate from the community rate filed by the carrier.

Unless continued or modified by law, this paragraph is repealed on July 15, 1994.

## PART C

**Sec. C-1. 24-A MRSA §238** is enacted to read:

**§238. Data collection**

The Bureau of Insurance shall establish a data collection program to collect data on health insurance that makes possible the examination and analysis of information that distinguishes health, disability, medicare supplement and other policies, individual policies from group policies, policies issued to persons age 65 and older from other policies, policies offering primary care case management from traditional policies and state data from national data.

## PART D

**Sec. D-1. 24 MRSA §2347, sub-§1,** as amended by 1991, c. 695, §2, is further amended to read:

**1. Contracts subject to this section.** Notwithstanding any other provision of law, this section applies to all individual and group contracts, except group long-term care policies as defined in Title 24-A, section 5051, issued by nonprofit hospital or medical service organizations to contract holders who are obtaining coverage individually or for a group or subgroup to replace coverage under a different contract or policy issued by any self-insurer, insurer, health maintenance organization or nonprofit hospital or medical service organization. For purposes of this section, the individual or group contract issued to replace the prior contract or policy is the "replacement contract." The group contract or policy being replaced is the "replaced contract or policy."

**Sec. D-2. 24 MRSA §2349, sub-§§1 and 2,** as enacted by PL 1989, c. 867, §1 and affected by §10, is amended to read:

**1. Contracts subject to this section.** This section applies to all individual policies and group contracts issued by nonprofit hospital or medical service organizations, except group long-term care policies as defined in Title 24-A, section 5051.

**2. Persons provided continuity of coverage.** Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under a an individual policy or group nonprofit hospital or medical service organization contract if:

A. That person was covered under an individual or group contract or policy issued by any self-insurer, insurer, health maintenance organization, nonprofit hospital or medical service organization, or governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, and the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072, Subsection 4. For purposes of this section, the individual policy or group contract under which the person is seeking coverage is the "succeeding contract." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding contract. A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

**Sec. D-3. 24 MRSA §2349, sub-§3,** as amended by PL 1991, c. 695, §4, is further amended to read:

**3. Exception for late enrollees.** Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. For purposes of this section, a "late enrollee" is a person who requests enrollment under an individual policy or in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment, termination of the individual policy or group policy or group contract under which the individual was covered, death of a spouse or divorce; or

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order.

**Sec. D-4. 24 MRSA §2349, sub-4,** as enacted by PL 1989, c. 867, §1 and affected by §10, is amended to read:

**4. Prohibition against discontinuity.** Except as provided in this section, in an individual policy or a group contract subject to this section, a nonprofit hospital or medical service organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if that contract or policy were still in effect. The issuer of the succeeding contract is not required to duplicate any benefits covered by the issuer of the prior contract or policy.

**Sec. D-5. 24 MRSA §2349, sub-§7** is enacted to read:

**7. Reinsurance, excess insurance or administrative services.** A nonprofit hospital or medical service organization providing reinsurance, excess insurance coverage or administrative services to a plan for the payment of health services by an employer to a group of employees shall provide that the plan and reinsurance and excess insurance coverage meet the requirements of continuity of coverage for a group health insurance policy in this section.

**Sec. D-6. 24-A MRSA §2849, sub-§1,** as repealed and replaced by PL 1991, c. 695, §7 and c. 824, Pt. A, §53, is repealed and the following enacted in its place:

**1. Policies subject to this section.** Notwithstanding any other provision of law, this section applies to all individual and group medical insurance policies issued by insurers or health maintenance organizations to policyholders who are obtaining coverage individually or for a group or subgroup to replace coverage under a different contract or policy issued by any nonprofit hospital or medical service organization, self-insurer, insurer or health maintenance organization. For purposes of this section, the individual or group policy issued to replace the prior contract or policy is the "replacement policy." The group contract or policy being replaced is the "replaced contract or policy."

**Sec. D-7. 24-A MRSA §2849, sub-§3, ¶A,** as repealed and replaced by PL 1991, c. 695, §7 and c. 824, Pt. A, §53, is repealed and the following enacted in its place:

A. Request that the person provide or otherwise seek to obtain evidence of individual insurability. This in no way limits the insurer's right to require information concerning the health of the individuals in the group to determine whether the group as a whole is insurable or to determine rates for the group as a whole;

**Sec. D-8. 24-A MRSA §2849-B, sub-§1,** as amended by PL 1991, c. 695, §9, is further amended to read:

**1. Policies subject to this section.** This section applies to all individual and group medical insurance policies issued by insurers or health maintenance organizations.

**Sec. D-9. 24-A MRSA §2849-B, sub-§2,** as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

**2. Persons provided continuity of coverage.** Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under an individual or a group insurance policy or health maintenance organization policy if:

A. That person was covered under an individual or group contract or policy issued by any nonprofit hospital or medical service organization, self-insurer, insurer, health maintenance organization, or governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, or the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072, Subsection 4. For purposes of this section, the individual or group policy under which the person is seeking coverage is the "succeeding policy." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding policy. A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

**Sec. D-10. 24-A MRSA §2849-B, sub-§3,** as amended by PL 1991, c. 695, §10, is further amended to read:

**3. Exception for late enrollees.** Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. For purposes of this section, a "late enrollee" is a person who requests enrollment in an individual policy or a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract or policy because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment, termination of the individual or group policy or group contract under which the individual was covered, death of a spouse or divorce; or

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order.

**Sec. D-11. 24-A MRSA §2849-B, sub-§4,** as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

**4. Prohibition against discontinuity.** Except as provided in this section, in an individual policy or a group policy subject to this section, an the insurer or health maintenance organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

**Sec. D-12. 24-A MRSA §2949-B, sub-§7** is enacted to read:

**7. Reinsurance, excess insurance or administrative services.** An insurer providing reinsurance, excess insurance

coverage or administrative services to a plan for the payment of health services by an employer to a group of employees shall provide that the plan and reinsurance and excess issuance coverage meet the requirements of continuity of coverage for a group health insurance policy in this section.

## PART E

**Sec. E-1. 24 MRSA c. 21, sub-c. X** is enacted to read:

**SUBCHAPTER X**

**HEALTH CARE PROVIDERS**

**§2981. Health care fees**

The charges for common medical services provided in the office by a health care provider must be posted in a conspicuous place in the office of the health care provider.

**§2982. Referrals by physicians prohibited**

**1. Prohibited referrals.** A physician who has an ownership or investment interest in a diagnostic laboratory or facility, clinical laboratory, physical therapy center or comprehensive rehabilitation center located outside the office of the physician may not refer patients to that laboratory, facility or center.

**2. Ownership or investment interest.** For the purposes of this section, an ownership or investment interest in a diagnostic laboratory or facility, clinical laboratory, physical therapy center or comprehensive rehabilitation center exists when a physician or a member of a physician's immediate family directly or indirectly:

A. Is a general partner, officer, director or employer;

B. Has contributed capital; or

C. Owns, controls or has power to vote.

**§2983. Health provider bargaining**

Notwithstanding any other provision of law, health care providers may join together for the purpose of negotiating the reimbursement rate for Medicaid services.

## PART F

**Sec. F-1. 22 MRSA §304-A, sub-§2,** as amended by PL 1989, c. 919, §4 and affected by §18, is repealed and the following enacted in its place:

**2. Acquisitions of certain major medical equipment.** Acquisitions of major medical equipment with a cost of $1,000,000 or more. There is a waiver for the use of major medical equipment on a temporary basis is provided in section 308, subsection 4;

**Sec. F-2. 22 MRSA §304-A, sub-§2-A** is enacted to read:

**2-A. Establishment of independent medical centers.** Establishment of independent medical centers, acquiring major medical equipment with a cost in the aggregate of $1,000,000 or more, including, but not limited to, independent ambulatory surgical centers, independent catheterization centers and independent radiologic service centers;

**Sec. F-3. 22 MRSA §396-K, sub-§3,** as amended by PL 1991, c. 771, §1, is further amended to read:

**3. Hospital Development Account.** For the 3rd and subsequent payment year cycles, the commission shall establish a ~~Hospital~~ Certificate of Need Development Account to support the development of hospital facilities and services and nonhospital facilities using major medical equipment that receive certificates of need pursuant to section 304-A. This account ~~shall be~~ is administered as follows.

A. The commission shall annually establish, by rule, the amount to be credited to the ~~Hospital~~ Certificate of Need Development Account. In establishing the amount of the credit, the commission shall, at a minimum, consider:

(1) The State Health Plan;

(2) The ability of the citizens of the State to underwrite the additional costs;

(3) The limitations imposed on payments for new facilities and services by the Federal Government pursuant to the United States Social Security Act, ~~Title~~ Titles XVIII and XIX;

(4) The special needs of small hospitals;

(5) The historic needs and experience of hospitals and other facilities subject to this account over the past 5 years;

(6) The amount in the account for the previous years and the level of utilization ~~by hospitals~~ in those years;

(7) Obsolescence of physical plants;

(8) Technological developments; and

(9) Management services or other improvements in the quality of care.

The commission shall report, no later than January 15th of each year, to the joint standing committee of the Legislature having jurisdiction over human resources regarding the rationale the commission used in establishing the amount credited to the ~~Hospital~~ Certificate of Need Development Account in the previous year.

The amount to be credited in a particular payment year cycle ~~will be~~ is deemed credited to the ~~Hospital~~ Certificate of Need Development Account as of the first day of that payment year cycle.

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 increase or decrease the amount of the annual credit by the adoption of a rule change proposed 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 applies solely to the "statewide" component of the credit.

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 ~~Hospital~~ Certificate of Need Development Account as of the date of approval of the project by the department, after accounting for previously approved projects.

F. Debits and carry-overs ~~are~~ must be determined as follows.

(1) Except as provided in subparagraph (2), the commission shall debit against the ~~Hospital~~ Certificate of Need 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 and with each project for which certificate of need approval has been granted pursuant to section 304-A, subsection 2. Incremental annual capital and operating costs ~~are~~ must be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 5, for the 3rd year of implementation of the ~~project~~ projects subject to such an adjustment. For acquisitions of equipment by persons other than hospitals, incremental annual capital and operating costs must be determined in a manner consistent with the manner in which project costs are determined for hospitals.

(2) In the case of a project ~~which~~ that is approved under paragraph C and ~~which~~ that 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) Amounts credited to the ~~Hospital~~ Certificate of Need Development Account for which there are no debits ~~are~~ must be carried forward to subsequent payment year cycles as a credit.

## PART G

**Sec. G-1. 5 MRSA §1543, first ¶,** as repealed and replaced by PL 1979, c. 312, §3, is amended to read:

~~No money shall~~ Money may not be drawn from the State Treasury, except in accordance with appropriations duly authorized by law. Every disbursement from the State Treasury ~~shall~~ must be upon the authorization of the State Controller and the Treasurer of State, as evidenced by their facsimile signatures, except that the Treasurer of State may authorize interbank and intrabank transfers for purposes of pooled investments. Disbursements ~~shall~~ must be in the form of a check or an electronic transfer of funds against a designated bank or trust company acting as a depository of the State Government.

## PART H

**Sec. H-1. 24 MRSA §2979** is enacted to read:

**§2979. Expanded practice parameters; expanded risk management protocols**

The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration may develop practice parameters and risk management protocols in the medical specialty areas not listed in section 2972. The practice parameters must define appropriate clinical indications and methods of treatment within that specialty as determined by the Board of Registration in Medicine and the Board of Osteopathic Examination and Registration. The risk management protocols must establish standards of practice designed to avoid malpractice claims and increase the defensibility of malpractice claims that are pursued. The parameters and protocols must be consistent with appropriate standards of care and levels of quality as determined by the Board of Registration in Medicine and the Board of Osteopathic Examination and Registration. The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration shall review the parameters and protocols, approve the parameters and protocols appropriate for each medical specialty area and adopt rules in accordance with the Maine Administrative Procedure Act.

All practice parameters and risk management protocols adopted pursuant to this section are subject to the provisions of the medical liability demonstration project established in chapter 21, subchapter IX.

## PART I

**Sec. I-1. 20-A MRSA §12101, sub-§10,** as enacted by PL 1991, c. 830, §4 and c. 832, §10, is repealed.

**Sec. I-2. 20-A MRSA §12104, sub-§5, ¶A,** as enacted by PL 1991, c. 830, §4 and c. 832, §10, is amended to read:

A. Upon completion of professional education the student shall repay the loan in accordance with the following schedule.

(1) A loan recipient who does not obtain loan forgiveness pursuant to this section shall repay the entire principal portion of the loan plus simple interest at a rate ~~to--~~be determined by rule of the authority. Interest does not begin to accrue until the loan recipient completes medical education, including residency and internship. The authority may establish differing interest rates to encourage loan recipients to practice primary health care medicine in the State.

(2) Primary health care physicians and dentists practicing in a designated health professional shortage area~~,---any---physician---practicing---in---an---underserved specialty~~ or any physician providing services to a designated underserved group are forgiven the larger of 25% of the original outstanding indebtedness plus any accrued interest or $7,500 for each year of practice.

(3) Veterinarians providing services to Maine residents with insufficient veterinary services are forgiven the larger of 25% of the original outstanding indebtedness plus any accrued interest or $7,500 for each year of practice.

(4) Any student electing to complete an entire residency at any family practice residency program in the State is forgiven 50% of the original outstanding indebtedness for each year of practice in a designated health professional shortage area or as a physician practicing in an underserved specialty ~~or---as---a physician-providing-services-to-an-underserved-group~~.

**Sec. I-3. 20-A MRSA §12107,** as enacted by PL 1991, c. 830, §4 and c. 832, §10, is amended to read:

**§12107. Rules**

The authority shall ~~establish~~ adopt rules necessary to implement this chapter. The Commissioner of Human Services shall develop rules for determining health professional shortage areas for the practice of primary health care medicine and dentistry, for determining the reasonableness of the service provided by loan recipients to Medicaid and Medicare patients and participation by loan recipients in public health clinics, and for determining underserved groups ~~and---for---determining underserved-specialties~~. The Commissioner of Agriculture, Food and Rural Resources shall develop rules for the determination of insufficient veterinary services. The rules authorized by this section must be adopted in accordance with Title 5, chapter 375, subchapter II.

## PART J

**Sec. J-1. 32 MRSA §1082,** as amended by PL 1983, c. 378, §11, is further amended to read:

**§1082. Qualifications**

Before receiving a certificate to practice dentistry in this State, a person ~~shall~~ must be at least 18 years of age and ~~shall~~ be a graduate of or have a diploma from an acceptable dental

college, school or dental department of a domestic or foreign university approved by the board.

## PART K

**Sec. K-1. 22-A MRSA** is enacted to read:

**TITLE 22-A**

**HEALTH**

**PART 1**

**ADMINISTRATION AND ORGANIZATION**

**CHAPTER 1**

**DEPARTMENT OF HEALTH**

**§101. Department established**

The Department of Health is established to provide health services to the citizens in this State.

**§102. Definitions**

As used in this Part, unless the context otherwise indicates, the following terms have the following meanings.

**1. Commissioner.** "Commissioner" means the Commissioner of Health.

**2. Department.** "Department" means the Department of Health within the executive branch responsible for administering multiple major programs and multimillion dollar budgets to provide health services pursuant to provisions of state and federal laws.

**§103. Commissioner**

**1. Appointment.** The department is administered by a commissioner appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health matters and confirmation by the Legislature. The commissioner serves at the pleasure of the Governor.

**2. Qualifications.** The qualifications of the commissioner must include postgraduate education and extensive experience in the fields of health and public administration, public policy analysis and development, public financial and program administrative matters and must be knowledgable concerning the

relationship between the legislative and executive branchs of State Government.

**3. Application.** Notwithstanding the establishment of the department in this Part, the department may not undertake administration of programs or services until the legislation developed by the Commission on the Establishment of the Department of Health is adopted.

**Sec. K-2. Acting commissioner.** Until the legislation proposed by the Commission on the Establishment of the Department of Health is enacted, the Commissioner of Human Services is the Acting Commissioner of Health.

**Sec. K-3. Reorganization of health services.** It is the intent of the Legislature that by July 1, 1994 the Department of Health be established and have jurisdiction over health services currently performed by other state departments, including, but not limited to, the Department of Human Services, the Department of Mental Health and Mental Retardation and the Office of Substance Abuse. The establishment of the Department of Health must be accomplished without diverting any direct service funds or incurring additional administrative costs.

## PART L

**Sec. L-1. Commission on the Establishment of the Department of Health.**

1. The Commission on the Establishment of the Department of Health, referred to in this section as the "commission," is established and consists of 13 members of the Legislature, including 3 Senators appointed by the President of the Senate and 10 members of the House of Representatives appointed by the Speaker of the House of Representatives as follows:

A. Two members of the Joint Standing Committee on Appropriations and Financial Affairs;

B. Two members of the Joint Standing Committee on Banking and Insurance;

C. Four members of the Joint Standing Committee on Human Resources;

D. Two members of the Joint Standing Committee on State and Local Government; and

E. Three additional members of the Legislature.

Each appointing authority shall ensure that the composition of appointees from the authority's chamber reflects the proportion of majority and minority parties in that chamber. All members must be appointed by July 1, 1993. The commission is abolished on January 1, 1994.

2. The Chair of the Legislative Council shall call the first meeting of the commission within 30 days of the appointment of all commission members no later than August 1, 1993. At that meeting, the commission shall select a chair from among its members.

3. The chair of the commission may form working groups on an ad hoc basis to develop legislative proposals to the full commission. A working group must consist of at least 3 members who are Legislators and who are members of the commission in addition to any other persons the chair may appoint as nonvoting members of the working group.

4. The commission may request staffing assistance within existing resources from the Legislative Council.

5. All officials of the Department of Human Services, the Department of Mental Health and Mental Retardation and the Office of Substance Abuse shall provide information, advice and assistance to the commission upon request.

6. The members of the commission are not entitled to the legislative per diem pursuant to the Maine Revised Statutes, Title 3, section 2.

7. The Executive Director of the Legislative Council shall administer the commission's budget.

8. The commission shall develop, with the advice and assistance of officials of the executive branch, all legislation needed to implement the reorganization of services in accordance with this Act, including amendments to the laws, reallocation of funds and transitional language as needed. The legislation, together with a report identifying specific positions that are added or deleted as a result of the reorganization, must be submitted to the Executive Director of the Legislative Council and to the Joint Standing Committee on State and Local Government by November 1, 1993 for consideration during the Second Regular Session of the 116th Legislature.

9. The legislation prepared by the commission must include the following.

A. The Department of Health must be established containing the following functional clusters: public health; medical

care finance; substance abuse; mental health; developmental services and physical disability; and aging.

(1) The public health cluster includes, but is not limited to:

(a) All functions of the Department of Human Services, Bureau of Health;

(b) All functions of the Department of Human Services, Bureau of Medical Services, Office of Health Planning;

(c) All functions of the Department of Human Services, Office of Vital Statistics; and

(d) All AIDS case management and other AIDS-related services.

(2) The medical care finance cluster includes, but is not limited to:

(a) All functions of the Department of Human Services, Bureau of Medical Services.

(3) The substance abuse cluster includes, but is not limited to:

(a) All functions of the Executive Department, Office of Substance Abuse.

(4) The mental health cluster includes, but is not limited to:

(a) All adult services provided by the Department of Mental Health and Mental Retardation, Bureau of Mental Health; and

(b) The Bangor Mental Health Institute and the Augusta Mental Health Institute.

(5) The developmental services and physical disability cluster includes, but is not limited to:

(a) All adult services provided by the Department of Mental Health and Mental Retardation, Bureau of Mental Retardation, except guardianship services;

(b) The Aroostook Residential Center and Pineland Center; and

(c) All services of the Department of Human Services, Bureau of Rehabilitation, except services for people with visual impairments and services related to job training and placement.

(6) The aging cluster includes, but is not limited to:

(a) All functions of the Department of Human Services, Bureau of Elder and Adult Services; and

(b) All adult protection and adult guardianship functions.

B. A universal information and referral system for all health services must be established and phased in as funds become available.

C. A single case management system responsive to unique consumer needs must be established within the Department of Health.

## PART M

**Sec. M-1. Report on Multiple Employer Welfare Arrangements.** The Bureau of Insurance shall study the regulation of fully and partially insured Multiple Employer Welfare Arrangements under the Employment Retirement Income Security Act of 1974, Section 514(b)(6)(A) and submit a report and implementing legislation to the Joint Standing Committee on Banking and Insurance on or before March 1, 1993.

**Sec. M-2. Report on preexisting conditions exclusion periods.** The Bureau of Insurance shall undertake a study and report to the Joint Standing Committee on Banking and Insurance on or before March 1, 1993 on the length of time of preexisting condition exclusion periods, including the option of making the period run for a minimum of 3 months and a maximum corresponding to the length of time a person is eligible to receive unemployment compensation.

**Sec. M-3. State Medicaid Plan amendment.** By July 1, 1993, the Department of Human Services shall submit for approval to the appropriate federal authorities an amendment to the state Medicaid plan to provide Medicaid coverage, to pregnant women and infants, on a sliding fee scale from 185% to 285% of the federal poverty level. The department shall devise the sliding fee scale in a manner that raises sufficient funds from consumers to provide all of the state financial match for the services proposed under this section.

**Sec. M-4. Standardized billing forms, instructions and procedures for completion.** The Bureau of Insurance is directed to work cooperatively with the Department of Health and the

Department of Human Services and agencies in other states toward the development of standardized billing forms, instructions and procedures for completion of the forms.

**Sec. M-5. Examination of barriers to electronic billing and payment.** The Department of Human Services and the Bureau of Insurance are directed to examine the barriers to increasing the rate of standardized electronic billing and payment in the Medicaid, Maine Health Program and any other program administered by the Bureau of Medical Services.

**Sec. M-6. Report on medical malpractice rate setting.** The Superintendent of Insurance shall review and report to the Joint Standing Committee on Banking and Insurance on or before March 1, 1993 on the current rate-setting procedures for medical malpractice insurance.

**Sec. M-7. Report on medical malpractice screening panels and dispute resolution systems.** The Superintendent of Insurance is directed to review the arbitration panels for medical malpractice established in the Vermont Statutes Annotated, Title 12, section 7001 et seq. and the mandatory prelitigation screening and mediation panels established in the Maine Revised Statutes, Title 24, chapter 21, subchapter IV. The Superintendent of Insurance is directed to consult with interested parties, including, but not limited to, consumers, trial attorneys and physicians, to develop a proposal for a nonadversarial dispute resolution system for addressing small claims. A preliminary report must be submitted to the Joint Standing Committee on Banking and Insurance as soon as possible. A final report containing implementing legislation must be submitted to the Executive Director of the Legislative Council and to the Joint Standing Committee on Banking and Insurance by March 1, 1993.

## PART N

**Sec. N-1. Special Committee to Study Health Care Professions.** There is established the Special Committee to Study Health Care Professions composed of 6 Legislators and 3 members of the public for the purpose of studying the allocation of human and financial resources in health care.

1. The Governor shall appoint 3 members to represent the interests of the public. The President of the Senate shall appoint 3 members of the Senate. The Speaker of the House of Representatives shall appoint 3 members of the House of Representatives. All appointments must be made within 30 days of the effective date of this Act.

2. The President of the Senate shall convene the first meeting of the committee and the members shall select a chair and vice-chair.

3. The committee shall complete a study and submit a report to the Joint Standing Committee on Banking and Insurance on or before January 1, 1994 on the qualifications and full utilization of health care professionals, identifying the legal barriers to appropriate utilization and the extent to which health policies determine health care policy, the degree to which health care professionals drive the system and the effect of full and partial participation of health care professionals in health care programs funded by the public sector. The committee may request staff assistance from the Legislative Council.

## PART O

**Sec. O-1. Information on federal health insurance earned income tax credit.** The Bureau of Insurance and the Bureau of Taxation are directed to jointly publish and distribute information for the public on the federal health insurance earned income tax credit.

**Sec. O-2. Report on unification of administration of all publicly funded and publicly administered health insurance programs.** The Department of Human Services is directed to report to the Joint Standing Committee on Banking and Insurance on or before March 1, 1993 on options for the unification of administration of all publicly funded and publicly administered health insurance programs.

**Sec. O-3. Report on single point of entry and eligibility determinations.** The Department of Human Services is directed to report to the Joint Standing Committee on Banking and Insurance on or before March 1, 1993 on single point of entry and eligibility determinations utilizing the FAMIS computer system.

**Sec. O-4. Report on the feasibility of combining the medical portion of automobile insurance and health insurance.** The Bureau of Insurance is directed to report to the Joint Standing Committee on Banking and Insurance on or before January 1, 1994 on the feasibility of combining the medical portion of automobile insurance and health insurance.

**Emergency clause.** In view of the emergency cited in the preamble, this Act takes effect when approved.

## STATEMENT OF FACT

This bill accomplishes the following.

1. Part A allows groups to purchase health insurance and subjects those groups to the community rating law, Public Law 1991, chapter 861. It allows municipalities to assist residents in the purchase of health insurance.

2. Part B expands the community rating law, Public Law 1991, chapter 861, by making it applicable to individual policies and to employee groups of fewer than 50 employees and by prohibiting gender based rating.

3. Part C requires the Bureau of Insurance to collect insurance data that distinguishes health policies from other policies, policies sold to people age 65 and older, disability policies from other policies, policies offering primary care case management from other policies, individual policies from group policies and Maine data from national data.

4. Part D applies the continuity law, the Maine Revised Statutes, Title 24-A, chapter 36, to persons moving from group to individual policies, to persons who are leaving their jobs with self-insured employers for new jobs, thus changing from the health plan of the self-insured employers to group or individual insurance policies and Part D also applies the continuity law to persons moving from individual or group policies to self-insured employers with health plans that utilize reinsurance policies.

5. Part E requires health care providers to post in their offices the charges for medical services provided in the office. Part E prohibits a physician, who has an ownership or investment interest in a diagnostic laboratory or facility, clinical laboratory, physical therapy center or comprehensive rehabilitation center located outside the office of the physician, from referring patients to the laboratory, facility or center. It allows health care providers to join together to negotiate the reimbursement rate for Medicaid services.

6. Part F expands the certificate of need requirements to physicians' offices acquiring equipment of $1,000,000 or more.

7. Part G amends the law that currently prohibits funds from being transmitted electronically to providers.

8. Part H authorizes the Board of Registration in Medicine and the Board of Osteopathic Examination and Registration to expand work on practice parameters, approving them and adopting them as rules. The new parameters and protocols are subject to the medical liability demonstration project.

9. Part I removes "underserved specialty" as eligible service and reemphasizes primary care in underserved areas in the Health Professions Loan Program.

10. Part J allows the licensing of foreign trained dentists by the Board of Dental Examiners.

11. Part K establishes the Department of Health.

12. Part L establishes the Commission on the Establishment of the Department of Health to plan for the new agency.

13. Part M-1 directs the Bureau of Insurance to study the feasibility of a regulatory scheme for Multiple Employer Welfare Arrangements, MEWA's, that are not fully insured and to submit its report, along with implementing legislation, to the Joint Standing Committee on Banking and Insurance by March 1, 1993.

14. Part M-2 directs the Bureau of Insurance and the Department of Labor to submit a report to the Joint Standing Committee on Banking and Insurance by March 1, 1993, on the question of making the preexisting condition exclusion period run for at least 3 months and up to the period of a person's eligibility for unemployment compensation.

15. Part M-3 directs the Department of Human Services to amend the state Medicaid plan to include children and pregnant women who are not receiving cash assistance on a sliding fee scale up to 285% of the federal poverty level.

16. Part M-4 directs the Superintendent of Insurance to work cooperatively with the Federal Government and other states toward the development of standardized billing forms, instructions and procedures for the completion of the forms.

17. Part M-5 directs the Department of Human Services and the Bureau of Insurance to examine barriers to increasing the rate of standardized electronic billing in the Medicaid, Maine Health Program and other programs administered by the Bureau of Medical Services.

18. Part M-6 directs the Superintendent of Insurance to examine Maine's current rate-setting procedures for medical malpractice insurance and to report to the Joint Standing Committee on Banking and Insurance by March 1, 1993.

19. Part M-7 directs the Superintendent of Insurance to review Vermont's medical malpractice arbitration system and Maine's medical malpractice screening panels and propose a nonadversarial dispute resolution system for addressing smaller claims. The proposal must be developed in consultation with all interested parties, including, but not limited to, consumers, trial attorneys and physicians. A report to the Joint Standing Committee on Banking and Insurance is due March 1, 1993, containing the review and legislation. A preliminary report is due as soon as possible.

20. Part N-1 establishes a Special Committee to Study Health Care Professions, comprised of 6 legislators and 3 members of the public to study the allocation of human and financial resources in health care. The committee is charged with completing its study and reporting back to the Joint Standing Committee on Banking and Insurance on January 1, 1994.

21. Part O-1 directs the Bureau of Insurance, in cooperation with the Bureau of Taxation, to put together information on the federal health insurance earned income tax credit for distribution to consumers.

22. Part O-2 directs the Department of Human Services to report by March 1, 1993 to the Joint Standing Committee on Banking and Insurance on the options for unifying the administration of all health insurance programs that are publicly funded or publicly administered.

23. Part O-3 directs the Department of Human Services to report by March 1, 1993 to the Joint Standing Committee on Banking and Insurance on single point of entry and eligibility determinations utilizing the FAMIS computer system.

24. Part O-4 directs the Bureau of Insurance to report to the Joint Standing Committee on Banking and Insurance on or before January 1, 1994 on the feasibility of combining the medical portion of automobile insurance and health insurance.