117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document **No. 1219**

H.P. 869 House of Representatives, April 5, 1995

An Act to Consolidate Health Care Planning, Oversight and Regulation in Maine.

Reference to the Committee on Human Resources suggested and ordered printed.

JOSEPH W. MAYO, Clerk

Presented by Representative AHEARNE of Madawaska.

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

Sec. 1. 5 MRSA §12004-G, sub-§19-A is enacted to read:

19-A.	State Health Coordinating Council	Legislative Per Diem	22 MRSA §282
Human Services/Health			

Sec. 2. 22 MRSA §1, as amended by PL 1993, c. 658, Pt. B, §2, is further amended by adding at the end a new paragraph to read:

The commissioner, after consultation with the Maine Health Care Authority Board, shall appoint the Director of the Maine Health Care Authority, who shall serve in the unclassified service at the pleasure of the commissioner and the board.

Sec. 3. 22 MRSA c. 102 is enacted to read:

CHAPTER 102

HEALTH CARE AUTHORITY

SUBCHAPTER I

ORGANIZATION; POWERS AND DUTIES

§271. Definitions

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

1. Authority. "Authority" means the Maine Health Care Authority established under section 272.

2. Board. "Board" means the Maine Health Care Authority Board established under section 272.

3. Common benefits. "Common benefits" means, at a minimum, medically necessary and appropriate medical services and preventative care, as determined by the authority.

4. Community rate. "Community rate" means the rate to be charged to all eligible individuals and groups for health care coverage based on statewide rating.

5. Health care expenditure target or target. "Health care expenditure target" or "target" means the amount determined by the authority annually to be expended for health care services in the State.

6. Health resource management plan. "Health resource management plan" means the plan adopted by the authority under section 273, subsection 2.

7. Insurer. "Insurer" includes all insurers as defined in 24-A, section 4 that provide health insurance as defined in Title 24-A, section 704 and includes without limitation nonprofit hospital and medical service corporations, health maintenance organizations, 3rd-party administrators of health care plans, health insurance programs administered by the State and, to the extent permitted under federal law, the Medicare and Medicaid programs and self-funded health benefit plans.

8. State agency. "State agency" means any agency, department, division, office, council, board or other state entity administering a program that pays for health care services or maintains data related to the utilization or costs of health care services.

§272. Maine Health Care Authority and board established

1. Authority established. The Maine Health Care Authority is established to design a universal access health care system for the people of this State and to ensure that this universal health care system functions in an efficient, cost-effective manner.

2. Board established. The Maine Health Care Authority Board is established to supervise and direct the authority. The board consists of a chair and 2 members, who must be appointed by the Governor subject to confirmation by the Legislature. All members must be conversant with the organization, delivery, financing and purchase of health care services. The Governor shall designate one member to serve as chair of the State Health Coordinating Council and the other member to serve as chair of both the Certificate of Need Advisory Committee and the Maine Health Care Finance Commission.

3. Terms of members. The chair serves for a term of 2 years. The 2 other members serve for terms of 6 years, except that the initial appointment of one of these members must be for a term of 3 years.

4. Vacancies. If a vacancy occurs in the membership of the board, the vacancy must be filled in the same manner as the original appointment for the unexpired portion of the term of the original appointee.

5. Removal for cause. The Governor may remove a member for just cause.

6. Compensation. The members of the board are full-time employees in the unclassified service. The annual salary of the chair and each member is the same as the annual salary for a Superior Court Judge.

§273. Board; powers and duties

The board shall:

1. Unified health care budget. Beginning January 1, 1996 and annually thereafter, adopt a unified health care budget. The budget must:

A. Serve as the basic framework within which health care costs are controlled, resources directed and quality and access ensured;

B. Establish the total amount of money to be spent annually for all health care services provided by health care facilities and providers in the State and for all health care services provided to residents of this State;

C. Be consistent with the health resource management plan adopted under subsection 2;

D. Establish the total amounts paid for services provided by various sectors of the health care system; and

E. Apply to the hospital budget review and the certificate of need review and any other regulatory mechanism in which its application is authorized by law.

When preparing the budget, the board shall consider health care costs and the impact of the budget on those who receive, provide and pay for health care services.

The board shall adopt, by rule, the various sectors of the health care system to be separately identified in the budget, those methods and processes used to allocate resources among those sectors, the economic indicators used to define the parameters of the rate of growth in the cost of the system and various sectors of the system and processes and criteria for responding to exceptional and unforeseen circumstances that affect the system and the budget.

The board shall enter into discussions or nonbinding negotiations with health care facilities and with any health care provider bargaining groups created under this chapter concerning matters related to the sectors of the unified health care budget. By May 1, 1997, and annually thereafter, the board shall present a proposed budget to the State Health Coordinating Council for

review. The State Health Coordinating Council shall hold public hearings on the proposed budget and forward its recommendations to the board. After receiving the recommendations and before adoption of a unified health care budget, the board shall hold one or more public hearings for the purpose of receiving oral and written comment on the proposed budget;

2. State health plan. Beginning March 15, 1996, and every 2nd year thereafter, adopt a health resource management plan;

3. Certificate of need. Administer the certificate of need program;

4. Common benefits package. By January 1, 1996, determine the scope and duration of a common benefits package that on January 1, 1997 becomes the minimum standard for any health insurance plan offered in the State. Additional coverage may be offered as riders to the package. The package must be reviewed annually for adequacy and modification;

5. Prescription drugs and medical equipment. Develop, implement and require a unified system for the purchase of prescription drugs, medical equipment and supplies on behalf of persons enrolled in any plan of health benefits developed or administered by the authority;

6. Employees. Employ an executive director, who is an unclassified employee, and other professional and support staff required to carry out the functions of the board. The board may employ consultants and may contract with individuals and entities for the provision of services;

7. Technical assistance. In conjunction with the Bureau of Health, provide assistance to local communities, institutions and provider groups in the development of organized primary health care systems in the State;

8. Quality assurance. Designate a quality review panel and implement a mechanism for ongoing quality assurance and utilization review; and

9. Standardization. Require all insurers and companies that offer utilization review services to apply the standard criteria and procedures established by the authority, use common claims forms and participate in other common practices, including service delivery practices, that the authority determines to be cost-effective. The procedures developed under this section must be consistent with those required of patients whose care is reimbursed by the Medicare and Medicaid programs.

§274. Additional powers

The authority may:

1. Accept gifts and funds. Apply for and accept gifts, grants or contributions from any person for purposes consistent with this chapter;

2. Adopt rules. Adopt rules necessary to implement this chapter;

3. Advisory groups. Establish advisory groups as necessary to assist the authority in carrying out its duties;

4. Contracts. Enter into contracts, perform any acts or make any arrangements necessary to accomplish the purposes of this chapter;

5. Technical assistance. Provide technical assistance or make grants to individuals and public and nonprofit private entities consistent with state and federal law for the development of projects and programs that the authority determines are necessary to achieve its objectives;

6. Approval for reviews. Seek approval from the federal Health Care Financing Administration to conduct the required reviews of patients whose care is reimbursed by the Medicare and Medicaid programs according to procedures established by the authority;

7. Waivers. Apply for waivers authorized by federal law or regulations necessary to accomplish the purposes of this chapter;

8. Phase in enrollment. Phase in enrollment of individuals and employer groups under section 276, subsection 3;

9. Relative value scale. Require insurers to adopt a resource-based relative value scale for reimbursement of providers;

10. Practice guidelines. Require insurers to use practice guidelines adopted by the authority as a basis for payment;

11. Quality review organization. Use the services of the quality review panel designated by the authority to assist in the analyses and use of health services in the State to carry out special studies of the use of health services and to develop standards of care and practice guidelines; and

12. Cost containment. Require all insurance companies, nonprofit hospital and medical service corporations and health

maintenance organizations doing business in the State to submit a plan for cost containment and proposals for the development of organized systems for health care delivery by January 1, 1996. The authority and the Superintendent of Insurance shall evaluate these plans and submit their findings and recommendations to the Legislature before January 15, 1996.

§275. Production and examination of books and witnesses

The authority may examine the books, accounts and papers of any person subject to this chapter and may require the filing of reports, data, schedules, statistics or information as needed to carry out those functions.

Reports, data, schedules, statistics and information must be filed at the time and place and in the manner established by the authority.

Records and information protected by confidentiality or otherwise required by law are not subject to this section.

§276. Public sponsor of common benefits plan

1. Negotiations for common benefits. The authority shall serve as the public sponsor of a common benefits plan and the administrator and single negotiator with hospitals and health care providers for common benefits provided by the plan. In negotiating reimbursement rates under this section, the authority shall negotiate with provider organizations such as the Maine Medical Association, the Maine Hospital Association and other professional health care provider groups. The common benefits plan should encourage appropriate utilization of medical services that do not unduly restrict patient freedom of choice of provider.

2. Restrictions on appropriations. Common benefits supported, in whole or in part, by appropriations from the General Fund must be provided by the common benefits plan in accordance with subsection 1.

3. Coverage of uninsured persons. The authority shall subsidize and make common benefits available to all otherwise uninsured individuals and groups. For purposes of this subsection, the authority shall establish a sliding fee scale premium structure based on the income of enrollees.

4. Availability of benefits. The authority may make common benefits available under the common benefits plan upon payment of the premium determined by the authority to individuals and public and private employer groups.

5. Universal access. If a universal access health care system is authorized by the Legislature, the authority shall subsidize and make common benefits available under the plan available to otherwise uninsured individuals and groups who are not eligible for a subsidy under subsection 3. For purposes of this subsection, the authority shall establish a sliding fee scale premium structure based on the income of enrollees.

§277. Health Insurance Trust Fund

1. Establishment. A Health Insurance Trust Fund, referred to in this chapter as the "fund," is established, separate and apart from all other funds of the State, for the purpose of implementing the common benefits plan authorized under section 276. The authority shall administer the fund.

2. Assets. The fund consists of all tax revenues dedicated to the fund including payments from the increase in the cigarette tax from 18.5 mills to 21.0 mills levied pursuant to Title 36, section 4365-D, beginning in fiscal year 1996; all premiums, fees, contributions and money from any source paid into the State Treasury and credited to the fund and all money appropriated to the fund; all property and securities acquired by the fund; and all interest earned by the fund, less withdrawals from the fund for payments made in connection with administration of plan benefits, expenses of the authority and other expenses authorized under this chapter.

3. Reversion. All money appropriated from the General Fund to support the common benefits plan, in whole or in part, that is saved as a result of participation in the plan under section 276, subsection 2 must revert to the fund.

4. Withdrawals. The authority may withdraw from the fund the amounts necessary to provide benefits for persons enrolled in the common benefits plan.

§278. Report required

Annually, on January 15, the authority shall file a report with the President of the Senate, the Speaker of the House of Representatives and the Commissioner of Human Services. The report must include:

1. Budget review evaluation. An evaluation of budget reviews and the effect on health care expenditures;

2. Progress. The progress made in implementing this chapter; and

3. Certificate of need approvals. A summary of certificate of need applications approved in the preceding year.

SUBCHAPTER II

STATE HEALTH COORDINATING COUNCIL

§281. Definitions

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

1. Council. "Council" means the State Health Coordinating Council.

2. Provider. "Provider" means an individual who:

A. Is a direct provider of health care, including a physician, dentist, nurse, podiatrist, physician assistant or ancillary personnel employed under the supervision of a physician, whose primary current activity is the provision of health care to individuals or the administration of facilities or institutions, including hospitals, long-term care facilities, rehabilitation facilities, alcohol and drug abuse treatment facilities, outpatient facilities and health maintenance organizations, in which such care is provided and who, when required by law, has received professional training in the provision of such care or administration and is licensed or certified;

B. Is an indirect provider of health care and who:

(1) Holds a fiduciary position with, or has a fiduciary interest in, any entity described in subparagraph 2, division (b) or (d); except that this subparagraph does not apply to a board member of an entity described in the Internal Revenue Code of 1954, Section 501 (c) (3), as amended, as long as the person is not otherwise a provider;

(2) Receives either directly or from a spouse more than 1/5 of that person's gross annual income from any one or combination of the following:

(a) Fees or other compensation for research into or instruction in the provision of health care;

(b) Entities engaged in the provision of health care or in research or instruction in the provision of health care;

(c) Producing or supplying drugs or other articles for persons or entities for use in the provision of or in research into or instruction in the provision of health care; or

(d) Entities engaged in producing drugs or such other articles;

C. Is a member of the immediate family of an individual described in this subsection; or

D. Is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

3. Public member. "Public member" means an individual who represents the public and who is not a provider.

4. Third-party payor. "Third-party payor" means any health insurer or nonprofit hospital or medical insurance corporation as defined in Title 24-A.

5. Mid-level practitioner. "Mid-level practitioner" includes physician assistants, nurse practitioners and certified nurse midwives.

§282. State Health Coordinating Council; established; membership

1. Establishment. The State Health Coordinating Council is established under the Maine Health Care Authority established in section 272. The council shall serve in an advisory capacity to the authority.

2. Membership. The council consists of 31 members who must be residents of the State. The Governor shall appoint 23 members. Members appointed by the Governor, except at-large members, are appointed from a list of 3 nominees for each membership category submitted in accordance with subsection 3. Before making an appointment, the Governor may request a new list of nominees for any category. Nominations by the authority and appointment by the Governor must be made in a manner designed to ensure representation from all geographic areas of the State. The Governor shall appoint:

A. One provider member from each of the following categories: physicians, hospitals, nurses, dentists, allied health professions, 3rd-party payors, providers of mental health services, long-term health care facilities and providers of community health services;

B. Two public members from each of the following categories: low-income, elderly, handicapped, labor and environmental health;

C. Two public members representing major purchasers of health care from the private sector; and

D. Two at-large members.

Four members must be members of the Legislature: 2 Senators appointed by the President of the Senate and 2 Representatives appointed by the Speaker of the House of Representatives.

The remaining 4 members are the Commissioner of Human Services, the Dean of the College of Osteopathic Medicine at the University of New England, a representative of the Bureau of Health or a designee and the supervisor of the Division of Veterans' Services, or the supervisor's designee, who is a nonvoting member.

3. Membership committee. The authority shall establish a council membership committee for purposes of initiating the selection of representatives in accordance with subsection 2, paragraphs A and B. For the purposes of convening the initial nomination meeting, the council membership committee shall notify organizations in each category and through notices published in papers of general circulation in the State invite additional organizations to participate. The council membership committee may decline to accept an organization whose stated purposes do not coincide with the interests of the designated constituency, but an organization may not be excluded for any other reason. The council shall establish by rule a grievance procedure for organizations excluded under this section. The membership committee may adopt temporary rules for the organizational meetings of nominating committees. Thereafter, the nominating committees may adopt their own rules of procedure, except that all matters to be decided by a nominating committee must be decided by a majority vote of members present at a duly warned and convened meeting and not by a majority of organizations represented and nominees must be members of categories to be represented.

4. Terms. Members who are members of the Legislature serve for 2 years or until their successors are appointed, beginning February 15th in the first year of each biennium. The other members serve for 3-year terms or until their successors are appointed, beginning February 15th in the year in which the appointments are made. A member may not serve for more than a total of 6 years.

5. Vacancies. If a vacancy occurs in the membership of the council, the vacancy must be filled for the unexpired portion of the term in the same manner as the original appointment.

§283. Officers and meetings

1. Officers. The council shall elect a chair and a vice-chair from its membership, who shall serve for one year or until their successors are elected.

2. Voting. A majority of the members of the council constitute a quorum if 7 of the members present are public members. The council may act only by vote of a majority of its members present and voting at a meeting called after adequate notice to all its members and at which a quorum is in attendance.

3. Compensation. Members of the council, except for legislative members while the Legislature is in session, are entitled to per diem in the amount of the legislative per diem.

§284. Duties of council

The council shall:

1. Advise authority. Advise the authority on matters related to the authority's responsibilities;

2. Conduct studies. Carry out special studies or projects related to health care or the duties of the authority as requested by the authority, including the assessment of the need for and appropriate distribution of services and technologies;

3. Prepare plan. Before January 15, 1996, and every 3rd year thereafter, recommend a health resource management plan to the board. The health resource management plan must identify the health care, facility and human resource needs in the State, the resources available to meet those needs and priorities for addressing those needs on a statewide basis.

A. The health resource management plan must include:

(1) A statement of principles used in the allocation of resources and in establishing priorities for health services;

(2) Identification of the current supply and distribution of hospital, nursing home and other inpatient services; home health and mental health

services; treatment services for alcohol and drug abuse; emergency care; ambulatory care services including primary care resources; human resources; major medical equipment; and health screening and early intervention services;

(3) A determination of the appropriate supply and distribution of the resources and services identified in subparagraph (2) and mechanisms that encourage the appropriate integration of these services on a local or regional basis. In making this determination, the council shall consider the following factors: the needs of the population on a statewide basis; the needs of particular geographic areas of the State; the use of facilities in this State by out-of-state residents; the use of out-of-state facilities by residents of this State; the needs of populations with special health care needs; the desirability of providing high-quality services in an economical and efficient manner including the appropriate use of mid-level practitioners; and the cost impact of these requirements on health care expenditures; and

(4) A component that addresses health promotion and disease prevention prepared by the Bureau of Health in a format established by the authority.

B. The council shall conduct at least 5 public hearings, in different regions of the State, on the health resource management plan as proposed and give interested persons an opportunity to submit their views orally and in writing. To the extent possible, the council shall arrange for hearings to be broadcast on interactive television. Not less than 30 days before each hearing, the authority shall publish in a newspaper of general circulation in the region the time and place of the hearing, the place where interested persons may review the plan in advance of the hearing and the place to which and period during which written comment may be directed to the council;

4. Recommendations. Review and make recommendations concerning the unified health care budget proposed by the authority as provided in section 273; and

5. Certificate of need. Be a party to any certificate of need review.

Sec. 4. 22 MRSA §303, sub-§2-C is enacted to read:

2-C. Authority. "Authority" means the Maine Health Care Authority established under section 272.

Sec. 5. 22 MRSA §303, sub-§2-D is enacted to read:

2-D. Board. "Board" means the Maine Health Care Authority Board established under section 272.

Sec. 6. 22 MRSA §303, sub-§5, as enacted by PL 1981, c. 705, Pt. V, §3, is repealed.

Sec. 7. 22 MRSA §303, sub-§20, as enacted by PL 1977, c. 687, §1, is repealed and the following enacted in its place:

20. State Health Coordinating Council. "State Health Coordinating Council" means the council established in Title 5, section 12004-G, subsection 19-A.

Sec. 8. 22 MRSA §303, sub-§21, as amended by PL 1985, c. 418, §3, is repealed and the following enacted in its place:

21. State health plan. "State health plan" means the health resource management plan adopted by the Maine Health Care Authority Board under section 273.

Sec. 9. 22 MRSA §304-A, 2nd ¶, as amended by PL 1987, c. 725, §1, is further amended to read:

Except as provided in sections 304-D and 304-E, a certificate of need from the ~~department shall be~~ authority is required for:

Sec. 10. 22 MRSA §304-A, sub-§4, ¶C, as enacted by PL 1981, c. 705, Pt. V, §16, is amended to read:

C. The addition of a health service ~~which~~ that falls within a category of health services ~~which~~ that are subject to review regardless of capital expenditure or operating cost and ~~which category~~ that the ~~department~~ authority has defined through regulations promulgated pursuant to section 312, based on recommendations from the State Health Coordinating Council;

Sec. 11. 22 MRSA §304-A, sub-§6-A, ¶B, as enacted by PL 1989, c. 919, §8 and affected by §18, is amended to read:

B. Increases the number of beds licensed or certified by the ~~department~~ authority to provide a particular level of care by more than 10% of that number or more than 5 beds, whichever is less;

Sec. 12. 22 MRSA §304-A, sub-§9, ¶B, as amended by PL 1985, c. 418, §4, is further amended to read:

B. If a person adds a health service not subject to review under subsection 4, paragraph A or C ~~and which~~ that was not ~~deemed~~ considered subject to review under subsection 4, paragraph B at the time it was established and ~~which~~ was not reviewed and approved prior to establishment at the request of the applicant, and its actual 3rd fiscal year operating cost, as adjusted by an appropriate inflation deflator ~~promulgated~~ adopted by the ~~department,~~ authority after consultation with the Maine Health Care Finance Commission, exceeds the expenditure minimum for annual operating cost in the 3rd fiscal year of operation following addition of these services.

Sec. 13. 22 MRSA §304-B, sub-§1, as enacted by PL 1981, c. 705, Pt. V, §17, is amended to read:

1. Criteria for subsequent review. The following activities require subsequent review and approval, if the ~~department~~ authority has previously issued a certificate of need and if within one year after the approved activity is undertaken:

A. There is a significant change in financing;

B. There is a change affecting the licensed or certified bed capacity as approved in the certificate of need;

C. There is a change involving the addition or termination of the health services proposed to be rendered by the facility;

D. There is a change in the site or the location of the proposed facility; or

E. There is a substantial change proposed in the design of the facility or the type of construction.

Sec. 14. 22 MRSA §304-B, sub-§2, as amended by PL 1985, c. 418, §5, is further amended to read:

2. Procedures for subsequent review. Any person proposing to undertake any activity requiring subsequent review and approval shall file with the ~~department~~ authority, within 30 days of the time that person first has actual knowledge of the circumstances requiring subsequent review, a notice setting forth the following information:

A. The nature of the proposed change;

B. The rationale for the change including, where appropriate, an explanation of why the change was not set forth in the original application or letter of intent; and

C. Other pertinent detail subject to the procedures and criteria set forth in section 309.

The ~~department~~ authority shall, within 30 days of receipt of the information, advise that person in writing whether the proposed change is approved. If not approved, the application ~~shall~~ must be treated as incomplete and reviewed in accordance with the application procedures in section 306-A, subsection 4. If approved, the ~~department~~ authority shall amend the certificate of need as appropriate.

Sec. 15. 22 MRSA §304-D, sub-§3, as enacted by PL 1985, c. 661, §2, is amended to read:

3. Waiver process for certain new health services. Any hospital may file a request for waiver under subsection 1, paragraph A, with the ~~department~~ authority describing the proposed project and its projected associated capital costs and projected operating costs, as appropriate. Within 15 days following receipt of the hospital's waiver request and other information, if requested, the ~~department~~ authority shall issue its waiver determination.

The ~~department~~ authority shall waive certificate of need review in all cases where the request demonstrates that:

A. The project meets the criteria of subsection 1, paragraph A; and

B. The hospital agrees to be bound by the conditions of subsection 2.

Sec. 16. 22 MRSA §304-E, sub-§§2 to 6, as enacted by PL 1987, c. 725, §2, are amended to read:

2. Public notice. The applicant shall give public notice, on a form provided by the ~~department~~ authority, of its intention to seek a waiver of full review. This notice ~~shall~~ must be given in the Kennebec Journal and in a daily newspaper of general circulation in the applicant's service area. The public ~~shall~~ must be given 10 days from the date of publication within which to submit to the ~~department~~ authority any comments concerning the proposed waiver of review.

3. Criteria for waiver. The ~~department~~ authority may waive the requirement for a full certificate of need review of a project, if the ~~department~~ authority finds that the waiver, rather than full review, would best further the purposes of the Maine Certificate of Need Act, as set forth in section 302, subsection 2. When making this determination, the ~~department~~ authority shall consider a number of factors including, but not limited to:

A. Whether the proposed project would incur no or minimal additional expense to the public or to the health care facility's clients;

B. Whether the proposed project is or will be in compliance with other state and local laws and regulations;

C. Whether the proposed project primarily involves the maintenance of a health care facility as is; and

D. Whether the health and welfare of any person the health care facility is already serving will be significantly adversely affected if a waiver is not granted.

4. Other action by authority. If the ~~department~~ authority finds that the proposal is not clearly eligible for a waiver of the review requirements, it may elect to conduct an emergency review, a simplified review pursuant to section 308, subsection 1, or a full review.

5. Notification of decision. The ~~department~~ authority shall notify the applicant of its decision in writing as soon as it determines whether to grant or deny the request for a waiver or decides to conduct a different review in accordance with subsection 4. The notice ~~shall~~ must include a brief summary of the reasons for the ~~department's~~ authority's decision.

6. Report to Legislature. The ~~department~~ authority shall submit an annual report to the joint standing committee of the Legislature having jurisdiction over human resources on the implementation and operation of this section no later than February 15th of each year.

Sec. 17. 22 MRSA §305, as enacted by PL 1977, c. 687, §1, is amended to read:

§305. Periodic reports

The ~~department~~ authority shall require health care facilities subject to the requirements of this chapter to maintain current health services and capital ~~requirements~~

requirements plans on file with the ~~department~~ authority. The ~~department~~ authority, in its rules ~~and--regulations~~, shall prescribe the form and contents of the health services and capital ~~requirements~~ requirements plans and ~~shall~~ require annual or other periodic reports updating the plans to be filed with the ~~department~~ authority. ~~No~~ An application for a certificate of need made pursuant to this Act ~~shall~~ may not be accepted from any health care facility for which the current health services and capital ~~requirements~~ requirements plans are not on file.

Sec. 18. 22 MRSA §306-A, as amended by PL 1987, c. 436, §§2 and 3, is further amended to read:

§306-A. Application process for a certificate of need

1. Letter of intent. Prior to filing an application for a certificate of need, an applicant shall file a letter of intent with the ~~department~~ authority. The letter of intent ~~shall form~~ forms the basis for determining the applicability of this chapter to the proposed expenditure or action. A letter of intent ~~shall be~~ is deemed withdrawn one year after receipt by the ~~department~~ authority, unless sooner superseded by an application~~,~~ provided that the applicant ~~shall~~ is not ~~be~~ precluded from resubmitting the same letter of intent.

2. Application filed. Upon a determination by the ~~department~~ authority that a certificate of need is required for a proposed expenditure or action, an application for a certificate of need ~~shall~~ must be filed with the ~~department~~ authority if the applicant wishes to proceed with the project. Prior to filing a formal application for a certificate of need, the applicant is required to meet with the ~~department~~ authority staff in order to assist the ~~department~~ authority in understanding the application and to receive technical assistance concerning the nature, extent and format of the documentary evidence, statistical data and financial data required for the ~~department~~ authority to evaluate the proposal. The ~~department shall~~ authority may not accept an application for review until the applicant has satisfied this technical assistance requirement unless waived in writing by both parties. The technical assistance meeting ~~shall~~ must take place within 30 days subsequent to receipt of the letter of intent, unless waived in writing by both parties.

3. Additional information required. Additional information may be required or requested as follows.

A. If, after receipt of an application, the ~~department~~ authority determines that additional information is necessary before the application can be considered complete, the ~~department~~ authority may:

(1) Require the applicant to respond to one set of requests for additional information from the ~~department~~ authority. Applicants must submit additional information requested by the ~~department~~ authority within 30 business days or within a longer period of time, provided that the ~~department~~ authority and the applicant agree; and

(2) Request, but not require, the applicant to respond to additional sets of requests for information, provided that each request is directly related to the last request or to the information provided in response to the last request.

C. Within 15 business days after the filing of an application or response to any information request, whichever is applicable, with the ~~department~~ authority, the ~~department~~ authority shall notify the applicant in writing that:

(1) The application contains all necessary information required and is complete; or

(2) Additional information is required by the ~~department~~ authority. If, after receipt of the applicant's response to the first or any subsequent request, the ~~department~~ authority determines that additional information is required, the notification ~~shall~~ must also include a statement of the basis and rationale for that determination.

4. Review of incomplete application. Upon receipt of the 2nd or any subsequent notice described in subsection 3, paragraph C, subparagraph 2, the applicant must notify the ~~department~~ authority in writing that:

A. ~~It~~ The applicant will provide the additional information requested by the ~~department~~ authority. Following completion, it ~~shall~~ will be entered into the next review cycle; or

B. ~~That it~~ The applicant is not able to or does not intend to provide the information requested and requests the application be entered into the next appropriate review cycle. In that case, the applicant ~~shall be~~ is prohibited from submitting the information ~~it~~ the applicant had declined to provide into the record after the 25th day of the review cycle and the information ~~shall~~ may not be considered in the determination to issue or to deny a certificate of need. If the applicant provides the

information requested prior to the 25th day of the review cycle, the application may, at the discretion of the ~~department~~ authority, be returned to the beginning of the review cycle. Failure to submit additional information requested by the ~~department~~ authority may result in an unfavorable recommendation and ~~may--result--in~~ subsequent denial of the application by the ~~department~~ authority, as long as the denial is related to applicable criteria and standards.

5. Competitive reviews. In cases of competitive reviews, applicants shall submit additional information requested by the ~~department~~ authority within 30 business days or within a longer period of time, provided that the ~~department~~ authority and all competing applicants agree.

6. Automatic withdrawal. Any incomplete application ~~shall be~~ is deemed withdrawn if the applicant fails to respond to a request for additional required information within one year of the date ~~such~~ that request was forwarded by the ~~department~~ authority.

Sec. 19. 22 MRSA §307, sub-§1, as amended by PL 1981, c. 705, Pt. V, §§20 to 23, is further amended to read:

1. Notice. Upon determination that an application is complete, or upon receipt of a notice under section 306-A, subsection 4, paragraph B, or upon grouping of the application with other pending applications, the ~~department~~ authority shall provide for written notification of the beginning of a review. Public notice ~~shall~~ must be given by publication in the Kennebec Journal and in a newspaper of general circulation in the area in which the proposed expenditure or other action will occur. The notice ~~shall~~ must be provided to all persons who have requested notification by means of asking that their names be placed on a mailing list maintained by the ~~department~~ authority for this purpose. This notice ~~shall~~ must include:

A. A brief description of the proposed expenditure or other action;

B. The proposed schedule for the review;

C. A statement that a public hearing will be held during the course of a review if requested by persons directly affected by the review and the date by which the requests must be received by the ~~department~~ authority;

D. A description of the manner in which public notice will be given of a public hearing if one is to be held during the course of the review; and

E. A statement of the manner and time in which persons may register as affected persons.

Sec. 20. 22 MRSA §307, sub-§2-A, as amended by PL 1989, c. 503, Pt. B, §79, is further amended by amending the first paragraph to read:

2-A. Certificate of Need Advisory Committee. The Certificate of Need Advisory Committee, established by Title 5, section 12004-I, subsection 38, and created within the ~~Department of Human Services~~ authority, shall participate with the ~~department~~ authority in the public hearing process.

Sec. 21. 22 MRSA §307, sub-§2-B, as amended by PL 1985, c. 342, is further amended to read:

2-B. Public hearing. A public hearing ~~shall~~ must be held during the course of a review by the Certificate of Need Advisory Committee if requested by persons directly affected by the review pursuant to subsection 1. Nothing in this section may be construed to prevent the ~~department~~ authority from holding informational meetings with applicants and interested and affected persons prior to the conduct of the hearing. In the event no hearing has been requested prior to an informational meeting or receipt of the preliminary staff report, the applicant or any directly affected persons may request a hearing within 10 days of either circumstance, provided that the review period ~~shall be~~ is extended by 60 days if such a hearing is requested. In the case of grouped applications, the extension ~~shall apply~~ applies to all competing applications.

A. The committee or agency shall provide notice of its hearings in accordance with the procedure described in subsection 1.

B. Findings, recommendations, reports, analyses and related documents prepared by the staff of the agency ~~shall~~ must be in final form and ~~be~~ made available to affected persons at least 5 business days prior to its hearings. The ~~department~~ authority shall make its preliminary staff report available to the committee and affected persons at least 5 business days prior to a public hearing conducted by the committee.

C. In a hearing conducted by the committee, any person ~~shall have~~ has the right to be represented by counsel or to present oral or written arguments and evidence relevant to the matter ~~which~~ that is the subject of the hearing. Any person directly affected by the matter may conduct

reasonable questioning of persons who make relevant factual allegations.

D. The chairman shall serve as a voting presiding officer and, in consultation with the members of the committee, shall rule on the relevance of argument and evidence and make determinations as to reasonable questioning. Members of the committee may conduct reasonable questioning in the course of a hearing.

E. The ~~department~~ authority or agency shall record all hearings and any subsequent proceedings of the committee with respect to the application in a form susceptible to transcription. The ~~department~~ authority shall transcribe the recording when necessary for the prosecution of an appeal.

F. During the first 7 business days following the close of a public hearing conducted by the committee interested or affected persons may submit written comments concerning the review under consideration. The ~~department~~ authority shall provide copies of comments submitted in that manner to all persons registered as affected persons and to appointed members of the committee. In reviews ~~where~~ when no hearing is held, interested or affected persons may submit comments 10 days after the submission of the preliminary staff report, but no later than the 70th day of a 90-day review cycle or the 130th day of a 150-day review cycle.

G. In the event that circumstances require the ~~department~~ authority to obtain further information from any source or to otherwise contact registered affected persons following the public hearing and submission of comments under paragraph F or, when no hearing is held, following the 80th day of a 90-day review cycle or the 140th day of a 150-day review cycle, the ~~department~~ authority shall:

(1) Provide written notice to all registered affected persons, who ~~shall~~ must have at least 3 business days to respond; or

(2) Convene a public meeting with reasonable notice with participation of the committee at its discretion and affording directly affected persons the opportunity to conduct reasonable questioning.

In either event, notwithstanding any other provision of this chapter, the time period in which a decision is required ~~shall~~ must be extended 20 days. Any written comments ~~shall~~ must be forwarded to the committee.

H. At its next meeting following the receipt of comments pursuant to paragraph F or G, or in the case of a public hearing pursuant to paragraph G, the committee shall make a recommendation of approval or disapproval with respect to the application or applications under consideration. The recommendation ~~shall be~~ is determined by majority vote of the appointed members present and voting. Members of the committee may make additional oral comments or submit written comments, as they ~~deem~~ consider appropriate, with respect to the basis for their recommendations or their individual views. The committee recommendation and any accompanying comments ~~shall~~ must be forwarded to the ~~commissioner~~ board.

I. At the time the staff submits its final report to the ~~commissioner~~ board, a copy of the report ~~shall~~ must be sent to the applicant and a notification ~~shall~~ must be sent to all registered affected persons. No further comments may be accepted.

J. After a hearing commences, no appointed members of the committee or the ~~department~~ authority may communicate directly or indirectly in connection with any application with any affected party or anyone acting in their behalf, except upon notice and opportunity for all affected parties to participate. This paragraph ~~shall~~ does not prohibit the ~~department~~ authority from communicating with any affected party or anyone acting on their behalf for the purpose of arranging a public meeting pursuant to paragraph G.

Sec. 22. 22 MRSA §307, sub-§3, as repealed and replaced by PL 1985, c. 737, Pt. A, §49, is amended to read:

3. Reviews. To the extent practicable, a review ~~shall~~ must be completed and the ~~department~~ authority shall make its decision within 90 days after the date of notification under subsection 1. The ~~department~~ authority shall establish criteria for determining when it is not practicable to complete a review within 90 days. Whenever it is not practicable to complete a review within 90 days, the ~~department~~ authority may extend the review period up to an additional 60 days.

Any review period may be extended with the written consent of the applicant. The request to extend the review period may be initiated by the applicant or the ~~department~~ authority. If the request is initiated by the ~~department~~ authority, it ~~shall~~ is not ~~be~~ effective unless consented to by the applicant in writing. If the request is initiated by the applicant, the ~~department~~ authority shall agree to the requested extension if it determines

that the request is for good cause. The ~~department~~ authority shall acknowledge the extension of the review period in writing.

Sec. 23. 22 MRSA §307, sub-§5-A, as amended by PL 1985, c. 661, §3, is further amended to read:

5-A. Decision by the authority. Decisions by the ~~commissioner~~ board ~~shall~~ must be made in accordance with the following procedures.

A. The ~~department~~ authority shall prepare its final staff report based solely on the record developed to date, as defined in paragraph C, subparagraphs (1) to (6).

B. After reviewing each application, the ~~commissioner~~ board shall make a decision either to issue a certificate of need or to deny the application for a certificate of need. The decision of the ~~commissioner~~ board ~~shall~~ must be based on the informational record developed in the course of review as specified in paragraph C. Notice of the decision ~~shall~~ must be sent to the applicant and the committee. This notice ~~shall~~ must incorporate written findings ~~which~~ that state the basis of the decision, including the findings required by section 309, subsection 1. If the decision is not consistent with the recommendations of the Certificate of Need Advisory Committee, the ~~commissioner~~ board shall provide a detailed statement of the reasons for the inconsistency.

C. For purposes of this subsection, "informational record developed in the course of review" includes the following:

(1) All applications, filings, correspondence and documentary material submitted by applicants and interested or affected persons prior to the termination of the public comment period under subsection 2-B, paragraph F or, if no hearing is held, prior to the 80th day of a 90-day review cycle and prior to the 140th day of a 150-day review cycle;

(2) All documentary material reflecting information generated by the ~~department~~ authority prior to termination of the public comment period or, if no hearing is held, prior to the 80th day of a 90-day review cycle and prior to the 140th day of a 150-day review cycle;

(3) Stenographic or electronic recording of any public hearing or meeting held during the course of review, whether or not transcribed;

(4) All material submitted or obtained in accordance with the procedures in subsection 2-B, paragraph G;

(5) The staff report of the agency, the preliminary staff report of the ~~department~~ authority and the recommendations of the committee;

(6) Officially noticed facts; and

(7) The final staff report of the ~~department~~ authority.

Documentary materials may be incorporated in the record by reference, provided that registered affected persons are afforded the opportunity to examine the materials.

In making a determination on any pending application under the certificate of need program, the ~~department~~ authority ~~shall~~ may not rely on the contents of any documents relating to the application when those documents are submitted to the ~~department~~ authority anonymously.

Sec. 24. 22 MRSA §307, sub-§6-A, as amended by PL 1993, c. 410, Pt. FF, §2, is further amended to read:

6-A. Review cycles. The ~~department~~ authority shall establish review cycles for the review of applications. There must be at least one review cycle for each type or category of project each calendar year, the dates for which must be published at least 3 months in advance. An application must be reviewed during the next scheduled review cycle following the date on which the application is either declared complete or submitted for review pursuant to section 306-A, subsection 4, paragraph B. Hospital projects that must be considered within the constraints established by the Certificate of Need Development Account established pursuant to section 396-K may be grouped for competitive review purposes at least once each year; provided that, for minor projects, as defined by the ~~department~~ authority through rules adopted pursuant to section 312, the ~~department~~ authority shall allocate a portion of the Certificate of Need Development Account for the approval of those projects and ~~shall~~ establish at least 6 review cycles each year for the review of those projects. Nursing home projects that propose to add new nursing home beds to the inventory of nursing home beds within the State may be grouped for competitive review purposes consistent with appropriations made available for that purpose by the Legislature. A nursing home project that proposes renovation, replacement or other actions that will increase Medicaid costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by

the Legislature expressly for the purpose of meeting those costs. The ~~department~~ authority may hold an application for up to 90 days following the commencement of the next scheduled review cycle if, on the basis of one or more letters of intent on file at the time the application is either declared complete or submitted for review pursuant to section 306-A, subsection 4, paragraph B, the ~~department~~ authority expects to receive within the additional 90 days one or more other applications pertaining to similar types of services, facilities or equipment affecting the same health service area. Pertinent health service areas must be defined in rules adopted by the ~~department~~ authority pursuant to section 312, based on recommendations by the State Health Coordinating Council.

Sec. 25. 22 MRSA §308, as amended by PL 1987, c. 436, §§4 and 5, is further amended to read:

§308. Waiver of requirements; emergency certificate of need

1. Waiver of full review. The ~~department~~ authority may waive otherwise applicable requirements and establish a simplified review process for projects ~~which~~ that do not warrant a full review. Procedures for conducting these reviews ~~shall~~ must be established by the ~~department~~ authority in its rules. These procedures ~~shall~~ must provide for a shortened review and for a public hearing to be held during the course of a review, if requested by any person directly affected by the review. In order to waive requirements for a full review, the ~~department--shall~~ authority must find that the proposed project:

A. Meets an already demonstrated need as established by applicable state health plans or by the rules of the ~~department~~ authority;

B. Is a part of a minor modernization or replacement program ~~which~~ that is an integral part of an institutional health care facility's health services or capital expenditures plans required by section 305; and

C. Is required to meet federal, state or local life safety codes or other applicable requirements.

2. Waiver of other requirements. In order to expedite the review of an application submitted in response to an emergency situation, the ~~department~~ authority may:

C. Establish a schedule for the review of an application ~~which~~ that commences on a day other than the first day of an established review cycle.

3. Emergency defined. The ~~department~~ authority shall determine that an emergency situation exists whenever it finds that an applicant has demonstrated:

A. The necessity for immediate or temporary relief due to natural disaster, fire, unforeseen safety consideration or other circumstances;

B. The serious adverse effect of delay on the applicant and the community that would be occasioned by compliance with the regular requirements of this chapter and the rules ~~and regulations promulgated~~ adopted by the ~~department~~ authority; and

C. The lack of substantial change in the facility or services ~~which~~ that existed before the emergency situation.

4. Waiver of review of acquisitions of major medical equipment. The ~~department~~ authority may waive the review of an acquisition or proposed use of major medical equipment required pursuant to section 304-A if the equipment will be used to provide services to inpatients of a hospital only on a temporary basis in the case of:

A. A natural disaster;

B. A major accident; or

C. Equipment failure.

5. Provision for expedited administrative reviews. The ~~department~~ authority shall ~~promulgate~~ adopt rules ~~by January 1, 1988,~~ to create a procedure for administrative reviews for at least the replacement of major medical equipment.

Sec. 26. 22 MRSA §309, sub-§1, as amended by PL 1993, c. 477, Pt. D, §4 and affected by Pt. F, §4, is further amended to read:

1. Determinations for issue of certificate. A certificate of need ~~shall~~ must be issued whenever the ~~department~~ authority determines:

A. That the applicant is fit, willing and able to provide the proposed services at the proper standard of care;

B. That economic feasibility of the proposed services is demonstrated in terms of: Effect on the existing and projected operating budget of the applicant; the applicant's ability to establish and operate the facility or services in accordance with licensure rules adopted under pertinent

state laws; the projected impact on the facility's costs and rates the total health care expenditures in the community and the State; and the availability of State funds;

C. That there is a public need for the proposed services; and

D. That the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State, that the citizens of the State have the ability to underwrite the additional costs of the proposed services and that the proposed services are in accordance with standards, criteria or plans adopted and approved pursuant to the state health plan developed by the ~~department~~ authority and the findings of the Maine Health Care Finance Commission under section 396-J with respect to the ability of the citizens of the State to pay for the proposed services.

Sec. 27. 22 MRSA §309, sub-§2, as amended by PL 1985, c. 661, §§4 and 5, is further amended by amending the first paragraph to read:

2. Criteria for certificate of need. In the determination to issue or deny a certificate of need under subsection 1, the ~~department~~ authority shall, among other criteria, consider the following:

Sec. 28. 22 MRSA §309, sub-§2, ¶A-1 is enacted to read:

A-1. The relationship of the health services being reviewed to the unified health care budget adopted pursuant to section 273;

Sec. 29. 22 MRSA §309, sub-§2, ¶O, as amended by PL 1985, c. 661, §4, is further amended to read:

O. The special needs and circumstances of biomedical and behavioral research projects ~~which~~ that are designed to meet a national need and for which local conditions offer special advantages; ~~and~~

Sec. 30. 22 MRSA §309, sub-§2, ¶P, as enacted by PL 1985, c. 661, §5, is amended to read:

P. For any facility located within 30 miles of the state border, the gains that may be anticipated from the ability to attract health care consumers from out-of-state and the ability to provide health care for Maine citizens who formerly had to obtain that care out-of-state~~.~~ ; and

Sec. 31. 22 MRSA §309, sub-§2, ¶Q is enacted to read:

Q. The recommendation of the State Health Coordinating Council.

Sec. 32. 22 MRSA §309, sub-§3, as enacted by PL 1981, c. 705, Pt. V, §33, is amended to read:

3. Health maintenance organizations. Notwithstanding subsections 1 and 2, if a health maintenance organization or a health care facility ~~which~~ that is controlled, directly or indirectly, by a health maintenance organization applies for a certificate of need, the ~~department~~ authority shall issue a certificate of need if it finds that:

A. Approval of the application is required to meet the needs of the members of the health maintenance organization and of the new members ~~which~~ that the organization can reasonably be expected to enroll; ~~and~~

B. The health maintenance organization is unable to provide, through services or facilities ~~which~~ that can reasonably be expected to be available to the organization, its institutional health services in a reasonable and cost effective manner ~~which~~ that is consistent with the basic method of operation of the organization and ~~which~~ makes the services available on a long-term basis through physicians and other health professionals associated with it. In assessing the availability of the proposed health services from other providers, the ~~department~~ authority shall consider only whether the services from these providers:

(1) Would be available under a contract of at least 5 years' duration;

(2) Would be available and conveniently accessible to physicians and other health professionals associated with the health maintenance organizations;

(3) Would cost no more than if the services were provided by the health maintenance organization; and

(4) Would be available in a manner ~~which~~ that is administratively feasible to the health maintenance organization~~.~~; and

C. Approval is consistent with the recommendations of the State Health Coordinating Council or, if not consistent, the board provides detailed reasons why the health maintenance

organization is not conforming to the recommendations of the council.

Sec. 33. 22 MRSA §309, sub-§4, as amended by PL 1985, c. 418, §15, is further amended to read:

4. Required approvals. Approval of proposed capital expenditures ~~shall~~ must comply with the following:

A. Except as provided in paragraph B, the ~~department~~ authority shall issue a certificate of need for a proposed capital expenditure if:

(1) The capital expenditure is required to eliminate or prevent imminent safety hazards, as defined by applicable fire, building or life-safety codes and regulations; to comply with state licensure standards; or to comply with accreditation or certification standards ~~which~~ that must be met to receive reimbursement under the United States Social Security Act, Title XVIII, or payments under a state plan for medical assistance approved under Title XIX of that Act; and

(2) The ~~department~~ authority has determined that the facility or service for which capital expenditure is proposed is needed; the obligation of the capital expenditure is consistent with the state health plan; and the corrective action proposed by the applicant is the most ~~cost--effective~~ cost-effective alternative available under the circumstances.

B. Those portions of a proposed project ~~which~~ that are not required to eliminate or prevent safety hazards or to comply with licensure, certification or accreditation standards are subject to review in accordance with the criteria established under section 312.

Sec. 34. 22 MRSA §309, sub-§5, as enacted by PL 1981, c. 705, Pt. V, §33, is amended to read:

5. Standards applied in certificate of need. The ~~commissioner~~ board shall, in issuing a certificate of need, make ~~his~~ its decision, to the maximum extent practicable, directly related to criteria established under federal laws and standards or criteria prescribed in ~~regulations promulgated~~ rules adopted by the ~~department~~ authority pursuant to subsections 1 to 4 and section 312.

The ~~commissioner--shall~~ board may not deny issuance of a certificate of need, or make ~~his~~ its decision subject to fulfillment of a condition on the part of the applicant, except ~~where~~ when the denial or condition directly relates to criteria established under federal laws and standards or criteria prescribed in ~~regulations--promulgated~~ rules adopted by the ~~department~~ authority in accordance with subsections 1 to 4 and section 312~~,-which~~ that are pertinent to the application.

Sec. 35. 22 MRSA §309, sub-§6, as amended by PL 1989, c. 502, Pt. A, §65, is further amended to read:

6. Hospital projects. Notwithstanding subsections 1, 4 and 5, the ~~department~~ authority may not issue a certificate of need for a project ~~which~~ that is subject to the provisions of section 396-D, subsection 5, and section 396-K, if the associated costs exceed the amount ~~which~~ that the commission has determined will have been credited to the Certificate of Need Development Account pursuant to section 396-K, after accounting for previously approved projects. A project ~~shall~~ may not be denied solely on the basis of exceeding the amount remaining in the Certificate of Need Development Account or Hospital Development Account in a particular payment year and ~~shall~~ must be held for further consideration by the ~~department~~ authority in the first appropriate review cycle beginning after the Certificate of Need Development Account or Hospital Development Account is credited with additional amounts. Projects ~~which~~ that are carried forward ~~shall~~ compete equally with newly proposed projects. For the purposes of this subsection, a project may be held for a final decision beyond the time frames set forth in section 307, subsection 3.

Sec. 36. 22 MRSA §309, sub-§7, as enacted by PL 1989, c. 501, Pt. P, §24, is amended to read:

7. Intermediate care facilities. The ~~department~~ authority shall give preference when awarding a certificate of need for new nursing home facilities to those homes being proposed to be constructed in communities with populations of 4,000 or more and that do not currently have a nursing home.

Sec. 37. 22 MRSA §310, as amended by PL 1985, c. 433, §2, is further amended to read:

§310. Reconsideration

Any person directly affected by a review may, for good cause shown, request in writing a hearing for the purposes of reconsideration of the decision of the ~~department~~ authority to issue or to deny a certificate of need. The ~~department~~ authority,

if it determines that good cause has been demonstrated, shall hold a hearing to reconsider its decision. To be effective, a request for the hearing ~~shall~~ must be received within 30 days of the ~~department's~~ authority's decision. If the ~~Department of Human Services~~ authority determines that good cause for a hearing has been demonstrated, the hearing ~~shall~~ must commence within 30 days of receipt of the request. A decision ~~shall~~ must be rendered within 60 days of the commencement of the hearing. The decision may be rendered beyond this time period by mutual consent of the parties. For purposes of this section, a request for a hearing ~~shall be deemed~~ is considered to have shown good cause if it:

1. New information. Presents significant, relevant information not previously considered by the ~~department~~ authority;

2. Changes in circumstances. Demonstrates that there have been significant changes in factors or circumstances relied upon by the ~~department~~ authority in reaching its decision;

3. Failure to follow procedures. Demonstrates that the ~~department~~ authority has materially failed to follow its adopted procedures in reaching its decision; or

4. Other bases. Provides other bases for a hearing that the ~~department~~ authority has determined ~~constitutes~~ constitute good cause.

Sec. 38. 22 MRSA §311, as amended by PL 1985, c. 701, is further amended to read:

§311. Remedy

Any person aggrieved by a final decision of the ~~department~~ authority made under the provisions of this Act ~~shall be~~ is entitled to review in accordance with Title 5, chapter 375, subchapter VII, of the Maine Administrative Procedure Act. A decision of the ~~department~~ authority to issue a certificate of need or to deny an application for a certificate of need ~~shall~~ is not be considered final until the ~~department~~ authority has taken final action on a request for reconsideration under section 310.

A decision by the ~~department~~ authority is not final ~~where~~ when opportunity for reconsideration under section 310 exists with respect to matters involving new information or changes in circumstances. ~~Where~~ When new information or changes in circumstances are not alleged by the applicant or other person aggrieved by the decision, a person aggrieved by a decision of the ~~department~~ authority may, at its option, seek reconsideration under section 310 or may seek direct judicial review under this section.

In civil actions involving competitive reviews of proposals to construct new nursing home beds, the court shall require the party seeking judicial review to give security in such sums as the court ~~deems~~ considers proper, for the payment of such costs and damages as may be incurred or suffered by any other party who is found to have been wrongfully delayed or restrained from proceeding to implement the certificate of need, provided that for good cause shown and recited in the order, the court may waive the giving of security. A surety upon a bond or undertaking under this paragraph submits ~~himself~~ that party to the jurisdiction of the court and irrevocably appoints the clerk of the court as ~~his~~ that party's agent upon whom any papers affecting ~~his~~ that party's liability on the bond or undertaking may be served. ~~His~~ The party's liability may be enforced on motion without the necessity of an independent action. The motion and such notice of the motion as the court prescribes may be served on the clerk of the court, who shall forthwith mail copies to the persons giving the security if their addresses are known.

Sec. 39. 22 MRSA §312, as amended by PL 1981, c. 705, Pt. V, §34, is further amended to read:

§312. Rules

The ~~department~~ authority shall adopt any rules, ~~regulations,~~ standards, criteria or plans that may be necessary to carry out the provisions and purposes of this Act. The ~~department~~ authority shall, to the extent applicable, take into consideration recommendations contained in the state health plan as approved by the Governor. The ~~department~~ authority shall provide for public notice and hearing on all proposed rules, ~~regulations,~~ standards, criteria, plans or schedules pursuant to Title 5, chapter 375. The ~~department~~ authority is authorized to accept any federal funds to be used for the purposes of carrying out this chapter.

Sec. 40. 22 MRSA §313, as enacted by PL 1977, c. 687, §1, is amended to read:

§313. Public information

The general public ~~shall~~ must have reasonable access to all applications reviewed by the ~~department~~ authority and to all other written material pertinent to its review of these applications. The ~~department~~ authority shall prepare and publish at least annually a report on its activities conducted pursuant to this Act.

Sec. 41. 22 MRSA §314, as amended by PL 1985, c. 418, §16, is further amended to read:

§314. Conflict of interest

In addition to the limitations of Title 5, section 18, a member or employee of the ~~Department of Human Services~~ authority or Certificate of Need Advisory Committee who has a substantial economic or fiduciary interest ~~which~~ that would be affected by a recommendation or decision to issue or deny a certificate of need, or who has a close relative or economic associate whose interest would be so affected ~~shall be~~, is ineligible to participate in the review, recommendation or decision making process with respect to any application for which the conflict of interest exists.

Sec. 42. 22 MRSA §317-A, as amended by PL 1985, c. 418, §17, is further amended to read:

§317-A. Scope of certificate of need

1. Application determination. A certificate of need ~~shall be~~ is valid only for the defined scope, premises and facility or person named in the application and ~~shall~~ is not ~~be~~ transferable or assignable.

2. Maximum expenditure. In issuing a certificate of need, the ~~department~~ authority shall specify the maximum capital expenditures ~~which~~ that may be obligated under this certificate. The ~~department~~ authority shall, by ~~regulations promulgated~~ rules adopted pursuant to section 312, prescribe the method to be used to determine capital expenditure maximums, establish procedures to monitor capital expenditures obligated under certificates and establish procedures to review projects for which the capital expenditure maximum is exceeded or expected to be exceeded.

3. Periodic review. After the issuance of a certificate of need, the ~~department~~ authority shall periodically review the progress of the holder of the certificate in meeting the timetable for making the service or equipment available or for completing the project specified in the approved application. A certificate of need ~~shall expire~~ expires if the project for which the certificate has been issued is not commenced within 12 months following the issuance of the certificate. The ~~department~~ authority may grant an extension of a certificate for an additional specified time not to exceed 12 months if good cause is shown why the project has not commenced. The ~~department~~ authority may require evidence of the continuing feasibility and availability of financing for a project as a condition for extending the life of the certificate. In addition, if, on the basis of its periodic review of progress under the certificate, the ~~department~~ authority determines that the holder of a certificate is not otherwise meeting the timetable and is not

making a good faith effort to meet it, the ~~department~~ authority may, after a hearing, withdraw the certificate of need. The ~~department~~ authority shall in accordance with section 312 ~~promulgate~~ adopt the necessary procedures for withdrawal of certificates of need.

Sec. 43. 22 MRSA §319, as amended by PL 1985, c. 418, §18, is further amended to read:

§319. Withholding of funds

~~No~~ A health care facility or other provider ~~may be~~ is not eligible to apply for or receive any reimbursement, payment or other financial assistance from any state agency or other 3rd party payor, either directly or indirectly, for any capital expenditure or operating costs attributable to any project for which a certificate of need as required by this Act has not been obtained. For the purposes of this section, the ~~department~~ authority shall determine the eligibility of a facility to receive reimbursement for all projects subject to the provisions of this Act.

Sec. 44. 22 MRSA §320, as enacted by PL 1977, c. 687, §1, is amended to read:

§320. Injunction

The Attorney General, upon the request of the ~~department~~ authority, shall seek to enjoin any project for which a certificate of need as required by this Act has not been obtained, and shall take any other action as may be appropriate to enforce this Act.

Sec. 45. 22 MRSA §321, as amended by PL 1987, c. 436, §7, is further amended to read:

§321. Penalty

Whoever violates any provision of this chapter or any rate, rule or regulation established hereunder ~~shall be~~ is subject to a civil penalty payable to the State of not more than $5,000 to be recovered in a civil action. The ~~department~~ authority may hold these funds in a special revenue account ~~which shall~~ that may be used only to support certificate of need reviews, such as for hiring expert analysts on a short-term consulting basis.

Sec. 46. 22 MRSA §322, as amended by PL 1985, c. 418, §19, is further amended to read:

§322. Implementation reports

The holder of a certificate of need shall make a written report at the end of each 6-month period following its issuance regarding implementation activities, obligations incurred and expenditures made and any other matters ~~as~~ the ~~department~~ authority may require. A summary report ~~shall~~ must be made when the service or services for which the certificate of need was issued becomes operational. For a period of one year following the implementation of the service or services for which the certificate of need was granted, the provider shall file, at 6-month intervals, reports concerning the costs and utilization. The ~~department~~ authority, in its rules, shall prescribe the form and contents of the reports. Any holder of a certificate of need ~~which~~ that has been issued for the construction or modification of a facility or portion thereof shall file final plans and specifications ~~therefor~~ with the ~~department~~ authority within 6 months, or any other time that the ~~department~~ authority may allow, following the issuance of the certificate for review by the ~~department~~ authority to determine that the plans and specifications are in compliance with the certificate of need ~~which~~ that has been issued ~~therefor~~ and are in compliance with applicable licensure, life safety code and accreditation standards. The ~~department~~ authority may revoke any certificate of need it has issued when the person to whom it has been issued fails to file reports or plans and specifications required by this section on a timely basis.

Sec. 47. 22 MRSA §323, as enacted by PL 1981, c. 705, Part V, §39, is amended to read:

§323. Relationship to the United States Social Security Act, Section 1122

1. Administration of Section 1122 reviews. The ~~department~~ authority shall, in reviewing those capital expenditures ~~which~~ that require review under section 304-A and the United States Social Security Act, Section 1122, and regulations promulgated thereunder, allow the maximum flexibility permitted under the United States Social Security Act, Section 1122, consistent with this chapter.

2. Thresholds for review. The ~~department~~ authority shall waive review of proposed capital expenditures by health care facilities under the United States Social Security Act, Section 1122, and regulations promulgated thereunder, unless those expenditures are subject to review under section 304-A.

3. Procedures. The ~~department~~ authority shall, pursuant to section 312, modify its United States Social Security Act, Section 1122 Procedures Manual as required by this section, and

shall promulgate the revised manual as a regulation on or before January 1, 1983.

Sec. 48. 22 MRSA §324, as enacted by PL 1981, c. 705, Pt. V, §40, is repealed.

Sec. 49. 22 MRSA §382, sub-§1, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

1. Board. "Board" means the Maine Health Care Authority Board created by section 272.

Sec. 50. 22 MRSA §382, sub-§6-A is enacted to read:

6-A. Health resource management plan. "Health resource management plan" means the plan adopted by the board under section 273, subsection 2.

Sec. 51. 22 MRSA §382, sub-§19-A is enacted to read:

19-A. Unified health care budget. "Unified health care budget" means the budget adopted under section 273, subsection 1.

Sec. 52. 22 MRSA §383, sub-§1, ¶A, as amended by PL 1983, c. 812, §116, is repealed and the following enacted in its place:

A. The Maine Health Care Finance Commission operates as a component of the Maine Health Care Authority created in chapter 102.

Sec. 53. 22 MRSA §394, sub-§2, as amended by PL 1989, c. 595, is further amended to read:

2. Information required. In addition to any other requirements applicable to specific categories of health care facilities, as set forth in section 395, and in subchapters III and IV and pursuant to rules adopted by the commission for form, medium, content and time for filing, each health care facility shall file with the commission the following information:

A. ~~Financial information,~~ A budget for the next fiscal year including, without limitation, costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges, units of services, wage and salary data and such other financial information as the commission ~~deems~~ determines necessary for the performance of its duties;

B. Scope of service information, including bed capacity, by service provided, special services, ancillary services, physician profiles in the aggregate by clinical specialties,

nursing services and such other scope of service information as the commission ~~deems~~ determines necessary for the performance of its duties; ~~and~~

C. A completed uniform hospital discharge data set, or comparable information, for each patient discharged from the facility after June 30, 1983; and for each major ambulatory service listed pursuant to subsection 11, occurring after January 1, 1990~~.~~;

D. New hospital services and programs proposed for the next fiscal year; and

E. A projected 3-year capital expenditure budget.

Sec. 54. 22 MRSA §396, sub-§1, as repealed and replaced by PL 1989, c. 588, Pt. A, §9, is repealed and the following enacted in its place:

1. Authority. Before the beginning of a hospital's fiscal year, the commission shall review each hospital's budget based on the information provided under this chapter. The commission shall establish and approve revenue limits and apportionment methods for each hospital. In conducting budget reviews, the commission shall:

A. Review utilization information;

B. Consider goals and recommendations of the health resource management plan;

C. Consider the report of the professional review organization; and

D. From July 1, 1996 to July 1, 1997 consider the portion of the health care expenditure target applicable to hospitals and after July 1, 1996 consider the portion of the uniform health care budget applicable to hospitals.

After a budget review is completed and no later than the beginning of the hospital's fiscal year, the commission shall recommend a budget to each hospital and each hospital shall consider the recommendations of the commission and adopt a budget.

Sec. 55. 24 MRSA c. 21, sub-c. III-A is enacted to read:

SUBCHAPTER III-A

MEDICAL MALPRACTICE COMPENSATION SYSTEM

§2721. Administrative forum

This subchapter creates a medical compensation procedure administered by the Medical Compensation Board, as established in section 2723, as an administrative forum that is available to all injured patients; provides timely, predictable and fair resolution of claims; and provides a link to professional discipline and quality assurance by receiving information from and providing information to professional licensing boards and quality assurance programs.

§2722. Definitions

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

1. Authority. "Authority" means the Maine Health Care Authority established under Title 22, section 272.

2. Board. "Board" means the Medical Compensation Board established in section 2723.

3. Claimant. "Claimant" means a person who files a claim with the board, including a person who files the claim as a successor in interest, guardian or other representative of another person.

4. Failure to provide adequate health care services. "Failure to provide adequate health care services" means failure by a health care provider to provide health care services within the standards of this subchapter.

5. Health care provider. "Health care provider" means any hospital as defined in Title 22, section 303 or a physician licensed under Title 32, chapter 48.

6. Health care services. "Health care services" means the undertaking by a health care provider to prevent, diagnose, correct or treat in any manner or by any means or method, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of a person. "Health care services" also means the management of pregnancy and parturition.

7. Respondent. "Respondent" means a health care provider named in a claim as having caused injuries to a claimant by failing to provide adequate health care services to a patient.

§2723. Medical Compensation Board

The Medical Compensation Board is created within the Maine Health Care Authority, established under Title 22, section 272, to carry out the provisions of this subchapter.

1. Composition. The board consists of a chair and 2 members appointed by the Governor and subject to confirmation by the Legislature. The chair and the members are not required to be persons admitted to the practice of law in this State.

2. Compensation. The Legislature shall establish the annual salary of the chair, who shall serve on a full-time basis. Members other than the chair are entitled to per diem equal to the legislative per diem plus expenses.

3. Terms of office. The chair serves for a term of 6 years. The 2 members serve for terms of 6 years, except that of the initial appointees, one member serves for a term of 2 years and the other serves for a term of 4 years. Vacancies must be filled for the unexpired portion of a term in the same manner as the original appointment.

4. Board employees. Subject to the approval of the authority, the board may employ, exempt from state classified service, professional staff and other employees and contract with medical experts, attorneys or other persons for services necessary to accomplish the purposes of this subchapter. The board, subject to the approval of the authority, may determine the qualifications, duties and compensation for the employees and contractors.

§2724. Limitation on court jurisdiction

Beginning July 1, 1996, a court in this State does not have jurisdiction over any action for damages arising out of a health care provider's failure to provide adequate health care services, except as provided under this subchapter. The courts retain jurisdiction over actions filed before July 1, 1996. Actions filed with the court after July 1, 1996 are filed with the board, except as provided under this subchapter.

§2725. Prerequisite to suit

An action against a health care provider for medical malpractice may not be commenced in any court of this State before the claimant's proposed complaint has been presented to the board and a final decision has been issued.

§2726. Appeal to Superior Court

1. Right of appeal. Within 30 days after the board issues a final decision, either party may appeal the decision to the Superior Court of the county in which the claimant resides.

2. De novo review. The court shall hear the matter de novo.

3. Board decision admissible. In an appeal under this section, the decision of the board is admissible as substantive evidence and may be proved by either party by introduction of a certified copy of the decision.

4. Attorney's fees. If the respondent prevails upon appeal under this section, the court shall award the respondent reasonable attorney's fees.

§2727. Claims

1. Right to file. A person who has suffered an injury as a result of a health care provider's failure to provide adequate health care services may file a claim for compensation with the board.

2. Procedure for review; rulemaking. The authority shall by rule establish procedures for the review and hearing of claims by the board and for the determination of damages and award of compensation by the board to claimants. Rules adopted by the authority under this section must ensure an impartial and timely review of claims and a fair method for calculation of compensation that is consistent with the goals of universal access to health care for this State and containment of the cost of the health care system.

3. Rules. Rules adopted under this section must include the following:

A. A filing fee for claims;

B. Limitation on claims;

C. Settlement agreements;

D. Review of claims;

E. Hearing and disposition of claims;

F. Process and procedure for handling of claims;

G. Qualification of expert witnesses;

H. Assessment of costs;

I. Assignment of counsel for claimants;

J. The hourly rate to be paid for counsel;

K. The method of allocating the cost of counsel among the claimant, the respondent and the board;

L. Stay of board orders pending appeal or further proceedings before the board;

M. Reports by the board to licensing boards; and

N. Board application of practice guidelines.

§2728. Subpoena power; enforcement

1. Subpoena power. The board has the power to subpoena witnesses, to administer oaths and to demand the production of books, papers, records and documents for its examination.

2. Judicial enforcement. The Superior Court, a Justice of the Supreme Court or a Superior Court Justice has power to enforce the attendance and testimony of witnesses and the production of documents in any proceedings under this subchapter.

§2729. Evidence

The board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure except as provided by this subchapter. Evidence must be admitted if it is the kind of evidence upon which reasonable persons are accustomed to rely in the conduct of serious affairs.

§2730. Determination of questions

1. Board authority. Except as otherwise provided, the board shall determine questions arising under this chapter if not settled by agreement of the parties with the approval of the board.

2. Enforcement and appeal. A decision of the board under this section is enforceable by the Superior Court. A decision under this section may be appealed in the same manner as other appeals from decisions of the board. An appeal under this section does not operate as a stay unless the board or the court to which the appeal is taken orders a stay.

§2731. Determination of compensation

1. Items compensable. The claimant entitled to recovery must be awarded the full amount of money actually and reasonably expended as a result of the injury, the full value of income lost as a result of the injury, the present value of future lost income and other expenses including housekeeping and child care expenses.

2. Computation of damages. The board shall establish by rule guidelines for computing damage awards including:

A. Interest rate and inflation rate tables;

B. Life expectancy tables;

C. Work-life expectancy tables according to profession; and

D. Statistical records of the cost within the State of the most common medical treatments and services, child care and other housekeeping services.

3. Limitation on noneconomic damages. The total award for noneconomic damages may not exceed the average annual wage, on a per capita basis, representing all persons in the State covered under the unemployment compensation program administered by the Bureau of Employment Security as calculated in the year in which the injury occurred, multiplied by the patient's life expectancy in the absence of the injury, minus the patient's age.

4. Reduction of economic damages. The amount of economic damages must be reduced by the total amount of collateral source payments available to the patient under section 2906.

5. Structured awards. If the present value of all future damages awarded exceeds $250,000, the entire award of future damages is subject to the structured awards under subchapter VII.

§2732. Enforcement of awards

If an award made by the board is final and the respondent fails to comply with the award, the claimant may proceed to collect all or any part of a past due award in Superior Court. The court shall award to the claimant reasonable costs, attorney's fees and interest computed from the date of the award.

§2733. Elements of a valid claim

A health care provider is liable for injury to a patient for failure to provide adequate health care services if:

1. Duty. The health care provider was under a duty to provide health care services to the patient;

2. Fault. The health care provider was at fault when providing health care services to the patient;

3. Contributing factor. The health care provider's fault was a contributing factor to the injury to the patient;

4. Compensable damages. The patient suffered damages that are compensable under rules adopted pursuant to this subchapter; and

5. No defenses. The health care provider does not have any defenses to the liability.

§2734. Burden of proof

1. Claimant's burden. The claimant has the burden of proof, including the burden of going forward with the evidence and the burden of persuasion with respect to section 2733, subsections 1 to 4.

2. Respondent's burden. The respondent has the burden of proof including the burden of going forward with the evidence and the burden of persuasion with respect to section 2733, subsection 5.

§2735. Duty of care

A health care provider owes a duty of care to a patient as long as a provider-patient relationship exists. The scope of the provider's duty to the patient is defined by the nature of the patient-provider relationship and may include only one or several of the health care services defined in section 2334. A provider-patient relationship is created when any of the following situations occur:

1. Agreement. An individual knowingly seeks health care services from a health care provider and the health care provider knowingly agrees to provide health care services to the individual;

2. Incompetent persons. A legal guardian knowingly seeks health care services from a health care provider on behalf of an individual legally incompetent to make health care decisions and the health care provider knowingly agrees to provide health care services to the legally incompetent individual;

3. Provider initiative. A health care provider undertakes, gratuitously or for payment, to provide health care services to an individual;

4. Third-party agreement. A 3rd party, including an employer, insurer, educational institution, children's camp or other public or private organization, knowingly seeks health care services from a health care provider on behalf of an individual; the health care provider knowingly agrees to provide the health care services; and the individual knowingly accepts the services offered by the health care provider; or

5. Legal requirement. The patient knowingly seeks health care services from a health care provider and the health care provider is required by law to provide the care requested.

§2736. Fault

1. Standards. A health care provider is at fault when that provider lacks the degree of knowledge or skill ordinarily possessed or fails to exercise the degree of care ordinarily exercised by a skillful, careful and prudent health care provider engaged in a similar practice under the same or similar circumstances.

A health care provider is not at fault when the provider:

A. Fails to employ a particular procedure, test or treatment if the patient after being fully informed of the risks and benefits of the diagnostic and treatment options, including nontreatment, refuses the procedure, test or treatment; or

B. Chooses a course of health care services recognized as appropriate by a respectable minority of health care providers, even if the patient suffers an injury as a result of the chosen course of health care services and the injury might not have occurred if an alternative course of health care services had been chosen and the patient has been fully informed of the risks and benefits of the diagnosis and treatment options.

2. Guidelines. The standards under subsection 1 include the following guidelines:

A. The degree of skill required of a health care provider depends on the expertise of that provider. A specialist must exercise greater skill than a nonspecialist. If a nonspecialist provides health care services normally provided by a specialist, the nonspecialist must meet the

standard of care expected of a specialist. In an emergency, a nonspecialist must meet the standard of care expected of a nonspecialist. A health care provider has an obligation to consult with a specialist when a prudent, competent practitioner with similar training, expertise and certification in a similar circumstance would consult with a specialist.

B. Whether health care services are within the reasonable range of treatment options depends upon the extent to which the patient's general health or specific medical conditions limit the health care provider's options in providing health care service; and

C. Whether health care services are within the reasonable range of treatment options must be determined on the basis of the state of knowledge at the time the health care services are provided and not on later developments in medical knowledge.

§2737. Causation

A health care provider's fault is a contributing factor to a claimant's injury if it measurably increased the risk of injury and that injury occurred. When, in addition to the fault of the respondent, actions of individuals other than the respondent contributed to the claimant's injury, the liability of the respondent is limited to the same ratio as the respondent's fault is to the total injury.

§2738. Standard of care; proof

1. Expert testimony. In order to prove that a health care provider is at fault, the claimant must establish through the testimony of one or more qualified experts the standard of care expected under this chapter and that the health care provider's health care services did not meet that standard.

2. Expert testimony not required. Notwithstanding subsection 1, if fault can be determined from common knowledge ordinarily possessed by an average person, expert testimony regarding standard of care is not required.

3. Circumstantial evidence. Fault by a health care provider may be found on the basis of circumstantial evidence alone if:

A. The event that caused the patient's injury does not ordinarily occur in the absence of fault; and

B. It is more likely than not that the health care provider charged with fault was responsible for the occurrence of the event.

4. Medical literature. A statement in medical literature may be used as evidence of the standard of care expected if the source of the statement is established as a reliable authority by an expert witness or by stipulation of the parties.

5. Practice guidelines. Practice guidelines established by professional organizations of health care providers, by licensed hospitals or by quality assurance programs recognized by law may be used as evidence of whether the respondent provided a reasonable level of care. Those guidelines are considered to establish a desirable level of care and are not considered a minimum level of care. The board may also use guidelines developed by specialty organizations and guidelines developed by nationally recognized health organizations if those guidelines have been approved by the authority.

§2739. Informed consent

1. Duty to obtain consent. A health care provider who has a duty to provide health care services has a duty to obtain the informed consent of the patient or the patient's legal guardian for health care decisions.

2. Failure to obtain consent. A health care provider who, before providing health care services, fails to obtain the informed consent of the patient is liable, subject to the terms of sections 2905 and 2905-A, for injury to the patient resulting from the health care services provided if the patient suffers damages that are compensable under rules pursuant to this subchapter.

§2740. Notice to be posted

A health care provider shall post a notice of the provisions of this subchapter related to the filing of claims in a conspicuous place in the provider's office.

Sec. 56. 24 MRSA c. 21, sub-c. IV-A, as amended, is repealed.

Sec. 57. 24 MRSA §2903, as amended by PL 1991, c. 505, §6, is repealed.

Sec. 58. 24-A MRSA c. 33-A is enacted to read:

CHAPTER 33-A

SMALL GROUP AND INDIVIDUAL HEALTH BENEFIT PLANS

SUBCHAPTER I

SMALL GROUP HEALTH PLANS

§2761. Definitions

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

1. Small employer. "Small employer" means an employer who, on at least 50% of the working days during the preceding calendar quarter, employed at least one and no more than 49 employees. "Small employer" includes self-employed persons. Calculation of the number of employees of a small employer does not include a part-time employee who works less than 30 hours a week.

2. Small group. "Small group" means a small employer or an association, trust or other small group issued a health insurance policy subject to regulation by the superintendent.

3. Small group plan. "Small group plan" means a group health insurance policy, a nonprofit hospital or medical service corporation service contract or a health maintenance organization health benefit plan offered or issued to a small group, including, but not limited to, common health care plans approved by the superintendent. "Small group plan" does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies, dental policies or Medicare supplemental policies.

4. Registered small group carrier. "Registered small group carrier" means a person, except an insurance agent, broker, appraiser or adjuster, who issues a small group plan and who has a registration in effect with the superintendent as required by this section.

§2762. Authority

A person may provide a small group plan only if the plan complies with this subchapter.

§2763. Registration

A person may provide a small group plan only if that person is a registered small group carrier. The superintendent, by rule, shall establish the minimum financial, marketing, service

and other requirements for registration. The registration is effective upon approval by the superintendent and remains in effect until revoked or suspended by the superintendent for cause or until withdrawn by the carrier. A small group carrier may withdraw its registration upon a 6-month prior written notice to the superintendent. A registration filed with the superintendent is considered approved unless it is disapproved by the superintendent within 30 days of filing.

§2764. Requirements

1. Guaranteed acceptance. A registered small group carrier shall guarantee acceptance of all small groups for any small group plan offered by the carrier. A registered small group carrier shall guarantee acceptance of all employees or members of a small group and each dependent of those employees or members for any small group plan offered. This section may not be construed to limit an employer's discretion in contracting with employees for insurance coverage.

2. Health maintenance organizations. Notwithstanding subsection 1, a health maintenance organization is not required to cover:

A. A small employer that is not physically located in the health maintenance organization's approved service area; or

B. A small employer or an employee or member of a small group located or residing within the health maintenance organization's approved service area for which the health maintenance organization:

(1) Is not providing coverage; and

(2) Reasonably anticipates and demonstrates to the satisfaction of the superintendent that it will not have the capacity within its network of providers to deliver adequate service because of its existing group contract obligations including contract obligations subject to this subchapter and any other group contract obligations.

3. Approved plans. A registered small group carrier shall offer one or more common health care plans approved by the superintendent. The superintendent, by rule, shall adopt standards and a process for approval of common health care plans that ensure that consumers may compare the cost of plans offered by carriers and that ensure the development of an affordable common health care plan providing for deductibles, coinsurance arrangements, managed care, cost containment provisions and any

other term, not inconsistent with the provisions of this Title, that is useful in making the plan affordable. A health maintenance organization may add limitations to a common health care plan if the superintendent finds that the limitations do not unreasonably restrict the insured's access to the benefits covered by the plans.

4. Rate structures. A registered small group carrier shall offer a small group plan rate structure that differentiates among single-person rates, 2-person rates and family rates.

5. Preexisting conditions. For a 3-month period from the effective date of coverage, a registered small group carrier may limit coverage of preexisting conditions that exist during the 12-month period before the effective date of coverage, except that a registered small group carrier shall waive any preexisting condition provisions for all new employees or members of a small group and their dependents who produce evidence of continuous health benefit coverage during the previous 9 months substantially equivalent to the common health care plan of the carrier approved by the superintendent.

6. Community-rating method. A registered small group carrier shall use a community-rating method acceptable to the superintendent for determining premiums for small group plans. Except as provided in this subsection, the following risk classification factors are prohibited from use in rating small groups, employees or members of those groups and dependents of those employees or members:

A. Demographic rating, including age and gender rating;

B. Geographic area rating;

C. Industry rating;

D. Medical underwriting and screening;

E. Experience rating;

F. Tier rating; and

G. Durational rating.

The superintendent shall, by rule, adopt standards and a process for permitting registered small group carriers to use one or more risk classifications in their community-rating method if the premium charged does not deviate above or below the community rate filed by the carrier by more than 20%. The rules may not permit any medical underwriting and screening.

7. Exemption. The superintendent may exempt from the requirements of this section an association that:

A. Offers a small group plan to a member small employer that is community rated in accordance with subsection 6;

B. Offers a small group plan that guarantees acceptance of all persons within the association and their dependents; and

C. Offers one or more of the common health care plans approved by the superintendent under subsection 3.

8. Revocation of exemption. The superintendent may revoke or deny an exemption under subsection 7 if the superintendent determines that:

A. Because of the nature, size or other characteristics of the association and its members, the employees or members are in need of protections provided by this section; or

B. The exemption has or would have a substantial adverse effect on the small group market.

9. Certification. A registered small group carrier shall file with the superintendent an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this subchapter. The superintendent shall by rule prescribe the requirements for certification.

10. Full disclosure. A registered small group carrier shall provide, on forms prescribed by the superintendent, full disclosure to a small group of all premium rates and any risk classification formulas or factors prior to acceptance of a small group plan.

11. Guarantee rates. A registered small group carrier shall guarantee the rates on a small group plan for a minimum of 6 months.

12. Participation. A registered small group carrier that is not a nonprofit health maintenance organization shall require that at least 75% of the employees or members of a small group participate in the carrier's plan. If a nonprofit health maintenance organization provides a small group plan to more than 25% of the employees or members of the small group, a registered small group carrier may offer or continue to provide its small group plan to the remaining employees or members. For purposes of this requirement, the registered small group carrier may not include in its calculation an employee or member who is already

covered by another group health benefit plan as a spouse or dependent. If the small group is an association, trust or other similar group, this participation requirement must be calculated on an employer-by-employer basis.

13. Individual policies; when allowed. This section applies to the provision of small group plans. This section may not be construed to prevent any person from issuing or obtaining a bona fide individual health insurance policy. A person may not offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the requirements of this section.

Registered small group carriers, except nonprofit medical and hospital service organizations and nonprofit health maintenance organizations, shall form a reinsurance pool for the purpose of reinsuring small group risks. This pool becomes operative only after the superintendent approves a plan of operation. The superintendent may not approve any plan that is inconsistent with any other provision of this subchapter. Failure or delay in the formation of a reinsurance pool does not delay implementation of this subchapter. The participants in the plan of operation of the pool shall guarantee without limitation, the solvency of the pool and that guarantee constitutes a permanent financial obligation of each participant on a pro rata basis.

SUBCHAPTER II

NONGROUP HEALTH BENEFIT PLANS

§2766. Definitions

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

1. Individual. "Individual" means a person who is not eligible for coverage by group insurance under chapter 35.

2. Nongroup plan. "Nongroup plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract or a health maintenance organization health benefit plan offered or issued to an individual, including, but not limited to, common health care plans approved by the superintendent under section 2768. "Nongroup plan" does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies and dental policies.

3. Registered nongroup carrier. "Registered nongroup carrier" means any person, except an insurance agent, broker, appraiser or adjuster, who issues a nongroup plan and who has a registration in effect with the superintendent as required by section 2768.

§2767. Compliance

A person may provide a nongroup plan if the plan complies with this subchapter.

§2768. Registration

A person may not provide a nongroup plan unless that person is a registered nongroup carrier. The superintendent, by rule, shall establish the minimum financial, marketing, service and other requirements for registration. Registration under this section is effective upon approval by the superintendent and remains in effect until revoked or suspended by the superintendent for cause or until withdrawn by the carrier. A nongroup carrier may withdraw its registration upon at least a 6-month prior written notice to the superintendent. A registration filed with the superintendent is approved unless it is disapproved by the superintendent within 30 days of filing.

§2769. Requirements

1. Guaranteed acceptance. A registered nongroup carrier shall guarantee acceptance of an individual for any nongroup plan offered by the carrier. A registered nongroup carrier shall guarantee acceptance of each dependent of that individual for any nongroup plan it offers.

2. Health maintenance organization. Notwithstanding subsection 1, a health maintenance organization is not required to cover:

A. An individual who is not physically located in the health maintenance organization's approved service area; or

B. An individual residing within the health maintenance organization's approved service are for which the health maintenance organization:

(1) Is not providing coverage; and

(2) Reasonably anticipates and demonstrates to the satisfaction of the superintendent that the health maintenance organization does not have the capacity within its network of providers to deliver adequate

service because of its existing contract obligations including contract obligations subject to the provisions of this subchapter and any other group contract obligations.

3. Approved plans. A registered nongroup carrier shall offer one or more common health care plans approved by the superintendent. The superintendent, by rule, shall adopt standards and a process for approval of common health care plans that ensure that consumers may compare the cost of plans offered by carriers and that ensure the development of an affordable common health care plan providing for deductibles, coinsurance arrangements, managed care, cost containment provisions and any other term, not inconsistent with the provisions of this Title, that is useful in making the plan affordable. A health maintenance organization may add limitations to a common health care plan if the superintendent finds that the limitations do not unreasonably restrict the insured's access to the benefits covered by the plans.

4. Rate structures. A registered nongroup carrier shall offer a nongroup plan rate structure that differentiates among single-person rates, 2-person rates and family rates.

5. Preexisting conditions. For a 12-month period from the effective date of coverage, a registered nongroup carrier may limit coverage of preexisting conditions that exist during the 12-month period before the effective date of coverage, except that a registered nongroup carrier shall waive any preexisting condition provisions for all new individuals and their dependents who produce evidence of continuous health benefit coverage during the previous 9 months substantially equivalent to the common health care plan of the carrier approved by the superintendent.

6. Community-rating method. A registered nongroup carrier shall use a community-rating method acceptable to the superintendent for determining premiums for nongroup plans. Except as provided in this subsection, the following risk classification factors are prohibited from use in rating individuals and their dependents:

A. Demographic rating, including age and gender rating;

B. Geographic area rating;

C. Industry rating;

D. Medical underwriting and screening;

E. Experience rating;

F. Tier rating; and

G. Durational rating.

The superintendent shall, by rule, adopt standards and a process for permitting registered nongroup carriers to use one or more risk classifications in their community-rating method if the premium charged does not deviate above or below the community rate filed by the carrier by more than 20%. The rules may not permit any medical underwriting and screening.

7. Certification. A registered nongroup carrier shall file with the superintendent an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this subchapter. The superintendent shall prescribe by rule the requirements for certification.

8. Guaranteed rates. A registered nongroup carrier shall guarantee the rates on a nongroup plan for a minimum of 12 months.

§2770. Discrimination prohibited

A nonprofit health maintenance organization, hospital service corporation or medical service corporation subject to this subchapter shall offer nongroup plans to individuals without discrimination based on age, gender, medical history or, except health maintenance organizations under section 2769, geographic area.

Sec. 59. 36 MRSA §4365-D is enacted to read:

§4365-D. Rate of tax after November 30, 1995

Cigarettes stamped at the rate of 18.5 mills per cigarette and held for resale after November 30, 1995 are subject to tax at the rate of 21.0 mills per cigarette.

A person holding cigarettes for resale is liable for the difference between the tax rate of 21.0 mills per cigarette and the tax rate of 18.5 mills per cigarette in effect before December 1, 1995. Stamps indicating payment of the tax imposed by this section must be affixed to all packages of cigarettes held for resale as of December 1, 1995, except that cigarettes held in vending machines as of that date do not require that stamp.

Notwithstanding any other provision of this chapter, it is presumed that all cigarette vending machines are filled to capacity on December 1, 1995 and the tax imposed by this section

must be reported on that basis. A credit against this inventory tax must be allowed for cigarettes stamped at the 21.0-mill rate placed in vending machines before December 1, 1995.

Payment of the tax imposed by this section must be made to the State Tax Assessor before February 15, 1996, must be accompanied by forms prescribed by the State Tax Assessor and must be credited to the Health Insurance Trust Fund.

STATEMENT OF FACT

This bill, modeled on Vermont legislation, is designed to consolidate health care planning, oversight and regulation in Maine with the goal of providing cost containment within 2 1/2 years in this State .

The bill includes the following significant components:

1. It establishes the Maine Health Care Authority, governed by a 3-person board, to serve as an umbrella agency for health care planning including oversight of the Maine Health Care Finance Commission and the Certificate of Need Advisory Committee. The authority's duties include:

A. Establishing a unified health care budget in fiscal year 1997-98 that establishes the total amount of money to be spent annually for health care services provided in the State;

B. Adopting a statewide health resource management plan;

C. Administering the certificate of need program; and

D. Developing a common benefit package that, on January 1, 1996, becomes the minimum standard health insurance policy offered in the State;

2. It establishes a Health Insurance Trust Fund to implement the common benefits package;

3. It creates the State Health Coordinating Council, consisting of 31 members and develops the health resource management plan;

4. It requires annual approval of each hospital's budget;

5. It repeals the existing medical malpractice mediation provisions, replacing them with a medical malpractice

compensation system administered by the Medical Compensation Board, with appeal and de novo review in Superior Court; and

6. It establishes requirements for the issuance of small group, fewer than 50 employees, and nongroup health benefit plans.

7. It also increases the cigarette tax by 5¢ per pack beginning December 1, 1995. Proceeds from the cigarette tax increase are paid to the Health Insurance Trust Fund.