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117th MAINE LEGISLATURE

SECOND REGULAR SESSION-1996

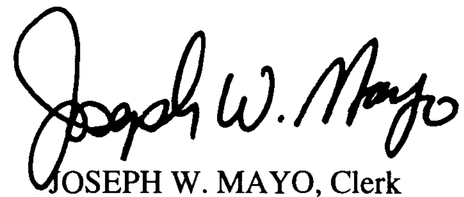
Legislative Document **No. 1798**

H.P. 1314 House of Representatives, February 20, 1996

An Act to Create a Multi-payor System for Universal Health Care.

Reported by Representative FITZPATRICK for the Maine Health Care Reform Commission pursuant to Public Law 1993, chapter 707, Part AA, section 5.

Reference to the Joint Standing Committee on Banking and Insurance suggested and printing ordered under Joint Rule 20.



JOSEPH W. MAYO, Clerk

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

2

PART A

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Sec. A-1. 5 MRSA § 12004-G, sub-§16-A is enacted to read:

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16-A. Health	Maine Health Care Authority	Expenses Only	24 MRSA §3403

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10

Sec. A-2. 24 MRSA c. 29 is enacted to read:

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CHAPTER 29

14

THE MAINE HEALTH CARE AUTHORITY AND PURCHASING ALLIANCE

16

SUBCHAPTER I

18

GENERAL PROVISIONS

20

§3401. Definitions

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

26 **1. Agent.** "Agent" means an agent or broker licensed to do business in this State under Title 24-A, chapter 17.

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2. Alliance. "Alliance" means the purchasing alliance
30 within the Maine Health Care Authority, established in section 3413.

32

3. Alliance member. "Alliance member" means an employer or
34 an enrolled individual.

36 **4. Authority.** "Authority" means the Maine Health Care Authority established in section 3403.

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5. Board. "Board" means the alliance board pursuant to
40 section 3403.

42 **6. Bureau.** "Bureau" means the Bureau of Insurance, within the Department of Professional and Financial Regulation.

44

7. Carrier. "Carrier" means an insurer, health maintenance
46 organization or nonprofit hospital or medical service organization licensed to do business in this State.

48

8. Department. "Department" means the Department of Human
50 Services.

2 **9. Employer.** "Employer" means an employer as defined in Title 26, section 1043.

4

10. Enrollee. "Enrollee" means an enrolled individual or a
6 dependent of an enrolled individual.

8 **11. Enrolled individual.** "Enrolled individual" means an enrolled individual as defined in section 3412.

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12. Global budget. "Global budget" means a statewide
12 aggregate amount budgeted for the provision of all health care services as established pursuant to section 3422.

14

13. Participating carrier. "Participating carrier" means
16 an eligible carrier under section 3404 that contracts with the alliance.

18

14. Plan. "Plan" means the Maine Health Care Plan
20 established under section 3411.

22 **15. Quality improvement foundation.** "Quality improvement foundation" means the quality improvement foundation designated
24 by the Maine Health Data Organization pursuant to Title 22, chapter 1681-A.

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16. Resident. "Resident" means a person who meets the
28 definition of resident adopted by the board pursuant to section 3412.

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17. State health resource plan. "State health resource
32 plan" means the state health resource plan adopted by the board pursuant to section 3421.

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18. Superintendent. "Superintendent" means the
36 Superintendent of Insurance within the Department of Professional and Financial Regulation.

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§3402. Jurisdiction of Bureau of Insurance

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Nothing in this chapter is intended to conflict with or
42 limit the duties and powers granted to the superintendent under the laws of this State. The board and alliance established under
44 this chapter shall report to the bureau any suspected or alleged violations of this chapter. Violations of this chapter are
46 subject to the full range of regulatory actions, processes and remedies available to the superintendent in dealing with other
48 entities that the superintendent may regulate.

50 **§3403. Maine Health Care Authority**

2 The Maine Health Care Authority is established as an independent, executive agency.

4

1. Board of directors. The authority operates under the supervision of a board of directors, which consists of 11 voting members and 2 nonvoting members.

8

A. Ten of the voting board members are designated as follows. Five members must be persons who represent enrolled individuals. The remaining 5 members must be persons who represent employers: one employer representative must represent a self-employed business; one employer representative must represent a public employer; one employer representative must represent a business with fewer than 100 employees; one employer representative must represent a business with 100 to 999 employees; and one employer must represent a business with 1,000 or more employees.

20

(1) Initially, the Governor shall appoint the 10 board members subject to review by the joint standing committee of the Legislature having jurisdiction over insurance matters and confirmation by the Legislature. For the purpose of the initial appointment, a person represents an enrolled individual or group of employers if that person is eligible to participate as an enrolled individual or as a member of that group of employers. A person may not represent enrolled individuals if that person is eligible to participate as an employer representative.

32

(2) After the initial appointment of the board, the 10 board members must be elected by alliance members. The board shall establish procedures in its bylaws governing the election of board members and maintaining the distribution of consumer and employer representatives. For the purpose of electing board members, a person represents a consumer or a group of employers if that person is elected by enrolled individuals or by employers from each employer group.

42

B. The 10 board members shall choose the 11th voting board member prior to the adoption of the board's bylaws.

46 C. The Commissioner of Human Services is an ex officio nonvoting member of the board.

48

D. The executive director of the alliance is an ex officio nonvoting member of the board.

E. A person may not be a board member if that person or a member of that person's household is currently employed as or by, is a consultant for, a member of the board of directors of, affiliated with, an agent of or a representative of a carrier of a health care provider, or other entity having an interest in board decisions distinct from the interest of the general public. Prior to appointment or election to the board, potential board members shall disclose to those persons appointing or electing those board members any other personal financial interest in an entity having an interest in board decisions distinct from the interest of the general public. Board members may not accept gifts or any other financial gain from any carrier, agent, health care provider or other entity having an interest in board decisions distinct from the interest of the general public. This paragraph does not preclude a board member from purchasing coverage from a carrier.

F. All board members must be knowledgeable about the health care financing and delivery system.

G. A person may not be a board member if that person or if that person's employer is in violation of premium payment or employer contribution requirements under section 3412.

2. Operations. The board shall adopt rules that govern the operation of the authority. The rules must include procedures for the election of board members consistent with the terms set forth in this section.

3. Terms of office. The terms of office of the voting members are staggered. Of the initially appointed members of the board of directors, the terms of office are as follows: 3 members serve one-year terms; 3 members serve 2-year terms; and 4 members serve 3-year terms. Of the initial appointees, 3 consumer representatives may not have the same term length. The 10 appointed members shall determine the initial term of the 11th voting member. After the initial term, voting members serve 3-year terms. Board members may serve a maximum of 2 consecutive terms.

4. Officers. The Governor shall appoint the first chair of the board. Subsequently, the members of the board shall elect the chair.

5. Compensation. The board members are entitled to compensation in accordance with Title 5, chapter 379.

6. Powers and duties. The board has the powers and duties regarding operation of the alliance set forth in section 3404.

§3404. Powers and duties of the board

The board has the following powers and duties.

1. Universal access. The board shall establish and maintain a system of universal access to medical care for all residents, in accordance with this chapter.

2. Alliance. The board shall oversee the operations of the alliance as provided in this subsection. The board shall ensure that the alliance administers the plan consistent with the requirements of this chapter and that the activities of the alliance are consistent with the goals of achieving universal access, the delivery of quality, cost-effective health care and the most efficient and effective use of resources as set forth by the authority pursuant to this chapter. Notwithstanding this subsection, the board may not interfere with the exercise of discretion, granted by statute to the alliance, in negotiating the terms of participation with carriers, selecting participating carriers or administering contracts with participating carriers.

3. Global budget; state health resource plan; certificate of need. The board shall develop a global budget and state health resource plan as required in sections 3421 and 3422, and integrate the global budget and the state health resource plan with the certificate of need program administered under Title 22, chapter 103.

4. Maine Health Care Plan. Consistent with section 3411, the board shall determine the health services covered under the plan.

5. Quality assurance; affordability. The board shall adopt quality assurance and cost-containment measures as required under section 3423 to monitor and improve the quality and affordability of health care delivered in the State.

6. Alliance participation. Consistent with section 3412, the board shall establish standards and procedures for determining eligibility and enrolling eligible persons in the plan. In accordance with the requirements of this chapter, the board shall implement procedures for distributing subsidies for the purchase of health insurance to eligible employers and individuals.

7. Data; standardization. The board shall collect data consistent with the requirements of section 3424.

8. Underserved areas. The board shall develop standards for designating underserved and rural populations.

9. Risk adjustment. The board shall establish a procedure for adjusting payments to participating carriers if the board finds that some carriers have a significantly disproportionate share of high-risk or low-risk enrollees.

10. Report cards. The board shall develop a uniform format for the report cards to be prepared and provided by participating carriers. The report cards must include data necessary for evaluation of the performance of participating carriers and their provider networks by consumers, providers, employers and the board, including, but not limited to, information on consumer satisfaction, service utilization and the cost of the health benefit plan over time. In formulating the report card format, the board shall use standards based on, and consistent with, existing state and national health care data collection initiatives and shall take into account their feasibility and cost-effectiveness. The board shall also develop standards and procedures for reviewing and auditing the report cards before the alliance publishes and distributes the report cards.

11. Quality performance reports. The board shall develop uniform standards for the collection of data to be provided by participating carriers. The board shall collect data necessary for evaluating the performance of participating carriers and their provider networks by the alliance. The board shall develop methods of quality analysis for analyzing the data for use within quality performance reports. The board may use the reports for determining the qualifications of plans. The board shall use standards based on, and consistent with, existing state and national health care data collection initiatives and shall take into account their feasibility and cost-effectiveness. The board shall use the quality performance reports as feasible to work with participating carriers and their provider networks to improve the quality and cost-effectiveness of the care provided. The board may contract with the quality improvement foundation to assist in the evaluation of the quality and appropriateness of care for participating providers. At its discretion, the board may publish part or all of the quality performance reports.

12. Contracts with 3rd parties. The board may contract with qualified, independent 3rd parties for services necessary to carry out the powers and duties of the board. Unless permission is granted specifically by the board, a 3rd party hired by the authority may not release, publish or otherwise use any information to which the 3rd party has access under its contract. Except with the express written approval of the board,

an entity may not act, directly or through an affiliated person, both as a participating carrier and a 3rd party under contract to the board.

13. Contracts generally. The board may enter into all other contracts necessary to carry out the powers and duties of this chapter.

14. Legal action. The board may sue or be sued, including taking any action necessary for securing legal remedies for, on behalf of or against, the authority, the alliance, alliance members, any board member or other parties subject to this chapter.

15. Executive director; staff. The board shall hire an executive director to perform those duties delegated by the board. The executive director serves at the pleasure of the board. The executive director may employ other staff as needed to administer the authority, subject to the personnel policies established by the board.

16. Advisory committees. The board may appoint advisory committees that may include persons with expertise in health benefits management and representatives of participating carriers, consumer groups and health care providers, as may be necessary to carry out the purposes of this chapter.

17. Coordination with federal, state and local health care systems. The board shall institute a system to coordinate the activities of the authority, the plan and the alliance with the health care programs of the municipal government, State Government and Federal Government.

18. Fees. The board may charge and retain fees to recover the reasonable costs incurred in reproducing and distributing reports, studies and other publications in responding to requests for information.

19. Studies and analyses. The board may conduct studies and analyses related to the provision of health care, health care costs and other related matters considered appropriate. The board shall publish and disseminate information helpful to the residents of this State in making informed choices in obtaining health care.

20. Funding. The board shall determine the level of funding required to carry out the purposes of this chapter. The board shall submit, biennially, to the Legislature for approval a proposed budget with levels of assessments and taxes to be collected in the Maine Health Care Trust Fund, as established in

section 3406. Funding for the authority budget approved by the
2 Legislature is paid from the fund.

4 **21. Reports to the Legislature.** On or before January 1st
of each year, the authority shall submit to the Governor and the
6 Legislature an annual report of its operations and activities
during the previous year, including an internal and independent
8 audit and an accounting of all outside revenue received by the
alliance. The board shall submit the annual report to the
10 Governor, the joint standing committee of the Legislature having
jurisdiction over insurance matters and the State Auditor no
12 later than January 15th of each year. The report must address
the authority's performance in setting and enforcing the global
14 budget, the state health resource plan and the certificate of
need program. The report must include the funding, taxes and
16 budget requirements under the global budget. The report must
include facts, suggestions and policy recommendations that the
18 board considers necessary and a report on access to health care
under the plan, the economic impact of the plan on the State's
20 gross state product, employment and per capita income and the
quality of health care offered under the plan, with comparative
22 statistics from comparable states.

24 **22. Grants.** The board may solicit, receive and accept
grants, funds or anything of value from any public or private
26 agency; receive and accept contributions from any legitimate
source of money, property, labor or any other thing of value; and
28 enter into agreements that involve the undertaking of studies,
plans, demonstrations and projects. The board may not accept
30 grants from any carrier, agent or health care provider or other
person or entity that might have a financial interest in the
32 decisions of the board.

34 **23. Rulemaking.** The board may adopt, amend and repeal
rules as necessary for the proper administration and enforcement
36 of this chapter, subject to the Maine Administrative Procedure
Act.

38

24. Other state agencies. The board shall coordinate the
40 exercise of its powers and execution of its duties with the role
of other state agencies, including, but not limited to, the
42 bureau, the department, the Department of Mental Health and
Mental Retardation and the Maine Health Data Organization.

44

25. Complaint resolution. In cooperation with health care
46 providers and plan members, the board shall institute a complaint
resolution system to handle the complaints of providers, plans
48 and plan members.

26. Other powers. The board may exercise all powers reasonably necessary to carry out the powers and responsibilities granted or imposed by this chapter.

§3405. Proceedings before the board

1. Actions before the board. As provided in this section, any person or entity aggrieved by an act or decision of the alliance or the authority may seek redress before the board. Proceedings before the board are subject to the Maine Administrative Procedure Act and any further rules established by the board consistent with the Maine Administrative Procedure Act. In all actions arising under this chapter, the burden of proof is upon the party seeking to set aside any determination, requirement, direction or order of the board.

2. Appeals. Any person aggrieved by a final determination of the board may appeal to the Superior Court in accordance with the Maine Administrative Procedure Act.

§3406. Maine Health Care Trust Fund

1. Establishment of the fund. The Maine Health Care Trust Fund, referred to in this chapter as the "fund," is established to finance the plan pursuant to this chapter. Deposits to the fund must be made pursuant to this section and to rules adopted by the board to carry out the purposes of this chapter. All money in the fund must be used for the purposes set forth in this chapter. This fund consists of:

A. All payments collected under this section;

B. Interest earned upon any money in the fund;

C. Any property or securities acquired through the use of money belonging to the fund;

D. All earnings of such property or securities; and

E. All other money received for the fund from any other source.

The fund does not lapse, but must be carried forward.

2. Use of the fund. All revenue paid into the fund is made available to the board and must be expended solely for the purpose of defraying the cost of administering the plan, including, but not limited to, payments to the carriers for coverage purchased through the alliance. The board shall adopt rules setting the requirements for expenditures from the fund.

The board shall perform quarterly reviews of expenditures within the plan to determine whether expenditures are within the global budget.

3. Payment to the fund. Payments are deposited to the fund from the following sources:

A. Payments equal to 12.5% of the state liquor tax collected, pursuant to Title 28-A, section 1651, between December 31, 1996 and January 1, 2001 and payments equal to 6.67% of the state liquor tax collected after January 1, 2001;

B. Payments equal to 50% of the excise tax on malt liquor, low-alcohol spirit products, fortified wines and wine, collected pursuant to Title 28-A, section 1652;

C. Payments of the sales tax collected pursuant to Title 36, section 1811, as follows:

(1) For a payment of 34.88% of the sales tax on the value of liquor sold in licensed establishments;

(2) For a payment of 12.5% of the sales tax on the value of rental of living quarters in a hotel, motel, rooming house, tourist camp or trailer camp between December 31, 1996 and January 1, 2001 and 6.67% of that amount after January 1, 2001;

(3) For a payment of 9.1% of the sales tax on the value of automobile rental for a period of less than one year between December 31, 1996 and January 1, 2001 and 4.76% of that amount after January 1, 2001;

(4) For a payment of 14.29% of the sales tax on the value of prepared food sold in establishments that are licensed for on-premises consumption of liquor between December 31, 1996 and January 1, 2001 and 7.69% of that amount after January 1, 2001;

(5) For a payment of 38.46% of the sales tax on value of the all other tangible personal property and taxable services;

D. Payment of the payroll tax collected pursuant to Title 36, section 2870;

E. Payment equal to 18.6% of the personal income tax collected pursuant to Title 36, section 5101;

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F. Payment equal to 5.4% the corporate income tax collected pursuant to Title 36, section 5203; and

G. Payment of the premium tax collected pursuant to Title 24, section 2311.

SUBCHAPTER II

THE MAINE HEALTH CARE PLAN AND THE PURCHASING ALLIANCE

§3411. Maine Health Care Plan

The Maine Health Care Plan is established to provide health benefits to residents of the State as provided in this chapter beginning July 1, 1997.

1. Services covered. The plan must provide coverage for health care services if the service is necessary for prevention, diagnosis or treatment, or maintenance or rehabilitation after injury, disability or disease as follows:

A. Institutional inpatient services, including:

(1) Medical, surgical, intensive and emergency care, that include organ transplants that improve patient clinical status, as measured by medical conditions, survival rates and other variables;

(2) Rehabilitation for disease or injury but excluding long-term, in-hospital rehabilitation; and

(3) Skilled nursing facility care required for continued recovery after an acute inpatient hospitalization but excluding supportive activities of daily living care;

B. Outpatient and ambulatory services including coverage of diagnostic, surgical and emergency care but excluding:

(1) Nonessential emergency room care;

(2) Ambulance services determined to be medically unnecessary; and

(3) Random health screenings for specific conditions for which no risk factors or indicators exist;

C. Professional services at all sites, including all medically necessary professional services delivered by any licensed, certified or registered health care practitioner

within the practitioner's legal scope of practice, with the
2 following exclusions:

4 (1) Speech and occupational therapy for persons 5 years of age or older with chronic conditions;

6

(2) Physical, occupational and speech therapy for
8 nonacute rehabilitation;

10 (3) Vision care other than the treatment of disease or injury;

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(4) Counseling and health education other than that
14 integral to the care of an individual as a result of illness, injury or other health conditions;

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(5) Chiropractic services provided as nonacute care;

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(6) Podiatry other than the equivalent of that
20 provided by Medicare;

22 (7) Accredited Christian Science facilities other than the equivalent of those provided by Medicare;

24

(8) Acupuncture provided as nonacute care; and

26

(9) Massage therapy provided as nonacute care;

28

D. Mental health and substance abuse services, both
30 inpatient and ambulatory, including detoxification and rehabilitation.

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E. Preventive services as follows:

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(1) Preventive medical services for both children and
36 adults in accordance with the United States Task Force on Preventive Services Guidelines except that screening
38 mammograms must be provided in accordance with the guidelines of the American Cancer Society;

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(2) Dental services for persons under 21 years of age,
42 including education, examinations, cleanings, fluoride treatments and sealants at 6-month intervals and annual
44 radiographs; and

46 (3) Annual dental services for persons 21 years of age and older, including education, examinations,
48 cleanings, sealants and fluoride treatments;

F. Reproductive services, including prenatal, delivery and postpartum care, diagnosis and treatment of sexually transmitted disease, birth control procedures, including sterilization, birth control devices and abortion;

G. Laboratory, radiology and special diagnostic procedures, when medically necessary, including electromyograms, nerve conduction studies, nuclear medicine procedures, pulmonary function studies and electrophysiology studies;

H. Hospice and palliative care, only when medically necessary, including medical supplies, drugs and medications, equipment and care for pain control and symptom management in the last 6 months of life;

I. Supplemental services as follows:

(1) Prosthetic devices when medically necessary;

(2) Durable medical equipment when medically necessary, including rental or purchase of equipment for therapeutic use, oxygen equipment and hearing aids; and

(3) Appropriate medical transportation to the nearest facility that can render necessary emergency treatment; and

J. Prescription drugs:

(1) Including prescription legend drugs, prescribed nonlegend drugs and insulin syringes; and

(2) Excluding:

(a) Experimental and investigational drugs, unless prescribed as part of an established clinical trial and drugs, prescribed as part of such a trial that are covered by another financing mechanism; and

(b) Hair-growth supplements, smoking deterrents, weight control drugs, nonroutine immunizations, infertility treatments, nonprescription legend vitamins, with the exception of those used to supplement the diets of pregnant women.

2. Excluded services. In addition to those exclusions listed in subsection 1, the following benefits are excluded from coverage under the plan:

A. Experimental diagnostic and treatment services other than those provided as part of an established clinical trial and services provided as part of such a trial that are covered by another party;

B. Infertility diagnosis and treatment and reversal of sterilization;

C. Cosmetic surgery except to correct congenital anomalies and repair of injury resulting from an accident;

D. Nonacute ventilator support provided solely for the purposes of prolonging life;

E. Personal comfort items; and

F. Private rooms, except when medically necessary.

3. Expansion or substitution of covered services. The board may expand benefits beyond the minimum listed in subsection 1 upon a finding that the cost of the benefit is justified based upon the improvement in patient health outcomes resulting from the benefit and that there are sufficient funds to cover the additional benefit. The board may substitute any service or benefit not previously covered under the plan for a listed service, if the board determines that it is of equivalent therapeutic value or is a less costly treatment alternative to the listed service and if the service or benefit is delivered by a health care practitioner acting within the practitioner's scope of practice. In making a substitution or expansion under this subsection, the board shall consider the impact that the substitution or expansion will have on the public health goals of the Bureau of Health within the department.

4. Fee-for-service and managed care plans. The plan must be offered as a fee-for-service plan and as a managed care plan, consistent with this subsection.

A. The fee-for-service plan has the following features:

(1) A $500 deductible;

(2) A $5 copayment for generic prescription drugs and a $10 copayment for nongeneric prescription drugs;

(3) A $1,500 out-of-pocket maximum per individual per year; and

(4) A $3,000 out-of-pocket maximum per family.

B. The managed care plan has the following features:

(1) A $10 copayment per office visit, except for preventive or prenatal visits as defined by the board, for which there is no copayment;

(2) A $5 copayment for generic prescription drugs and a $10 copayment for nongeneric prescription drugs; and

(3) A $100 copayment per hospital day, up to $500.

§3412. Plan participation

Each person not already covered under a federally sponsored health plan who is a resident of this State for one month and who is not a listed dependent on a tax return filed in this State is an enrolled individual. Each enrolled individual shall purchase coverage under the plan on behalf of the enrolled individual and the enrolled individual's dependents through the alliance.

1. Individual premium payment. In accordance with subsection 3, each enrolled individual shall pay a premium equal to the difference between the premium cost and the employer contribution pursuant to subsection 2, if applicable.

2. Employer contribution. Each employer shall pay an employer contribution toward the purchase of coverage under the plan for each employee. For a full-time employee, the employer contribution is equal to a maximum of 50% of the lowest-cost premium price offered by a participating carrier providing coverage in the area where the employee lives. According to rules adopted by the board, the employer contribution is reduced on a pro rata basis for an employee working less than full time.

3. Individual subsidies. An enrolled individual is eligible to receive a subsidy toward the purchase of coverage under the plan if the enrolled individual is a resident of this State for one month and the enrolled individual family income is less than 250% of the nonfarm income official poverty line. The board shall respond within 30 days of receipt of a completed application for a subsidy or provide a written explanation for its denial or any restrictions placed on the subsidy. If good cause exists to believe that the applicant may not meet the eligibility requirements in this section, the board may extend the time period in this section for an additional 30 days. The subsidy is equal to the difference between the premium payment calculated pursuant to subsection 1 and the limit on premium payments determined pursuant to this subsection. The limit on premium payments is calculated on a sliding scale basis according

to rules adopted by the board and based on family income as a percent of the nonfarm income official poverty line as follows.

Family Income as a Percent of the Nonfarm Income Official Poverty Line	Premium Payment Limit
less than 100%	1% of family income
100% - 149%	1% to 3.5% of family income
150% - 199%	3.5% to 7% of family income
200% - 249%	7% to 10% of family income

4. Employer subsidies. An employer is eligible for a subsidy equal to that amount of the total employer contribution owed on behalf of all of the employer's employees in excess of 7.5% of wages paid to those employees, as defined in Title 26, section 1043. The board shall ensure that the remaining portion of the employer's contribution is paid from revenues held in the fund.

5. Residency. The board shall establish standards for determining when a person is an enrolled individual under subsection 1 and when an enrolled individual is eligible for a subsidy under subsection 3.

6. Presumed coverage. A person is presumed covered under the plan if:

A. The person is unconscious, comatose or otherwise unable because of the person's physical or mental condition to document eligibility or to act in the patient's own behalf, or the patient is a minor; or

B. The person is involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds.

A provider of health care services shall provide care to a person presumed covered as if the person were covered. If the person is not covered, the board shall pay the provider of health care services for services provided and shall seek reimbursement from the person served.

7. Enrollment. The board shall establish an enrollment procedure that ensures that all persons subject to this section are formally enrolled and aware of the right to a subsidy if qualified. The enrollment procedures must include, but are not limited to, open enrollment for those joining the alliance, procedures that allow enrollees to change participating carriers for good cause and annual open enrollment for enrollees that desire to change type of plan or participating carriers without

good cause. The board shall provide that each enrollee may enroll in either type of plan offered by any participating carrier, as long as the carrier provides coverage where that enrollee lives.

8. Enforcement of individual premium payment and employer contribution. As permitted under this subsection, the board may institute an enforcement action against an enrolled individual or an employer not complying with the requirements of this section.

A. If a party, required under this section to pay a premium payment or employer contribution, fails to pay any part of that obligation, the executive director may assess the obligation and any interest or penalties due. Payments and contributions that are unpaid on the date on which they are due and payable:

(1) Bear interest at the rate determined by the State Tax Assessor as established by Title 36, section 186, from and after the due date, until payment is received by the executive director; and

(2) Are subject to a penalty of 2% of the amount of the unpaid premium payment or contribution for the first 30 days after the due date and a penalty of 5% of the amount of the unpaid premium payment or contribution after the 30 days.

B. A party may appeal determinations by the executive director by filing an appeal to the board within 15 days after notification is mailed to the party's last known address or within 15 days after the notification is delivered. After a hearing pursuant to section 3405, the board may affirm, modify or reverse the executive director's assessment. Final board decisions may be appealed by the party and by the executive director.

C. Upon the failure of a party to pay the premium payment or employer contribution required under this section, the board may file in the registry of deeds of any county a certificate under the board's official seal, stating the name of the party, the party's address, the amount of the contributions and interest or penalties assessed and in default and that the time in which an appeal is permitted is expired. When the certificate is filed and recorded, the amount of the assessment is a lien upon the entire interest of the party, legal or equitable, in any real or tangible personal property situated within the jurisdiction of the office in which that certificate was filed. The lien is subordinate to any real estate mortgage previously recorded

as required by law. A lien filed under this paragraph is not valid against one who purchases personal property from the party in the usual course of business, in good faith and without actual notice of the lien. The lien may be enforced against any real or personal property by a civil action in the name of the board. The board shall discharge its lien upon receiving from the party a bond with sureties conditioned upon the payment of the amount of contributions and interest as finally determined, together with any additional amount that may have become due or may have accrued under this chapter and court costs, if any. Any property upon which a lien has been claimed may be sold, after due notice, in conformity with the law applicable to sales of real or personal property on executions issued in personal actions, in connections with which sale the board has the same rights, privileges, duties and responsibilities as one in whose favor an execution is issued. The remedies under this paragraph are in addition to all other remedies available to the authority.

§3413. Purchasing alliance

The alliance is a division within the authority. The alliance is a purchasing sponsor and may not bear risk. The board shall appoint an alliance director to administer the alliance. The alliance director shall serve at the pleasure of the board and may employ other staff as needed. The alliance has the following powers and duties.

1. Purchasing coverage under the plan. The alliance shall purchase health care coverage under the plan on behalf of alliance members. In accordance with the requirements of section 3414, the alliance shall develop a request for proposals for the plan, solicit bids from qualified carriers, review bids and negotiate with carriers. The alliance shall establish conditions and procedures for determining the eligibility of carriers, including, but not limited to, those conditions set forth in section 3414. The alliance may enter into contracts with eligible carriers to provide health care coverage to enrolled individuals.

2. Eligibility of individuals. The alliance shall implement eligibility standards and enrollment procedures as established by the board pursuant to section 3412.

3. Report cards. The alliance shall publish and distribute audited report cards, pursuant to section 3404, subsection 10, to current and potential alliance members.

4. Risk adjustment. The alliance shall implement risk adjustment according to the procedures established by the authority.

5. Collection of premium; payment of rates. The alliance shall establish procedures for the collection of premiums from employers and from enrolled individuals. When feasible, the alliance shall allow enrollees to pay through a voluntary automatic payment system. The alliance may institute enforcement actions for nonpayment pursuant to section 3412. The alliance shall pay contracted rates to participating carriers on a monthly basis or as otherwise provided by mutual agreement.

6. Administrative and accounting procedures. The alliance shall establish administrative and accounting procedures for operating the alliance and for providing services to alliance members.

7. Ombudsman services. The alliance shall establish procedures for assisting enrollees in resolving problems associated with enrollment, coverage and other disputes arising between the carrier and the enrollee.

8. Marketing; marketing materials. The alliance shall develop standards for reviewing and approving marketing materials offered to alliance members by participating carriers. The alliance shall establish procedures for distributing marketing information to both alliance members and to potential alliance members.

9. Underserved areas. The alliance shall develop standards for determining when a carrier has made all best efforts to extend its service area to, and improve access for, populations of underserved areas. When applicable, all best efforts include good faith negotiation with providers serving those populations.

10. Agents. The alliance may establish relationships with agents to facilitate the purchase of health care coverage through the alliance. The alliance may offer training and information programs to educate agents on alliance operations and products.

11. Contracts with 3rd parties. The alliance may contract with qualified, independent 3rd parties for services necessary to carry out the powers and duties of the alliance. Unless permission is granted specifically by the alliance, a 3rd party hired by the alliance may not release, publish or otherwise use any information to which the 3rd party has access under its contract. Except with the express written approval of the alliance, an entity may not act both as a participating carrier

and a 3rd party under contract to the alliance, directly or through an affiliated person.

12. Contracts generally. The alliance may enter into all other contracts necessary to carry out the powers and duties of this chapter.

§3414. Eligible carriers

1. Qualifications. In order to be eligible to be a participating carrier, a carrier must be able to demonstrate the following operating characteristics to the alliance's satisfaction.

A. The carrier must be licensed by the bureau as authorized to operate in this State.

B. The carrier must have the ability to provide alliance enrollees with adequate capacity and reasonable access to covered services in any part of the State where that carrier is authorized to do business.

C. The carrier must have established grievance procedures, including the ability to respond to enrollees' calls, questions and complaints.

D. If the carrier does not have a license to operate in all parts of the State, the carrier must have demonstrated that it has made all best efforts to extend its service area to and improve access for rural and underserved populations designated by the board.

E. The carrier must have the ability, to the satisfaction of the alliance, to provide the data necessary for reviewing the quality of care covered and reviewing the appropriateness of the care covered.

2. Selection of carriers. In evaluating which eligible carriers may participate, the alliance shall consider, in addition to other factors it considers relevant, the following factors:

A. Pricing and competitiveness of each bid from a carrier;

B. The effect of contracting with additional carriers on the administrative costs of the alliance and alliance members, the efficiency of the alliance and the competitiveness of the premiums that will be paid to participating carriers; and

C. Evidence of quality of care and consumer satisfaction.

3. Participation. Every participating carrier shall:

A. Offer one or both types of benefit plans authorized pursuant to section 3411;

B. Accept all applicants for enrollment and enroll and disenroll individuals as directed by the alliance or its designee;

C. Provide for the collection and reporting to the authority information on the effectiveness and outcomes of the health benefit plan in providing selected services;

D. Provide advance notice of its decision to terminate its contract with the alliance to the alliance, to the bureau and to affected enrollees at least 180 days prior to the nonrenewal of any health benefit plan to enrollees.

E. Comply with all rules regarding rating, underwriting, claims handling, sales, solicitation, licensing, fair marketing, unfair trade practices and other provisions in this chapter, established by the alliance or adopted by the bureau; and

F. Comply with any other requirement established by the alliance pursuant to this chapter or pursuant to the contract between the alliance and the participating carrier.

4. Failure to maintain compliance. The alliance may suspend or revoke the eligibility of any carrier that fails to maintain compliance with the requirements listed in this section.

§3415. Agent commissions

Commissions paid to an agent must be collected directly from the purchaser of the agent's services and may not be considered part of the premium collected by the alliance. An agent may not be paid a commission calculated as a percent of actual premium cost. The agent may be paid a commission calculated as a percent of average premium cost for the relevant enrollment period. The alliance shall determine an average premium cost for the relevant enrollment period.

SUBCHAPTER III

COMPREHENSIVE HEALTH PLANNING

§3421. State health resource plan

The board shall, before January 15, 1997 and every 2nd year after January 15, 1997, adopt a state health resource plan in accordance with the United States Public Health Services Act, 42 United States Code, Section 201 to 300aaa-13, (1988). This 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.

1. Data; supporting information. In developing the state health resource plan, the board shall use the best and most recent data describing the current supply and distribution of health care, facilities and human resources. The board shall consult with relevant state agencies and may establish advisory committees that include consumer groups, health care providers, insurance and health benefit carriers and other 3rd party payors, as determined necessary to carry out the purposes of this chapter.

2. Plan components. The state health resource plan must include:

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

B. 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 substance abuse, emergency care, ambulatory care services including primary care resources, human resources, major medical equipment, and health screening and early intervention;

C. A determination of the appropriate supply and distribution of resources and services identified in paragraph B and mechanisms that encourage the appropriate integration of these services on a local or regional basis. In making this determination, the department 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

D. A component that addresses health promotion and disease prevention prepared by the Bureau of Health, within the

Department of Human Services, in a format established by the board.

3. Public hearings. Prior to adopting the state health resource plan, the board shall conduct public hearings, in different regions of the State, on the proposed state health resource plan. Interested persons have the opportunity to submit oral and written testimony. Not less than 30 days before each hearing, the board 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 state health resource plan in advance of the hearing and the place and period during which written comment may be directed to the board.

4. Funds. The board is authorized to accept and expend federal funds allotted or otherwise made available under the United States Public Health Services Act, 42 United States Code, Section 201 to 300aaa-13, (1988) to states for the purposes of the Act and in accordance with the Act, as amended, and in accordance with the applicable laws of the State, rules or fiscal policies or practices.

5. Health work force forum. The board shall convene at least once annually a health work force forum to consider health work force issues. The forum must include representatives from health professionals, licensing boards and health education programs. The forum shall:

A. Develop an inventory of present health work force and education programs; and

B. Develop research and analytical methods for understanding population-based health care needs on an ongoing basis.

Through the forum, the board shall serve as a clearinghouse for information relating to health work force issues. The board shall use the information gathered through the forum to inform its health policy and planning decisions authorized under this Title.

§3422. Global budget

The board shall before January 1st of each year prepare a global budget for all health care expenditures under the plan. The global budget must include the cost of all services and benefits provided under the plan, administrative costs, data gathering and other activities, and revenues deposited in the Maine Health Care Trust Fund. The board shall establish the base-year global budget through a public process. The board

shall consider current and projected expenditures as future expenditures may be affected by the plan, changing technology, population and other factors. The board shall determine an appropriate rate of increase for the global budget based upon the quality of care under the plan, access to care under the plan, the economic impact of the plan on gross state product, employment and per capita income and projected revenues to be deposited in the Maine Health Care Trust Fund. The board shall monitor the ongoing affect of the global budget on these considerations. The global budget is enforced by a limit on premium costs, as determined by the board.

§3423. Quality and affordable health care services

In coordination with the alliance, the board shall ensure that the plan provide quality and affordable health care services.

1. Quality assurance. The board shall develop methods of analysis for analyzing the data to determine the quality and cost effectiveness of care provided by participating provider of health care services. The board may consult the quality improvement foundation to assist in this process.

2. Cost containment. In order to control costs and ensure that funds are used for optimal service delivery, the board shall:

A. Eliminate administrative and other costs that do not contribute to health care services;

B. Identify and eliminate unnecessary health care services to patients receiving that care;

C. Identify and foster those measures that prevent disease and maintain health; and

D. Take such other steps as necessary to ensure that the rate or increase in health care expenditures not exceed the rate of increase allowed by the global budget.

§3424. Data collection and monitoring

1. Data collection. The board shall advise and assist the data collection activities of the Maine Health Data Organization.

2. Analyses of data. The board shall conduct analyses of data necessary for the functioning of the plan, including, but not limited to, the review of access to care, quality, efficiency, and appropriateness of care and services, health care provider participation, population-based health outcomes and geographic distribution of health care resources.

3. Standard measurements. In cooperation with the Maine Health Data Organization, the board shall adopt a standard set of indicators and methods to assess the effectiveness of the plan in implementing and fulfilling the requirements of this chapter.

Sec. A-3. Effective date. This Part takes effect January 1, 1997.

PART B

Sec. B-1. Waivers for Medicaid and Medicare. The Maine Health Care Authority, as established in Part A of this Act, the Maine Revised Statutes, Title 24, section 3403, and the Department of Human Services shall conduct a joint study of the provision of health care services under the Medicaid and Medicare programs to determine the best method of coordinating benefit delivery and compensation under those programs and the reorganization of State Government necessary to achieve the objectives of the authority. The Department of Human Services shall apply for all waivers necessary to allow the State to incorporate the Medicaid program into the Maine Health Care Plan to the maximum degree possible. The Maine Health Care Authority and the Department of Human Services shall apply for all waivers required to coordinate the benefits of the Maine Health Care Plan with the Medicare and Medicaid programs. The Department of Human Services and the Maine Health Care Authority shall report their actions taken, pursuant to this section, to the Legislature no later than January 1, 1998 and include any necessary implementing legislation.

Sec. B-2. Effective date. This Part takes effect July 1, 1996.

PART C

Sec. C-1. 22 MRSA §253, as amended by PL 1981, c. 470, Pt. A, §§55 and 56, is repealed.

Sec. C-2. 22 MRSA §304-A, as amended by PL 1993, c. 477, Pt. D, §2 and affected by Pt. F, §1, is further amended to read:

§304-A. Certificate of need required

~~No~~ A person may not enter into any commitment for financing a project that requires a certificate of need or incur an obligation for the project without having sought and received a certificate of need, except that this prohibition does not apply to commitments for financing conditioned upon the receipt of a

certificate of need or to obligations for predevelopment activities of less than $150,000 for health care facilities other than hospitals or $250,000 for hospitals.

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

1. Acquisition by lease, donation, transfer. Any acquisition by or on behalf of a ~~health care facility~~ person under lease or comparable arrangement or through donation~~, which~~ that would have required review if the acquisition had been by purchase;

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

~~**2-A. Acquisitions of major medical equipment with a cost in the aggregate of $1,000,000 or more.** Acquisitions of major medical equipment with a cost in the aggregate of $1,000,000 or more by ambulatory surgical centers, independent cardiac catheterization centers, independent radiologic service centers and centers providing endoscopy, sigmoidoscopy, colonoscopy or other similar procedures associated with gastroenterology;~~

3. Capital expenditures. The obligation by or on behalf of a ~~health care facility,~~ person except by a skilled or intermediate care facility or hospital, of any capital expenditure of $350,000 or more. Intermediate care and skilled nursing care facilities have a threshold of $500,000, except that any transfer of ownership is reviewable;

3-A. Hospital capital expenditures. The obligation, by or on behalf of a ~~hospital,~~ person of any capital expenditure of $1,000,000 or more, except that:

A. A capital expenditure for the purpose of acquiring major medical equipment is reviewable only to the extent provided in subsection 2; and

B. Any transfer of ownership of a hospital is reviewable.

4. New health services. The offering or development of any new health service. For purposes of this section, "new health services" ~~shall include~~ includes only the following:

A. The obligation of any capital expenditures by or on behalf of a ~~health care facility which~~ person that is

associated with the addition of a health service ~~which~~ that was not offered on a regular basis by or on behalf of the ~~facility~~ person within the 12-month period prior to the time the services would be offered;

B. The addition of a health service ~~which is~~ to be offered by or on behalf of a ~~health care facility~~ person, which was not offered on a regular basis by or on behalf of the ~~facility~~ person within the 12-month period prior to the time the services would be offered, and which, for the 3rd fiscal year of operation, including a partial first year, following addition of that service, absent any adjustment for inflation, is projected to entail annual operating costs of at least the expenditure minimum for annual operating costs; or

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

5. Termination of a health service. The obligation of any capital expenditure by or on behalf of a ~~health care facility~~ person other than a hospital that is associated with the termination of a health service that was previously offered by or on behalf of the health care facility;

6. Changes in bed complement. Any change in the existing bed complement of a health care facility other than a hospital;

6-A. Increases in licensed bed capacity of a hospital. Any change in the existing bed complement of a hospital, in any 2-year period, that:

A. Increases the licensed or certified bed capacity of the hospital by more than 10% or more than 5 beds, whichever is less; or

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

7. Predevelopment activities. Any appropriately capitalized expenditure of $150,000 or more or, in the case of hospitals, $250,000 or more for predevelopment activities

proposed to be undertaken in preparation for any project that would itself require a certificate of need;

8. New health care facilities. The construction, development or other establishment of a new health care facility, subject to the following limitations.

A. Except as provided in paragraph B, the department shall review certificate of need applications, including business plans, for home health care providers only to determine whether the provider is fit, willing and able to provide the proposed services at the proper standard of care as provided in section 309, subsection 1, paragraph A. The department shall establish a reduced filing fee for home health care providers whose applications are reviewed under this paragraph.

B. The department shall review an application for a home health care provider to determine its compliance with all the requirements of section 309, subsection 1 if the application involves:

(1) A business plan that forecasts 3rd-year operating costs exceeding $500,000; or

(2) A transfer of ownership of an existing home health care provider; and

9. Other circumstances. In the following circumstances:

A. Any proposed use of major medical equipment to serve inpatients of a hospital, if the equipment is not located in a health care facility and was acquired without a certificate of need, except acquisitions waived under section 308, subsection 4; or

B. If a person adds a health service not subject to review under subsection 4, paragraph A or C ~~and~~, which was not ~~deemed~~ determined 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, ~~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. C-3. Effective date. This Part takes effect January 1, 1997.

PART D

Sec. D-1. Maine Health Care Plan and the Bureau of Insurance. The following provisions apply to the implementation of the Maine Health Care Plan, as established in Part A of this Act, as the plan relates to insurance regulation under Title 24 and Title 24-A. The Maine Health Care Authority and the Superintendent of the Bureau of Insurance shall study the coordination of the delivery of health benefits under the Maine Health Care Plan and the regulation of insurers, health maintenance organizations and nonprofit hospital and medical organizations. The study must consider the repeal of unnecessary statutes and rules and the elimination of unnecessary functions within the Bureau of Insurance. By January 1, 1997, the Maine Health Care Authority, with the advice and assistance of the Superintendent of the Bureau of Insurance, shall submit to the Legislature all legislation necessary to coordinate the functions of the Bureau of Insurance with the implementation of the Maine Health Care Plan, including amendments of statutes, reallocation of funds and transitional language as needed.

Sec. D-2. Effective date. This Part takes effect July 1, 1996.

PART E

Sec. E-1. 5 MRSA §285, as amended by PL 1995, c. 368, Pt. G, §§1 to 4, is repealed.

Sec. E-2. 5 MRSA §285-A, as amended by PL 1995, c. 97, §1, is repealed.

Sec. E-3. 5 MRSA §286, as amended by PL 1991, c. 780, Pt. Y, §§26 and 27, is repealed.

Sec. E-4. 5 MRSA §286-A, as amended by PL 1991, c. 780, Pt. Y, §28, is repealed.

Sec. E-5. Effective date. This Part takes effect January 1, 1997.

PART F

Sec. F-1. 24-A MRSA c. 81 is enacted to read:

CHAPTER 81

THE HEALTH PLAN QUALITY IMPROVEMENT ACT

§6651. Definitions

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

1. Bureau. "Bureau" means the Bureau of Insurance.

2. Carrier. "Carrier" means an insurance company licensed in accordance with this Title, a health maintenance organization licensed pursuant to chapter 56, a preferred provider organization licensed pursuant to chapter 32, a physician-hospital organization, a nonprofit hospital or medical service organization organized pursuant to Title 24, an administrator licensed pursuant to chapter 18, a utilization review entity licensed pursuant to chapter 34, or any other entity that provides or administers health care coverage. This definition does not include employers exempted from the applicability of this Act under the federal Employee Retirement Income Security Act of 1974.

3. Direct service ratio. "Direct service ratio" means the ratio of benefits returned to policyholders or contract holders, not including refunds or credits, to premiums collected.

4. Emergency medical condition. "Emergency medical condition" means:

A. A medical condition manifesting itself by acute symptoms of such severity, including extreme pain, that the absence of immediate medical attention could reasonably result in:

(1) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or the unborn child in jeopardy;

(2) Serious impairment to bodily function due to injury or accident; or

(3) Serious dysfunction of any bodily organ or part due to disease; and

B. With respect to a pregnant woman who is having contractions:

(1) That there is inadequate time to effect a safe transfer from one hospital to another hospital before delivery; or

(2) That the transfer from one hospital to another hospital may pose a threat to the health or safety of the woman or the unborn child.

5. Emergency services. "Emergency services" means those covered services provided after the sudden onset of an emergency medical condition.

6. Enrollee. "Enrollee" means an enrolled individual or a dependent of an enrolled individual.

7. Health plan. "Health plan" means a plan operated or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan.

8. Managed care plan. "Managed care plan" means a plan operated or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan through:

A. Arrangements with selected providers to furnish health care services;

B. Explicit standards for the selection of participating providers;

C. Financial incentives for persons enrolled to use the participating providers and procedures furnished by the plan; or

D. Arrangements that share risks with providers.

9. Participating provider. "Participating provider" means a licensed or certified provider of health care services, including mental health services, or a licensed health care supplier that has entered into an agreement with a carrier to provide services or supplies to a patient enrolled in a managed care plan.

10. Superintendent. "Superintendent" means the Superintendent of Insurance.

§6652. Reporting requirements

To operate in this State, a carrier must comply with the following requirements.

1. Description of plan. A health plan must provide a brochure to prospective enrollees and members of the public and nonparticipating providers upon request information on the terms and conditions of the health plan to enable those persons to make informed decisions regarding their choice of plan. A health plan must provide this information annually to current enrollees, participating providers and the superintendent. This information must be presented in a format acceptable to the superintendent. All written and oral descriptions of the health plan must be truthful and use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII. Descriptions of health plans under this subsection must be standardized so that enrollees may compare the attributes of the health plans. After a health plan has provided the required information, the information requirement under this subsection may be satisfied by providing amendments to the information on an annual basis. Specific items that must be included in a description are:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, specific service, including, but not limited to, the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type; and

(4) Health care services that are provided only by referral;

B. Any prior authorization or other requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may lead the enrollee to be denied coverage or not be provided a particular service;

C. Financial arrangements or contractual provisions with hospitals, review companies, physicians and any other provider or health care services that could potentially limit the services offered, restrict referral or treatment options or negatively affect the provider's fiduciary responsibility to the provider's patients, including, but

not limited to, financial incentives not to provide medical services or other services;

D. An explanation of how health plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or out-of-plan services or other services not covered and limits on preexisting conditions and waiting periods;

E. The terms under which the health plan may be renewed by the plan member or enrollee, including any reservation by the health plan of any right to increase premiums;

F. A statement as to when benefits cease in the event of nonpayment of the premium and the effect of nonpayment upon the enrollee who is hospitalized or is being treated for an ongoing condition;

G. A description of the enrollee's right to appropriate and accessible care in a timely fashion, an effective and timely grievance process, timely determinations of coverage issues, confidentiality of medical records, written copies of coverage decisions that are not explicit in the health plan agreement and 2nd opinions when used in grievance procedures as outlined in section 6657. The description must also include the enrollee's right not to be discriminated against based on health status and the right to refuse treatment without jeopardizing future treatment; and

H. The relative value of the health plan based on an actuarial index of benefit factors developed by the bureau. The benefit factors use standard assumptions for all plans and measure the cost differences associated with benefit levels and the expected impact of the benefit level on utilization.

2. Schedule of revenue costs and expenses. A health plan must provide the following information annually to the superintendent:

A. A schedule of revenues and expenses, including direct service ratios;

B. Health plan revenue;

C. Health plan administrative costs, as defined by the superintendent; and

D. Health plan costs of medical services, as defined by the superintendent;

The superintendent may require the health plan to furnish supporting detail for the information required in this subsection.

3. Plan complaints, adverse decisions and prior authorization statistics. A health plan must provide information annually to the superintendent on complaints, adverse decisions and prior authorization statistics. This statistical information must contain:

A. The ratio of the number of complaints received to the total number of enrollees, reported by type of complaint and category of enrollees;

B. The ratio of the number of adverse decisions issued to the number of complaints received, reported by category;

C. The ratio of the number of prior authorizations denied to the number of prior authorizations requested, reported by category;

D. The ratio of the number of successful enrollee appeals to the total number of appeals filed;

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and

F. Enrollee satisfaction statistics, including complaints received, provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints.

4. Acceptable methods of providing information. A carrier may meet any of the reporting requirements set forth in this section by providing information in conformity with the requirements of the federal Health Maintenance Organization Act of 1973 or any other applicable state or federal law or any accrediting organization recognized by the superintendent, as long as the superintendent finds that the information is substantially similar to the information required by this section and is presented in a format that provides a comparison between health plans. When the superintendent determines that the information required by this section is feasible and appropriate, this information must be provided by geographic region, age, gender and employer or group. With respect to geographic

breakdown, the information must be provided in a manner that permits comparisons between urban and rural areas.

The superintendent shall compile information relevant to a comparison of health plans from the information reported according to this section into an annual report and make that report available to the general public and other interested persons. The report must be presented in a format that provides a comparison between health plans, including a description of the data reported as well as a disclaimer regarding limitations on the use of the data.

§6653. Plan requirements

A health plan operating in this State must meet the following requirements.

1. Provider participation; credentials. For managed care plans, the participation of providers and credential granting is governed by the following conditions.

A. A managed care plan must establish credentials for participating providers and allow all providers within the managed care plan's geographic service area to apply for credentials, if those providers offer services covered by the managed care plan.

B. The credential-granting process begins upon application of a provider to a managed care plan, except when a managed care plan demonstrates that the plan's provider panel is full, the managed care plan need not undertake the credential-granting process. To qualify for this exception, the managed care plan must demonstrate, to the superintendent's satisfaction, that it meets all of the access standards set forth in this chapter.

C. If a managed care plan is accepting applications and a provider is denied participation, that provider's application must be reviewed by a credential-granting committee, that contains appropriate representation of the applicant's specialty.

D. Credential granting must be based on standards of quality and performance, which may include economic profiling, with input from providers granted credentials by the managed care plan. Economic profiling of a provider must reflect variation in case mix, patient age and other factors outside the provider's control that influence the cost of care. A description of these standards must be made

available to applicants and enrollees. Providers may review
2 and contest these economic profiles.

4 E. A managed care plan may not discriminate against an enrollee's health status by excluding a provider whose
6 practice contains a substantial number of patients with chronic or disabling medical conditions.
8
F. All decisions regarding credential granting must be in
10 writing. The applicant must be provided with all reasons for denial of an application or nonrenewal contract.
12
G. A managed care plan may not include any clause in a
14 provider's contract that allows the managed care plan to terminate the contract without cause. Nothing in this
16 subsection prohibits a managed care plan from terminating a provider on the grounds of excess capacity when the managed
18 care plan demonstrates, to the superintendent's satisfaction, that the managed care plan complies with the
20 access standards set out in this section.

22 H. A managed care plan may not terminate or restrict a provider's contract because the provider advocates for
24 medically appropriate health care.

26 (1) For the purposes of this paragraph, "to advocate for medically appropriate health care" means to appeal
28 a decision of the managed care plan to deny payment for a service pursuant to a reasonable grievance or appeal
30 procedure, or to protest a decision, policy or practice that the provider, consistent with the degree of
32 learning and skill ordinarily possessed by a reputable provider practicing in the same or similar locality
34 under similar circumstances, reasonably believes impairs the provider's ability to provide medically
36 appropriate health care to the provider's patients.

38 (2) Nothing in this paragraph may be construed to prohibit a managed care plan from making a
40 determination not to pay for a particular medical treatment or service or to prohibit a managed care plan
42 from enforcing reasonable peer review or utilization review protocols or determining whether a provider has
44 compiled those protocols.

46 There must be an appeal process available for all adverse decisions. The bureau shall determine whether the process
48 provided by a managed care plan is consistent with due process, using as a standard due process provisions contained in the

federal Health Care Quality Improvement Act of 1986, 42 United States Code, Sections 11101 to 11152.

2. Confidentiality. A health plan must establish procedures to ensure that all applicable federal and state laws designed to protect the confidentiality in provider and individual medical records are followed.

3. Grievance procedures. All health plans must have a grievance procedure as set out in section 6657.

§6654. Utilization review

If a health plan operating in this State requires prior authorization or other review requirements, including those causing a patient to be denied coverage or not be provided a particular service, that health plan shall comply with chapter 34 and any applicable rules in conducting utilization reviews. In addition, the health plan shall comply with the following requirements.

1. Requirements for medical or utilization review practices. A health plan must appoint a medical director who is responsible for all clinical decisions made by the health plan and provide assurances that its medical or utilization review practices and those of its contracted payors or reviewers comply with the following requirements.

A. Screening criteria, weighting elements and computer algorithms utilized in the review process and their method of development must be released, upon request, to providers and the general public. This criteria must be based on sound scientific principles.

B. Any person who recommends denial of coverage or payment or determines that a service should not be provided, based on medical necessity standards, must have relevant training and expertise that is comparable to the treating provider.

2. Same-day telephone responses. Health plan personnel must respond to telephone inquiries about medical necessity, including approval of continued length of stay, on the same day the inquiry is made.

3. Prior authorization of nonemergency services. The health plan must answer provider requests for prior authorization of a nonemergency service within 2 business days. If the information submitted is insufficient to make a decision, the health plan must notify the provider within 2 business days of the additional information necessary to render a decision. If

the health plan determines that outside consultation is necessary, the plan must notify the provider and the enrollee for whom the service was requested within 2 business days. The health plan must make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

4. Medical information release-consent forms. When prior authorization is a condition to coverage of a service, a health plan must ensure that an enrollee signs a medical information release-consent form upon enrollment.

§6655. Quality of care

A health plan must ensure that the health care services provided to enrollees is rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community.

1. Internal quality-assurance program. A health plan must have an ongoing quality-assurance program for health care services provided or reimbursed by the health plan.

2. Written standards. The quality of care standards must be described in a written document, which must be available for examination by the superintendent or the Department of Human Services.

§6656. Enrollee's choice of provider

1. Choice of provider. A managed care plan must allow enrollees to choose their own participating provider or providers, as allowed under the rules of the managed care plan, from among the slate of participating providers. A managed care plan must allow enrollees to change providers without good cause at least once annually and change providers with good cause as necessary. In the event an enrollee fails to choose a participating provider, the managed care plan may assign the enrollee a participating provider, as long as the participating provider is located in the same geographic area in which the enrollee resides.

2. Chronic disease or condition. When the enrollee has a chronic disabling disease or condition and it is in the enrollee's best interest to continue an existing provider-patient relationship with a nonparticipating provider or establish a new provider-patient relationship with a nonparticipating provider, that provider must be permitted to enroll as a participating

provider, even if only to continue care for that particular patient. The provider must meet the standards of quality set by the managed care plan and accept the managed care plan's standard contractual requirements, fee schedules and financial arrangements.

§6657. Grievance procedure

1. Statement of reasons for denial. An enrollee or a provider, who has had a claim denied or is otherwise aggrieved by any decision of a health plan, must be provided a written statement of reasons for the decision, which must be clearly documented in the health plan's permanent records of the grievance, whether those records are automated or manual. The written statement must include a general description of the denial or of the grievance, an explanation of both the enrollee's and the provider's appeal rights, and instructions for both the enrollee and the provider to appeal pursuant to the grievance process described in subsection 2.

2. Grievance process. A health plan must have a grievance process that meets requirements established by the superintendent. The grievance process described in this subsection may not be construed as mandatory for the enrollee or the provider. Exhaustion of the grievance process or administrative remedies may not be construed as a prerequisite to civil court action against the health plan.

3. Appeal process. An enrollee or a provider, upon assignment of an enrollee who has had a claim denied, must be provided an opportunity for a due process appeal to a medical consultant or peer review group. The independent medical consultant or peer review group must be agreed upon by the appealing party and the health plan and may not be affiliated with the organization that performed the initial review. This subsection applies only to claims for services for life-threatening conditions or conditions likely to lead to permanent impairment.

4. Independent 2nd opinion. In any appeal when a professional opinion regarding a health condition is a material issue in the dispute, the appealing party is entitled to an independent 2nd opinion paid for by the health plan.

§6658. Cost containment

A managed care plan must work with its participating providers to establish evidence-based, cost-effective practice guidelines.

§6659. Enforcement by enrollees or participating providers

Enrollees and participating providers have the right to bring a private action at law or equity to enforce any of the standards, rights or requirements of this chapter in a court of law and, if successful, be awarded costs and legal fees.

§6660. Construction

Nothing in this chapter may be construed to:

1. Purchase services with own funds. Prohibit an individual from purchasing any health care services with that individual's own funds, whether these services are covered within the individual's benefit package or from another health care provider or plan, except as otherwise provided by federal or state law;

2. Additional benefits. Prohibit any plan sponsor from providing additional coverage for benefits, rights or protections not set out in this chapter; or

3. Provider participation. Permit any provider willing to abide by the terms and conditions of a managed care plan to be admitted to the managed care plan.

§6661. Liability

1. Indemnification. A contract between a carrier and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with any claim or action brought against the health plan based on the carrier's own fault.

2. Immunity from liability. A participating provider is immune from civil liability for a health plan's negligent decision that causes an enrollee's injury when the participating provider has informed the enrollee or, if the enrollee is incapacitated, the enrollee's legal representative, of the provider's disagreement with the decision, the medical consequences of acting according to the decision and the enrollee's opportunity to appeal the decision pursuant to rules adopted by the superintendent. The provider's disclosure to the enrollee must be in terms understandable to a reasonable person. The health plan is civilly liable to a enrollee for its negligent decisions that cause a enrollee's injury. Nothing in this subsection may be construed to immunize the provider from civil liability arising from the provider's own negligence.

Sec. F-2. Effective date. This Part takes effect January 1, 1997.

PART G

Sec. G-1. 24 MRSA §2311 is repealed and the following enacted in its place:

§2311. Taxation

Title 36, chapter 357 applies to every corporation subject to this chapter.

Sec. G-2. 28 MRSA §1651, sub-§1, as amended by PL 1993, c. 615, §5, is further amended to read:

1. State liquor tax. Except as provided in subsection 2, the commission shall determine and set the price at which to sell all spirits and fortified wine that will produce a state liquor tax of not less than ~~65%~~ 70% based on the delivered case cost F.O.B. liquor warehouse.

C. The commission shall add any cost to the State related to handling containers returned for refund pursuant to Title 32, section 1863-A to the established price without markup.

Sec. G-3. 28-A MRSA §1652, sub-§1, as repealed and replaced by PL 1987, c. 342, §116, is amended to read:

1. Excise tax on malt liquor. An excise tax is imposed on the privilege of manufacturing and selling malt liquor in the State. The Maine manufacturer or importing wholesale licensee shall pay an excise tax of ~~25¢~~ 50¢ per gallon on all malt liquor sold in the State.

Sec. G-4. 28-A MRSA §1652, sub-§1-A, as amended by PL 1993, c. 462, §7, is further amended to read:

1-A. Excise tax on low-alcohol spirits products and fortified wines. An excise tax is imposed on the privilege of manufacturing and selling low-alcohol spirits products and fortified wines in the State. The Maine manufacturer or importing wholesale licensee shall pay an excise tax of ~~$1~~ $2 per gallon on all low-alcohol spirits products and fortified wines manufactured in or imported into the State.

Sec. G-5. 28-A MRSA §1652, sub-§2, as amended by PL 1987, c. 623, §16, is further amended to read:

2. Excise tax on wine. An excise tax is imposed on the privilege of manufacturing and selling wine in the State. The Maine manufacturer or importing wholesale licensee shall pay an excise tax of ~~30¢~~ 60¢ per gallon on all wine other than sparkling wine manufactured in or imported into the State and $1 per gallon on all sparkling wine manufactured in or imported into the State.

Sec. G-6. 36 MRSA §1811, first ¶, as amended by PL 1993, c. 701, §6 and affected by §10, is further amended to read:

A tax is imposed on the value of all tangible personal property and taxable services sold at retail in this State. The rate of tax ~~is 7%~~ on the value of liquor sold in licensed establishments as defined in Title 28-A, section 2, subsection 15, in accordance with Title 28-A, chapter 43~~;~~ is 7% ~~on~~ before December 31, 1996, 8% between December 31, 1996 and January 1, 2001 and 7.5% after January 1, 2001. The rate of tax on the value of rental of living quarters in any hotel, motel, rooming house, tourist camp or trailer camp~~, 10%~~ is 7% before December 31, 1996, 8% between December 31, 1996 and January 1, 2001 and 7.5% after January 1, 2001. The rate of tax on the value of rental for a period of less than one year of an automobile~~, 7%~~ is 10% before December 31, 1996, 11% between December 31, 1996 and January 1, 2001 and 10.5% after January 1, 2001. The rate of tax on the value of prepared food sold in establishments that are licensed for on-premises consumption of liquor pursuant to Title 28-A, chapter 43~~, and 6%~~ is 7% before December 31, 1996, 8% between December 31, 1996 and January 1, 2001 and 7.5% after January 1, 2001. The rate of tax on the value of all other tangible personal property and taxable services is 6% before December 31, 1996, 7% between December 31, 1996 and January 1, 2001 and 6.5% after January 1, 2001. Value is measured by the sale price, except as otherwise provided.

Sec. G-7. 36 MRSA §2513, first ¶, as amended by PL 1985, c. 783, §11, is further amended to read:

Every insurance company ~~or~~, association, nonprofit hospital or medical services organization, which does business or collects premiums or assessments including annuity considerations in the State, except those mentioned in section 2517, including surety companies and companies engaged in the business of credit insurance or title insurance, shall~~,~~ for the privilege of doing business in this State~~,~~ and in addition to any other taxes imposed for such privilege pay a tax upon all gross direct premiums or subscription income as pursuant to Title 24, section 2332, including annuity considerations, whether in cash or otherwise, on contracts written on risks located or resident in the State for insurance of life, annuity, fire, casualty and other risks at the rate of 2% a year.

2 **Sec. G-8. 36 MRSA §5111, sub-§1-A,** as enacted by PL 1991, c. 591, Pt. YY, §2 and affected by §7, is repealed and the following
4 enacted in its place:

6 **1-A. Single individuals and married persons filing separate returns.** For single individuals and married persons filing
8 separate returns:

If Maine taxable income is:	The tax is:
Less than $4,050	2.480% of the Maine taxable income
At least $4,050 but less than $8,100	$81 plus 5.579% of the excess over $4,050
At least $8,100 but less than $16,200	$263 plus 8.678% of the excess over $8,100
$16,200 or more	$830 plus 10.538% of the excess over $16,200

26 **Sec. G-9. 36 MRSA §5111, sub-§2-A,** as enacted by PL 1991, c. 591, Pt. YY, §4 and affected by §7, is repealed and the following
28 enacted in its place:

30 **2-A. Heads of households.** For unmarried individuals or legally separated individuals who qualify as heads of households:

If Maine taxable income is:	The tax is:
Less than $6,100	2.480% of the Maine taxable income
At least $6,100 but less than $12,150	$122 plus 5.579% of the excess over $6,100
At least $12,150 but less than $24,300	$394 plus 8.678% of the excess over $12,150
$24,300 or more	$1,245 plus 10.538% of the excess over $24,300

48 **Sec. G-10. 36 MRSA §5111, sub-§3-A,** as enacted by PL 1991,

c. 591, Pt. YY, §6 and affected by §7, is repealed and the following enacted in its place:

3-A. Individuals filing married joint return or surviving spouses. For individuals filing married joint returns or surviving spouses permitted to file a joint return:

If Maine taxable income is:	The tax is:
Less than $8,100	2.480% of the Maine taxable income
At least $8,100 but less than $16,200	$162 plus 5.579% of the excess over $8,100
At least $16,200 but less than $32,400	$527 plus 8.678% of the excess over $16,200
$32,400 or more	$1,661 plus 10.538% of the excess over $32,400

Sec. G-11. 36 MRSA §5200, as amended by PL 1985, c. 675, §§1 and 5, is further amended to read:

§5200. Imposition and rate of tax

A tax is imposed upon the Maine net income of taxable corporations for each taxable year at the following rates:

If the Maine net income is:	The tax is:
Not over $25,000	~~3.5%~~ 4.0% of Maine net income
$25,000 but not over $75,000	$875 plus ~~7.93%~~ 8.43% of excess over $25,000
$75,000 but not over $250,000	$4,840 plus ~~8.33%~~ 8.83% of excess over $75,000
$250,000 or more	$19,417 plus ~~8.93%~~ 9.43% of excess over $250,000

In the case of an affiliated group of corporations engaged in a unitary business, the respective preferential rates provided in this section ~~shall be applied~~ only apply to the first $250,000 of Maine net income of the entire group and ~~shall~~ must be apportioned equally among the taxable corporations unless those taxable corporations jointly elect a different apportionment.

The balance of the Maine net income of the entire group ~~shall be~~ is taxed at ~~8.93%~~ 9.43%.

Sec. G-12. 36 MRSA §5202-C is enacted to read:

§5202-C. Payroll tax on employers

Between December 31, 1996 and January 1, 2001 each employer in the State, as defined in Title 26, section 1043, for each calendar year shall pay a payroll tax at the rate of 2.25% of aggregate total wages, referred to in Title 26, section 1043. After January 1, 2001, the rate of payroll tax is 0.5%. The payroll taxes become due and are paid by each employer in accordance with any rules the State Tax Assessor may prescribe and are not deducted, in whole or in part, from the wages of individuals in the employer's employ. In the payment of any contribution, a fractional part of a cent is disregarded unless the amount is 1/2¢ or more, in which case it is increased to 1¢.

Sec. G-13. PL 1939, c. 149, §10 is repealed.

Sec. G-14. P&SL 1939, c. 24, §15 is repealed.

Sec. G-15. Effective date. This Part takes effect July 1, 1996.

PART H

Sec. H-1. 22 MRSA c. 1683 is enacted to read:

CHAPTER 1683

MAINE HEALTH DATA ORGANIZATION

§8701. Definitions

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

1. Behavioral risk factor survey. "Behavioral risk factor survey" means the behavioral risk factor survey conducted by the federal Centers for Disease Control.

2. Board. "Board" means the Board of Directors of the Maine Health Data Organization established pursuant to section 8702.

3. Carrier. "Carrier" means a 3rd-party payor or an insurance administrator licensed pursuant to Title 24-A, chapter 18.

4. Group purchaser. "Group purchaser" means a person or organization that purchases health care coverage on behalf of an identified group of persons, regardless of whether the cost of coverage is paid by the purchaser.

5. Health care facility. "Health care facility" means a public or private, proprietary or not-for-profit entity or institution providing health services, including but not limited to a health care facility licensed under chapter 405, a home health care provider licensed under chapter 419, a residential care facility licensed under chapter 1665, a community rehabilitation program licensed under Title 20-A, chapter 701, a hospice provider licensed under chapter 1681, a state institution as defined under Title 34-B, chapter 1 and a mental health facility licensed under Title 34-B, chapter 1.

6. Health care practitioner. "Health care practitioner" means an allopathic or osteopathic physician, a chiropractor, a dentist, an optometrist, a podiatrist, a pharmacist, a psychologist, a nurse, a physical therapist, an occupational therapist, an acupuncturist, a dental hygienist, a physician assistant, a social worker, a speech therapist or audiologist, a dietitian, a substance abuse counselor, a respiratory care practitioner, a counseling professional, a denturist, a dental radiographer, a chiropractic assistant, a medical radiation practitioner or any other person certified, registered or licensed to provide health services.

7. Health products. "Health products" means durable medical equipment, including but not limited to oxygen tents, hospital beds and wheelchairs, used in the patient's home or in an institution used as the patient's home.

8. Health product vendor. "Health product vendor" is a person or entity that sells health products to patients.

9. Health services. "Health services" means diagnostic, treatment, rehabilitative, therapeutic or other clinically related services and includes acute-care alcohol and drug abuse and mental health services, the sale of prescription drugs and the sale of health products.

10. Inpatient health services. "Inpatient health services" means health services rendered to a person who has been admitted to a health care facility as an inpatient.

11. Organization. "Organization" means the Maine Health Data Organization established under this chapter.

12. Outpatient health services. "Outpatient health services" means health services rendered to a person who has not been admitted to a health care facility as an inpatient.

13. Patient. "Patient" means a person receiving health services from a provider, including a person purchasing prescription drugs from a pharmacist or a health product from a health product vendor.

14. Provider. "Provider" means a health care facility, health care practitioner or health product vendor.

15. Quality improvement research. "Quality improvement research" means research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition to determine the most appropriate and cost-effective means to prevent, diagnose, treat or manage the condition or to develop test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

16. Quality improvement foundation. "Quality improvement foundation" means a public or private sector entity designated by the board under section 8703 that is engaged in quality improvement research.

17. Third-party payor. "Third-party payor" or "3rd-party payor" means a health insurer, health maintenance organization, nonprofit hospital or medical services organization licensed in this State.

§8702. Maine Health Data Organization; established

The Maine Health Data Organization is established as an independent, executive agency and referred to in this chapter as "organization."

1. Board of directors. The organization operates under the supervision of a board of directors, which consists of 15 voting members as follows.

A. The Governor shall appoint 13 board members, subject to review by the joint standing committee of the Legislature having jurisdiction over human resource matters and confirmation by the Legislature. The 13 board members appointed by the Governor must be selected in accordance with the following requirements.

(1) Two members must represent consumers. For the purposes of this section, "consumer" means a person who is not affiliated with or employed by a 3rd-party payor, a provider or an association representing payors or providers.

(2) Two members must represent employers.

(3) Two members must represent 3rd-party payors.

(4) Seven members must represent providers. Two provider members must represent hospitals and 2 provider members must be physicians. Three provider members must each represent a different provider type or discipline and may not represent a hospital or a physician. At least 2 of these provider members, including one physician, must provide services in a rural community.

B. Two members must be appointed by the commissioner to represent the department. One of these members must have medical and epidemiological credentials and expertise in public health.

2. Terms of office. For the initial appointed members of the board of directors, the terms of office are staggered as follows: Five members serve one-year terms; 5 members serve 2-year terms; and 5 members serve 3-year terms. Of the initial appointees, representatives of the same group may not have the same term length, except that 3 provider representatives may have the same term length. Thereafter, members serve 3-year terms, except that a member appointed to fill a vacancy in an unexpired term serves only for the remainder of that term. Members hold office until the appointment and confirmation of their successors. Board members may serve a maximum of 2 consecutive terms.

3. Officers. Members of the board shall elect the chair of the board.

4. Legal counsel. The Attorney General and the several district attorneys within their respective counties, when requested, shall furnish any legal assistance, counsel or advice the organization requires in the discharge of its duties. The organization may also hire outside legal counsel at its discretion.

5. Quorum. Eight members of the organization constitute a quorum. No action of the organization is effective without the concurrence of at least 8 members.

6. Powers and duties. The board has the powers and duties set forth in section 8703.

7. Compensation. The board members are entitled to compensation according to the provisions of Title 5, chapter 379.

§8703. Powers and duties of the board

The board has the following powers and duties.

1. Collection of data. Consistent with the objectives set forth in section 8704, the board shall develop and implement data collection procedures as required under this chapter. The board is responsible for editing, processing and storing the collected data in a form suitable for public and private sector use.

2. Contracts for data collection. To the maximum extent feasible, the board shall contract with one or more qualified, independent 3rd-parties for services necessary to carry out the data collection activities required under this chapter. Unless permission is granted specifically by the board, a 3rd-party hired by the organization may not release, publish or otherwise use any information to which the 3rd-party has access under its contract and shall otherwise comply with the requirements of this chapter.

3. Contracts generally. The board may enter into all other contracts necessary or proper to carry out the powers and duties of this chapter.

4. Legal action. The board may sue or be sued, including taking any action necessary for securing legal remedies on behalf of or against the organization, any board member or any other party subject to this chapter.

5. Executive director; staff. The board shall appoint an executive director to serve as the chief operating officer of the organization and to perform those duties delegated to the executive director by the board. The executive director serves at the pleasure of the board. The executive director may employ other staff as needed, subject to the board's approval.

6. User fees. In order to fund the operation of the organization, the board may assess reasonable fees for the right to access and use the health data. The board shall waive user fees for public health research and health workforce planning

research conducted by the department. The board shall establish a sliding scale of user fees. The board may waive or set lower fees for a user that is engaged in research of value to the general public if that user can demonstrate to the satisfaction of the board that the user is unable to afford the standard fee. Unless permission is granted specifically by the board, those users purchasing or granted the right to use the health data may not transfer or sell that right to other users and shall otherwise comply with the requirements of this chapter. Nothing in this subsection may be construed to limit the release, publication, use or sale of analyses, reports or compilations derived from the health data that otherwise comply with the requirements of this chapter. The board shall deposit all payments made pursuant to this section with the Treasurer of State. The deposits must be used for the sole purpose of paying the expenses of the organization.

7. Report on operations. The board shall prepare an annual report on the operations of the organization, which must include:

A. An annual accounting of all outside revenue received by the board; and

B. Summary statistics relating to the cost and quality of health care, the health status of the citizens of the State and the allocation of the health work force derived from the health data collected by the organization.

The board shall submit the annual report to the Governor and the joint standing committee of the Legislature having jurisdiction over human resource matters no later than January 15th of each year.

8. Grants. The board may receive and accept grants, funds or anything of value from any public or private agency and receive and accept contributions of money, property, labor or any other thing of value from any legitimate source, except that the board may not accept grants or other funds, except user fees pursuant to subsection 7, from any entity that might have a vested interest in the decisions of the board.

9. Rulemaking. In accordance with the Maine Administrative Procedure Act, the board shall adopt emergency and permanent rules implementing the requirements of this chapter.

10. Public hearings. In accordance with the Maine Administrative Procedure Act, the board may conduct any public hearings necessary and proper to carry out the requirements of this chapter.

11. Quality improvement foundation. The board shall designate a quality improvement foundation to conduct quality improvement research upon a finding that the quality improvement foundation conducts reliable and accurate research consistent with standards of health services and clinical effectiveness research and that the foundation has an established protocol acceptable to the board for safeguarding confidential or privileged information.

12. Unique identification numbers. The board shall adopt unique identification numbers to be used by providers filing the health data to identify providers, group purchasers, 3rd-party payors and patients. For patients, the unique identification number is the patient's social security number except when the patient does not have or refuses to provide a social security number, in which case the patient is identified according to an alternative numbering system developed by the board. The board shall adopt procedures for encoding the unique identification numbers to prevent identification of individual patients and health care practitioners.

13. Barriers to data collection. The board shall coordinate public and private sector efforts to eliminate technical and economic barriers to implementing the data collection requirements under this chapter.

14. Other powers. The board may exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

§8704. Objectives

To the maximum extent feasible and consistent with the requirements of this chapter, the organization has the following objectives.

1. Use of existing data sources. The organization shall use and build upon existing data sources and measurement efforts and improve upon and coordinate these existing data sources and measurement efforts through the integration of data systems and the standardization of concepts.

2. Linked information system. The organization shall coordinate the development of a linked public sector and private sector information system that:

A. Electronically transmits, collects, archives and provides users of data with the data necessary for their specific interests to promote a high quality, cost-effective, consumer-responsive health care system;

B. Provides the State, consumers, employers, providers and group purchasers with data for determining cost, health status, the appropriateness of health care, the effectiveness of cost-containment strategies and the distribution of health care practitioners and facilities and other health resources;

C. Provides employers with the capacity to analyze benefit plans and workplace health; and

D. Provides researchers and providers with the capacity to conduct health services and clinical effectiveness research.

3. Usefulness of data. The organization shall emphasize data that is useful, relevant and nonredundant of existing data while ensuring that the data collected is in the public domain.

4. Minimize burden. The organization shall minimize the administrative burden on carriers, health care providers and the health care delivery system and minimize any privacy concerns for patients and providers.

5. Reliability of data. The organization shall preserve the reliability, accuracy and integrity of the data collected pursuant to this chapter.

§8705. Advisory committees

The board shall appoint appropriate advisory committees to evaluate methods of data collection and to recommend methods of data collection that minimize the administrative burden on providers, address data confidentiality concerns and meet the needs of health service researchers. The board may appoint other advisory committees as necessary to carry out the purposes of this chapter.

§8706. Public access to data

1. Public access. Any information, except privileged medical information, provided to the organization under this chapter must be made available to any person upon request as long as individual patients or health care practitioners are not directly identified.

2. Notice and comment period. The board shall adopt rules establishing criteria for determining whether information is privileged medical information and adopt procedures to afford affected health care practitioners notice and opportunity to

comment in response to requests for information that may be
2 considered privileged.

4 **3. Public health and quality improvement studies.** The
board, by rule or order, may allow, pursuant to subsection 1,
6 exceptions to the rules adopted only to the extent authorized in
this subsection.

8

A. In accordance with this subsection, the board may
10 approve access to identifying information for patients or
for health care practitioners to the following parties:

12

(1) The department;

14

(2) The quality improvement foundation; and

16

(3) Other researchers with established protocols
18 approved by the board for safeguarding confidential or
privileged information.

20

B. The board shall adopt rules that ensure that:

22

(1) Identifying information is used only to gain
24 access to medical records and other medical information
pertaining to public health or quality improvement
26 research of substantial public importance;

28 (2) Medical information about any patient identified
by name is not obtained without the consent of that
30 patient except when the information sought pertains
only to verification or comparison of health data and
32 the board finds that confidentiality can be adequately
protected without patient consent;

34

(3) Those persons conducting the research or
36 investigation do not disclose medical information about
any patient identified by name to any other person
38 without that patient's consent;

40 (4) Those persons gaining access to medical
information about an identified patient use that
42 information to the minimum extent necessary to
accomplish the purposes of the research for which
44 approval was granted; and

46 (5) The protocol for any research is designed to
preserve the confidentiality of all medical information
48 that can be associated with identified patients, to
specify the manner in which contact is made with
50 patients or health care practitioners and to maintain

public confidence in the protection of confidential information.

C. The organization shall establish or identify an institutional review board independent of the department, the quality improvement foundation or any other user of data with identifying information. The institutional review board is responsible for approving the protocol of the research, overseeing the conduct of the research to ensure consistency with the protocol and the board's rules and assessing both the scientific validity of the research and its effects upon patients. The institutional review board may endorse or accept the findings of other independent review boards.

D. The quality improvement foundation may publish a report identifying health care practitioners. The report may not be published unless it is approved by the board and follows a 30-day period during which any identified health care practitioner has an opportunity to review and respond to the report.

E. The board may not grant approval under this subsection if the board finds that the proposed identification of or contact with patients or health care practitioners would violate any state or federal law or diminish the confidentiality of medical information or the public's confidence in the protection of that information in a manner that outweighs the expected benefit to the public of the proposed investigation.

F. With respect to a health care practitioner, the board shall report to the relevant board of licensure identifying information and other data that the board reasonably believes to evidence incompetence in the practice for which the health care practitioner is licensed, certified or registered.

§8707. Utilization data

Consistent with the schedule of implementation developed in subsection 3, the board shall establish procedures, including rules that govern timing, form, medium and content, for filing utilization data as required in this section.

1. Inpatient health services. Each health care facility shall file with the organization as follows:

A. A completed uniform discharge data set or comparable information for each patient discharged from the facility; and

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 other scope-of-service information the board considers necessary for fulfillment of its objectives.

When more than one health care facility is operated by the reporting entity, the information required by this chapter must be reported for each health care facility separately.

2. Outpatient health services. For each encounter with a patient, each provider shall file with the organization a completed uniform data set or comparable information for all outpatient health services provided. When a provider operates in more than one location, the board may require that information be reported separately for each location.

3. Implementation of data collection requirements. Consistent with its objectives, the board shall implement the data collection requirements of this section in as timely a manner as practicable. The board shall develop a schedule of implementation that prioritizes the implementation of the data requirements for each type of provider based on the added administrative burden imposed by the data collection requirements, given the administrative resources and technical and economic barriers to compliance typically faced by that type of provider, and based on the impact that the added administrative burden would typically have on that type of provider's ability to provide health services and the immediate need for the data to be collected. To the maximum extent feasible, the board shall assist providers in overcoming the technical and economic barriers to compliance with data collection requirements under this section.

4. Health outcomes data. The data collected may include, but is not limited to, information on health outcomes such as information on mortality and morbidity and patient functional status, quality of life, symptoms and satisfaction. The data collected must also include information necessary to measure and make adjustments for differences in the severity of patient illness and comorbidities across providers. The data may be obtained directly from the patient or the patient's medical records. The data must be collected in a way that allows comparisons between providers, 3rd-party payors, public programs and other entities.

5. Claims forms. To the extent permitted by federal law, the board shall implement standardized claims and reporting methods. The board shall solicit the cooperation of self-insured employers in adopting the standardized claim forms with a minimum amount of payor-specific codes.

§8708. Population and worksite surveys

The board shall establish procedures for the collection of population and worksite data as follows.

1. Behavioral risk factor survey. The board shall advise, in consultation with its advisory committees and in cooperation with the Director of the Bureau of Health, the commissioner regarding the expansion of the behavioral risk factor survey. In making its recommendations, the board shall consider private sector and public sector health data needs, including, but not limited to, information relating to the following:

A. Health care quality, outcomes and satisfaction;

B. Access to health care, including insurance coverage and access to health care practitioners, health care facilities and other health resources;

C. Health status;

D. Health risk behaviors; and

E. The economic impact of poor physical or emotional health.

The board shall also consider the need to coordinate satisfaction and outcome surveys with the behavioral risk factor survey to provide a basis for comparing outcome and satisfaction data with statewide norms. The board shall also consider the need to expand the behaviorial risk factor survey to collect health data on children.

2. Worksite surveys. The organization may conduct worksite surveys to obtain statewide data relating to occupational health. The organization shall collect systematic information about the nature, extent, cost and outcomes of employer worksite programs in health promotion and stress reduction.

§8709. Workforce and health resource data

The board shall establish procedures for the collection of workforce and health resource data as follows.

1. Licensing boards. The following licensing boards shall cooperate with the organization in the collection of workforce and health resource data:

A. Board of Licensing of Dietetic Practice;

B. Board of Hearing Aid Dealers and Fitters;

C. Board of Examiners in Physical Therapy;

D. Board of Licensure of Podiatric Medicine;

E. State Board of Examiners of Psychologists;

F. Radiologic Technology Board of Examiners;

G. Board of Respiratory Care Practitioners;

H. State Board of Social Worker Licensure;

I. Board of Examiners on Speech Pathology and Audiology;

J. State Board of Substance Abuse Counselors;

K. Acupuncture Licensing Board;

L. Board of Commissioners of the Profession of Pharmacy;

M. Board of Chiropractic Licensure;

N. Board of Counseling Professionals Licensure;

O. Board of Dental Examiners;

P. Board of Licensure in Medicine;

Q. State Board of Nursing;

S. Board of Optometric Examiners;

T. Board of Osteopathic Licensure; and

U. Any other licensing board for health care practitioners.

2. Workforce survey. In conjunction with the license renewal process, each licensing board subject to this section shall survey those health care practitioners within its jurisdiction. The survey must be designed to collect workforce data and be developed or approved by the organization. The workforce data collected may include, but need not be limited to,

work setting, practice specialty and the amount of time spent providing direct patient care. The licensing board has access to the workforce data for health care practitioners within its jurisdiction and may not be charged a user fee for that data.

3. Workforce data collection. The organization shall collect, edit, process and store the workforce data in a manner to ensure that the data is accurate and complete. In consultation with its advisory committees and with the licensing boards, the organization shall identify workforce data that may be used by public and private sector users to identify regions of the State with an insufficient supply of health care practitioners, develop solutions to regional disparities, plan health workforce educational programs and aid accurate statewide health planning.

§8710. Enforcement

1. Fine. The failure to file data as required under this chapter is a civil violation. Any provider who fails to file data required under this chapter may be fined not more than $1,000 a day if that provider is a health care facility or $500 a day for all other providers, except that any fine imposed under this section may not exceed $25,000 for health care facilities for any one occurrence and $12,500 for all other providers for any one occurrence. The board, or legal counsel of the board's choice, may enforce the fine in a civil action brought in the name of the board.

2. License revoked. Upon a finding that a provider has repeatedly and intentionally refused to comply with the requirements of this chapter, the board may file a complaint with the provider's licensing board seeking the revocation of the provider's license or other disciplinary action from the board.

3. Court order. If a provider refuses to file the data required, the board may obtain a court order requiring the provider to produce the data required.

§8711. Revenues and expenditures

1. Budget. The organization's expenditures are subject to legislative approval. The organization shall report annually, before February 1st, to the joint standing committee of the Legislature having jurisdiction over human resource matters on its planned expenditures for the year and on its use of funds in the previous year.

2. Expenditures. The organization may use its revenues, including revenues from assessments and user fees, to defray the

reasonable costs incurred by the organization pursuant to this chapter.

3. Unexpended funds. Any funds not expended at the end of a fiscal year may not lapse, but must be carried forward to the succeeding fiscal year.

§8712. Assessment for expense of maintaining the Maine Health Data Organization

The expense of maintaining the organization must be assessed annually by the board against each carrier in proportion to the respective number of persons in this State for whom the carrier either provides health-related coverage or on whose behalf the carrier administers health-related benefits during the year ending December 31st immediately preceding the fiscal year for which assessment is made. The annual assessment upon all carriers must be applied to the budget of the organization for the fiscal year commencing July 1st. The assessment must be in an amount not exceeding $1.50 per person covered by the carrier. In calculating the amount of the annual assessment, the board shall consider, among other factors, the staffing level required to administer the responsibilities of the organization as well as the expense of contracts for data management services.

1. Number of persons covered. For purposes of this section, "number of persons covered" means the number of persons for whom the carrier provides or administers health-related benefits. In the case of insurance administrators, the number of persons covered refers to only those persons on whose behalf the insurance administrator administers benefits and whose health benefits are provided under a self-insured plan. On or before March 1st of each year, each carrier shall provide to the board a written report of the number of persons covered by the carrier in this State during the immediately preceding calendar year. In calculating the number of persons covered, the carrier shall add the number of persons covered in this State by the carrier in each month of the year for which the report is being made and divide that sum by 12. The result of this calculation is considered by the board to be the number of persons covered by the carrier in the calendar year for which the report is being made.

2. Minimum assessment. In any year in which a carrier has no health-related contracts in force in this State or in which the number of persons covered by the carrier is not sufficient to produce at the rate prescribed an amount equal to or in excess of $100, the minimum assessment payable by any carrier is $100.

3. Notification of assessment. On or before July 1st of each year, the board shall notify each carrier, in writing, of the assessment due.

4. Time of payment. Payment must be made on or before August 10th.

5. Revocation or suspension. Upon a finding by the board that a carrier has failed to comply with the requirements of this chapter, the board may file a complaint with the superintendent seeking a revocation of the carrier's license or certificate of authority to transact business in this State.

6. Recalculation of assessment. Immediately following the close of the fiscal year ending June 30, 1997 and at the close of each 2nd succeeding fiscal year, the board shall recalculate the assessment made against each carrier after giving recognition to the actual expenditures of the organization during the preceding biennial period. On or before October 1st, the board shall render to each carrier assessed a statement showing the difference between the respective recalculated assessment and the amount paid with respect to the preceding biennium. Any overpayment of annual assessment resulting from complying with the requirements of this chapter must be refunded or, at the option of the assessed carrier, applied as a credit against the assessment for the succeeding fiscal year. Any overpayment of $100 or less must be applied as a credit against the assessment for the succeeding fiscal year.

7. Deposit with Treasurer of State. The board shall deposit all payments made pursuant to this section with the Treasurer of State. The money must be used for the sole purpose of paying the expenses of the organization.

8. Applicability. This section applies to fiscal years commencing on or after July 1, 1996.

§8713. Interim hospital assessment

1. Assessment. Every hospital is subject to an assessment of not more than .075% of its gross patient service revenue. The organization shall determine the assessment annually prior to July 1st, October 1st, January 1st and April 1st of each year.

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

A. "Gross patient service revenue" means a hospital's gross patient service revenue calculated by the department as

2 required under Public Law 1995, chapter 368, Part W, section 10, subsection 2.

4 B. "Hospital" means any acute care institution required to be licensed pursuant to chapter 405 or its successor, with
6 the exception of the Cutler Health Center and the Dudley Coe Infirmary.
8
3. **Repeal.** This section is repealed June 30, 1998.
10
Sec. H-2. PL 1995, c. 368, Pt. W, §12, sub-§5 is amended to read:
12
5. The task force shall report its findings and
14 recommendations concerning the statutory and rule changes necessary to further implement the elimination of the regulatory
16 functions of the Maine Health Care Finance Commission, including any necessary implementing legislation in completed form, to the
18 Legislature no later than December 15, 1995. Any necessary implementing legislation concerning the elimination of regulatory
20 functions ~~or replacement~~ of the Maine Health Care Finance Commission must be drafted so as to take effect no later than
22 July 1, 1996. Any implementing legislation concerning the elimination of the Maine Health Care Finance Commission must be
24 drafted so as to take effect no later than 120 days after confirmation or appointment of the 13th member of the board of
26 the Maine Health Data Organization or December 31, 1996, whichever is earlier.
28
Sec. H-3. Appointments. The Governor shall appoint the board
30 members of the Maine Health Data Organization, as required under the Maine Revised Statutes, Title 22, section 8702, subsection 1,
32 no later than 30 days after the effective date of this Part.

34 **Sec. H-4. Appropriation.** The following funds are appropriated from the General Fund to carry out the purposes of
36 this Act.

	1996-97
MAINE HEALTH DATA ORGANIZATION	
Positions - Other Count	(4.0)
Personal Services	$189,724
All Other	405,964
Capital Expenditures	35,170
MAINE HEALTH DATA ORGANIZATION TOTAL	$630,858

Sec. H-5. Transition. The following provisions apply to the transfer of the health facilities data from the Maine Health Care Finance Commission to the Maine Health Data Organization.

1. The Maine Health Data Organization is the successor in every way to the Maine Health Care Finance Commission with respect to the authority to collect inpatient and outpatient health care information from health care facilities and providers of health care. All responsibilities, power and authority relating to the collection of such health care information that were formerly vested in the Maine Health Care Finance Commission are transferred to the Maine Health Data Organization.

2. Notwithstanding the provisions of the Maine Revised Statutes, Title 5, all accrued expenditures, assets and liabilities and any balances, appropriations, allocations, transfers, revenues or other available funds in an account or subdivision of an account of the Maine Health Care Finance Commission must be transferred to the proper accounts of the Maine Health Data Organization by the State Controller upon the request of the State Budget Officer and with the approval of the Governor.

3. All rules and procedures in effect, in operation or adopted on the effective date of this Part by the Maine Health Care Finance Commission regarding data collection requirements remain in effect until rescinded, revised or amended by the Maine Health Data Organization.

4. All contracts, agreements and compacts in effect on the effective date of this Part in the former Maine Health Care Finance Commission remain in effect until rescinded, revised or amended by the Maine Health Data Organization.

5. All data required to have been filed with the Maine Health Care Finance Commission pursuant to Title 22, chapter 107 are transferred to the Maine Health Data Organization. In the event that any data have not been filed with the Maine Health Care Finance Commission as of the effective date of this Part, the Maine Health Data Organization shall direct that data be filed with the Maine Health Data Organization.

6. All records, property and equipment previously belonging to or allocated for the use of the Maine Health Care Finance Commission necessary for performing the data collection activities are transferred to the Maine Health Data Organization.

PART I

Sec. I-1. 10 MRSA §8002, sub-§§7 and 8, as enacted by PL 1995, c. 502, Pt. H, §9, is amended to read:

7. Delegate authority. Authorize the heads of bureaus, offices, boards and commissions within the department to carry out the commissioner's duties and authority; ~~and~~

8. Adequate resources. Ensure that each bureau, office, board and commission has adequate resources to carry out regulatory functions and that the department's expenditures are equitably apportioned~~.~~; and

Sec. I-2. 10 MRSA §8002, sub-§9 is enacted to read:

9. Coordinated data collection. Cooperate with the Maine Health Data Organization in planning and coordinating the health data collection activities of the licensing boards within and affiliated with the department as they relate to the Maine Health Data Organization's duties. The commissioner shall direct the cooperation of the internal and affiliated licensing boards.

Sec. I-3. 22 MRSA §257 is enacted to read:

§257. Coordinated data collection

The commissioner shall cooperate with the Maine Health Data Organization in planning and coordinating the health data collection activities within the department as they relate to the Maine Health Data Organization's duties. To the extent practicable and consistent with federal and state law, the commissioner shall implement the recommendations of the Maine Health Data Organization as they relate to the data collection activities within the department.

PART J

Sec. J-1. 5 MRSA §12004-G, sub-§14-B is enacted to read:

14-B. Health	Maine Health Data Organization	Expenses Only	22 MRSA §8702

PART K

Sec. K-1. 32 MRSA §503-A, sub-§2, ¶H, as amended by PL 1993, c. 600, Pt. A, §46, is further amended to read:

H. A violation of this chapter or a rule adopted by the board; ~~or~~

Sec. K-2. 32 MRSA §503-A, sub-§2, ¶I, as enacted by PL 1983, c. 378, §4, is amended to read:

I. Engaging in false, misleading or deceptive advertising~~.~~; or

Sec. K-3. 32 MRSA §503-A, sub-§2, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-4. 32 MRSA §557, sub-§§2 and 3, as enacted by PL 1991, c. 884, §1, are amended to read:

2. Nonsupervision. Perform other than at the direction and under the supervision of a chiropractor licensed by the board; ~~or~~

3. Inadequate training. Perform a task that they have not been trained or are not clinically competent to perform~~.~~; or

Sec. K-5. 32 MRSA §557, sub-§4 is enacted to read:

4. Data requirements. Repeatedly and intentionally fail to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-6. 32 MRSA §1077, sub-§2, ¶H, as amended by PL 1993, c. 600, Pt. A, §62, is further amended to read:

H. A violation of this chapter or a rule adopted by the board; ~~or~~

Sec. K-7. 32 MRSA §1077, sub-§2, ¶I, as enacted by PL 1983, c. 378, §7, is amended to read:

I. Engaging in false, misleading or deceptive advertising~~.~~; or

Sec. K-8. 32 MRSA §1077, sub-§2, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-9. 32 MRSA §1100-Q, sub-§1, ¶¶E and F, as amended by PL 1993, c. 600, Pt. A, §99, are further amended to read:

E. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or that relates directly to the practice of dental radiography or conviction of a crime for which incarceration for one year or more may be imposed; ~~or~~

F. A violation of this chapter or a rule adopted by the board~~.~~; or

Sec. K-10. 32 MRSA §1100-Q, sub-§1, ¶G is enacted to read:

G. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-11. 32 MRSA §1658-N, sub-§6, as repealed and replaced by PL 1983, c. 413, §80, is amended to read:

6. Violations. ~~For any~~ Any violation of this chapter or the rules; ~~or~~

Sec. K-12. 32 MRSA §1658-N, sub-§7, as enacted by PL 1983, c. 413, §80, is amended to read:

7. Conviction of a criminal offense. Conviction of a crime, subject to the limitations of Title 5, chapter 341~~.~~; or

Sec. K-13. 32 MRSA §1658-N, sub-§8 is enacted to read:

8. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-14. 32 MRSA §2105-A, sub-§2, ¶H, as amended by PL 1993, c. 600, Pt. A, §116, is further amended to read:

H. A violation of this chapter or a rule adopted by the board; ~~or~~

Sec. K-15. 32 MRSA §2105-A, sub-§2, ¶I, as enacted by PL 1983, c. 378, §21, is amended to read:

I. Engaging in false, misleading or deceptive advertising~~.~~; or

Sec. K-16. 32 MRSA §2105-A, sub-§2, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-17. 32 MRSA §2286, sub-§2, ¶¶C and D, as enacted by PL 1983, c. 746, §2, are amended to read:

C. Subject to the limitations of Title 5, chapter 341, conviction of a crime ~~which~~ that involves dishonesty or false statement or ~~which~~ that relates directly to the practice for which the licensee is licensed or conviction of any crime for which imprisonment for one year or more may be imposed; ~~or~~

D. Any violation of this chapter or rules adopted by the board~~.~~; or

Sec. K-18. 32 MRSA §2286, sub-§2, ¶E is enacted to read:

E. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-19. 32 MRSA §2431-A, sub-§2, ¶O, as amended by PL 1987, c. 439, §16 and c. 542, Pt. K, §§16 and 20, is further amended to read:

O. Failure to display a diagnostic or therapeutic drug license issued under section 2419-A or 2425; ~~or~~

Sec. K-20. 32 MRSA §2431-A, sub-§2, ¶P, as amended by PL 1993, c. 600, Pt. A, §160, is further amended to read:

P. Splitting or dividing a fee with an individual not an associate in conformance with section 2434, or giving or accepting a rebate from an optician or ophthalmic dispenser~~.~~; or

Sec. K-21. 32 MRSA §2431-A, sub-§2, ¶Q is enacted to read:

Q. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-22. 32 MRSA §2591-A, sub-§2, ¶L, as amended by PL 1989, c. 291, §2, is further amended to read:

L. Division of professional fees not based on actual services rendered; ~~or~~

Sec. K-23. 32 MRSA §2591-A, sub-§2, ¶M, as enacted by PL 1989, c. 291, §3, is amended to read:

M. Failure to comply with the requirements of Title 24, section 2905-A~~.~~; or

Sec. K-24. 32 MRSA §2591-A, sub-§2, ¶N is enacted to read:

N. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-25. 32 MRSA §2594-D, sub-§1, ¶D is enacted to read:

D. Repeatedly and intentionally fails to comply with the data collection requirements established under Title 22, chapter 1683;

Sec. K-26. 32 MRSA §3117-A, sub-§§6 and 7, as enacted by PL 1983, c. 413, §139, are amended to read:

6. Criminal conviction. Subject to the limitations of Title 5, chapter 341, conviction of a Class A, B or C crime or of a crime ~~which~~ that, if committed in this State, would be punishable by one year or more of imprisonment; ~~or~~

7. Violation. Any violation of this chapter or any rule adopted by the board~~.~~; or

Sec. K-27. 32 MRSA §3117-A, sub-§8 is enacted to read:

8. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-28. 32 MRSA §3270-C, sub-§1, ¶¶C and D, as amended by PL 1993, c. 600, Pt. A, §207, are further amended to read:

C. Been delegated and performed a task or tasks beyond the physician assistant's competence; ~~and~~

D. Administered, dispensed or prescribed a controlled substance otherwise than as authorized by law~~.~~; or

Sec. K-29. 32 MRSA §3270-C, sub-§1, ¶E is enacted to read:

E. Repeatedly and intentionally failed to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-30. 32 MRSA §3282-A, sub-§2, ¶K, as amended by PL 1989, c. 291, §4, is further amended to read:

K. Failure to report to the secretary of the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee; ~~or~~

Sec. K-31. 32 MRSA §3282-A, sub-§2, ¶L, as enacted by PL 1989, c. 291, §5, is amended to read:

L. Failure to comply with the requirements of Title 24, section 2905-A~~.~~; or

Sec. K-32. 32 MRSA §3282-A, sub-§2, ¶M is enacted to read:

M. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-33. 32 MRSA §3655-A, sub-§2, ¶I, as enacted by PL 1983, c. 378, §59, is amended to read:

I. Engaging in false, misleading or deceptive advertising; ~~or~~

Sec. K-34. 32 MRSA §3655-A, sub-§2, ¶K, as enacted by PL 1993, c. 600, Pt. A, §248, is amended to read:

K. Prescribing narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes~~.~~; or

Sec. K-35. 32 MRSA §3655-A, sub-§2, ¶L is enacted to read:

L. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-36. 32 MRSA §3837, sub-§8, as enacted by PL 1983, c. 413, §157, is amended to read:

8. Negligence. Negligence in the performance of ~~his~~ duties; ~~or~~

9. Violations. Violating any provision of this chapter or any rule of the board~~.~~; or

Sec. K-37. 32 MRSA §3837, sub-§10 is enacted to read:

10. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-38. 32 MRSA §6026, sub-§4, as amended by PL 1983, c. 413, §205, is further amended to read:

4. Conviction of a criminal offense. Subject to the limitations of Title 5, chapter 341, being convicted of a felony in any court of this State or the United States if the acts for which ~~she or he~~ that person is convicted are found by the board to have a direct bearing on whether ~~she or he~~ that person should be entrusted to serve the public in the capacity of a speech pathologist or audiologist; ~~or~~

Sec. K-39. 32 MRSA §6026, sub-§4-A is enacted to read:

4-A. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683; or

Sec. K-40. 32 MRSA §6217-A, sub-§6, as repealed and replaced by PL 1983, c. 413, §218, is amended to read:

6. Criminal conviction. Subject to the limitations of Title 5, chapter 341, conviction of a Class A, B or C crime or of a crime ~~which~~ that, if committed in this State, would be punishable by one year or more of imprisonment; ~~or~~

Sec. K-41. 32 MRSA §6217-A, sub-§6-A, as enacted by PL 1991, c. 456, §29, is amended to read:

6-A. Incompetence in the practice of counseling. Any incompetence in the practice of counseling such as engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed by the counselor to a client or engaging in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which that person is licensed, certified or registered; ~~or~~

Sec. K-42. 32 MRSA §6217-A, sub-§6-B is enacted to read:

6-B. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683; or

Sec. K-43. 32 MRSA §7059, sub-§1, ¶F, as enacted by PL 1983, c. 413, §229, is amended to read:

F. Subject to the limitations of Title 5, chapter 341, conviction of a Class A, B or C crime or of a crime ~~which~~ that, if committed in this State, would be punishable by one year or more of imprisonment; ~~or~~

Sec. K-44. 32 MRSA §7059, sub-§1, ¶G, as amended by PL 1985, c. 736, §18, is further amended to read:

G. Violation of any provision of this chapter or any rule of the board~~.~~; or

Sec. K-45. 32 MRSA §7059, sub-§1, ¶H is enacted to read:

H. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-46. 32 MRSA §9713, sub-§2, ¶¶C and D, as enacted by PL 1985, c. 288, §3, are amended to read:

C. Subject to the limitations of Title 5, chapter 341, conviction of a crime ~~which~~ that involves dishonesty or false statement or ~~which~~ that relates directly to the practice for which the licensee is licensed or conviction of any crime for which imprisonment for one year or more may be imposed; ~~or~~

D. Any violation of this chapter or rules adopted by the board~~.~~; or

Sec. K-47. 32 MRSA §9713, sub-§2, ¶E is enacted to read:

E. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683;

Sec. K-48. 32 MRSA §9860, sub-§7, as enacted by PL 1983, c. 524, is amended to read:

7. Conviction of certain crimes. Subject to the limitations of Title 5, chapter 341, conviction of a crime ~~which~~ that involves dishonesty or false statement or ~~which~~ that relates directly to the practice for which the licensee is licensed, or conviction of any crime for which incarceration for one year or more may be imposed; ~~or~~

Sec. K-49. 32 MRSA §9860, sub-§7-A is enacted to read:

7-A. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683; or

Sec. K-50. 32 MRSA §9910, sub-§2, ¶C, as amended by PL 1987, c. 313, §6, is further amended to read:

C. Subject to the limitations of Title 5, chapter 341, conviction of a crime ~~which~~ that involves dishonesty or false statement or ~~which~~ that relates directly to the practice for which the individual is licensed or convicted of any crime for which imprisonment for one year or more may be imposed; ~~or~~

Sec. K-51. 32 MRSA §9910, sub-§2, ¶D, as enacted by PL 1985, c. 389, §28, is amended to read:

D. Any violation of this chapter or rules adopted by the board~~.~~; or

Sec. K-52. 32 MRSA §9910, sub-§2, ¶E is enacted to read:

E. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-53. 32 MRSA §12413, sub-§5, as enacted by PL 1987, c. 488, §3, is amended to read:

5. Criminal conviction. Subject to the limitations of Title 5, chapter 341, conviction of a Class A, Class B or Class C crime or of a crime ~~which~~ that, if committed in this State, would be punishable by one year or more of imprisonment; ~~or~~

Sec. K-54. 32 MRSA §12413, sub-§6, as enacted by PL 1987, c. 488, §3, is amended to read:

6. Good cause. Any other good cause~~,~~ relevant to qualifications to practice~~.~~; or

Sec. K-55. 32 MRSA §12413, sub-§7 is enacted to read:

7. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-56. 32 MRSA §13742, sub-§2, ¶¶H and I, as enacted by PL 1987, c. 710, §5, is amended to read:

H. Engaging in false, misleading or deceptive advertising; ~~or~~

I. Any violation of this Act or of any rule adopted by the board~~.~~; or

Sec. K-57. 32 MRSA §13742, sub-§2, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-58. 32 MRSA §13861, sub-§1, ¶H, as amended by PL 1989, c. 895, §17, is further amended to read:

H. The licensee or registrant has had any professional or occupational license revoked for disciplinary reasons, or any application rejected for reasons relating to untrustworthiness, within 3 years of the date of application; ~~or~~

Sec. K-59. 32 MRSA §13861, sub-§1, ¶I, as enacted by PL 1989, c. 465, §3, is amended to read:

I. Violation of any provisions of this chapter or any rule of the board~~.~~; or

Sec. K-60. 32 MRSA §13861, sub-§1, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. K-61. 32 MRSA §14308, sub-§1, ¶¶F and G, as enacted by PL 1991, c. 403, §1, are amended to read:

F. Revocation in any state of a professional or occupational license, certification or registration for disciplinary reasons, or rejection of any application for reasons related to untrustworthiness, within 3 years of the date of application; ~~and~~

G. Violating any provisions of this chapter or any rule of the department~~.~~ ; or

Sec. K-62. 32 MRSA §14308, sub-§1, ¶H is enacted to read:

H. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

2

PART L

4

Sec. L-1. Submission of legislation. The Department of Human
6 Services, by July 1, 1996, shall submit to the Legislature
legislation to amend the statutes to correct cross-references and
8 make any other technical changes necessitated by this Act.

10

STATEMENT OF FACT

12

Part A establishes the Maine Health Care Authority. The
14 authority is required to administer the Maine Health Care Plan, a
universal health care plan for all residents meeting a one-month
16 residency requirement. The plan requires all persons that have
resided in Maine for one month to pay a premium for health care
18 coverage under the plan. The premium is equal to the cost of the
coverage less an employer's contribution, if applicable. The
20 employer is required to pay 50% of the premium if the employee is
full time, reduced on a pro rata basis for persons working less
22 than full time. Premium payments and employer contributions are
enforced by the authority and the authority may impose a lien on
24 real and personal property owned by any person or entity failing
to pay the amount owed. Subsidies are available for individuals
26 and employers meeting certain eligibility criteria.

28 Part A also establishes a purchasing Alliance, a division
within the Maine Health Care Authority. The alliance is a
30 purchasing sponsor, through which Maine residents can choose a
carrier to provide coverage under the Maine Health Care Plan.
32 The alliance shall negotiate with carriers based on both the
price and quality offered by the carrier. The alliance shall
34 collect premiums and pay carriers as appropriate.

36 Part A also assigns to the Maine Health Care Authority the
task of creating a comprehensive state health resource plan,
38 establishing a global budget, integrating the certificate of need
program into the global budget and state health resource plan,
40 and ensuring the quality and affordability of health care in the
State.

42

Part A allows the members of the alliance board under the
44 Maine Health Care Authority to be paid for expenses.

46 Part B requires the Maine Health Care Authority and the
Department of Human Services to coordinate the Maine Health Care
48 Plan with the health benefits provided under the Medicaid and
Medicare programs. The department is required to apply for all

waivers necessary to integrate the Medicaid program with the Maine Health Care Plan to the maximum extent possible.

Part C eliminates the requirement for the Department of Human Services to create a comprehensive health plan. This Part also amends the certificate of need program to extend to all providers.

Part D requires the Bureau of Insurance and the Maine Health Care Authority to study the laws and rules currently enforced by the bureau and report to the Legislature regarding any statutory changes needed to coordinate the role of the bureau with the function of the authority and its division, the alliance.

Part E repeals the statutes creating the State Employee Health Commission and the State Employees Health Insurance Plan. The State will purchase health care coverage under the Maine Health Care Plan through the alliance.

Part F requires health plans operating in the State to comply with certain disclosure requirements, provider credentialling restrictions, utilization review protections and other patient or provider protections.

Part G increases the taxes necessary for raising the revenue.

Part H establishes the Maine Health Data Organization, an independent state agency that will oversee and coordinate health collection activities and collect, edit and store statewide health data resources.

Part I requires the Commissioner of Professional and Financial Regulation to cooperate with the Maine Health Data Organization's data collection activities and to require the cooperation of the health care practitioner licensing boards within and affiliated with the Department of Professional and Financial Regulation. Part B also requires the Commissioner of Human Services to cooperate with the Maine Health Data Organization's data collection activities.

Part J allows the board members for the Maine Health Data Organization to be reimbursed for their expenses.

Part K amends the licensing statutes for all health care practitioners to provide that repeated and intentional failure to comply with the data collection requirements imposed under the Maine Revised Statutes, Title 22, chapter 1683 is grounds for terminating a health care practitioner's license.

Part L requires the Department of Human Services to submit legislation to the Legislature to amend the statutes to correct cross-references and make any other necessary changes by July 1, 1996.