LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND FIFTEENTH LEGISLATURE

THIRD SPECIAL SESSION
October 1, 1992 to October 6, 1992

FOURTH SPECIAL SESSION
October 16, 1992

ONE HUNDRED AND SIXTEENTH LEGISLATURE

FIRST REGULAR SESSION
December 2, 1992 to July 14, 1993

THE GENERAL EFFECTIVE DATE FOR
FIRST REGULAR SESSION
NON-EMERGENCY LAWS IS
OCTOBER 13, 1993

PUBLISHED BY THE REVISOR OF STATUTES
IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED,
TITLE 3, SECTION 163-A, SUBSECTION 4.

J.S. McCarthy Company
Augusta, Maine
1993

PUBLIC LAWS

OF THE

STATE OF MAINE

AS PASSED AT THE

FIRST REGULAR SESSION

of the

ONE HUNDRED AND SIXTEENTH LEGISLATURE

1993

State Controller in the same department or agency; and 16 2/3% into a Highway Fund statewide account established by the State Controller.

3. Total quality management initiatives. Available balances transferred into each departmentwide and statewide account in accordance with subsection 2 must be used for the payment of nonrecurring expenditures representing total quality management initiatives in the same department or agency or on a statewide basis, respectively.

4. Copies of proposals to Bureau of the Budget and Office of Fiscal and Program Review. Copies of each approved proposal for the expenditure of funds transferred into each departmentwide and statewide account in accordance with subsection 2 must be submitted from each department's or agency's quality management council and the Maine Quality Management Council, respectively, to the Bureau of the Budget and the Office of Fiscal and Program Review.

5. Payments in accordance with allotments. Payments from each departmentwide and statewide account established in accordance with subsection 2 representing expenditures in support of approved proposals submitted to the Bureau of the Budget in accordance with subsection 4 will be authorized by the State Controller on the basis of allotments approved by the Governor in accordance with established law.

6. Report required. The Department of Administrative and Financial Services and the Maine Quality Management Council shall report to the joint standing committee of the Legislature having jurisdiction over state and local government matters annually no later than February 1st, the following:

A. The total amount authorized for transfer, by department, under subsection 1;

B. A description of initiatives submitted under subsection 4; and

C. A recommendation from the Maine Quality Management Council and the Department of Administrative and Financial Services on any changes in the transfer amount authorized under subsections 1 and 2.

7. Sunset. Authorization for this section expires on July 1, 1995. In their report to the joint standing committee of the Legislature having jurisdiction over state and local government matters, the Maine Quality Management Council and the Department of Administrative and Financial Services shall provide their recommendations to the Governor and the Legislature concerning the need for extending authorization for this section.

Sec. 4. 5 MRSA §12004-I, sub-§77-A is enacted to read:

77-A. State Government	Maine Quality Management Council	Not Authorized	5 MRSA §49

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

Effective July 13, 1993.

CHAPTER 477

S.P. 525 - L.D. 1548

An Act to Amend the Laws Regarding Health Insurance and Health Care Services

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

PART A

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

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

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

A. That person was covered under an individual or group contract or policy issued by any insurer, health maintenance organization, nonprofit hospital or medical service organization, or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, the Maine High-Risk Insurance Organization, as established in Title 24-A, section 6052, and the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072, Subsection 4. For purposes of this section, the individual or group contract under which the person is seeking coverage is the "succeeding contract." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

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

Sec. A-2. 24 MRSA §2349, sub-§3, ¶A, as amended by PL 1991, c. 695, §4, is further amended to read:

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

Sec. A-3. 24 MRSA §2349, sub-§3, ¶B, as enacted by PL 1989, c. 867, §1 and affected by §10, is amended to read:

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

Sec. A-4. 24 MRSA §2349, sub-§3, ¶C is enacted to read:

C. That person was covered by the Maine High-Risk Insurance Organization on December 1, 1993 and the request for replacement coverage is made while coverage is in effect or within 30 days of the termination of coverage.

Sec. A-5. 24 MRSA §2349, sub-§4, as enacted by PL 1989, c. 867, §1 and affected by §10, is amended to read:

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

Sec. A-6. 24 MRSA §2349, sub-§7 is enacted to read:

7. Reinsurance, excess insurance or administrative services. A nonprofit hospital or medical service organization may only offer, issue or renew reinsurance or excess insurance coverage or offer administrative services to an uninsured employee benefit plan that provides payment for health services received by employees and their dependents when that plan for the payment of health services and reinsurance and excess insurance coverage meets the requirements of continuity of coverage in this chapter.

Sec. A-7. 24 MRSA §2350, sub-§2, as enacted by PL 1989, c. 867, §1 and affected by §10, is amended to read:

2. Limitation. An individual or group contract between a subscriber and a nonprofit hospital or medical service organization may not impose a preexisting condition exclusion period of more than ~~6~~ 12 months~~, except that the contract may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation or treatment~~. The exclusion may only relate to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage, or to a pregnancy existing on the effective date of coverage. A routine preventive screening or test yielding only negative results may not be deemed to be diagnosis, care or treatment for the purposes of this subsection.

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

1. Policies subject to this section. This section applies to all individual and group medical insurance policies except hospital indemnity, specified accident, specified disease, long-term care and Medicare supplement policies issued by insurers or health maintenance organizations.

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

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

A. That person was covered under an individual or group contract or policy issued by any nonprofit

hospital or medical service organization, insurer, health maintenance organization, or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, the Maine High-Risk Insurance Organization, as established in section 6052 or the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072, Subsection 4. For purposes of this section, the individual or group policy under which the person is seeking coverage is the "succeeding policy." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

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

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

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

Sec. A-11. 24-A MRSA §2849-B, sub-§3, ¶B, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

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

Sec. A-12. 24-A MRSA §2849-B, sub-§3, ¶C is enacted to read:

C. That person was covered by the Maine High-Risk Insurance Organization on December 1, 1993 and the request for replacement coverage is made while coverage is in effect or within 30 days of the termination of coverage.

Sec. A-13. 24-A MRSA §2849-B, sub-§4, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

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

Sec. A-14. 24-A MRSA §2849-B, sub-§7 is enacted to read:

7. Reinsurance, excess insurance or administrative services. An insurer may only offer, issue or renew reinsurance or excess insurance coverage or offer administrative services to an uninsured employee benefit plan that provides payment for health services received by employees and their dependents when that plan for the payment of health services and reinsurance and excess insurance coverage meets the requirements of continuity of coverage in this chapter.

Sec. A-15. 24-A MRSA §2850, sub-§2, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

2. Limitation. An individual ~~policy~~ or group contract issued by an insurer may not impose a preexisting condition exclusion waiting period of more than ~~6~~ 12 months~~, except that the policy may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation or treatment~~. The exclusion may only relate to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage, or to a pregnancy existing on the effective date of coverage. A routine preventive screening or test yielding only negative results may not be deemed to be diagnosis, care or treatment for the purposes of this subsection.

PART B

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

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

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

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

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

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

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

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

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

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

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

3. Coverage for late enrollees. In providing coverage to late enrollees, small group health plan carriers are allowed to exclude a late enrollee for ~~18~~ 12 months or provide coverage subject to ~~an 18-month~~ a 12-month preexisting conditions exclusion. The exclusion may only relate to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage, or to a pregnancy existing on the effective date of coverage. A routine preventive screening or test yielding only negative results may not be deemed to be diagnosis, care or treatment for the purposes of this subsection.

Sec. B-3. 24-A MRSA §2808-B, sub-§6, ¶I is enacted to read:

I. Notwithstanding any other provision of this section, a carrier may choose whether it will offer to groups having only one member coverage under the carrier's individual health policies offered to other individuals in this State in accordance with section 2736-C or coverage under a small group health plan in accordance with this section, or both, but the carrier need not offer to groups of one both small group and individual health coverage.

PART C

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

§2736-C. Individual health plans

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

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

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

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

(1) Accident;

(2) Credit;

(3) Disability;

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

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

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

(9) Workers' compensation;

(10) Automobile medical payment; or

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

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

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

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

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

C. A carrier may vary the premium rate due to family membership.

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

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

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

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

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

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

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

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

A. Coverage must be guaranteed to all individuals.

B. Renewal must be guaranteed to all individuals except:

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

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

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

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

C. A carrier is exempt from the guaranteed issuance requirements of paragraph A provided that the following requirements are met.

(1) The carrier does not issue or deliver any new individual health plans on or after the effective date of this section;

(2) If any individual health plans that were not issued on a guaranteed renewable basis are renewed on or after December 1, 1993, all such policies must be renewed by the carrier and renewal must be guaranteed after the first such renewal date; and

(3) The carrier complies with the rating practices requirements of subsection 2.

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

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

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

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

5. Loss ratios. For all policies issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums.

6. Fair marketing standards. Carriers providing individual health plans must meet the following standards of fair marketing.

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

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

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

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

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

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

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

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

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

7. Applicability. This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after December 1, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

PART D

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

~~No money shall~~ Money may not be drawn from the State Treasury, except in accordance with appropriations duly authorized by law. Every disbursement from the State Treasury ~~shall~~ must be upon the authorization

of the State Controller and the Treasurer of State, as evidenced by their facsimile signatures, except that the Treasurer of State may authorize interbank and intrabank transfers for purposes of pooled investments. Disbursements ~~shall~~ must be in the form of a check or an electronic transfer of funds against a designated bank or trust company acting as a depository of the State Government.

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

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

Sec. D-3. 22 MRSA §304-A, sub-§2-A is enacted to read:

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;

Sec. D-4. 22 MRSA §309, sub-§1, ¶D, as amended by PL 1985, c. 418, §13, is further amended to read:

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

Sec. D-5. 24 MRSA §2332-E is enacted to read:

§2332-E. Standardized claim forms

On or after December 1, 1993, all nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. D-6. 24 MRSA §2979 is enacted to read:

§2979. Expanded practice parameters; expanded risk management protocols

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

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

Sec. D-7. 24 MRSA c. 21, sub-c. X is enacted to read:

SUBCHAPTER X

BILLING FOR HEALTH CARE

§2985. Billing for health care

On or after December 1, 1993, all licensed physicians and chiropractors who bill for health care services must use the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all licensed hospitals must use the current standardized claim form approved by the Federal Government.

Sec. D-8. 24-A MRSA §1912 is enacted to read:

§1912. Standardized claim forms

On or after December 1, 1993, all administrators who administer claims and who provide payment or re-

imbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. D-9. 24-A MRSA §2680 is enacted to read:

§2680. Standardized claim forms

On or after December 1, 1993, administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. D-10. 24-A MRSA §2753 is enacted to read:

§2753. Standardized claim forms

On or after December 1, 1993, insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. D-11. 24-A MRSA §2823-B is enacted to read:

§2823-B. Standardized claim forms

On or after December 1, 1993, all insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. D-12. 24-A MRSA §4235 is enacted to read:

§4235. Standardized claim forms

On or after December 1, 1993, all health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

PART E

Sec. E-1. Report on unification of administration of all publicly funded and publicly administered health insurance programs. The Department of Human Services is directed to report to the Joint Standing Committee on Banking and Insurance on or before January 1, 1994 on options for the unification of administration of all publicly funded and publicly administered health insurance programs.

Sec. E-2. Report on single point of entry and eligibility determinations. The Department of Human Services is directed to report to the Joint Standing Committee on Banking and Insurance on or before January 1, 1994 on single point of entry and eligibility determinations utilizing the FAMIS computer system.

PART F

Sec. F-1. Effective date. This Act takes effect December 1, 1993.

PART G

Sec. G-1. PL 1993, c. 410, Pt. R, §4 is amended to read:

Sec. R-4. Effective date; transition provisions. Sections 1 to 3 of this Part take effect January 1, 1997, except that no new policies of insurance may be issued providing coverage by the Maine High-Risk Insurance Organization on or after the effective date of this Act. During the period prior to July 1, 1997, the board of directors and the administrator of the organization shall continue to exercise those powers and responsibilities necessary to the operation of the Maine High-Risk Insurance Organization with respect to policies issued prior to the effective date of this Act and necessary to concluding the affairs of the organization. Coverage under

all policies issued by the organization terminates as of January 1, 1995, except that, if at any time after December 1, 1993 an actuarial review indicates that the organization's remaining funds may be insufficient to provide continuing coverage to all remaining policies in force until January 1, 1995, the board may cancel these policies on 30 days' notice. Any funds remaining when the affairs of the organization are concluded revert to the General Fund.

See title page for effective date, unless otherwise indicated.

CHAPTER 478

S.P. 540 - L.D. 1562

An Act to Clarify Tax on Intangible Income

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

Whereas, the Maine Supreme Judicial Court has recently decided Boulet v. State Tax Assessor and the holding on that case is contrary to the established practice of the Bureau of Taxation; and

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

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

Sec. 1. 36 MRSA §5142, sub-§1, as amended by PL 1981, c. 706, §37, is further amended to read:

1. General. The adjusted gross income of a nonresident derived from sources within this State ~~shall be~~ is the sum of the following:

A. The net amount of items of income, gain, loss, and deduction entering into ~~his~~ the federal adjusted gross income ~~which~~ that are derived from or connected with sources in this State including (i) ~~his~~ the nonresident's distributive share of partnership income and deductions determined under section 5192, (ii) ~~his~~ the nonresident's share of estate or trust income and deductions determined under section 5176, and (iii) ~~his~~ the nonresident's distributive share of the income of an electing small business corporation for federal income tax purposes derived from or connected with sources within this State; ~~and~~

B. The portion of the modifications described in section 5122, subsections 1 and 2 ~~which~~ that relate to income derived from sources in this State, including any modifications attributable to ~~him~~ the nonresident as a partner; and

C. Proceeds from any Maine State Lottery or Tristate Lotto tickets purchased in this State.

Sec. 2. Moratorium on processing of claims. Notwithstanding any other provision of law, the State Tax Assessor may not process any claims filed under the Maine Residents Property Tax Program pursuant to the Maine Revised Statutes, Title 36, chapter 907, from August 1, 1993 to October 1, 1993.

Sec. 3. Effective date; contingent on passage of legislation. Section 2 of this Act takes effect only if the changes proposed to the benefit calculation and income eligibility for claimants representing nonelderly households under the Maine Revised Statutes, Title 36, section 6207, subsection 1, paragraph A-1 and subsection 2 that are contained in L.D. 1565 are enacted by the 116th Legislature.

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

Effective July 13, 1993, unless otherwise indicated.

CHAPTER 479

S.P. 34 - L.D. 40

An Act to Amend the Laws Pertaining to the Visitation Rights of Grandparents

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

Sec. 1. 19 MRSA §1003, sub-§1, as enacted by PL 1991, c. 414, is repealed and the following enacted in its place:

1. Standing to petition for visitation rights. A grandparent of a minor child may petition the court for reasonable rights of visitation or access if:

A. At least one of the child's parents or legal guardians has died;

B. There is a sufficient existing relationship between the grandparent and the child. This paragraph is repealed October 1, 1995; or

C. If a sufficient existing relationship between the grandparent and the child does not exist, a sufficient effort to establish one has been made. This paragraph is repealed October 1, 1995.