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OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND SEVENTEENTH LEGISLATURE

FIRST REGULAR SESSION

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TITLE 3, SECTION 163-A, SUBSECTION 4

J.S. McCarthy Company
Augusta, Maine
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4. The Atlantic Salmon Authority is the successor in every way to the Atlantic Sea Run Salmon Commission.

5. The Governor, the President of the Senate and the Speaker of the House of Representatives shall make all appointments required by this Act not later than 30 days after the effective date of this Act.

6. On the effective date of this Act, all position counts, appropriations and allocations to the former Atlantic Sea Run Salmon Commission are transferred to the Atlantic Salmon Authority and become position counts, appropriations and allocations of the Atlantic Salmon Authority. On and after the effective date of this Act, the Department of Inland Fisheries and Wildlife shall continue to provide the Atlantic Salmon Authority with the same level of administrative support that the department provided to the former Atlantic Sea Run Salmon Commission.

7. Not later than January 1, 1996, the Chair of the Atlantic Salmon Board shall submit a report to the Joint Standing Committee on Inland Fisheries and Wildlife. The report must include the board's plan for managing the Atlantic salmon fishery in the State and any statutory recommendations pertaining to staffing or budget matters that the board determines necessary to implement that plan. The Joint Standing Committee on Inland Fisheries and Wildlife may report out legislation to the Second Regular Session of the 117th Legislature to implement the statutory recommendations of the board.

See title page for effective date.

CHAPTER 407

H.P. 432 - L.D. 595

An Act Regarding Insurance Coverage for Mental Illness

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

Sec. 1. 24 MRSA §2325-A, sub-§5-C, as amended by PL 1995, c. 19, §1, is repealed and the following enacted in its place:

5-C. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A is subject to this subsection.

A. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital or medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 2. 24 MRSA §2325-A, sub-§5-D is enacted to read:

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided,

coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group nonprofit hospital and medical services organization health care plan contracts is subject to this subsection.

A. All individual and group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. Every nonprofit hospital and medical services organization and nonprofit health care plan must make available coverage in all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 that provides benefits meeting the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital or medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 3. 24 MRSA §2325-A, sub-§8, as enacted by PL 1983, c. 515, §4, is amended to read:

8. Reports to the Superintendent of Insurance. Every nonprofit hospital or medical service organization subject to this section shall report its experience for each calendar year ~~beginning with 1984~~ to the superintendent not later than April 30th of the following year. The report ~~shall~~ must be in a form prescribed by the superintendent and ~~shall~~ include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all nonprofit hospital or medical service organizations in an annual report.

Sec. 4. 24 MRSA §2325-A, sub-§9, as amended by PL 1993, c. 586, §2, is repealed.

Sec. 5. 24-A MRSA §2749-C is enacted to read:

§2749-C. Mandated offer of coverage for certain mental illnesses

1. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A by all individual policies is subject to this section.

A. All individual policies must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All individual policies and contracts executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this paragraph. For

purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual policy.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

2. Contracts; providers. Subject to approval by the superintendent pursuant to section 2305, an insurer incorporated under this chapter shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.

3. Limits; coinsurance; deductibles. A policy or contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

4. Reports to the superintendent. Every insurer subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for individual health care policies, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

5. Application. Except as otherwise provided, the requirements of this section apply to all policies and contracts executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996. For purposes of this section, all policies are deemed renewed no later than the next yearly anniversary of the contract date. Nothing in this section applies to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

Sec. 6. 24-A MRSA §2843, sub-§5-C, as amended by PL 1995, c. 19, §1, is repealed and the following enacted in its place:

5-C. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A is subject to this subsection.

A. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital or medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical

treatment for physical illness under the group contract.

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 7. 24-A MRSA §2843, sub-§5-D is enacted to read:

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided in subsection 5-C, coverage for medical treatment for mental illnesses listed in paragraph A by all group contracts is subject to this subsection.

A. All group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 8. 24-A MRSA §2843, sub-§7, as enacted by PL 1983, c. 515, §6, is amended to read:

7. Reports to the Superintendent of Insurance. Every insurer subject to this section shall report its experience for each calendar year ~~beginning with 1984~~ to the superintendent not later than April 30th of the following year. The report ~~shall~~ must be in a form prescribed by the superintendent and ~~shall~~ include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

Sec. 9. 24-A MRSA §2843, sub-§8, as amended by PL 1993, c. 586, §4, is repealed and the following enacted in its place:

8. Application. This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

Sec. 10. 24-A MRSA §4234-A is enacted to read:

§4234-A. Mental health services coverage

1. Findings. The Legislature finds that:

A. Mental illness affects nearly 170,000 people of this State each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families;

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by businesses in the State in accidents, absenteeism, nonproductivity and turnover. Excessive stress

and anxiety and other forms of mental illness clearly contribute to general health problems and costs;

C. Typical health coverage in this State discriminates against mental illness, the victims and affected families with nonexistent or limited benefits compared to provisions for other illnesses; and

D. Experience in this State and several other states demonstrates that the risk of mental illness can be insured at reasonable cost and with adequate controls on quality and utilization of treatment.

2. Policy and purpose. The Legislature declares that it is the policy of this State to:

A. Promote equitable and nondiscriminatory health coverage benefits for all forms of illness including mental and emotional disorders that are of significant consequence to the health of people of the State and that can be treated in a cost-effective manner;

B. Ensure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in the least restrictive settings;

C. Ensure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and

D. Ensure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits must be provided.

3. Definitions. For purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Day treatment services" includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes necessary to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours a day.

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes used in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Human Services or in an accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting.

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups.

D. "Person suffering from a mental or nervous condition" means a person whose psychobiological processes are impaired severely enough to manifest problems in the area of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the area of intellect, emotion or physical well-being.

E. "Provider" means an individual included in Title 24, section 2303, subsection 2, a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Mental Health and Mental Retardation. All agency or institutional providers named in this paragraph shall ensure that services are supervised by a psychiatrist or licensed psychologist.

4. Requirement. Every health maintenance organization that issues individual or group health care contracts providing coverage for hospital care to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

5. Services. Each individual or group contract must provide, at a minimum, the following benefits for a person suffering from a mental or nervous condition:

A. Inpatient services;

B. Day treatment services; and

C. Outpatient services.

6. Coverage for treatment of certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A is subject to this subsection.

A. All group contracts must provide, at a minimum, benefits according to paragraph B, sub-

paragraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection does not apply to policies, contracts or certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

7. Mandated offer of coverage for certain mental illnesses. Except as provided in subsection 6, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group contracts is subject to this subsection.

A. All individual and group contracts shall make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

8. Contracts; providers. Subject to approval by the superintendent pursuant to section 4204, a health maintenance organization incorporated under

this chapter shall allow providers to contract, subject to the health maintenance organization's credentialling policy, for the provision of mental health services within the scope of the provider's licensure.

9. Limits; coinsurance; deductibles. A policy or contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

10. Reports to the superintendent. Every health maintenance organization subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for individual and group health care contracts, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all health maintenance organizations in an annual report.

11. Application. Except as otherwise provided, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on and after July 1, 1996. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

See title page for effective date.

CHAPTER 408

H.P. 619 - L.D. 829

An Act to Strengthen Maine's Live Harness Racing Industry

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

Whereas, the harness racing industry is an important industry in the State; and

Whereas, a more equitable distribution of purse funds must be provided immediately in order to strengthen live racing in the State; and

Whereas, this legislation will provide for a more equitable distribution of purse funds; 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. 8 MRSA §271, sub-§1, as amended by PL 1991, c. 579, §10, is further amended to read:

1. Licensing. If the commission is satisfied that all of this chapter and rules prescribed by the commission have been substantially complied with during the past year and will be fully complied with during the coming year by the person, association or corporation applying for a license; that the applicant, its members, directors, officers, shareholders, employees, creditors and associates are of good moral character; that the applicant is financially responsible; and that the award of racing dates to the applicant is appropriate under the criteria contained in subsection 2, it may issue a license for the holding of harness horse races or meets for public exhibition with pari-mutuel pools, which must expire on December 31st. The commission shall set licensing and license renewal fees sufficient to carry out the administration and enforcement of the licensing program. These fees may not exceed annually the greater of $100 or $10 for each calendar week or part of a week of harness racing regardless of whether pari-mutuel pools are sold. The commission shall provide a booklet containing harness racing laws and rules and relevant portions of the Maine Administrative Procedure Act to every initial licensee and a fee not to exceed $10 must be included in the license fee to cover the cost of this publication. The commission shall provide necessary revisions of this booklet to those persons renewing licenses at the time of renewal and shall include the cost of the revisions, not to exceed $10, in the renewal fee. The license must set forth the name of the licensee, the place where the races or race meets are to be held and the specific race dates and time of day or night during which racing may be conducted by the licensee. The location stated in the license where the race or race meet is to be held may be transferred to any other licensee on the dates set forth in the license during which the racing may be conducted, but, with respect to that transfer, the transfer may only be made to another licensee and the licensee is liable for compliance with all laws and regulations governing the conduct of harness racing. Any such license issued is not transferable or assignable. The Administrative Court Judge, as designated in Title 4, chapter 25, may revoke any license issued at any time for violation of the commission's rules or licensing provisions upon notice and hearing. The license of any corporation is automatically revoked, subject to Title 5, chapter 375, upon the change in ownership, legal or equitable, of 50% or more of the voting stock of the corporation