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OF THE

STATE OF MAINE

AS PASSED BY THE

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by law to be published in a newspaper ~~shall~~ must appear in all editions of that newspaper.

See title page for effective date.

CHAPTER 406

H.P. 1315 - L.D. 1866

An Act to Allow the Maine Harness Racing Commission to Issue Conditional Licenses

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

Sec. 1. 8 MRSA §271, sub-§6 is enacted to read:

6. Conditions. The commission may impose conditions on a license if one or more of the criteria established in this section are not met at the time the license is issued, but may be brought into compliance within a time period during the licensing year.

See title page for effective date.

CHAPTER 407

S.P. 454 - L.D. 1428

An Act to Amend the Child Support Laws Concerning Notice to Co-owners of Property Subject to Support Liens

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

Sec. 1. 19-A MRSA §2357, sub-§5 is enacted to read:

5. Notice and hearing prior to disposition. When the department is provided with reliable information that another person, in addition to the responsible parent, has an ownership interest in the property of the responsible parent subject to a support lien, the department shall provide written notice to the other person before the foreclosure or other disposition of the property explaining that:

A. The department has a support lien against the property; and

B. The person may request a hearing to establish the value of that person's interest in the property before the foreclosure or other disposition of the property.

Sec. 2. 19-A MRSA §2361, sub-§3, ¶¶F and G, as enacted by PL 1995, c. 694, Pt. B, §2 and affected by Pt. E, §2, are amended to read:

F. That, if a record of the proceeding is filed in court and the responsible parent is not making regular child support payments, the burden of proof is on the responsible parent to show why regular payments can not be made; ~~and~~

G. The penalties as provided by this section that could be incurred by the responsible parent for failure to appear, failure to provide documents, papers and other evidence as required or intentionally providing false information~~.~~; and

Sec. 3. 19-A MRSA §2361, sub-§3, ¶H is enacted to read:

H. That the responsible parent must provide to the department the name and last known address of any other person that has an ownership in any property in which the responsible parent has an ownership interest.

Sec. 4. 19-A MRSA §2364, sub-§3 is enacted to read:

3. Liens; hearing to determine ownership interest. Before the foreclosure, the obligor and any other persons who claim an ownership interest in the property subject to the lien have a right to an administrative hearing to establish the value of their relative interest in the property. A request for a hearing must be in writing and must be received by the department within 10 calendar days of the notice of the foreclosure. Upon receiving a request for a hearing, the department shall notify all persons the department has reason to believe have an ownership interest in the property of the time, place and nature of the hearing. At the hearing, the hearing officer shall determine the value of the interests of all persons with an ownership interest in the property.

Sec. 5. Effective date. This Act takes effect October 1, 1997.

Effective October 1, 1997.

CHAPTER 408

H.P. 1113 - L.D. 1556

An Act to Establish Breast Cancer Patient Protection

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

Sec. 1. 24 MRSA §2320-A, sub-§2, as enacted by PL 1989, c. 875, Pt. I, §2, is repealed and the following enacted in its place:

2. Required coverage. All individual and group nonprofit hospital and medical services plan contracts must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

Sec. 2. 24 MRSA §2320-C, as corrected by RR 1995, c. 1, §13, is repealed and the following enacted in its place:

§2320-C. Coverage for breast cancer treatment

1. Inpatient care. All individual and group nonprofit hospital and medical services plan contracts providing coverage for medical and surgical benefits must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual and group nonprofit hospital and medical services plan contract may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual and group nonprofit hospital and medical services plan contracts must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. Reconstruction. All individual and group nonprofit hospital and medical services plan contracts providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 3. 24-A MRSA §2745-A, sub-§2, as amended by PL 1991, c. 156, §1, is repealed and the following enacted in its place:

2. Required coverage. All individual insurance policies that cover radiologic procedures, except those designed to cover only specific diseases, accidental injury or dental procedures, must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

Sec. 4. 24-A MRSA §2745-C, as corrected by RR 1995, c. 1, §15, is repealed and the following enacted in its place:

§2745-C. Coverage for breast cancer treatment

1. Inpatient care. All individual health policies providing coverage for medical and surgical benefits, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual health policy may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. Reconstruction. All individual health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on

which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 5. 24-A MRSA §2837-A, sub-§2, as amended by PL 1991, c. 156, §2, is repealed and the following enacted in its place:

2. Required coverage. All group insurance policies that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

Sec. 6. 24-A MRSA §2837-C, as corrected by RR 1995, c. 1, §17, is repealed and the following enacted in its place:

§2837-C. Coverage for breast cancer treatment

1. Inpatient care. All group health policies providing coverage for medical and surgical benefits, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, a group health policy may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All group health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. Reconstruction. All group health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 7. 24-A MRSA §4237, as corrected by RR 1995, c. 1, §21, is repealed and the following enacted in its place:

§4237. Coverage for breast cancer treatment

1. Inpatient care. All individual and group coverage subject to this chapter that provides coverage for medical and surgical benefits must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual or group coverage contract may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual and group coverage subject to this subsection must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

2. Reconstruction. All individual and group coverage subject to this chapter that provides coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

Sec. 7. 24-A MRSA § 4237-A is enacted to read:

§4237-A. Screening mammograms

1. Definition. For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast.

2. Required coverage. All individual and group coverage subject to this chapter must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

Sec. 8. Application. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 1998. For purposes of this Act, all policies, contracts and certificates are deemed to be renewed no later than the next yearly anniversary of the contract date.

See title page for effective date.

CHAPTER 409

H.P. 1172 - L.D. 1649

An Act to Provide a Funding Mechanism for the E-9-1-1 System

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

Sec. 1. 25 MRSA §2927, as amended by PL 1995, c. 672, §§1-4, is further amended to read:

§2927. E-9-1-1 funding

1-A. Statewide E-9-1-1 surcharge. The activities authorized under this chapter are funded through a special statewide E-9-1-1 surcharge to be levied on each residence and business telephone exchange line, including private branch exchange, or PBX, lines and Centrex lines, ~~trunks serving cellular communications providers in the State~~ cellular or wireless telecommunications service subscribers and semipublic coin and public access lines. The statewide E-9-1-1 surcharge may not be imposed on more than 25 lines or numbers per customer billing account. Through July 31, ~~1996~~ 1998, the statewide E-9-1-1 surcharge is ~~2¢~~ 20¢ per month per line or number. Beginning August 1, ~~1996~~ 1998, the statewide E-9-1-1 surcharge is ~~20¢~~ 32¢ per month per line or number. The statewide E-9-1-1 surcharge must be billed on a monthly basis by each local exchange telephone utility or cellular or wireless telecommunications service provider and be shown separately as a statewide E-9-1-1 surcharge on the customer's bill.

2-A. Surcharge remittance. Each local exchange telephone utility and cellular or wireless telecommunications service provider shall remit the statewide E-9-1-1 surcharge revenues collected from its customers pursuant to this section on a monthly basis to the Treasurer of State for deposit in a separate account known as the E-9-1-1 fund.

3. Expenditure of funds. The bureau may use the revenues in the E-9-1-1 fund to fund staff and to defray costs associated with the implementation, operation and management of E-9-1-1.

4. Unexpended funds; interest. Any amount of the E-9-1-1 fund not expended at the end of the fiscal year may not lapse but must be carried forward to be expended for the purposes specified in this chapter in succeeding fiscal years. The Treasurer of State shall credit all interest on fund balances to the fund.

5. Legislative annual report. The bureau shall report annually, before February 1st, to the joint standing committee of the Legislature having jurisdiction over ~~public~~ utilities and energy matters on:

A. The bureau's planned expenditures for the year and use of funds for the previous year; ~~and~~

B. The statewide E-9-1-1 surcharge collected under this section~~.~~;

C. The bureau's recommended statewide E-9-1-1 surcharge for the coming year; and

D. The bureau's recommendations for amending existing and enacting new law to improve the E-9-1-1 system.

5-A. Committee recommendations; budget. The joint standing committee of the Legislature having jurisdiction over utilities and energy matters shall make recommendations to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs regarding all expenditures from the E-9-1-1 fund established in subsection 2-A.

6. Violations. A telephone utility or a cellular or wireless telecommunications service provider~~,~~ subject to this section~~,~~ that ~~willfully~~ intentionally and knowingly fails to remit the statewide E-9-1-1 surcharge revenues collected under this section commits a civil violation for which a forfeiture of not more than $500 may be adjudged for each day that payment is not made after the due date.

~~**7. Repeal.** Subsections 1 and 2 are repealed 90 days after the adjournment of the Second Regular Session of the 117th Legislature.~~

7-A. Repeal. Subsections 1-A and 2-A are repealed ~~August 1, 1998~~ 90 days after the adjourn-