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OF THE

STATE OF MAINE

AS PASSED BY THE

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November 13, 2002 to November 14, 2002

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

Penmor Lithographers
Lewiston, Maine
2003

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

Sec. 1. 22 MRSA §4056, sub-§5 is enacted to read:

5. Financial support. If, prior to the termination of parental rights, the parent was convicted of a crime against the child, the court may include in the termination order the requirement that the parent whose rights are terminated make a lump sum payment to assist in the future financial support of the child.

See title page for effective date.

CHAPTER 217

S.P. 90 - L.D. 231

An Act To Strengthen Delivery of Electricity Conservation Programs

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

Sec. 1. 35-A MRSA §3211-A, sub-§4, ¶D, as enacted by PL 2001, c. 624, §4, is amended to read:

D. Are proportionally equivalent on a per-kilowatt-hour basis to the total conservation expenditures of other transmission and distribution utilities, unless the commission finds that a different amount is justified~~; however, any increase in an assessment on a transmission and distribution utility by the commission must be based on factors other than the achievement of proportional equivalency~~.

See title page for effective date.

CHAPTER 218

S.P. 292 - L.D. 897

An Act Concerning Health Insurance Reimbursement and Contracting Practices

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

Sec. 1. 24 MRSA §2332-E, as enacted by PL 1993, c. 477, Pt. D, §5 and affected by Pt. F, §1, is amended to read:

§2332-E. Standardized claim forms

~~On or after December 1, 1993, all~~ 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 for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ 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 for professional or facility services, as applicable, approved by the Federal Government. A nonprofit hospital or medical service organization or nonprofit health care plan may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 2. 24-A MRSA §1912, as enacted by PL 1993, c. 477, Pt. D, §8 and affected by Pt. F, §1, is amended to read:

§1912. Standardized claim forms

~~On or after December 1, 1993, all~~ All administrators who administer claims and who provide 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 for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ 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 for professional or facility services, as applicable, approved by the Federal Government. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 3. 24-A MRSA §2436, sub-§2-A, as enacted by PL 2001, c. 569, §1, is amended to read:

2-A. ~~For~~ Except as provided in this subsection, for purposes of this section, an "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. After January 1, 2005, for a provider with 10 or more full-time-equivalent employees, an "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer in the insurer's standard electronic data format using the most current

published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. This subsection applies only to a policy or certificate of a health plan as defined in section 4301-A, subsection 7.

Sec. 4. 24-A MRSA §2436, sub-§3, as amended by PL 1999, c. 256, Pt. I, §1, is further amended to read:

3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date. Notwithstanding this subsection, the superintendent may adopt rules that establish a minimum amount of interest payable on an overdue undisputed claim to a health care provider before a payment must be issued. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 5. 24-A MRSA §2680, as repealed and replaced by PL 1999, c. 609, §18, is amended to read:

§2680. Standardized claim form

Administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician, chiropractor or licensed hospital shall accept the current standardized claim form for professional or facility services, as applicable, approved by the ~~federal Health Care Financing Administration~~ Federal Government. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 6. 24-A MRSA §2753, as enacted by PL 1993, c. 477, Pt. D, §10 and affected by Pt. F, §1, is amended to read:

§2753. Standardized claim forms

~~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 physician or chiropractor must accept the current standardized claim form for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ 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 for professional or facility services, as applicable, approved by the Federal Government. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 7. 24-A MRSA §2823-B, as enacted by PL 1993, c. 477, Pt. D, §11 and affected by Pt. F, §1, is amended to read:

§2823-B. Standardized claim forms

~~On or after December 1, 1993, all~~ 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 for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ 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 for professional or facility services, as applicable, approved by the Federal Government. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 8. 24-A MRSA §4235, as enacted by PL 1993, c. 477, Pt. D, §12 and affected by Pt. F, §1, is amended to read:

§4235. Standardized claim forms

~~On or after December 1, 1993, all~~ 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 for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ 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 for professional or facility services, as applicable, approved by the Federal Government. A health maintenance organization may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 9. 24-A MRSA §4303, sub-§§9 and 10 are enacted to read:

9. Notice of amendments to provider agreements. A carrier offering a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the

provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment.

10. Limits on retrospective denials. A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. The carrier has provided the reason for the retrospective denial in writing to the provider; and

B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 18 months. The retrospective denial of a previously paid claim may be permitted beyond 18 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by the provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;

(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(6) The claim payment is the subject of legal action.

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.

See title page for effective date.

CHAPTER 219

S.P. 128 - L.D. 352

An Act To Encourage Energy Efficiency and Security

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

Sec. 1. 35-A MRSA §3211-A, sub-§2, as enacted by PL 2001, c. 624, §4, is amended by amending the first paragraph to read:

2. Programs. The commission shall develop and, to the extent of available funds, implement conservation programs in accordance with this section. The commission shall establish and, on a schedule determined by the commission, revise objectives and an overall energy strategy for conservation programs. Conservation programs implemented by the commission must be consistent with the objectives and an overall energy strategy developed by the commission and be cost effective, as defined by the commission by rule or order. In defining "cost effective," the commission may consider the extent to which a program promotes sustainable economic development or reduces environmental damage to the extent the commission can quantify or otherwise reasonably identify such effects. Consistent with the other requirements of this section, the commission, in adopting and implementing conservation programs, shall seek to encourage efficiency in electricity use, provide incentives for the development of new, energy-efficient business activity in the State and take into account the costs and benefits of energy efficiency and conservation to existing business activity in the State.

Sec. 2. Report. The Public Utilities Commission shall undertake an investigation to identify rate designs, mechanisms or other means that provide incentives for transmission and distribution utilities to promote energy efficiency and that promote the security and robustness of the electric grid by appropriately compensating transmission and distribu-