LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTY-THIRD LEGISLATURE

FIRST REGULAR SESSION
December 6, 2006 to June 21, 2007

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FIRST REGULAR SESSION
NON-EMERGENCY LAWS IS
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IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED,
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Penmor Lithographers
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2007

(2) That the person is unable or unwilling to comply with recommended treatment;

(3) That the need for the treatment outweighs the risks and side effects; and

(4) That the recommended treatment is the least intrusive appropriate treatment option.

Alternatively, the court may appoint a surrogate to make treatment decisions on the person's behalf for the duration of the commitment if the court is satisfied that the surrogate is suitable, willing and reasonably available to act in the person's best interests.

B. The need for involuntary treatment under paragraph A may be based on findings that include, but are not limited to, the following:

(1) That a failure to treat the illness is likely to produce lasting or irreparable harm to the person; or

(2) That without the recommended treatment the person's illness or involuntary commitment may be significantly extended without addressing the symptoms that cause the person to pose a likelihood of serious harm.

C. The hospital and person may agree to changes in the treatment plan during the time period of an order for involuntary treatment.

D. If a change in the treatment plan is needed and the hospital and patient do not agree on the change, the hospital shall apply to the court for a change in the treatment plan.

Sec. 5. Commissioner to adopt rules. The Commissioner of Health and Human Services shall adopt rules to implement the Maine Revised Statutes, Title 34-B, section 3003, subsection 2, paragraph C, subparagraphs 1 to 5 no later than January 1, 2008 for use beginning on that date. The rules must include amendment of Rule 14-198 Chapter 1: "Rights of Recipients of Mental Health Services." Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and are not subject to the provisions of Title 34-B, section 3003, subsection 4.

Sec. 6. Appropriations and allocations. The following appropriations and allocations are made.

JUDICIAL DEPARTMENT

Courts - Supreme, Superior, District and Administrative 0063

Initiative: Provides funds for additional physician services related to certain involuntary treatment examinations.

GENERAL FUND	2007-08	2008-09
All Other	$40,000	$40,000
GENERAL FUND TOTAL	$40,000	$40,000

Sec. 7. Effective date. Those sections of this Act that enact the Maine Revised Statutes, Title 34-B, section 3864, subsections 1-A and 7-A and amend section 3003, subsection 2, paragraph C and section 3864, subsection 4 take effect January 1, 2008.

See title page for effective date, unless otherwise indicated.

CHAPTER 447

H.P. 347 - L.D. 431

An Act To Enable the Dirigo Health Program To Be Self-administered

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

Sec. 1. 5 MRSA §12004-G, sub-§14-D, as enacted by PL 2003, c. 469, Pt. A, §3, is amended to read:

14-D.

Health Care	Board of ~~Directors~~ Trustees of Dirigo Health	$100 per diem and expenses	24-A MRSA §6904

Sec. 2. 22 MRSA §3174-DD, as amended by PL 2005, c. 400, Pt. C, §2, is further amended to read:

§3174-DD. Dirigo health coverage

The department may contract with one or more health insurance carriers or the Dirigo Health Self-administered Plan established pursuant to Title 24-A, section 6981 to purchase Dirigo Health Program coverage for MaineCare members who seek to enroll through their employers pursuant to Title 24-A, section 6910, subsection 4, paragraph B. A MaineCare member who enrolls in the Dirigo Health Program as a member of an employer group receives full MaineCare benefits through the Dirigo Health Program. The benefits are delivered through the employer-based health plan, subject to nominal cost sharing as permitted by 42 United States Code, Section 1396o(2003) and additional coverage provided under contract by the department.

Sec. 3. 24-A MRSA §6903, sub-§1, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

1. Board. "Board" means the Board of ~~Directors~~ Trustees of Dirigo Health, as established in section 6904.

Sec. 4. 24-A MRSA §6904, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

§6904. Board of Trustees of Dirigo Health

Dirigo Health operates under the supervision of ~~a~~ the Board of ~~Directors~~ Trustees of Dirigo Health established in accordance with this section.

1. Appointments. The board consists of ~~5~~ 9 voting members and ~~3~~ 4 ex officio, nonvoting members as follows.

A. The ~~5~~ 9 voting members of the board ~~must be~~ are appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate in accordance with this paragraph.

(1) Five members qualified in accordance with subsection 2-A, paragraph A are appointed by the Governor.

(2) One member qualified in accordance with subsection 2-A, paragraph A is appointed by the Governor and must be selected from candidates nominated by the President of the Senate.

(3) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from candidates nominated by the Speaker of the House.

(4) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from the candidates nominated by the Senate Minority Leader.

(5) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from candidates nominated by the House Minority Leader.

B. The ~~3~~ 4 ex officio, nonvoting members of the board are:

(1) The Commissioner of Professional and Financial Regulation or the commissioner's designee;

(2) The director of the Governor's Office of Health Policy and Finance or the director of a successor agency; ~~and~~

(3) The Commissioner of Administrative and Financial Services or the commissioner's designee~~.~~; and

(4) The Treasurer of State or the treasurer's designee.

~~**2. Qualifications of voting members.** Voting members of the board:~~

~~A. Must have knowledge of and experience in one or more of the following areas:~~

~~(1) Health care purchasing;~~

~~(2) Health insurance;~~

~~(3) MaineCare;~~

~~(4) Health policy and law;~~

~~(5) State management and budget; or~~

~~(6) Health care financing; and~~

~~B. Except as provided in this paragraph, may not be:~~

~~(1) A representative or employee of an insurance carrier authorized to do business in this State;~~

~~(2) A representative or employee of a health care provider operating in this State; or~~

~~(3) Affiliated with a health or health related organization regulated by State Government.~~

~~A nonpracticing health care practitioner, retired or former health care administrator or retired or former employee of a health insurance carrier is not prohibited from being considered for board membership as long as that person is not currently affiliated with a health or health related organization.~~

2-A. Qualifications of voting members. Voting members of the board must be qualified in accordance with this subsection.

A. Six of the voting members of the board must have knowledge of and experience in one or more of the following areas:

(1) Health care purchasing;

(2) Health insurance;

(3) MaineCare;

(4) Health policy and law;

(5) State management and budgeting;

(6) Health care financing;

(7) Labor or consumer advocacy; and

(8) Marketing.

B. Three of the voting members of the board must have knowledge of and experience in one or more of the following areas:

(1) Accounting;

(2) Banking;

(3) Securities; and

(4) Insurance.

C. Except as provided in this paragraph, a voting member of the board may not be:

(1) A representative or employee of a health insurance carrier authorized to do business in this State;

(2) A representative or employee of a health care provider operating in this State;

(3) Affiliated with a health or health-related organization regulated by State Government; or

(4) A representative or employee of Dirigo Health.

A nonpracticing health care practitioner, retired or former health care administrator or retired or former employee of a health insurance carrier is not prohibited from being considered for board membership as long as that person is not currently affiliated with a health or health-related organization.

3. Terms of office. Voting members serve 3-year terms. Voting members may serve up to 2 consecutive terms. Of the initial appointees, one member serves an initial term of one year, 2 members serve initial terms of 2 years and 2 members serve initial terms of 3 years. ~~The Governor shall fill any~~ Any vacancy for an unexpired term must be filled in accordance with subsections 1 and ~~2~~ 2-A. Members reaching the end of their terms may serve until replacements are named.

4. Chair. The Governor shall appoint one of the voting members as the chair of the board.

5. Quorum. ~~Three~~ Five voting members of the board constitute a quorum.

6. Affirmative vote. An affirmative vote of ~~3~~ 5 members is required for any action taken by the board.

7. Compensation. A member of the board must be compensated according to the provisions of Title 5, section 12004-G, subsection 14-D; a member must receive compensation whenever that member fulfills any board duties in accordance with board bylaws.

8. Meetings. The board shall meet ~~at least 4 times a year at regular intervals~~ monthly and may also meet at other times at the call of the chair or the executive director. All meetings of the board are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.

Sec. 5. 24-A MRSA §6905, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed and the following enacted in its place:

§6905. Limitation on liability

1. Indemnification of Dirigo Health employees. An employee of Dirigo Health is not subject to any personal liability for having acted within the course and scope of membership or employment to carry out any power or duty under this chapter. Dirigo Health shall indemnify any member of the board and any employee of Dirigo Health against expenses actually and necessarily incurred by that member or employee in connection with the defense of any action or proceeding in which that member or employee is made a party by reason of past or present authority with Dirigo Health.

2. Limitation on liability of board members. The personal liability of a member of the board is governed by Title 18-B, section 1010.

Sec. 6. 24-A MRSA §6908, sub-§2, ¶E, as amended by PL 2005, c. 400, Pt. C, §6, is further amended to read:

E. Arrange the provision of Dirigo Health Program benefit coverage to eligible individuals and eligible employees through contracts with one or more qualified bidders in accordance with section 6910 or through the Dirigo Health Self-administered Plan authorized pursuant to section 6981;

Sec. 7. 24-A MRSA §6908, sub-§13, as reallocated by PL 2005, c. 683, Pt. B, §20, is amended to read:

13. Report; jurisdiction. Dirigo Health shall report twice annually, once in January and once during the last month of the regular legislative session, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on the Dirigo Health Program and budget. Minutes of meetings of the Board of ~~Directors~~ Trustees of Dirigo Health must be provided to each member of the joint standing committees of the Legislature having jurisdiction over insurance and financial services matters, health and human services matters and appropriations and financial affairs.

Sec. 8. 24-A MRSA §6909, sub-§2, ¶A, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

A. Serve as the liaison between the board ~~of directors~~ and Dirigo Health and serve as secretary and treasurer to the board;

Sec. 9. 24-A MRSA §6910, sub-§1, as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

1. Dirigo Health Program. Dirigo Health shall arrange for the provision of health benefits coverage through the Dirigo Health Program not later than October 1, 2004. The Dirigo Health Program must com-

ply with all relevant requirements of this Title. Dirigo Health Program coverage may be offered by health insurance carriers that apply to the board and meet qualifications described in this section and any additional qualifications set by the board or may be provided through the Dirigo Health Self-administered Plan pursuant to section 6981.

Sec. 10. 24-A MRSA §6916 is enacted to read:

§6916. Marketing and sale of Dirigo Health Program; qualifications of insurance producers

1. Qualifications of insurance producers. An insurance producer licensed pursuant to chapter 16 may solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program if the following conditions are met prior to any such solicitation, negotiation or sale:

A. The producer is authorized by the superintendent to solicit, negotiate and sell insurance products for the health line of business;

B. The producer has successfully completed all training offered and required by the Dirigo Health Program for the solicitation, negotiation and sale of Dirigo Health Program insurance products, including any continuing training offered and required by the Dirigo Health Program;

C. The producer provides the carrier or carriers with which the Dirigo Health Program has contracted to underwrite and provide Dirigo Health Program coverage a current certificate from the Dirigo Health Program certifying the successful completion of all training offered and required by the Dirigo Health Program; and

D. The producer successfully completes all training specific to the sale of Dirigo Health Program insurance products offered and required by the carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage, including any continuing training offered and required by such carrier or carriers.

2. Annual certification required. Training pursuant to subsection 1 must be completed annually, and any certificate establishing successful completion of training is valid for one year from the date of issuance. If a producer fails to obtain certification following the expiration of the prior year's certification, the producer may not continue to solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program.

3. Carrier appointment not required. Notwithstanding any other provision of law, an insurance producer licensed pursuant to chapter 16 who complies with this section may solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program without being appointed by the carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage. A producer may not solicit, negotiate or sell insurance products offered by or through the Dirigo Health Program if the producer is not in compliance with this subsection. Notwithstanding section 1445, the carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage are not liable for the actions of an insurance producer who has not been appointed to solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program.

Sec. 11. 24-A MRSA c. 87, sub-c. 4 is enacted to read:

SUBCHAPTER 4

DIRIGO HEALTH SELF-ADMINISTERED PLAN

§6981. Dirigo Health Self-administered Plan

Notwithstanding section 6910, subsection 2, Dirigo Health may provide access to health benefits coverage by establishing the Dirigo Health Self-administered Plan, referred to in this subchapter as "the self-administered plan," pursuant to this section.

1. Establishment. Dirigo Health may provide access to health benefits coverage through the self-administered plan subject to the requirements of this section. The board may make a determination that Dirigo Health will provide access to health benefits coverage through the self-administered plan after the board evaluates competitive bids for health benefits coverage for self-administered and fully underwritten health benefits coverage. If the board determines that Dirigo Health will provide access to health coverage through the self-administered plan as authorized under this section, the board shall submit a report explaining the reasons for the decision to the joint standing committee of the Legislature having jurisdiction over health insurance matters within 30 days of the decision. Upon receipt of a report from the board, the chairs of the joint standing committee of the Legislature having jurisdiction over health insurance matters may call a meeting of the committee. Following receipt of such a report, the joint standing committee of the Legislature having jurisdiction over health insurance matters may report out legislation to the next regular or special session of the Legislature relating to the establishment of the self-administered plan.

2. Cooperative agreements. Dirigo Health may enter into voluntary cooperative agreements with a public purchaser for purchasing purposes and administrative functions. If a cooperative agreement is entered into pursuant to this subsection, the self-administered plan and any public purchaser shall maintain separate and distinct risk pools and reserves

and may not commingle risk pools or reserve funds under any circumstances. For the purposes of this subsection, "public purchaser" means an entity that purchases health coverage in whole or in part with public funds, including, but not limited to, the state employee health insurance program, the University of Maine System, the Maine Community College System, the Maine Education Association benefits trust, the Maine School Management Association benefits trust and municipal and county governments. For the purposes of this subsection, "public purchaser" does not mean the Department of Health and Human Services, Office of MaineCare Services except for cooperative agreements for the purchasing of pharmaceuticals pursuant to Title 5, section 2031.

3. Additional responsibilities of board. In addition to the duties and responsibilities set out in sections 6908 and 6910, the board is authorized to:

A. Operate the self-administered plan pursuant to a trust instrument in accordance with Title 18-B;

B. Develop, maintain and modify a business plan for the self-administered plan as appropriate in consultation with the executive director;

C. Establish an operating budget for the self-administered plan subject to legislative approval in the biennial budget process in accordance with section 6908, subsection 3;

D. Ensure the ongoing fiscal integrity and stability of the self-administered plan in accordance with subsections 5 and 11 and monitor statistics provided by the executive director relating to the number of plan enrollees, working rates, utilization of benefits, operating costs and reimbursement for losses related to excess or stop loss coverage;

E. Establish administrative and accounting procedures in accordance with section 6908, subsection 2, paragraph A and develop financial statements that are consistent with generally accepted accounting principles;

F. Obtain necessary contracts for services, including, but not limited to, actuarial services, accounting services, auditing services, investment advice and counsel and custodial services for financial assets in accordance with subsection 4;

G. Take any actions necessary to comply with federal and state Medicaid rules regarding Dirigo Health plan members eligible for MaineCare;

H. Take any actions necessary to comply with federal Medicaid managed care organization contract requirements as provided in 42 Code of Federal Regulations, Part 438 (2002); and

I. Have and exercise all powers necessary and appropriate to carry out the purposes of this section.

4. Services. If the board determines that Dirigo Health will provide access to health coverage through the self-administered plan pursuant to subsection 2, the board shall contract for the following services through a competitive bidding process unless the requirement for competitive bidding is waived pursuant to Title 5, section 1825-B, subsection 2 or a carrier contracted by Dirigo Health to fully underwrite health benefits coverage terminates that contract.

A. The board shall secure the services of an actuary for technical advice on matters regarding the operation of the self-administered plan in accordance with this paragraph. The board shall contract for actuarial services after a competitive bidding process at least every 3 years and may award a bid only to an actuary who is a member in good standing of the American Academy of Actuaries or a successor organization. The contract must require the actuary to:

(1) Act as a technical advisor to the board on matters regarding the operation of the self-administered plan in accordance with this paragraph;

(2) Certify the amounts of the benefits paid and payable under this section;

(3) Analyze the year's operations and results and the experience of the self-administered plan;

(4) Determine appropriate actuarial assumptions for recommendation to the board; and

(5) Determine the appropriate level of reserves needed to sustain the self-administered plan and pay benefits.

B. The board shall secure the services of one or more fiduciaries or registered investment advisors through negotiated contractual arrangements. The contract must require the fiduciary or registered investment advisor to:

(1) Invest and reinvest the funds in accordance with appropriate financial and trust standards;

(2) Advise the board as to reasonable investment philosophy; and

(3) Submit regular reports of investments and changes to the board.

C. The board shall contract with an appropriate financial institution for custodial services for the securities and other investment assets of the self-administered plan. The contract must require the custodian to meet financial safeguards and other

qualifications determined by the board, including restrictions on the manner in which deposits and withdrawals of funds are completed.

D. When the self-administered plan is established, the board shall purchase, through contracts from one or more 3rd-party administrators or any organization necessary to administer and provide a health plan, a policy or policies or a contract to provide the benefits specified by this section. The purchase of policies by the board must be accomplished by use of a written contract for a term determined by the board.

The board may contract for any other applicable services necessary to comply with federal law.

5. Administration. The following provisions govern the administration of the self-administered plan.

A. The assets and liabilities of the self-administered plan are solely the assets and liabilities of Dirigo Health.

B. The actuary under contract with the board pursuant to subsection 4 shall determine:

(1) The appropriate level of reserves estimated to be sufficient to pay claims and administrative costs according to subsection 11, paragraph B;

(2) Whether the program is operating on an actuarially sound basis and any recommendations based on that determination;

(3) A rate structure for the self-administered plan, including working rates actuarially sufficient to pay anticipated claims for the current claims year as well as to provide sufficient reserves for incurred but not reported claims;

(4) Recommendations as to the purchase of excess or stop loss insurance including suggested attachment levels and limits; and

(5) Recommendations as to the need for a security deposit or surety bond to protect against insolvency.

The actuary shall annually present information to the board on the determinations made pursuant to this paragraph as well as the method of distribution of any accumulations above the reserves including use of excess reserves to moderate the working rates.

C. The superintendent shall complete a detailed review of the financial and actuarial aspects of the self-administered plan, including, but not limited to, the presentation and recommendations of the actuary and the audited financial statements of the self-administered plan. The superintendent shall report the superintendent's findings and any recommendations to the board and at a public meeting of the joint standing committee of the Legislature having jurisdiction over insurance matters on or before March 1st of each year.

D. The self-administered plan may not obligate the General Fund beyond that amount appropriated by the Legislature.

6. Audits; financial statements. The board shall arrange for an annual audit of its financial statements by an independent certified public accounting firm. Within 30 days of the completion of the audit, a copy of the audited financial statements must be distributed to the Legislature in the same manner as required by section 6908, subsection 4. A copy of the audited financial statements must also be made available for public inspection.

7. Public entity. The self-administered plan is a public entity for the purposes of 42 Code of Federal Regulations, Section 438.116.

8. Health benefit coverage. Health benefits coverage provided under the self-administered plan in accordance with this subchapter must be comprehensive and include a low deductible plan option for enrollees in the Dirigo Health Program.

9. Application of certain insurance provisions. The self-administered plan must meet or exceed the following requirements in the same manner as when health benefits coverage is provided by a health insurance carrier:

A. The requirements for rating practices pursuant to section 2736-C, subsection 2 and section 2808-B, subsection 2;

B. The requirements for guaranteed issuance pursuant to section 2736-C, subsection 3 and section 2808-B, subsection 4;

C. The requirements for guaranteed renewal pursuant to section 2736-C, subsection 3 and section 2808-B, subsection 4 subject to the limitations of available funds maintained by the self-administered plan in accordance with subsection 11;

D. The requirements for continuity of coverage, coverage of late enrollees and preexisting condition exclusions pursuant to chapter 36;

E. The requirements for mandated coverage of specific health care services and for specific diseases and for certain providers of health care services pursuant to Title 24 and this Title;

F. The requirements for the benefits, rights and protections for individuals enrolled in health plans pursuant to chapter 56-A and Bureau of Insurance Rule Chapter 850. Notwithstanding any statute or common law to the contrary, an individual en-

rolled in the self-administered plan may maintain a cause of action against the self-administered plan subject to the requirements of section 4313. This paragraph is a waiver of the State's defense of immunity under Title 14, chapter 741;

G. The requirements of the Insurance Information and Privacy Protection Act pursuant to chapter 24; and

H. The provisions of sections 2159-B and 2159-C relating to discrimination against victims of domestic abuse and discrimination on the basis of genetic information or testing.

The self-administered plan may not enter into any contract with a 3rd-party administrator, carrier or other organization to administer and provide health coverage that has not demonstrated compliance with all applicable state laws.

10. Self-administered plan not an insurer. The self-administered plan is not an insurer, reciprocal insurer or joint underwriting association under the laws of the State. The administration of the self-administered plan by the board does not constitute doing the business of insurance.

11. Reserves. This subsection applies to reserves of the self-administered plan.

A. The Dirigo Health Reserve is created as an account within the Dirigo Health Enterprise Fund, as established pursuant to section 6915, for the deposit of reserves as required by paragraph B.

B. The self-administered plan shall maintain a reserve at least equal to the sum of:

(1) An amount estimated by a qualified actuary under subsection 5 to be necessary to pay claims and administrative costs for the assumed risk for 2 1/2 months; and

(2) The amount determined annually by a qualified actuary under subsection 5 to be necessary to fund the unpaid portion of ultimate expected losses, including incurred but not reported claims, and related expenses incurred in the provision of benefits for eligible participants, less any credit, as determined by a qualified actuary, for excess or stop loss insurance.

C. The Dirigo Health Reserve must be adjusted on a quarterly basis in order to maintain a reserve at least equal to the amount determined in paragraph B.

D. The Dirigo Health Reserve is capitalized by money from the Dirigo Health Enterprise Fund, as established pursuant to section 6915, and any other fund advanced for initial operating expenses, monthly enrollee payments, any funds received from any public or private source, legislative appropriations, payments from state departments and agencies and such other means as the Legislature may approve. All money in the Dirigo Health Reserve is deemed to be the commingled assets of all covered enrollees and may be used only for the purposes of this section.

12. Stop loss insurance. The board may purchase excess or stop loss insurance for the self-administered plan, with attachment levels and limits as recommended by a qualified actuary pursuant to subsection 5. If the board is unable to purchase excess or stop loss insurance at the recommended attachment levels and limits, the board does not have the authority to establish a self-administered plan as provided in this section.

13. Marketing and distribution. The board may contract for the marketing and distribution of the self-administered plan in accordance with the requirements of this subsection. Any entity or individual that contracts with the self-administered plan shall successfully complete all training offered by Dirigo Health for the solicitation, negotiation and sale of health benefits coverage. Training must be completed annually, and any certificate establishing successful completion of training is valid for one year from the date of issuance. If an entity or individual fails to obtain certification following the expiration of the prior year's certification, the entity or individual may not continue to solicit, negotiate and sell health benefits coverage under the self-administered plan.

14. Provider reimbursement. In any contract with a 3rd-party administrator, carrier or other organization to administer and provide health coverage to enrollees of the self-administered plan, the board shall ensure that:

A. Providers contracting to provide health coverage to plan enrollees are reimbursed at a rate comparable to current market reimbursement rates among commercial carriers in the State;

B. Providers contracting to provide health coverage to plan enrollees are paid in a timely manner in accordance with the same requirements that would be required under state law for health insurance carriers pursuant to section 2436; and

C. If the self-administered plan fails to pay for health care services as set forth in the contract, providers are governed by the standards required pursuant to section 4204, subsection 6. This paragraph does not prohibit a provider from collecting or attempting to collect from a plan enrollee any amount for services not normally payable to the self-administered plan, including any applicable copayments and deductibles.

15. No liability for plan enrollees. This section does not create any liability on the part of eligible employers, eligible employees or eligible individuals en-

rolled in Dirigo Health in the event that the self-administered plan becomes insolvent or fails to pay claims.

Sec. 12. New appointments to Board of Trustees of Dirigo Health; staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 6904, subsection 3, the terms of the 4 members added to the Board of Trustees of Dirigo Health pursuant to this Act must be staggered. One member must be appointed for a term of one year, one member for a term of 2 years and 2 members for terms of 3 years.

See title page for effective date.

CHAPTER 448

S.P. 613 - L.D. 1746

An Act To Improve MaineCare and Promote Employment

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

Sec. 1. 19-A MRSA §2001, sub-§5-A is enacted to read:

5-A. Health plan. "Health plan" means a plan of a nonprofit hospital or medical service organization, an insurer, a health maintenance organization or a health insurance carrier licensed pursuant to Title 24 or 24-A; a health program administered by the department or the State in the capacity of provider of health coverage; or a plan of an employer, labor union or other group of persons organized in the State that provides health coverage to covered individuals who are employed or reside in the State. "Health plan" does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts.

Sec. 2. 19-A MRSA §2001, sub-§5-B is enacted to read:

5-B. Medical care costs. "Medical care costs" means the costs of medical and health care for a child, including but not limited to the cost of enrollment or participation in or purchase of a health plan and any cash payment required of a parent for premium, co-payment, deductible, coinsurance and routine and other medical expenses not covered by the health plan. Medical care costs reflect the cost of medical care ordinarily spent for the care of a child by parents living in the same household.

Sec. 3. 19-A MRSA §2001, sub-§5-C is enacted to read:

5-C. Medical support. "Medical support" means support for a child's medical care costs.

Sec. 4. 19-A MRSA §2012 is enacted to read:

§2012. Medical support

The department, after consultation with the Supreme Judicial Court and interested parties, shall adopt rules in accordance with Title 5, chapter 375 establishing medical support. Rules adopted pursuant to this section are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A.

Sec. 5. 19-A MRSA §2202, sub-§13, as enacted by PL 2003, c. 20, Pt. K, §1 and amended by c. 689, Pt. B, §6, is further amended to read:

13. Premium from noncustodial parents. The Department of Health and Human Services, Division of Support Enforcement and Recovery shall collect a premium from noncustodial parents whose children are MaineCare members and who have legally been determined to be responsible for medical care contributions for these children.

This subsection is repealed upon adoption of the final federal rules to implement the premium assistance provisions of the federal Deficit Reduction Act of 2005.

Sec. 6. 19-A MRSA §2202, sub-§13-A is enacted to read:

13-A. Premium from noncustodial parents. The Department of Health and Human Services, Division of Support Enforcement and Recovery shall collect a premium from noncustodial parents whose children are MaineCare members, including those who receive assistance under Title 22, section 3174-T, and from parents who have legally been determined to be responsible for medical care contributions for these children but do not have access to other health insurance that is at a reasonable cost and that is accessible and comprehensive as determined by rules adopted by the department. The department shall adopt rules to establish a sliding scale for premiums required under this section in accordance with the sliding scale that is applied by the department to custodial parents under 42 United States Code, Section 1396o-1 (2007) or 42 Code of Federal Regulations, Section 457.560 (2006). Rules adopted pursuant to this subsection are routine technical rules as described in Title 5, chapter 375, subchapter 2-A. This subsection takes effect upon adoption of the final federal rules to implement the premium assistance provisions of the federal Deficit Reduction Act of 2005.

Sec. 7. 22 MRSA §14, sub-§2-A, as amended by PL 2003, c. 20, Pt. K, §2, is further amended to read:

2-A. Assignment of rights of recovery. The receipt of benefits under the MaineCare program con-