LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTY-FOURTH LEGISLATURE

FIRST REGULAR SESSION
December 3, 2008 to June 13, 2009

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IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED,
TITLE 3, SECTION 163-A, SUBSECTION 4.

Augusta, Maine
2009

3. Confidentiality. Notifications and reports ~~of sentinel events~~ filed pursuant to this chapter and all information collected or developed as a result of the filing and proceedings pertaining to the filing, regardless of format, are confidential and privileged information.

A. Privileged and confidential information under this subsection is not:

(1) Subject to public access under Title 1, chapter 13, except for data developed from the reports that do not identify or permit identification of the health care facility;

(2) Subject to discovery, subpoena or other means of legal compulsion for its release to any person or entity; or

(3) Admissible as evidence in any civil, criminal, judicial or administrative proceeding.

B. The transfer of any information to which this chapter applies by a health care facility to the division or to a national organization that accredits health care facilities may not be treated as a waiver of any privilege or protection established under this chapter or other laws of this State.

C. The division shall take appropriate measures to protect the security of any information to which this chapter applies.

D. This section may not be construed to limit other privileges that are available under federal law or other laws of this State that provide for greater peer review or confidentiality protections than the peer review and confidentiality protections provided for in this subsection.

E. For the purposes of this subsection, "privileged and confidential information" does not include:

(1) Any final administrative action;

(2) Information independently received pursuant to a 3rd-party complaint investigation conducted pursuant to department rules; or

(3) Information designated as confidential under rules and laws of this State.

This subsection does not affect the obligations of the department relating to federal law.

Sec. 6. 22 MRSA §8754, sub-§4, as enacted by PL 2001, c. 678, §1 and affected by §3, is amended to read:

4. Report. The division shall ~~develop~~ submit an annual report by February 1st each year to the Legislature, health care facilities and the public that includes summary data of the number and types of sentinel events of the prior calendar year by type of health care facility, rates of change and other analyses and an outline of areas to be addressed for the upcoming year. ~~The report must be submitted by February 1st each year.~~

Sec. 7. 22 MRSA §8755, as enacted by PL 2001, c. 678, §1 and affected by §3, is repealed and the following enacted in its place:

§8755. Compliance

1. Oversight. The division shall place primary emphasis on ensuring effective corrective action by the facility.

2. Penalties. When the division determines that a health care facility failed to report a sentinel event pursuant to this chapter, the health care facility is subject to a penalty imposed in conformance with Title 5, chapter 375, subchapter 4 and payable to the State of not more than $10,000 per violation. If the facility in good faith notified the division of a suspected sentinel event and the division later determines it is a sentinel event, the facility is not subject to a penalty for that event. Funds collected pursuant to this section must be deposited in a dedicated special revenue account to be used to support sentinel event reporting and education.

3. Administrative hearing and appeal. To contest the imposition of a penalty under this section, a health care facility must submit to the division a written request for an administrative hearing within 10 days of notice of imposition of a penalty pursuant to this section. Judicial appeal must be in accordance with Title 5, chapter 375, subchapter 7.

4. Injunction. Notwithstanding any other remedies provided by law, the Office of the Attorney General may seek an injunction to require compliance with the provisions of this chapter.

5. Enforcement. The Office of the Attorney General may file a complaint with the District Court seeking injunctive relief for violations of this chapter.

Sec. 8. Authority to submit legislation. After reviewing recommendations in the CY 2008 Sentinel Events report dated April 28, 2009, the Joint Standing Committee on Health and Human Services may submit legislation related to the recommendations of the report to the Second Regular Session of the 124th Legislature.

See title page for effective date.

CHAPTER 359

H.P. 883 - L.D. 1264

An Act To Stabilize Funding and Enable DirigoChoice To Reach More Uninsured

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

Sec. 1. 24-A MRSA §6908, sub-§2, ¶B, as amended by PL 2007, c. 629, Pt. L, §1, is further amended to read:

B. Collect the savings offset payments provided in former section 6913 and the ~~health~~ access ~~surcharge~~ payment provided in section ~~6913-A~~ 6917;

Sec. 2. 24-A MRSA §6913, as amended by PL 2007, c. 1, Pt. X, §§1 and 2 and affected by §3, is repealed.

Sec. 3. 24-A MRSA §6915, as amended by PL 2005, c. 386, Pt. D, §3, is further amended to read:

§6915. Dirigo Health Enterprise Fund

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, any savings offset payments made pursuant to former section 6913, any access payments made pursuant to section 6917 and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. 4. 24-A MRSA §6917 is enacted to read:

§6917. Access payment

1. Access payments required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. All health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers shall pay an access payment of 2.14% on all paid claims, except claims under accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance. The following provisions govern access payments.

A. A health insurance carrier or employee benefit excess insurance carrier may not be required to pay an access payment on policies or contracts insuring federal employees.

B. Access payments apply to claims paid beginning on or after September 1, 2009.

C. Access payments must be made monthly to Dirigo Health and are due 30 days after the end of each month and must accrue interest at 12% per annum on or after the due date, except that access payments for 3rd-party administrators for groups of 500 or fewer members may be made annually not less than 60 days after the close of the plan year.

D. Access payments received by Dirigo Health must be pooled with other revenues of the agency in the Dirigo Health Enterprise Fund established in section 6915.

2. Failure to pay access payments. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any health insurance carrier or employee benefit excess insurance carrier or the license of any 3rd-party administrator to operate in this State that fails to pay an access payment. In addition, the superintendent may assess civil penalties in accordance with section 12-A against any health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator that fails to pay an access payment or may take any other enforcement action authorized under section 12-A to collect any unpaid access payments and may collect the cost of enforcement including attorney's fees from those who fail to pay an access payment.

3. Definitions. As used in this section, the following terms have the following meanings.

A. "Claims-related expenses" includes:

(1) Payments for utilization review, care management, disease management, risk assessment and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals, usually either by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping such covered individuals to maintain or improve their health; and

(2) Payments that are made to or by organized groups of providers of health and medical services in accordance with managed care risk arrangements or network access agreements and that are unrelated to the provision of services to specific covered individuals.

B. "Health and medical services" includes, but is not limited to, any services included in the furnishing of medical care, dental care to the extent covered under a medical insurance policy, pharmaceutical benefits or hospitalization, including but not limited to services provided in a hospital or other medical facility; ancillary services, including but not limited to ambulatory services; physician and other practitioner services, including but not limited to services provided by a physician's assistant, nurse practitioner or midwife; and behavioral health services, including but not limited to mental health and substance abuse services.

C. "Paid claims" means all payments made by health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers for health and medical services provided under policies that insure residents of this State or, in the

case of 3rd-party administrators, for health care for residents of this State, except that "paid claims" does not include:

(1) Claims-related expenses and general administrative expenses;

(2) Payments made to qualifying providers under a "pay for performance" or other incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals;

(3) Claims paid by carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, except that claims paid for dental services covered under a medical policy are included;

(4) Claims paid for services rendered to nonresidents of this State;

(5) Claims paid under retiree health benefit plans that are separate from and not included within benefit plans for existing employees;

(6) Claims paid by an employee benefit excess insurance carrier that have been counted by a 3rd-party administrator for determining its access payment;

(7) Claims paid for services rendered to persons covered under a benefit plan for federal employees; and

(8) Claims paid for services rendered outside of this State to a person who is a resident of this State.

In those instances in which a health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator is contractually entitled to withhold certain amounts from payments due to providers of health and medical services in order to help ensure that the providers can fulfill any financial obligations they may have under a managed care risk arrangement, the full amounts due the providers before application of such withholds must be reflected in the calculation of paid claims.

4. Rulemaking. The board may adopt any rules necessary to implement this section. 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 §6951, first ¶, as amended by PL 2007, c. 629, Pt. L, §5, is further amended to read:

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within Dirigo Health. The forum is governed by the board with advice from the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded, at least in part, through the savings offset payments made pursuant to former section 6913 and the ~~health~~ access ~~surcharge~~ payment pursuant to section ~~6913-A~~ 6917. Except as provided in section 6907, subsection 2, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties.

Sec. 6. Changes to Dirigo Health. The Board of Trustees of Dirigo Health, or "the board," shall:

1. Develop products, procedures. Develop more affordable products and procedures that can reach uninsured and underinsured residents of the State to reduce uncompensated care;

2. Maximize federal initiatives. Use subsidies to maximize federal initiatives, including Medicaid and any national health reform;

3. Asset tests. Determine the impact of asset tests on determining eligibility;

4. Voucher program. Consider offering a voucher-based program to provide health insurance benefits; and

5. Redesign. Redesign the DirigoChoice product or products.

The board shall report to the Joint Standing Committee on Insurance and Financial Services regarding changes that will be made to the Dirigo Health Program consistent with this section by January 1, 2010.

Sec. 7. Savings offset payments calculated prior to effective date. Notwithstanding that section of this Act that repeals the Maine Revised Statutes, Title 24-A, section 6913; the savings offset payments that have been calculated and required under former Title 24-A, section 6913 for claims paid prior to the effective date of this Act are due and payable in the same manner and subject to the same procedures set forth in former Title 24-A, section 6913.

Sec. 8. Effective date. This Act takes effect October 1, 2009.

Effective October 1, 2009.

CHAPTER 360

S.P. 548 - L.D. 1471

An Act Concerning Debarment from Contracts with the Department of Environmental Protection