

MAINE STATE LEGISLATURE

The following document is provided by the
LAW AND LEGISLATIVE DIGITAL LIBRARY
at the Maine State Law and Legislative Reference Library
<http://legislature.maine.gov/lawlib>



Reproduced from electronic originals
(may include minor formatting differences from printed original)

LAWS
OF THE
STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTY-EIGHTH LEGISLATURE

FIRST REGULAR SESSION
December 7, 2016 to August 2, 2017

THE GENERAL EFFECTIVE DATE FOR
FIRST REGULAR SESSION
NON-EMERGENCY LAWS IS
NOVEMBER 1, 2017

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

Augusta, Maine
2017

based on days actually raced during extended meets by that agricultural fair. Any amount remaining in the fund on January 30th after payments are made to commercial tracks and agricultural fairs must be transferred to the operating account of the commission under section 267-A.

For the purposes of this subsection, "region" is determined by measuring a distance of 50 miles from the center of the racing track along the most commonly used roadway, as determined by the Department of Transportation, drawing a circle around the center of the racing track using that 50-mile measurement and excluding those municipalities or unorganized territories that do not have boundaries contained entirely by that circle.

Sec. 25. 8 MRSA §299, sub-§5 is enacted to read:

5. Race day credits. For the purposes of this section, race day credits are awarded as follows:

A. One race day credit is earned for each day actually raced;

B. One additional race day credit is earned for each day raced when no other association licensed under section 271 is scheduled to race; and

C. One additional race day credit is earned for each day raced during the months of March and December. A maximum of 12 race day credits may be awarded per commercial track for the month of March and a maximum of 12 race day credits may be awarded per commercial track for the month of December.

Sec. 26. 8 MRSA §1037, first ¶, as enacted by PL 2011, c. 358, §6 and amended by c. 657, Pt. W, §6, is further amended to read:

Beginning February 15, 2012 April 1, 2018 and annually thereafter, the executive director of the State Harness Racing Commission, in consultation with the Commissioner of Agriculture, Conservation and Forestry, ~~annually~~ shall submit a report to the joint standing committees of the Legislature having jurisdiction over slot machines, harness racing, agricultural fairs and appropriations and financial affairs regarding the use of slot machine revenue deposited in funds under section 1036, subsection 2, paragraphs B, C, D, H and I. The executive director and the commissioner shall obtain the information as described in this section. The report required by this section must be completed using budgeted resources. The executive director may not distribute funds listed under section 1036, subsection 2, as applicable, to harness racing tracks, off-track betting facilities, agricultural fairs or the Sire Stakes Fund under section 281 until the information required to submit the report required by this section is provided. The report required by this section may be combined with the report required under section 267.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

Effective June 19, 2017.

CHAPTER 232

S.P. 147 - L.D. 445

An Act To Encourage Maine Consumers To Comparison-shop for Certain Health Care Procedures and To Lower Health Care Costs

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

Sec. 1. 22 MRSA §1718-B, sub-§2, ¶D is enacted to read:

D. Beginning January 1, 2018, at the time a referral or recommendation is made for a comparable health care service as defined in Title 24-A, section 4318-A, subsection 1, paragraph A during an in-person visit, the health care entity making that referral or recommendation shall notify a patient who has private health insurance coverage of the patient's right to obtain services from a different provider. A health care entity shall comply with this paragraph by providing a written notice at the time the health care entity recommends or refers a patient for a health care service or procedure that may qualify as a comparable health care service. A written notice provided under this paragraph must include a notification that, prior to obtaining the recommended service, the patient may review the health care price transparency tool provided by the patient's carrier or contact the patient's carrier directly via a toll-free telephone number so that the patient may consider whether the recommended provider of the comparable health care service represents the best value for the patient. A written notice provided under this paragraph must also include a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow the carrier to assist the patient in comparing prices for the comparable health care service.

Sec. 2. 22 MRSA §8712, sub-§2, as amended by PL 2011, c. 525, §1, is further amended to read:

2. Payments. The organization shall create a publicly accessible interactive website that presents reports related to payments for services rendered by health care facilities and practitioners to residents of the State. The services presented must include, but not be limited to, imaging, preventative health, radiology

and, surgical services, comparable health care services as defined in Title 24-A, section 4318-A, subsection 1, paragraph A and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance or are underinsured. The website must also be constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors. Beginning October 1, 2012, price information posted on the website must be posted semiannually, must display the date of posting and, when posted, must be current to within 12 months of the date of submission of the information. Payment reports and price information posted on the website must include data submitted by payors with regard to all health care facilities and practitioners that provide comparable health care services as defined in Title 24-A, section 4318-A, subsection 1, paragraph A or services for which the organization reports data pertaining to the statewide average price pursuant to this subsection or Title 24-A, section 4318-B. Upon notice made by a health care facility or practitioner that data posted by the organization pertaining to that facility or practitioner is inaccurate or incomplete, the organization shall remedy the inaccurate or incomplete data within the earlier of 30 days of receipt of the notice and the next semiannual posting date.

Sec. 3. 24-A MRSA §4302, sub-§1, ¶K, as amended by PL 2009, c. 439, Pt. B, §3, is further amended to read:

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended; and

Sec. 4. 24-A MRSA §4302, sub-§1, ¶L, as enacted by PL 2009, c. 439, Pt. B, §4, is amended to read:

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating; and

Sec. 5. 24-A MRSA §4302, sub-§1, ¶M is enacted to read:

M. If the health plan is subject to the requirements of section 4318-A, a description of the incentives available to an enrollee and how to earn such incentives if enrolled in a health plan offering a comparable health care service incentive program designed pursuant to section 4318-A.

Sec. 6. 24-A MRSA §4303, sub-§21 is enacted to read:

21. Health care price transparency tools. Beginning January 1, 2018, a carrier offering a health plan in this State shall comply with the following requirements.

A. A carrier shall develop and make available a website accessible to enrollees and a toll-free telephone number that enable enrollees to obtain information on the estimated costs for obtaining a comparable health care service, as defined in Title 24-A, section 4318-A, subsection 1, paragraph A, from network providers, as well as quality data for those providers, to the extent available. A carrier may comply with the requirements of this paragraph by directing enrollees to the publicly accessible health care costs website of the Maine Health Data Organization.

B. A carrier shall make available to the enrollee the ability to obtain an estimated cost that is based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the enrollee by the provider. Upon an enrollee's request, the carrier shall request additional or clarifying code information, if needed, from the provider involved with the comparable health care service. If the carrier obtains specific code information from the enrollee or the enrollee's provider, the carrier shall provide the anticipated charge and the enrollee's anticipated out-of-pocket costs based on that code information, to the extent such information is made available to the carrier by the provider.

C. A carrier shall notify an enrollee that the amounts are estimates based on information available to the carrier at the time the request is made and that the amount the enrollee will be responsible to pay may vary due to unforeseen circumstances that arise out of the proposed comparable health care service. This subsection does not prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the proposed comparable health care service or for a procedure or service that was not included in the original estimate. This subsection does not preclude an enrollee from contacting

the carrier to obtain more information about a particular admission, procedure or service with respect to a particular provider.

D. Notwithstanding the provisions of this subsection and at the request of a carrier, the superintendent may grant an additional year to comply with the provisions of this subsection as long as the carrier has demonstrated a good faith effort to comply with the provisions of this subsection and has provided the superintendent with an action plan detailing the steps to be taken by the carrier to comply with this subsection no later than January 1, 2019.

Sec. 7. 24-A MRSA §4303, sub-§22 is enacted to read:

22. Denial of referral by out-of-network provider prohibited. Beginning January 1, 2018, a carrier may not deny payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a provider who is not a member of the carrier's provider network.

Sec. 8. 24-A MRSA §4318-A is enacted to read:

§4318-A. Comparable health care service incentive program

Beginning January 1, 2019, a carrier offering a health plan in this State shall establish, at a minimum, for all small group health plans as defined in section 2808-B, subsection 1, paragraph G compatible with a health savings account authorized under federal law, a health plan design in which enrollees are directly incentivized to shop for low-cost, high-quality participating providers for comparable health care services. Incentives may include, but are not limited to, cash payments, gift cards or credits or reductions of premiums, copayments or deductibles. A small group health plan design created under this section must remain available to enrollees for at least 2 consecutive years, except that any changes made to the program after 2 years, including, but not limited to, ending the incentive, may not be construed as a change to the small group health plan design for the purpose of guaranteed renewability under section 2808-B, subsection 4 or section 2850-B. A multiple-employer welfare arrangement is not considered a carrier for the purposes of this section.

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Comparable health care service" means nonemergency, outpatient health care services in the following categories:

(1) Physical and occupational therapy services;

(2) Radiology and imaging services;

(3) Laboratory services; and

(4) Infusion therapy services.

B. "Program" means the comparable health care service incentive program established by a carrier pursuant to this section.

2. Filing with superintendent. Plans filed with the superintendent pursuant to this section must disclose, in the summary of benefits and explanation of coverage, a detailed description of the incentives available to a plan enrollee. The description must clearly detail any incentives that may be earned by the enrollee, including any limits on such incentives, the actions that must be taken in order to earn such incentives and a list of the types of services that qualify under the program. This subsection may not be construed to prevent a carrier from directing an enrollee to the carrier's website or toll-free telephone number for further information on the program in the summary of benefits and explanation of coverage. The superintendent shall review the filing made by the carrier to determine if the carrier's program complies with the requirements of this section.

3. Availability of program; notice to enrollees. Annually at enrollment or renewal, a carrier shall provide notice about the availability of the program to an enrollee who is enrolled in a health plan eligible for the program as required by section 4302, subsection 1, paragraph M.

4. Additional types of nonemergency health care services or procedures. Nothing in this section precludes a carrier from including additional types of nonemergency health care services or procedures in its program.

5. No administrative expense. An incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.

6. Study and evaluation. Beginning March 1, 2020 and annually thereafter, the superintendent shall undertake a study and evaluation of the programs created by carriers as required by this section. The superintendent may request information on enrollment and use of incentives earned by enrollees of a carrier as necessary. By April 15, 2020 and annually thereafter, the superintendent shall submit an aggregate report relating to the performance of the programs, the use of incentives, the incentives earned by enrollees and the cumulative effect of the programs to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

7. Rules. The superintendent may adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

8. Repeal. This section is repealed January 1, 2024.

Sec. 9. 24-A MRSA §4318-B is enacted to read:

§4318-B. Access to lower-priced services

1. Services from out-of-network provider; lower prices. Beginning January 1, 2019, if an enrollee covered under a health plan other than a health maintenance organization plan elects to obtain a covered comparable health care service as defined in section 4318-A, subsection 1, paragraph A from an out-of-network provider at a price that is the same or less than the statewide average for the same covered health care service based on data reported on the publicly accessible health care costs website of the Maine Health Data Organization, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's charge and, upon request by the enrollee, shall apply the payments made by the enrollee for that comparable health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the health care services had been provided by an in-network provider. A carrier may use the average price paid to a network provider for the covered comparable health care service under the enrollee's health plan in lieu of the statewide average price on the Maine Health Data Organization's publicly accessible website as long as the carrier uses a reasonable method to calculate the average price paid and the information is available to enrollees through a website accessible to the enrollee and a toll-free telephone number that provide, at a minimum, information relating to comparable health care services. The enrollee is responsible for demonstrating to the carrier that payments made by the enrollee to the out-of-network provider should be applied toward the enrollee's deductible or out-of-pocket maximum pursuant to this section. The carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of making such a demonstration and may require that copies of bills and proof of payment be submitted by the enrollee. For the purposes of this section, "out-of-network provider" means a provider located in Massachusetts, New Hampshire or this State that is enrolled in the MaineCare program and participates in Medicare.

2. Rules. The superintendent may adopt rules as 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.

3. Repeal. This section is repealed January 1, 2024.

See title page for effective date.

CHAPTER 233

H.P. 755 - L.D. 1077

An Act To Reduce the License Fee for High-stakes Beano

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

Sec. 1. 17 MRSA §314-A, sub-§4, as amended by PL 2015, c. 24, §1 and affected by §2, is further amended to read:

4. Term of license; fees. A license issued under this section is valid for a period of one year. The annual license fee for a high-stakes beano license is ~~\$50,000, except that the annual license fee due in 2008 to 2016 is \$25,000~~ **\$5,000**. License fees may be paid in advance in quarterly installments. All license fees must be paid to the Treasurer of State to be credited to the General Fund.

Sec. 2. High-stakes beano license reduction. Notwithstanding the Maine Revised Statutes, Title 17, section 314-A, subsection 4, a unit within the Department of Public Safety tasked with collecting fees for the conduct of high-stakes beano may not collect an amount totaling greater than \$5,000 in calendar year 2017 from any one federally recognized Indian tribe in the State eligible to conduct high-stakes beano.

See title page for effective date.

CHAPTER 234

S.P. 454 - L.D. 1340

An Act To Amend the Laws Governing the Maine State Housing Authority

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

Sec. 1. 5 MRSA §1742, sub-§23, ¶D, as amended by PL 1989, c. 502, Pt. A, §16, is further amended to read:

D. The department shall work closely with the Maine State Housing Authority to develop a procedure by which surplus state-owned land and structures are held in trust for the purpose set forth in this section and Title 30-A, chapter 201, ~~sub-chapters III A and XI~~ subchapter 3-A;

Sec. 2. 10 MRSA §363, sub-§11, as amended by PL 1999, c. 728, §8, is repealed.

Sec. 3. 30-A MRSA §4702, sub-§1, as enacted by PL 1987, c. 737, Pt. A, §2 and Pt. C, §106 and amended by PL 1989, c. 6; c. 9, §2; and c. 104, Pt. C, §§8 and 10, is further amended to read: