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Final Report

JOINT SELECT COMMITTEE TO STUDY THE FEASIBILITY OF A STATEWIDE HEALTH INSURANCE PROGRAM

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EXECUTIVE SUMMARY

This report is the result of the work of the Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program, a committee created by vote of the Legislative Council on August 22, 1991.

The Select Committee has chosen to make a large number of recommendations in this report. The recommendations include specific changes in Maine insurance laws in the areas of continuity of coverage and community rating. They include directives to state agencies to study and report back to the Joint Standing Committee on Banking and Insurance on issues such as Multiple Employer Welfare Arrangements and data collection for ambulatory services. They include statements of encouragement for practices such as utilization review and optional targeted case management for Medicaid patients. And they include presentation by the Select Committee of a list of options for comprehensive reform that could be undertaken by the State. The choices, which could be implemented progressively and which could be intertwined, include 1) establishment of a Maine Health Agency which consolidates and expands health planning and regulation functions, 2) restructuring and consolidating existing public health planning and regulation functions into a single new state agency, 3) consolidating existing health planning and regulation activities into the Maine Health Care Finance Commission and 4) drafting legislation for January 1, 1993 to provide health care coverage to all citizens, with freedom of choice of provider and an emphasis on primary and preventative care, a unified health care budget and a single administering agency.

The Select Committee will submit to the 116th Legislature a single bill. Recognizing the work to be done to achieve universal health care that is portable, accessible, affordable and accountable, the Select Committee invites the participation of all citizens, businesses, agencies, health care professionals, local, state and federal governments, interest groups, and any other interested parties. Anyone and everyone must participate in the process to achieve the goal of universal access to health care.

I. Introduction

The Select Committee is composed of the 13 members of the Joint Standing Committee on Banking and Insurance and 3 adjunct members, Senator Barbara Gill, Representative Richard A. Gould and Representative Charlene B. Rydell.

The Select Committee met from October 18, 1991 through November 5, 1992. During that time period the Select Committee accepted written information and heard testimony from citizens of the State, public and private agencies, hospitals and health care professionals, Blue Cross Blue Shield and the insurance industry, and lawmakers and agencies from other states. During the 13 months of the work of the Select Committee, campaigns for state and federal offices have opened, intensified and come to a close. Almost without exception these campaigns included platforms and plans for expanded access to health care.

The Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program believes that, if tied to strong cost control measures, universal coverage for health care for all Maine citizens is a realistic goal. The Committee recognizes, however, that a detailed proposal for universal coverage will take time to develop. With the election of William Clinton as President of the United States the Committee anticipates that reform of the health care system will begin in early 1993 at the federal level. The Committee recommends that work on state proposals to coordinate with the federal initiatives begin immediately and that a comprehensive package be offered to the Legislature for enactment.

The Joint Select Committee offers several interim measures designed to rein in runaway costs, expand access to health insurance and better coordinate existing health resources. These measures are designed to take Maine citizens a step closer to health coverage that is:

- ***Universal.*** Basic health care must be provided to citizens of all ages, regardless of employment status or personal resources;
- ***Portable.*** Health care needs do not go away when a person is in transition. Citizens must be able to undergo changes in their lives without the fear of losing insurance coverage or of preexisting condition exclusions looming over them;
- ***Accessible.*** Primary care and other essential health care services must be accessible to Maine citizens in every part of the State. Health care coverage is meaningless if health services are not available;
- ***Affordable.*** Health care coverage must be affordable for all citizens. Costs must be distributed equitably, based on ability to pay; and

- ***Accountable.*** Individually and collectively, directly and through elected representatives, citizens must be empowered to influence and improve the health care system continually.

Maine has made considerable progress toward these principals, particularly in the past 5 years. A brief history of initiatives follows.

1975 Low Cost Drugs for the Elderly Program established to provide prescription drugs to older persons with low income.

1977 Catastrophic illness program established

Health Security Act providing medical injury prevention and professional review programs.

1978 Certificate of Need program established, requiring approval from the Department of Human Services for capital and equipment development in hospitals and nursing homes.

Statewide voluntary hospital budget review program established.

1981 Home-based care program established to provide in-home services to older people and people with disabilities.

1983 Maine Health Care Finance Commission established to regulate hospital charges.

1985 Legislature commissions the Human Services Development Institute to study health insurance coverage in Maine.

1987 Blue Ribbon Commission to Study the Regulation of Health Care Expenditures is established to review the hospital regulation system and recommend changes.

Special Select Commission on Access to Health Care established to examine ways to expand access. The Commission's work later results in the creation of the Maine Health Program.

Legislature authorizes MaineCare demonstration, a public-private partnership with small businesses to expand health insurance coverage funded by the Robert Wood Johnson Foundation.

High Risk Insurance Organization created to provide insurance coverage to persons not otherwise insurable because of preexisting conditions or history of treatment.

Catastrophic illness program stops accepting new applications.

1988 Medicaid eligibility expanded to 185% of poverty for pregnant women and children; to 100% of poverty for older persons and persons with disabilities.

1989 Maine Health Program created to provide coverage to persons with low income who do not qualify for Medicaid.

MaineCare begins enrollment in the mid-coast area.

Hospitals and corporations affiliated with hospitals are permitted to purchase certain costly equipment and to initiate certain new ambulatory services without prior review by the Maine Health Care Finance Commission.

1990 Continuity law enacted, giving most group policy participants 3 months to transition from one policy to another without exclusion.

Community Health Program grants begin, providing funds to rural health centers.

Resource-based relative value scale implemented for physician fees in Medicaid, increasing reimbursement for primary care relative to specialty care.

1991 Medicaid Plan for Children and Families submitted to Legislature, recommending several options for expanding Medicaid for children's services.

Medicaid demonstration approved to cover children up to 125% of poverty, allowing Maine Health Program children to be transferred to Medicaid.

Enactment of legislation to expand primary care residency programs.

Establishment of process through which hospitals may be permitted to cooperate without being subject to state anti-trust actions.

Planning begins for primary care case management component for categorical Medicaid and Maine Health Program participants.

1992 Community rating law enacted, requiring insurance companies to establish rates based on broad community experience, rather than on individual group experience.

MaineCare demonstration expanded to Skowhegan area.

Unfortunately, the recession has taken a big bite out of these reform efforts. Laid-off workers have lost employment-based coverage. Cuts in categorical programs have jeopardized Medicaid coverage for some. Lack of funds has put the MaineCare program at risk. Enrollment in the Maine Health Program was capped just as large numbers were knocking at the door. Copayments were increased in the Low Cost Drugs for the Elderly program, and were instituted for a number of Medicaid services. Home-based care funding was reduced. Gains made with the relative value scale were undermined by a reduction in physician reimbursement in the Medicaid program.

With the recommendations in this report, the Joint Select Committee seeks to get reform back on track and, more importantly, to lend simplicity and efficiency to our patchwork health care system by making a commitment to comprehensive reform.

II. Existing Coverage

"The existing level and availability of insurance coverage for citizens of the State"

(From the Joint Select Committee's charge)

The U.S. Bureau of the Census has estimated that 11.1% of Maine residents (136,300 persons) lacked health insurance in 1991. (See Chart A) This number is up slightly from the 130,000 persons estimated to be without insurance in 1985.(1) Estimates for the intervening years are not available, but the overall direction from 1985 to 1989 was downward. It is reasonable to explain the decline as a response to access policies initiated in the 1985 to 1989 period, when the economy was robust. When the economy soured, however, gains were quickly offset by the rise in unemployment and decline in household income. Declining State revenues forced initiatives such as the Maine Health Program to be scaled back just as demand for the program was rising.

Despite the generous tradition among Maine health care providers of delivering services without compensation, lack of health insurance does reduce access to health care, particularly to care viewed as optional, such as prevention and early intervention. Chart B shows that those without insurance are much more likely to forgo needed care than those with insurance.(2) Persons without coverage tend to put off seeking health care until the health problem can no longer be ignored and a relatively expensive visit to the emergency room is necessary.

While employment increases the chances of having health coverage, it by no means guarantees it. In a 1985 survey conducted in Maine by the Human Services Development Institute, 63% of the uninsured respondents had worked in the previous month. (3) (See Chart C) The relatively high number of working people without health insurance is related to the fact that Maine has a very high percentage of small businesses, which are less likely than large businesses to provide health insurance. Chart D shows that 59% of businesses in Maine have 4 or fewer employees, and that nearly 50% of all workers are employed by businesses of fewer than 50 employees. Chart E shows that, nationally, large firms are much more likely to provide health insurance to their employees than small firms.

It stands to reason, then, that policies and programs that encourage small businesses to provide health insurance (such as the MaineCare demonstration) will be particularly effective in expanding coverage. The federal government and many states are debating the wisdom of requiring businesses of various sizes to provide or pay for health insurance for their employees. While coverage would certainly be expanded through businesses that could afford a "play-or-pay" mandate, jobs could be lost if the requirement were not applied with great care. The question of whether Maine should adopt an employment-based universal coverage requirement demands detailed study with particular emphasis on evaluating the impact

on small businesses. In the interim, Maine should amend its insurance laws to make health insurance more affordable to groups and small businesses. The following recommendations should be implemented immediately.

1. **Amend the statutes to allow groups to band together to purchase health insurance. Groups formed for the purchase of health insurance will be subject to the community rating law (PL 1991, c. 861). Municipalities may assist citizens in the purchase of health insurance.**

Currently, Title 24-A, §2808 requires that, in order for a group policy to be delivered, the Superintendent must find that the "policyholder is a bona fide group formed for purposes other than procurement of insurance." Consumers are prohibited from coming together for the sole purpose of purchasing group health insurance. The law should be amended to allow consumers to band together to form groups, thereby spreading the risk and reducing administrative costs. Municipalities should be allowed to assist groups of their citizens to purchase health insurance.

2. **Direct the Bureau of Insurance to study the feasibility of a regulatory scheme for Multiple Employer Welfare Arrangements (MEWA's) that are not fully insured and to submit its report, along with implementing legislation, to the Joint Standing Committee on Banking and Insurance by March 1, 1993.**

Small businesses that would like to form MEWA's that are not fully insured are currently prohibited from doing so in Maine. Under ERISA, states have broad authority to regulate MEWA's that are not fully insured. The Maine Bureau of Insurance has taken the position that such MEWA's would be unlawfully engaging in the business of insurance and are prohibited under current law. The Bureau should examine this issue closely to see if MEWA's that are not fully insured should be allowed under certain conditions. A change in policy could open MEWA opportunities to small businesses that otherwise can not afford to offer health benefits.

3. **Expand the community rating law (PL 1991, c. 861) by making it applicable to individual policies and to employee groups of 50 or fewer employees and by eliminating gender-based rating.**

PL 1991, c. 861 phases in community rating for group policies of fewer than 25 employees. Expanding the law to include groups up to 50 employees would allow larger small employers to spread their insurance risk among the broader community, perhaps making insurance affordable to employers who have not offered insurance in the past or who have dropped insurance coverage because of the claims experience of a few of their employees.

Also expanding the community rating law to individual policies would make individual coverage more affordable to persons with high claims histories. (It should be noted that Blue Cross/Blue Shield, which estimates that it issues roughly 67% of individual health policies in Maine, currently rates them on a community basis, so this change would affect the 33% of policies that are issued by commercial insurers.)

Finally, prohibiting gender-based rating (rather than on the schedule provided in c. 861 which would ban gender-based rating on 7/15/97) would lower the cost of coverage and open opportunities to small businesses that have a disproportionate number of female employees.

In order to make future policy decisions regarding insurance coverage, legislators and other policy makers need more detailed data about current insurance business in the State. The following recommendation is intended to establish minimum standards for the collection of insurance data.

4. Require the Bureau of Insurance to collect insurance data as follows:

- with data which distinguishes health, disability, Medicare supplement and other policies;
- with data which distinguishes individual from group policies, and policies which offer primary care case management from traditional policies;
- with policies issued to persons 65 and older distinct from those issued to persons under 65; and
- with Maine data distinct from national data; and

III. Continuity of Coverage

"The availability of insurance coverage during employment changes, unemployment, illnesses, travel or temporary absences and after injury"

(From the Joint Select Committee's charge)

For those who do enjoy coverage under an adequate health insurance policy, transition periods can jeopardize coverage, particularly for persons who have preexisting conditions. Although Maine did enact continuity requirements in 1990 (see 24-A MRSA c. 36) requiring the issuance of replacement insurance for individuals moving from group to group and from individual to group policies, gaps in the law have become apparent during the recession, as more people have become unemployed for longer periods of time. The value of health insurance is greatly diminished for those who are subject to preexisting condition exclusions. Unrestricted continuity should be a hallmark of any universal insurance program that Maine may implement in the future; as an interim measure, the continuity law should be strengthened.

5. **Apply the continuity law (24-A MRSA c. 36) to persons moving from group to individual policies.**

6. **Apply the continuity law to persons who are leaving their jobs with self-insured employers for new jobs, thus changing from the health plan of the self-insured employers to group or individual insurance policies.**

7. **To the extent allowed under ERISA, apply the continuity law to persons moving from individual or group policies to self-insured employers with health plans that utilize reinsurance policies.**

Current law applies to groups that replace existing policies and to individuals who (usually through a change of employment) move from a group policy or public program to a different group policy. It provides no assurances for persons moving from a group policy to an individual policy. Nor does it protect persons who leave a self-insured employer and seek coverage under a group or individual policy. Finally, the current law does not assure that the reinsurance carriers of a self-insured employer will agree to cover new employees who were previously covered under individual or group policies.

8. **Direct the Bureau of Insurance and the Department of Labor to submit a report to the Banking and Insurance Committee by March 1, 1993, on the question of making the pre-existing condition exclusion period run for at least 3 months and up to the period of a person's eligibility for unemployment compensation.**

Under current law, an individual moving from one group policy to another is guaranteed continuity without the imposition of a preexisting condition exclusion as long as the individual enrolls or is eligible to enroll in the new group within 3 months of the termination of coverage under the previous policy. In the current economy, many are unable to find new employment within 3 months. Tying the maximum length of guaranteed continuity to the length of unemployment compensation would give unemployed persons more time but would not allow them to delay coverage once they became employed. Having a 3 month minimum period of continuity would assure that persons who are not eligible for unemployment or who are eligible for less than 3 months would still have the protection offered under current law.

The Committee decided to request a study from the Bureau of Insurance and Department of Labor and decided not to submit legislation to change the length of the pre-existing condition exclusion period. This decision was not unanimous.

IV. Cost Control

"The feasibility of cost control through public accountability and negotiations with providers to achieve greater efficiency and improve quality of care"

(From the Joint Select Committee's charge)

Cost Statistics

The cost of health care is rising faster than the general rate of inflation, and recently it has risen much faster than income in Maine, which means that typical households are falling behind as prices skyrocket. (See Chart F) Families see health care costs taking up an increasing percentage of their household incomes, businesses experience health care costs that exceed their profit margins and governments desperately search for ways to fund health care cost increases that are out-pacing revenue growth. Chart G shows the dramatic increase in total and per capita expenditures on health care in Maine since 1980. The $2.7 billion spent in 1990 is roughly equivalent to the entire budget for all state government functions combined. If projections for the year 2000 hold up, Maine will spend over 600% more on health care than it did in 1980. Because health care expenditures are growing much more rapidly than the Maine economy, an increasing percentage of the gross State product is comprised of health care services.

Chart H shows that consumers and private insurance are paying for an increasing percentage of expenditures in Maine, while all levels of government are paying a decreasing percentage. Given the dramatic increase in the dollar amount, all payers are paying much more, whether their percentages are increasing or decreasing.

Chart I shows how those health care expenditures are distributed. Again, because total expenditures have increased so much, all providers received more in 1987 than in 1980, but the chart shows that the percentage to hospitals and nursing homes declined while the percentage to physicians and dentists increased.

What impact does this have on families and businesses? In 1991, the average Maine family spent nearly $4,000 on health care, mostly through taxes, out-of-pocket expenses and insurance premiums. (See Chart J) Businesses added over $2,300 in contributions per family, primarily through insurance premiums. If the family contribution remains constant as a percentage of expenditures, families can expect to contribute an average of nearly $10,000 per year in 2000. The figure will be higher if the trend of increased consumer contributions continues. Families USA has estimated that Maine families and businesses together will contribute an average of $13,422 per family in 2000.

Such a trend would obviously price more and more families out of the health care market, when affordability is already a significant problem. In a 1985 survey, over 40% of uninsured Mainers who were polled said they could not afford health insurance. (4) (See Chart K)

Causes of Spending Increases

Using data provided by the Health Care Financing Administration, the Congressional Budget Office has calculated the degree to which each of the following factors contributed to increases in health spending between 1980 and 1989: general inflation in the economy, excess medical inflation, increases in population, and all other factors, which include changes in use and intensity per capita. (5) The Congressional Budget Office arrived at the following results:

General Inflation	46%
Medical Inflation	22%
Population	10%
All Other	22%

Factors expected to increase health care costs more in the near future include the aging of the population and rapidly developing biotechnology and other medical advances.

Cost Containment Paradigms

Cost containment strategies can be categorized in various ways, as follows. (6)

Price v. Quantity: P X Q = E

The basic variables that comprise health care expenditures are the price per unit of health care (P) and the quantity of units provided (Q). P multiplied by Q results in total expenditures (E). Reductions in expenditures must come from reducing price or quantity, but reducing one without controlling the other can result in a shift that undermines the cost control measure. For example, reductions in physician fee scales are directed at P, but if Q is not controlled, a physician can make up lost revenue to the practice by increasing Q, resulting in no decrease of E.

Examples of cost containment strategies directed at P include rate-setting, diagnosis-related group (DRG) payment systems and competitive bidding of health care contracts. Strategies directed at Q include certificate-of-need programs, which are intended to limit Q by

controlling supply, utilization review, managed care and various cost-sharing proposals, which are intended to make consumers more selective about health care purchases. A list of major cost containment strategies grouped according to P and Q follows.

Strategies Aimed at P	Strategies Aimed at Q
Rate Setting	Certificate of Need
Competitive Bidding of Contracts	Utilization Review
	Cost Sharing

Strategies Aimed at Both P and Q

Managed Care

Global Budgets

Practice Parameters

Regulation v. Competition.

This particular paradigm framed the health care debate throughout the 1980s, but it is viewed increasingly as counterproductive. Observers point out that neither regulation as practiced in the 1970s nor competition as practiced in the 1980s has halted spiraling costs, and that the approaches are not mutually exclusive and could perhaps be more effective if applied simultaneously. For instance, global budgets (regulation) can coexist and even encourage the expansion of managed care (competition). Nonetheless, many policy makers, including the members of the Joint Select Committee, continue to engage in lively debate based on this dichotomy.

Demand v. Supply

Strategies that are directed at reducing demand for services include copayments, which make consumers more selective about services, and managed care, which generally emphasizes prevention and primary care to avoid more expensive care. Strategies aimed at reducing the supply of services include certificate-of-need (CON) programs.

Providers v. Consumers

Most cost containment strategies are aimed at providers, at consumers or at both. While diagnosis-related groups (DRGs) and resource-based relative value scales (RBRVS) do not fit well into the competition v.

regulation paradigm, they are clearly aimed at providers. Copayments, deductibles and benefit reductions are aimed at consumers. Managed care is a strategy aimed at both users and providers.

Administrative Costs v. Direct Services

Those who support a universal health program with fewer payers or with a single payer generally look to large administrative savings and cost controls to pay for much of the access expansion. Hellander et al. have estimated that, if a Canadian-style single payer system were implemented in the United States, Maine could save $506 to $577 million in 1991, or around 20% of total health care expenditures in the State. (7) Chart L shows the costs of insurance overhead in the U.S., Germany, Netherlands, and Canada. Chart M shows the total cost of health care administration, comparing the United States and Canada. The high estimates of $497 in the United States and $156 in Canada reveal a difference of $341 per person per year in administrative costs. The low estimates reveal a difference of $283 per person per year.

Others argue that the estimates of administrative savings are too high, that a single payer system would not capitalize on the strengths of the American system, that neither government nor a limited number of private contractors could administer the health care system less expensively than the current multiple payers, and that emphasis must be placed on other factors contributing to price increases, such as medical malpractice insurance, new technology, and unnecessary use of specialized services.

How administrative costs should be defined, how much they contribute to the price of health care, whether they can be reduced significantly, and whether savings can be redirected equitably are all questions being addressed in the national health care reform debate. Obtaining more precise answers to these questions must be a key focus of continuing planning efforts in Maine.

Recommendations

Comprehensive Reform

Although members of the Joint Select Committee certainly had different perspectives regarding the scope, focus and speed of reforms, all agreed that more focused attention must be brought to bear on the issue of cost control. All members expect health care reform from the new administration in Washington.

In Maine, the Select Committee believes that a number of options will be open to the State and that it will be important to be able to respond promptly to federal initiatives. Current efforts must be restructured and consolidated, and more focused analysis must be completed. The Select Committee envisions a new entity that engages in further study and

planning as a continuation of the work of the Select Committee and returns to the Legislature with recommendations in the form of policy options. This effort could be assigned to a newly consolidated health entity with renewed vigor and focus on cost containment and access.

The following options are offered by the Select Committee as possible approaches that could be taken by the State of Maine. The choices could be implemented progressively and could be intertwined.

9.a Establish the Maine Health Agency, consolidating and expanding existing health planning and regulation functions, and having at least the following features:

- 3 full-time commissioners;
- a charge to reduce the rate of growth in health care expenditures through the establishment of expenditure goals and other cost containment mechanisms;
- a charge to plan for comprehensive coverage and to submit legislation necessary legislation;
- a technical arm for data gathering and regulation (transfer the Maine Health Care Finance Commission into new agency); a planning arm with input from providers, consumers, and legislators;
- a charge to plan for and implement a required global budgeting process at some point in the future; and
- adequate financing from a provider assessment.

9.b Restructure and consolidate existing public health planning and regulation functions into a single agency. Include in the new agency the Maine Health Care Finance Commission, health planning efforts currently in the Department of Human Services, the certificate of need (CON) program, mental health planning, health planning efforts in the State Planning Office, and any other appropriate existing State health functions.

9.c Consolidate existing health planning and regulation activities by transferring health planning and certificate of need functions from the Department of Human Services to the Maine Health Care Finance Commission.

9.d Draft legislation for consideration by the 116th Legislature in 1993 which will accomplish the following:

- make health coverage a right of citizenship rather than an employer obligation (so that employers will no longer be burdened with finding coverage for workers and so that people losing their jobs will not lose their coverage. In addition, employers pay for the cost of workers' compensation, 23% of the annual costs of which goes to pay for medical benefits for workers);

- provide all citizens with comprehensive coverage (to eliminate cost-shifting to employers and eliminate out-of-pocket costs to families);

- give patients freedom to choose their own doctor, hospital or other health provider;

- finance comprehensive coverage by using cost savings from significantly reduced administrative costs and savings from cost controls;

- emphasize primary and preventive care (to reverse incentives in the present system which overly reward high cost specialty procedures);

- provide for non-profit, publicly accountable administration through one public or private agency (to make the system simple for consumers and save an estimated $577 million on insurer paperwork and bureaucracy);

- establish unified health care budget and expenditure targets to bring medical inflation in line with general inflation and the Maine wage index;

- require the administering agency to consolidate and coordinate all present health agencies;

- require the administering agency to collect and analyze health data to improve quality of care, and reduce costs to providers and consumers, and to decide where health resources should be located, with a focus on rural areas;

- have provider groups negotiate their fees with the administering agency (to give less powerful providers a voice in health policy decision making, to encourage cost-effective primary and preventive care, and to encourage more providers to serve rural areas);

- have hospitals negotiate annual budgets with the administering agency (to promote efficiency, reduce duplication of services, enable hospitals to coordinate care and services with other area hospitals to better serve their communities, and reduce excess technological and bed capacity);

- promote coordinated managed care efforts through the use of primary care providers as points of entry rather than high cost subspecialists and specialists;

- provide for retraining of workers displaced by the plan (with a focus on health care training to serve previously uninsured or under-insured Mainers);

- require individuals and businesses to pay for coverage using the broadest most equitable scheme (phase-in reduced payments for small businesses and exempt start-up and new small businesses for a period of years from premiums; ensure that costs to consumers and businesses is lower than or does not exceed their present payments);

- require the administering agency to establish regional advisory panels representing providers and payers (consumers and businesses) to appropriately allocate resources to meet local community needs;

- reduce prescription drug charges to the greatest extent possible on a state basis; and

- apply for necessary federal waivers.

Interim Measures

Regardless of the outcome of further study and future comprehensive reform, and despite the expectation of federal reform, the following steps can and should be taken immediately to slow the rate of growth of Maine health care spending.

10. Prohibit referrals to services in which a physician has a financial interest.

This would assure that physicians were referring patients for tests based on need alone, with no conflict-of-interest. Several other states have begun studies on the issue or have prohibited reimbursement for lab tests or diagnostic imaging when the work is ordered by a physician who has a financial interest in the lab or imaging center that does the work.

11. Expand certificate of need (CON) requirements to physician offices for equipment of $1 million or more.

This would close a loophole in existing CON law which allows physician practices to purchase and use expensive equipment such as imaging technology. Subjecting these large equipment purchases to CON review would assure that supply is consistent with actual need in the community.

12. Direct the Department of Human Services to amend the State Medicaid Plan to cover pregnant women and children who are not receiving cash assistance on a sliding fee scale up to 285% of the federal poverty level.

Under Title XIX of the Social Security Act, Section 1902(r)(2), states may use more liberal methods to determine eligibility for pregnant women and children who are not receiving cash assistance. By disregarding certain income in eligibility determinations, a state can effectively extend coverage up to 285% of the federal poverty level under Medicaid. Though no State has actually done so, Minnesota has received tentative approval to expand their 1902(r)(2) coverage to 275% of poverty.

Prenatal and early childhood services have been particularly effective in preventing low birth weight, disabilities and childhood diseases. Currently, under a demonstration program, Maine's Medicaid program covers children up to 125% of poverty. Also, Maine has exercised the 1902(r)(2) option of covering pregnant women and infants up to 185% of poverty. The State should establish a sliding fee scale and use collected premiums as State seed to expand coverage as far as possible under Section 1902(r)(2).

13. Encourage the Department of Human Services to ensure that all children receive immunizations at the appropriate times.

Although actual savings have been elusive in some prevention areas, immunization has been universally recognized as a cost-effective measure. Though the State may need to invest additional resources initially to assure that all children are immunized, savings would be realized in a relatively short period of time.

14. Encourage the Department of Human Services to put together a plan to establish a Healthy Start program to provide in-home services to children by health care professionals.

Programs such as Healthy Start have been found to reduce child abuse and neglect through community based maternal and child health programs.

15. Direct and authorize the Superintendent of Insurance to work cooperatively with the federal government and other states to develop and implement standard billings forms and standardized instructions and procedures for the completion of the forms for all health claims.

Requiring that all claims be submitted on the same billing form would have a double benefit: it would reduce administrative costs for providers and it would offer a cost effective method of collecting uniform data. New York has directed its Superintendent of Insurance to develop such a form and requires hospitals, physicians and other health care providers to use it.

16. Direct the Department of Human Services and the Bureau of Insurance to examine barriers to increasing the rate of standardized electronic billing in the Medicaid, Maine Health and other programs administered by the Bureau of Medical Services. Develop incentives for providers to switch to standardized electronic billing. Amend the law that currently prohibits funds from being transmitted electronically to providers.

Currently, the Bureau of Medical Services receives about 25% of its claims electronically. The Bureau needs additional hardware to allow providers with smaller personal computers to submit electronic claims, and enhanced software to process the claims and produce reports. Additional data analysts would allow the Bureau to generate utilization reports, which could then be sent to providers.

A related problem is a State prohibition against making payments to providers electronically. 5 MRSA Section 1543 requires that disbursements be made "in the form of a check against a designated bank or trust company." The requirement dates back to 1931, and is thought to have been enacted as a safeguard against the State issuing I.O.U.s during the Great Depression. (See PL 1931, c. 216). This anachronistic mandate reduces the incentive for providers to bill electronically since they cannot in turn be paid electronically.

17. Authorize the Board of Registration in Medicine and the Board of Osteopathic Examination and Registration to expand work on practice parameters, appointing specialty advisory committees and adopting new practice parameters.

As a result of tort reform legislation in 1990, practice parameters have been adopted for anesthesiology, emergency medicine, obstetrics and gynecology, and radiology. (See 24 MRSA §2971 et seq.) Now that rules have been adopted in these specialty areas, the Board of Registration in Medicine and Board of Osteopathic Examination and Registration should be authorized and encouraged to extend the effort to other specialties as

they have the administrative capacity to do so. The Boards should review national guidelines, solicit proposals from specialty groups in the State, and pursue any other options for expanding on this ground-breaking effort.

18. Direct the Superintendent of Insurance to examine Maine's current rate setting procedures for medical malpractice insurance and to report to the Joint Standing Committee on Banking and Insurance by March 1, 1993.

The current Superintendent has just issued his first decision regarding medical malpractice rates. In light of that experience, the Superintendent should consider whether reforms are needed, including whether rate setting should be abandoned altogether in this area, and should submit recommendations to the Legislature by March 1, 1993. Chart N provides data regarding medical malpractice insurance in Maine.

19. Direct the Superintendent of Insurance to review Vermont's medical malpractice arbitration system and Maine's medical malpractice screening panels and propose a non-adversarial system for addressing small claims. The proposal must be developed in consultation with all interested parties, including but not limited to consumers, trial attorneys and physicians. A report to the Joint Standing Committee on Banking and Insurance is due March 1, 1993, containing the review and proposal. A preliminary report should be submitted to the Committee as soon as possible.

Vermont requires that medical malpractice claims be submitted to arbitration prior to trial. At the parties' option, the arbitration is binding. If the parties do not agree that the finding of the arbitration panel should be binding, the parties appeal and have a trial de novo in court. The decision of the arbitration panel and its findings and conclusions are admissible into evidence in court.

Maine's medical malpractice screening panels, under the Health Security Act, can result in binding results or admissible evidence in a court trial. Utilization of the medical malpractice screening panel procedure is mandatory prior to suit in Superior Court in Maine.

Anecdotal evidence suggests that the cost of the screening panel process has been a barrier to small claim filings. Practices in Vermont and elsewhere should be reviewed with an eye to developing a less adversarial system with better access for small claimants.

20. Encourage efforts to adopt a relative value scale physician fee schedule that emphasizes primary care and that provides uniform compensation for any given procedure among types of health care professionals and if a global budget has been adopted that conforms with aggregate reimbursement within the global budget.

Currently, Maine regulates hospital charges but does not regulate physician fees. In the absence of a global budget, the aggregate reimbursement provision could be used to avoid a "volume offset," whereby reductions in price (P) are offset by increases in quantity (Q). The Select Committee recognizes that setting reimbursement totals and rates requires data not now available and requires consideration of providers paid through both the public and the private sectors.

21. Encourage the legal changes and cooperation necessary to negotiate reimbursement of Medicaid fees. Amend anti-trust law to allow providers to negotiate fees. Require the Department of Human Services to negotiate reimbursement levels of Medicaid fees.

Changes in the State anti-trust laws are required to allow health care providers to negotiate Medicaid fee reimbursement levels. This will require the participation of the Department of Human Services. As part of its universal access law, Vermont has amended its anti-trust law and set the stage for negotiation. One member abstains on this recommendation.

22. Require all health care providers to list publicly in their offices their basic fees.

Knowledge of fee levels is important to informed consumer choice and to cost containment.

23. Encourage Congress to amend the Medicare demonstration law to allow teaching hospitals to send interns to rural health clinics and centers. Encourage Maine hospitals to participate in the demonstration program.

Under current federal Medicare law (Omnibus Budget Reconciliation Act of 1987, §4038, as amended by the Omnibus Budget Reconciliation Act of 1989, §6216), teaching hospitals may apply to take part in a demonstration program that allows the hospitals to place interns in rural hospitals without jeopardizing their Medicare reimbursement for those interns. Unfortunately, the demonstration does not allow those teaching hospitals to place interns in rural health clinics. Regardless of whether the demonstration law is amended, Maine's teaching hospitals should be encouraged to participate in the program.

24. Encourage the expansion of the number of primary care health care providers. With regard to physicians, utilize loan and other incentive programs and expand the use of primary care case management.

Maine's postgraduate health professions program is being revised to reemphasize primary care and to make the purchase of slots more cost effective through a request-for-proposal procedure. Also, postgraduate slots in dentistry, optometry and veterinary medicine are being discontinued in favor of a singular emphasis on medical education.

The State has supported managed care initiatives in the state employee program and the Medicaid program. The Joint Select Committee supports these initiatives and encourages their swift implementation.

The Joint Select Committee commends the work of Maine health care institutions in the area of primary care. Specific recognition is given to the Eastern Maine Medical Center, the Central Maine Medical Center, the Maine Medical Center, the Brighton Medical Center, the Kennebec Valley Medical Center and the University of New England School of Medicine.

It should be noted here that the Joint Select Committee continues to support a person's option to pursue recognized spiritual healing in lieu of medical intervention. The Committee acknowledges the importance of the provision of health care and insurance benefits for health care for persons relying upon a recognized religious method of healing as provided for in Title XVIII for the federal Social Security Act and treatment and care compatible with such services and as permitted under state law.

25. Strongly urge the Department of Human Services to expand the use of optional targeted case management for Medicaid patients in rural health clinics and for other primary care providers.

Optional targeted case manatement is one way that the State could support primary care physicians in rural areas. Many rural doctors have expressed concern that they do not have the resources they need to assure that their Medicaid patients receive the range of health and social services they need. Optional targeted case management would allow the office to be paid for coordinating services from other sources for Medicaid patients.

26. Remove "underserved specialty" as eligible service and reemphasize primary care in underserved areas in the Health Professions Loan Program.

When the 115th Legislature enacted the recommendations of the Advisory Committee on Medical Education, it emphasized primary care in its loan forgiveness policy, but it also extended loan forgiveness to "any

physician serving in an underserved specialty" (See 20-A MRSA §12104, sub-§5, ¶A, sub-¶2.) An underserved specialty is a branch of medicine that is determined to be in short supply in any area of the State. Psychiatry, for instance, is an underserved specialty in the Portland area. The Joint Select Committee believes that the earnings potential of practitioners who provide underserved specialties is far greater than that of primary care physicians practicing in underserved areas, and recommends that loan forgiveness be reserved for primary care.

27. Encourage utilization review on a practice basis; support outcomes research and small area variation research.

The Joint Select Committee favors systems in which a practitioner or practice receives regular feedback in the form of data that compares that practice's utilization rates with the norm. The Joint Select Committee applauds the leadership of the Maine Medical Assessment Foundation in the areas of outcomes research and small area variation research. The State should make every effort to support these kinds of data analysis to assure that critical information is available as scarce resources are reallocated.

28. Direct the Maine Health Care Finance Commission to review current data collection for ambulatory services in light of current practice patterns and determine which procedures should be added to the data collection list.

Although Maine collects excellent hospital-based data through the regulatory process, only limited data on specified ambulatory surgical procedures is collected. In consultation with the Maine Medical Assessment Foundation, the Maine Ambulatory Care Coalition and the Maine Medical Association, the Maine Health Care Finance Commission should review the ambulatory data it currently collects and make recommendations to the Legislature for further collection.

29. Encourage efforts to work toward a global budget.

The Select Committee is interested in global budgeting for planning and cost containment purposes. Information on health care costs in the many components of our health care system is required before global budgeting can become a reality. One member of the Committee abstains on this recommendation.

30. Establish a special committee of 6 legislators and 3 public members to study the allocation of human and financial resources in health care, the issue of the qualifications and full utilization of health care professionals, identifying the legal barriers to appropriate utilization and the extent to which health policies determine health care policy,

the degree to which health care professionals drive the system and the effect of full and partial participation of health care professionals in health care programs funded by the public sector.

The Select Committee is interested in the full utilization of all health care professionals to maximize the benefit to the people of the State of Maine. Additional study is needed of the qualifications and abilities of our professionals, their roles in the health care system and the effect of their participation in public sector health care programs.

31. Allow the licensing of foreign-trained dentists and require rulemaking by the Board of Dental Examiners to license foreign-trained dentists.

The Select Committee heard of a situation in which foreign-trained dentists were unable to be licensed in the State of Maine, depriving our citizens of the services of a trained health care professional. (As an aside, when the dentist moved out-of-state to obtain employment, the spouse, a skilled neurosurgeon, went also.)

32. Establish a State of Maine Department of Health.

A State of Maine Department of Health could be the backbone of new health policy and planning for the State, providing the resources and direction to obtain for our citizens universal health care coverage that is portable, accessible, affordable and accountable. The Select Committee strongly urges the establishment of a Department of Health.

V. Funding

"Whether the current mechanisms for financing health care are appropriate and could be expanded to provide coverage for persons who are uninsured"

(From the Joint Select Committee's charge)

Returning to Chart H, we see that, although their shares are declining, federal, state and local government combined provide the greatest share of health care financing.

Medicare payments are set completely by the federal government, leaving little potential for the State to increase funding from that source. Medicaid offers more opportunities, since the State shares policy making with the federal government. The State has engaged in an aggressive "Medicaid maximization" policy in the last several years, taking optimal advantage of state options. Most recently, a large portion of the Maine Health Program was transferred to Medicaid under a children's demonstration project. Expansion of Medicaid to cover more pregnant women and children is recommended in Part IV. In addition, schools should aggressively pursue Medicaid reimbursement to partially fund school-based health clinics (recommended in Part VI).

Given the current fiscal situation, it is difficult to imagine expanding General Fund programs, despite the benefits that could be derived by doing so. The MaineCare program, for instance, is showing great promise as a public-private partnership including the State, small businesses, a Maine-based managed care company and local hospitals, but additional funds would be needed to expand it beyond its present pilot status.

After government, the next largest contributors are consumers themselves. Unfortunately, higher employee contributions, deductibles and copayments seem to be the trend, adding to the affordability problems discussed in earlier sections of this report. It does not seem reasonable to expect significant new resources to be contributed by consumers themselves.

The next largest source of funds is private insurance. Many of the recommendations in Part II are designed to stimulate the expansion of insurance coverage as an interim measure. Whether significant administrative savings could be reallocated to direct services in a system with fewer payers or a single payer is a question worthy of additional study.

33. Direct the Bureau of Insurance, in cooperation with the Department of Taxation, to put together information on the federal health insurance earned income tax credit for distribution to consumers.

One potential way to increase federal funds coming into the State for health insurance is to increase citizens' use of the federal health insurance earned income tax credit (HI-EITC). Beginning with tax year 1991, filers with lower incomes could qualify for a credit of up to $428 for premiums paid for health insurance for a qualifying child. Filers may elect to receive advance payment of the credit during the year through the payroll withholding system. Maine should encourage filing for the credit.

VI. Comprehensiveness and Coordination

"Whether a more comprehensive and coordinated system could be implemented by: consolidating all of the present sources of funding...from federal sources..., consolidating state programs..., and utilizing finance mechanisms that are income-based and permit all citizens to have access to health care coverage"

(From the Joint Select Committee's charge)

The Joint Select Committee supports continuing efforts to coordinate health programs for two reasons: a unified system would be more "user-friendly" for consumers, and the State would be better able to exercise its considerable purchasing power. Chart O, which is not an exhaustive compilation, puts the State's recent purchasing power at nearly $600 million. The total jumps to $800 million if recent increases in federal disproportionate share hospital payments are included.

34. Direct the Department of Human Services to examine the options for unifying the administration of all health insurance programs that are publicly funded or publicly administered and to report to the Joint Standing Committee on Banking and Insurance by March 1, 1993.

A major effort to unify State programs was made recently in the form of a grant proposal to the Robert Wood Johnson Foundation by the Department of Human Services. ("Stage Two: Extending Health Care Reform in Maine) Unfortunately, the proposal was not funded by the Foundation. It would have examined the feasibility of unifying and coordinating administrative and payment mechanisms for all programs in which the State is the payer for services, including Medicaid, the Maine Health Program, the state employee health program, and the medical component of the workers' compensation system. Such coordination would be a key element to minimizing administrative costs and maximizing the State's purchasing power in any type of universal coverage program. The Joint Select Committee urges the Department of Human Services to find other means to study this critical issue.

35. Support the continued development of single point of entry/eligibility determination for income maintenance programs through the FAMIS computer system. Direct the Department of Human Services to report to the Joint Standing Committee on Banking and Insurance on March 1, 1993 on single point of entry/eligibility determinations.

The Bureau of Income Maintenance is engaged in a long-term effort to unify the eligibility determination process for Medicaid, food stamps, AFDC and other programs through the development of a computer

program now operating in most other states. This would greatly facilitate access to public health programs and would increase administrative efficiency. Minimal funding of the project over the last few years has slowed progress to the point where full implementation is not expected for at least 3 years.

36. Encourage the expansion of school-based health clinics in conjunction with local primary care providers. Expand the mission of the clinics to serve the public during non-school hours.

Because Maine does not have a system of county health departments, coordination of rural health needs has relied on rural health clinics. Model school-based projects in Buxton, Dover-Foxcroft, Hampden, Lubec, and Readfield should be examined closely to determine what broader role they might play in providing health services to the community after school hours. These and future clinics should aggressively pursue Medicaid reimbursement to maximize federal financial participation.

37. Direct the Bureau of Insurance to study and report to the Banking and Insurance Committee by January 1, 1994 on the feasibility of combining the medical portion of automobile insurance and health insurance.

The Committee is aware that a portion of automobile liability insurance premiums is attributable to medical care. It may be possible to save money for Maine's citizens by combining health and the medical portion of automobile insurance. To explore this issue, the Committee recommends a study and report by the Bureau of Insurance.

38. Support the efforts of the federal government on the issue of pharmaceutical pricing in order to reduce prices to consumers.

The Committee is aware of the impact of pharmaceutical prices on the health care expenditures in this country and on the monthly budgets of Maine's citizens. Believing that cost control must address pharmaceutical pricing, the committee supports the work of the federal government on this issue.

Footnotes

1. Coburn et al. estimated the number of uninsured persons in Maine ages 18 to 65 to be over 93,000 in 1985. See Health Insurance Coverage in Maine: An Analysis of the Problem, Its Effects and Potential Solutions. Portland, ME: University of Southern Maine, Human Services Development Institute, 1986. The Special Select Commission on Access to Health Care adjusted that figure to include persons of all ages and estimated that 130,000 Maine residents were without insurance. See Special Select Commission on Access to Health Care, Assuring Access to Health Care, Augusta, ME, Maine Legislature, 1989.

2. Coburn et al., Ibid. 16.

3. Ibid., 11.

4. Ibid., 10.

5. Langwell, Kathryn M. "Escalating Health Care Expenditures: Trends and Causes." Presentation at "Strategies for Controlling Health Care Costs." U.S. Agency for Health Care Policy and Research, College Park, MD. July 20, 1992. Photocopied.

6. Much of this discussion is taken from Rep. Carleton's presentation to the Select Committee, based upon a cost containment workshop offered by the U.S. Agency for Health Care Policy and Research, College Park, MD, July 20-22, 1992.

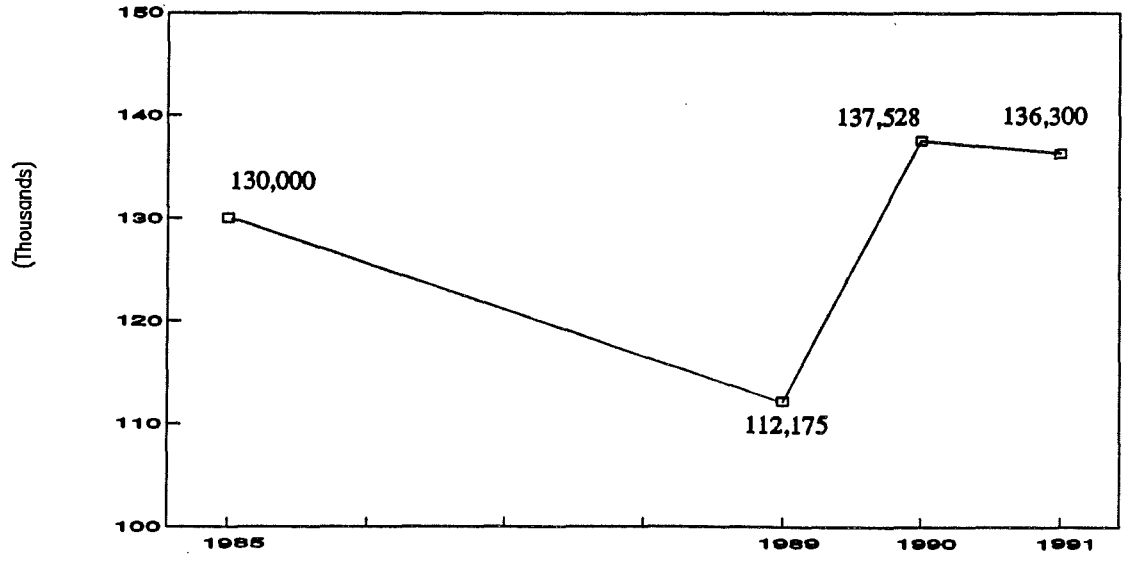
7. Hellender, Himmelstein, Wolfe and Woolhander. Administrative Waste in the U.S. Health Care System in 1991: The Costs to the Nation, the States and the District of Columbia. 1992.

Chart A

A-1 **Percent of Persons Not Covered by Health Insurance**
National and Selected States, 1989-91

	1991	1990	1989
Connecticut	7.5%	6.9%	8.3%
Maine	11.1% (136,300 persons)	11.2% (137,528 persons)	9.2% (112,175 persons)
Massachusetts	10.9%	9.1%	8.5%
New Hampshire	10.1%	9.9%	12.8%
Rhode Island	10.1%	11.1%	9.2%
Vermont	12.7%	9.6%	8.8%
Nationally	14.1%	14.1%	N/A

A-2 **Persons Not Covered by Health Insurance in Maine, 1985-1991**



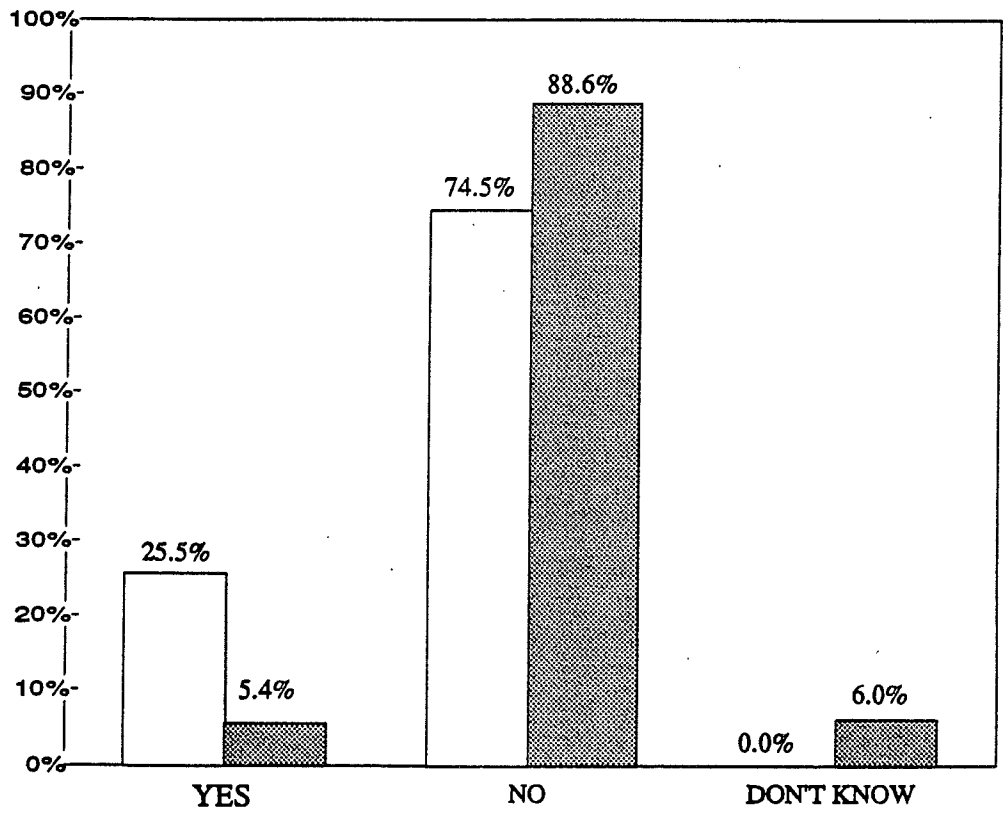
Source: 1989-1991 figures: U. S. Bureau of the Census, Background Information, Income and Poverty 1991, Health Insurance

1985 figure: Special Select Commission on Access to Healthcare (see footnote 1)

c:\pm\charta

CHART B

Self-Reported Access to Care and Insurance Status
(Maine Sample, 1985-1986)



Did Not Receive Needed Care in Past Year

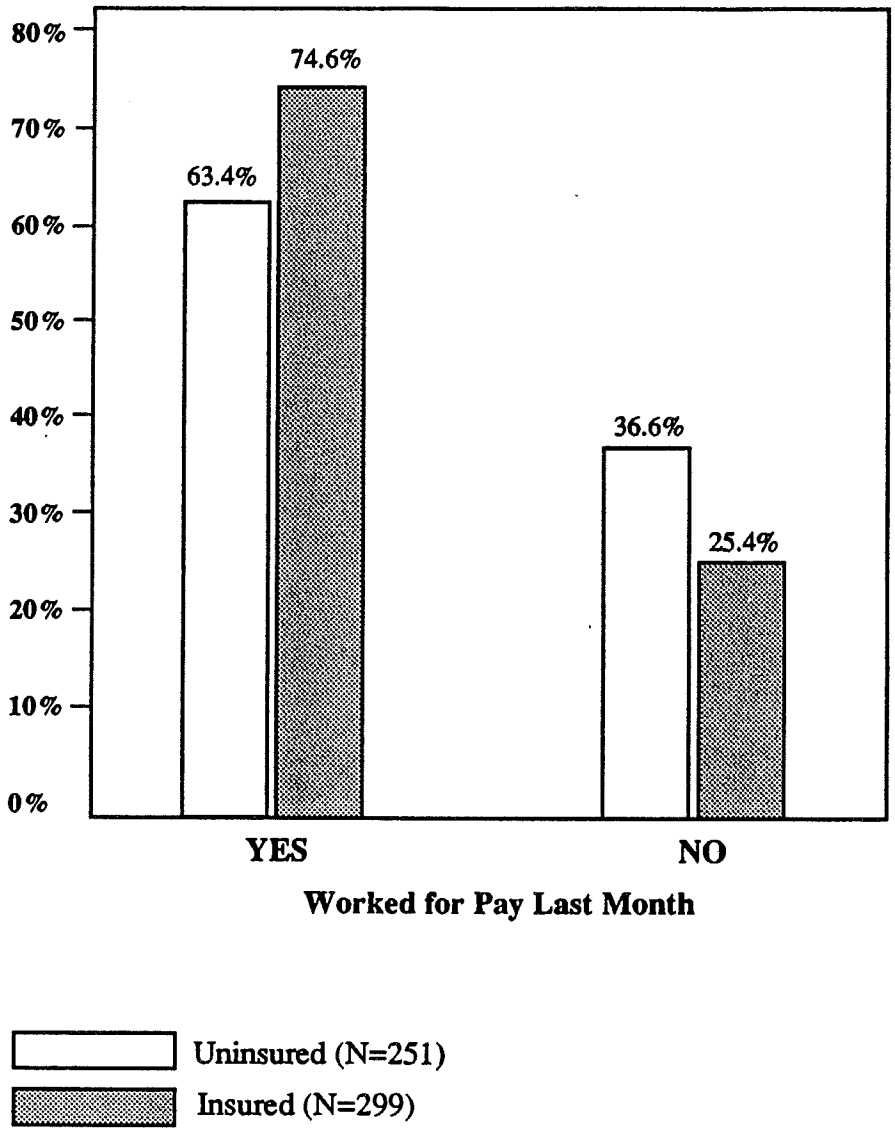
Uninsured (N=251)

Insured (N=299)

Source: HSDI Study (See footnote 2)

Chart C

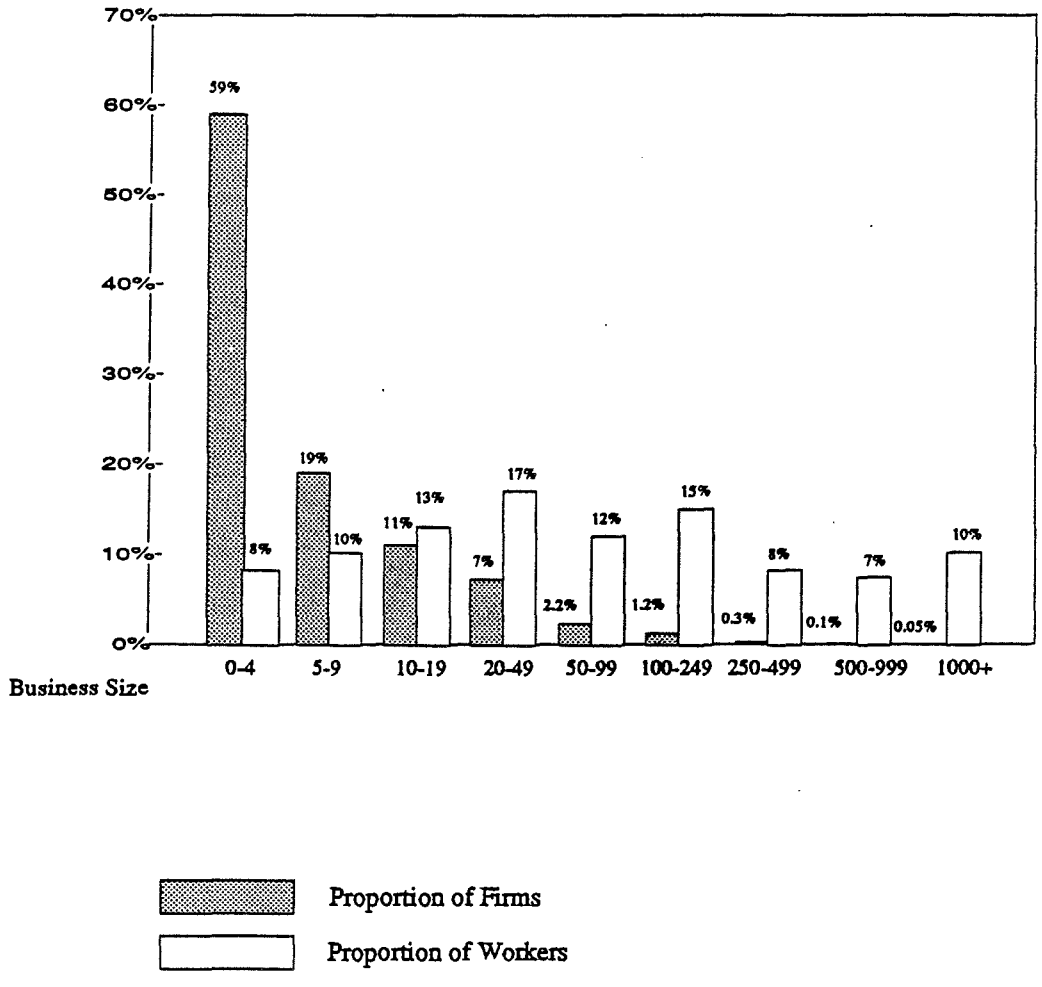
Employment Status and Insurance Status
(Maine Sample, 1985-1986)



Source: HSDI Study (See footnote 3)

CHART D

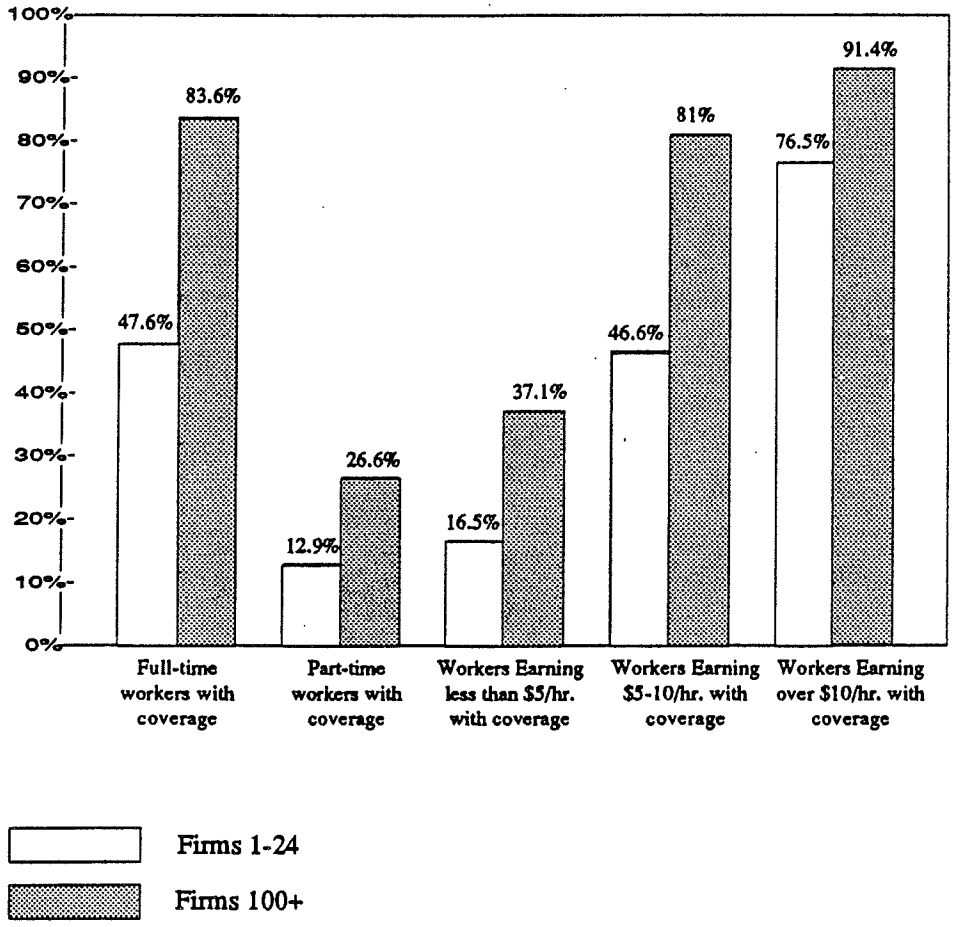
Distribution of Maine's Business Establishments and Workforce by Size of Firm, March 1990



Source: Maine Department of Labor
Chart reproduced from: The Maine Care Demonstration Project Program, HSDI, 1991

CHART E

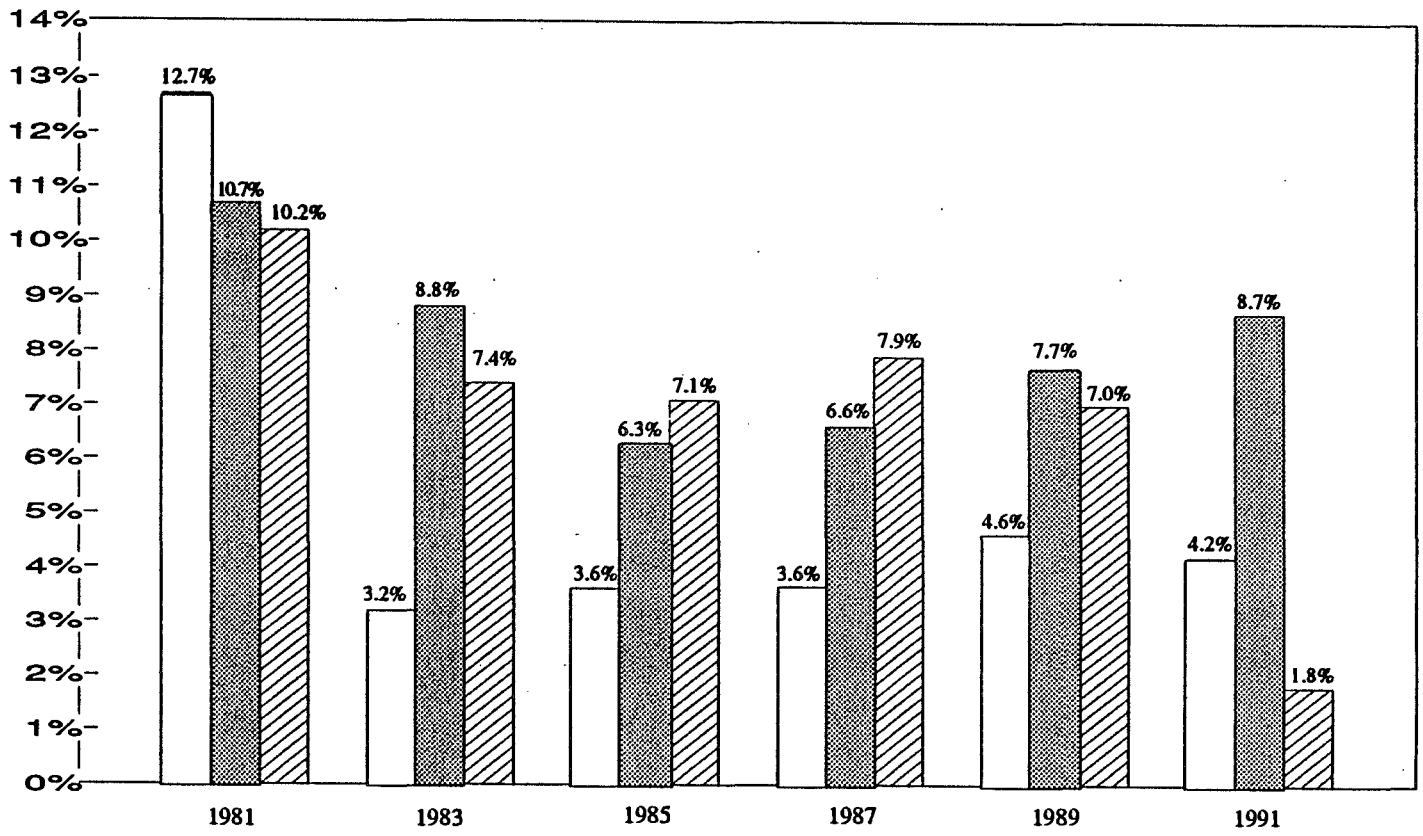
Comparison of Health Coverage in Small and Large Firms by Characteristics of the Workforce (Nationally)



Source: The State of Small Businesses, 1987, from 1984 census data.
Chart reproduced from: Access and the Uninsured: A guide for the States, HSDI, 1991

Chart F

Paychecks Don't Keep Up.
General Inflation, Medical Inflation, and Maine Income Growth
Selected Years



Consumer Price Index Medical Care Component of CPI Maine Personal Income Growth

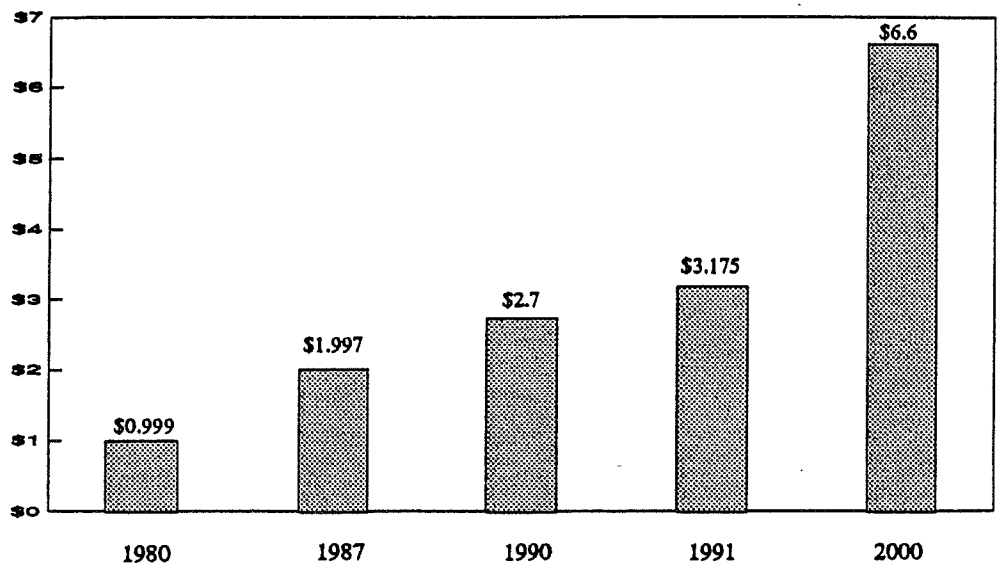
Source: Maine State Planning Office

CHART G

How Much Are We Spending?

G-1.

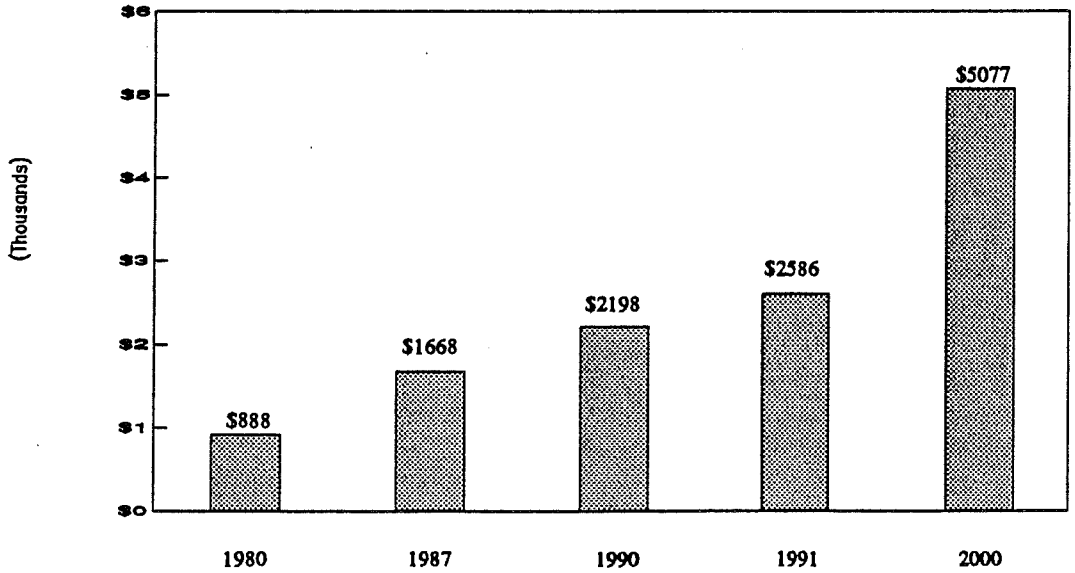
Total Health Care Expenditures, Maine Selected Years (in billions)



Sources: 1980 and 1987 data :Maine Department of Human Services, Office of Data, Research and Vital Statistics, 1990, 1991 and 2000 estimates: Families USA Foundation, 1990.

G-2.

Per Capita Health Care Expenditures, Maine Selected Years



Source: Total expenditure figure from chart G-1 divided by census data. Population of 1.3 million was estimated for 2000.

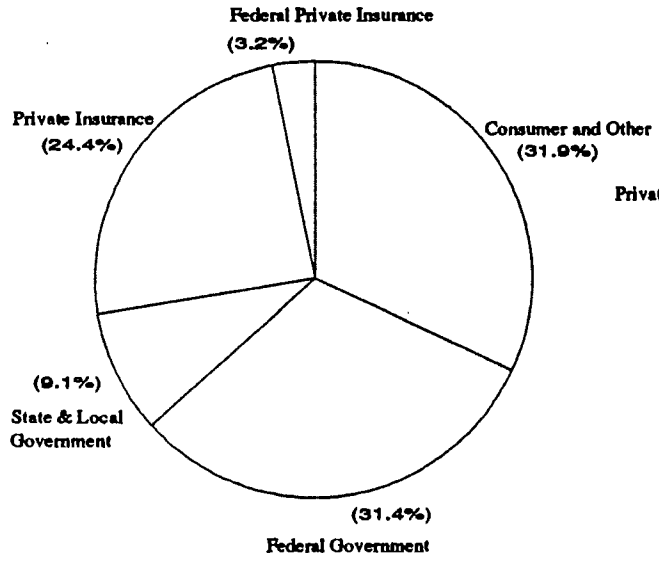
CHART H

Who Pays?

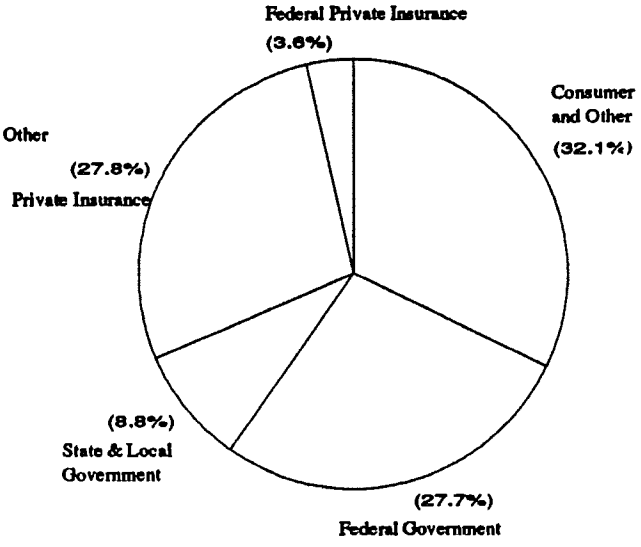
Health Care Expenditures
Maine, 1980 and 1987

	1980 (total=.999B)	1987 (total=1.997B)
Consumer and Other	31.9%	32.1%
Federal Government	31.4%	27.7%
State & Local Government	9.1%	8.8%
Private Insurance	24.4%	27.8%
Federal Private Insurance	3.2%	3.6%

1980



1987



Data Source: Maine Department of Human Services
Office of Data, Research and Vital Statistics, 1990

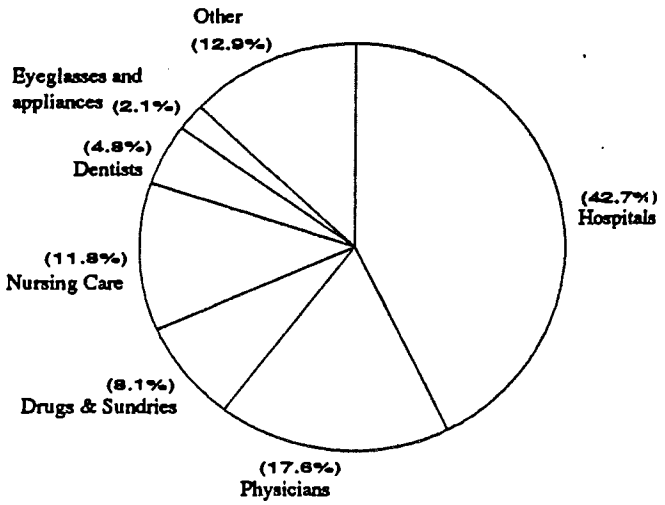
CHART I

Where are the dollars going?

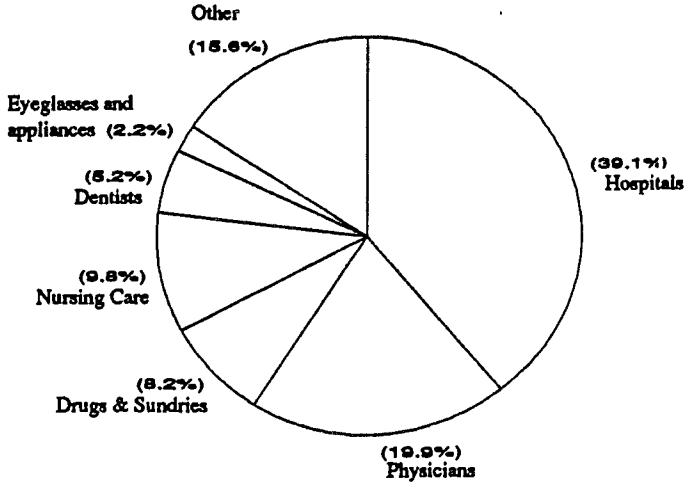
Health Care Expenditures
Maine, 1980 and 1987

	1980	1987
Hospitals	42.7%	39.1%
Physicians	17.6%	19.9%
Drugs and Sundries	8.1%	8.2%
Nursing Care	11.8%	9.8%
Dentists	4.8%	5.2%
Eyeglasses and Appliances	2.1%	2.2%
Other	12.9%	15.6%

1980



1987



Data Source: Maine Department of Human Resources
Office of Data, Research and Vital Statistics, 1990

CHART J

Family and Business Contributions to Health Care Costs in Maine, 1991

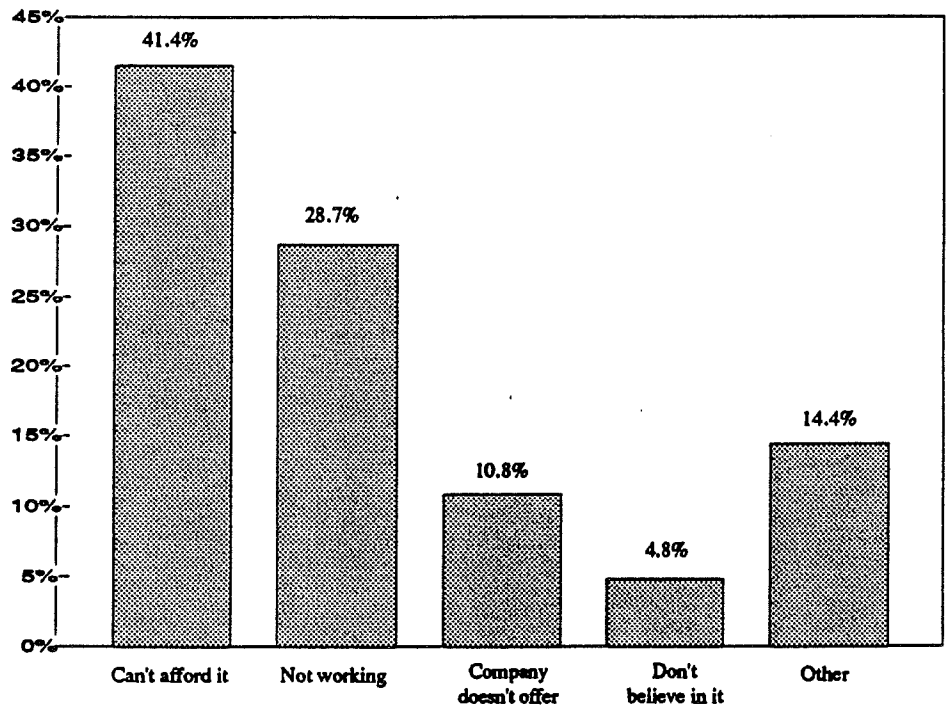
	Average Family Contribution	Avg Business Contribution Per Family
Out-of-Pocket	$1,218 (30.9%)	-0-
Insurance	$ 813 (20.6%)	$1,293 (55.7%)
Medicare Payroll Tax	$ 268 (6.8%)	$ 269 (11.6%)
Medicare Premiums	$ 128 (3.2%)	-0-
General Taxes	$1,520 (38.5%)	$ 337 (14.5%)
Other	-0-	$ 423 (18.2%)
TOTAL	$3,946 (100%)	$2,322 (100%)

Data Source:
Health Spending: The Growing Threat to the Family Budget
Families USA, 1992.

a:123/ship1

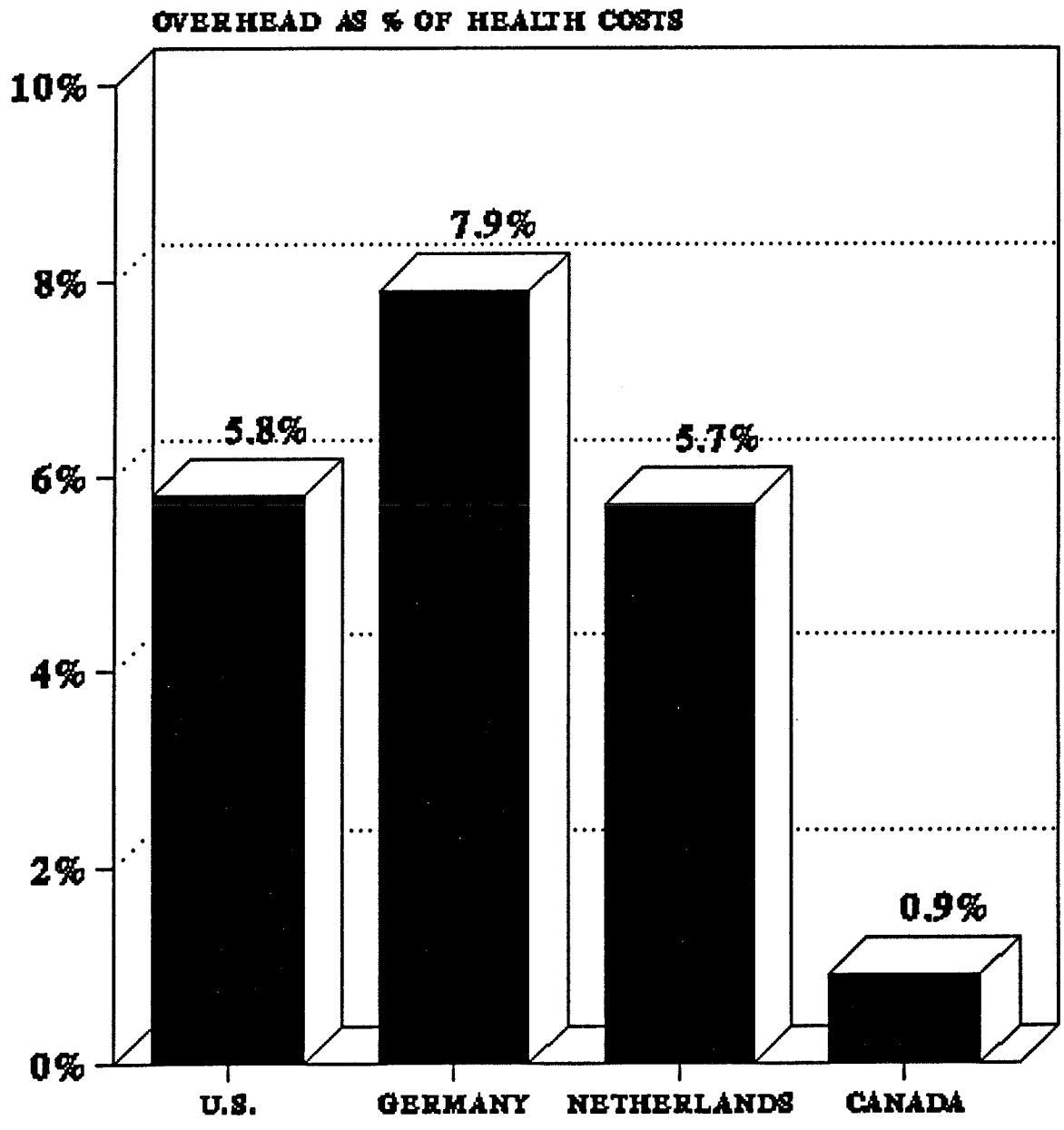
CHART K

Why Do Maine Uninsured Lack Health Insurance?
(1985 Sample)



Source: HSDI Study, 1986, (See footnote 4)

CHART L: INSURANCE OVERHEAD, 199
U.S., GERMANY, NETHERLANDS & CANADA



Source: Dr. David Himmelstein & Dr. Steffie Woodhandler.
Center for National Health Program Studies

CHART M: COST OF HEALTH CARE ADMINISTRATION IN THE UNITED STATES AND CANADA, 1987

COST CATEGORY	SPENDING PER CAPITA*	
	U.S.	CANADA
Insurance Administration	106	17
Hospital Administration	162	50
Nursing Home Administration	26	9
Physicians' overhead and billing expenses		
Expense-based estimate	203	80
Personnel-based estimate	106	41
Total costs of health care administration+		
High estimate	497	156
Low estimate	400	117

*All costs are expressed in U.S. dollars.
+The high estimate incorporates physicians' administrative costs derived by the expense-based method, and the low estimate costs derived by the personnel-based estimate.

Source: Woolhandler & Himmelstein (1991). The Deteriorating Administrative Efficiency of the U.S. Health Care System. The England Journal of Medicine, Vol. 324, No. 18, pp. 1255.

Chart N

Maine Medical Malpractice Calendar Year Totals, 1979-1991

Year	1 Earned Premium	2 Paid Losses	3 Incurred Losses	4 Loss Adj. Expense	5 Dividend Paid	6* Paid Loss Ratio	7+ Incurred Loss & LAE Ratio
1979	$ 3,323,407	$ 1,029,329	$ 2,889,243	$ 876,050		0.31	1.133
1980	$ 4,821,453	$ 712,646	$ 3,522,584	$1,270,935		0.148	0.994
1981	$ 6,392,761	$ 1,550,855	$ 5,344,755	$1,685,132		0.243	1.1
1982	$ 7,795,908	$ 3,121,773	$ 7,166,925	$2,055,001		0.4	1.183
1983	$ 9,178,026	$ 4,013,993	$ 8,058,573	$2,419,328		0.437	1.142
1984	$11,219,223	$ 3,976,363	$ 5,876,687	$2,957,387		0.354	0.787
1985	$15,333,769	$ 4,202,497	$10,581,460	$4,041,982		0.274	0.954
1986	$21,620,257	$ 5,870,441	$14,103,231	$5,699,100		0.272	0.916
1987	$26,061,481	$ 6,488,382	$13,165,169	$6,869,806		0.249	0.769
1988	$31,977,867	$ 9,268,070	$14,464,634	$8,429,366		0.29	0.716
1989	$32,520,666	$11,588,637	$17,039,785	$8,572,448		0.356	0.788
1990	$32,296,598	$ 8,034,658	$17,317,757	$8,513,383	$26,861	0.249	0.8
1991	$27,668,118	$ 7,761,336	$19,845,132	$7,293,316	$34,228	0.281	0.982
Total	$230,209,534	$67,618,980	$139,375,935	$60,683,234	$61,089	0.294	0.869

Source: Maine Bureau of Insurance. Annual Statement, page 14 totals.

* Column 2 divided by Column 1

\+ Column 3 plus Column 4, divided by Column 1.
For 1990 and 1991, dividends (Column 5) are subtracted from earned premiums.

CHART O

MAINE'S PURCHASING POWER

State Health Care Expenditures
Selected Programs

Medicaid[1]	$495,032,000
Federal Funds	$324,632,000
State Funds	$170,400,000
State Employee Health Program[2]	$70,400,000
Employee BC/BS	$47,198,000
Employee Dental	$3,989,000
Other	$19,213,000
Maine Health Program[3]	$9,386,000
Department of Corrections[4]	$4,715,000
Elderly Low Cost Drug[3]	$4,038,000
Elderly Home-Based Care[3]	$1,708,000
High Risk Insurance Organization[3]	$1,674,000
Department of Mental Health and Mental Retardation[5]	$800,000
Maine Care[6]	$597,000
TOTAL	$588,350,000

Notes:

1 FY91 figures. Both State and Federal are included, since the State controls the expenditures of both state and federal shares. Total state funds were derived by the Office of Fiscal and Program Review from Controller's Records (B906S).

2 FY92 estimated provided by the State Employees Health Program. "Other" is comprised of other groups in the program, including the Maine Turnpike Authority, Maine Maritime Academy, the Technical College System and union employees.

3 FY91

4 Health expenditures for inmates and juveniles, includes pharmacy, optical, dental For FY91.

5 Health expenditures for clients not otherwise covered. Estimate provided by the Department

6 State share and Robert Wood Johnson Foundation Grant.

CHARGE FROM THE LEGISLATIVE COUNCIL
TO THE JOINT SELECT COMMITTEE TO STUDY
THE FEASIBILITY OF A STATEWIDE HEALTH INSURANCE PROGRAM

Resolve, to Study the Feasibility of a Statewide Health Insurance Program

Sec. 1. Joint select committee. Resolved: That the Legislative Council establish the Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program; and be it further

Sec. 2. Select committee membership. Resolved: That the Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program consists of the members of the Joint Standing Committee on Banking and Insurance and 3 adjunct members, appointed jointly by the President of the Senate and the Speaker of the House of Representatives. The President of the Senate and the Speaker of the House of Representatives shall notify the Executive Director of the Legislative Council upon making their appointments; and be it further

Sec. 3. Duties. Resolved: That the joint select committee shall study and make recommendations on the feasibility of a statewide health insurance system that would include all Maine residents. The committee shall study developing all components of the present system of health insurance, its strengths and weaknesses, ways in which the system may be made more efficient and how or whether more universal coverage should be obtained. The committee shall study the following:

1. The existing levels and availability of insurance coverage for citizens of the State;

2. The availability of insurance coverage during employment changes, unemployment, illnesses, travel or temporary absences and after injury;

3. The feasibility of cost control through public accountability and negotiations with providers to achieve greater efficiency and improve quality of care;

4. Those aspects of the present system of health insurance that are efficient components of a comprehensive system of coverage; and

5. Whether the current mechanisms for financing health care financing are appropriate and could be expanded to provide coverage for persons who are uninsured.

6. Whether a more comprehensive and coordinated system could be implemented by:

A. Consolidating all of the present sources of funding requiring waivers or approval from federal sources such as Medicare, Medicaid, Champus, maternal and child health block grants and substance abuse block grant;

B. Consolidating state programs including the Maine Health Program, the Managed Care Insurance Plan Demonstration ("Robert Wood Johnson"), the High Risk Insurance Program, premium tax substance abuse programs, specific disease programs such a diabetes and heart education projects; and

C. Utilizing finance mechanisms that are income-based and permit all citizens to have access to health care coverage without placing a disproportionate burden on any individual or group of payors.

Sec. 4. Meeting; report. Resolved: That the joint select committee shall hold hearings in several regions of the State to provide for public testimony, shall report to the Second Regular Session of the 115th Legislature no later than February 1, 1992 and shall submit any necessary implementing legislation no later than November 1, 1992; and be it further

Sec. 5. Powers. Resolved: That the joint select committee may receive grants and hire consultants subject to provisions of section 7. Staff assistance and information may be provided as necessary by the Legislative Council except that staff assistance may not be provided while the Legislature is in session. Consultation and information must be provided as required by the Department of Human Services and the Department of Professional and Financial Regulation; and be it further

Sec. 6. Reimbursement. Resolved: That members of the joint select committee are entitled to legislative per diem and expenses for the days of attendance at committee meetings upon request from the Executive Director of the Legislative Council. The Executive Director of the Legislative Council shall administer the budget of the joint select committee; and be it further

Sec. 7. Funding. Resolved: That the Legislative Council may seek funding from outside sources to finance the joint select committee established in this resolve. The Legislative Council may authorize the joint select committee to develop funding proposals. The Executive Director of the Legislative Council shall review and approve any proposal before its

submission to a funding source. Before approving a funding source, the Legislative Council shall examine whether accepting funds from this source will risk the appearance of undue influence or actual undue influence upon the study. If the Legislative Council determines that accepting funds from the source will cause this risk, the Legislative Council may not approve the funding source. The Legislative Council shall administer any outside funds acquired for the conduct of the study. Administration of these funds includes the authorization for the Executive Director of the Legislative Council to approve or disapprove any contract for assistance to the study in accordance with guidelines adopted by the Legislative Council; and be it further

Sec. 8. Allocation. Resolved: That the following funds are allocated from Other Special Revenue to carry out the purposes of this resolve.

Sec. 9. Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

LEGISLATURE	1991-92
Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program	
Personal Services	$7,040
All Other	6,880

Provides funding for the Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program for the per diem and expenses for members, printing and advertising costs and other meeting expenses.

(EMERGENCY)

FIRST REGULAR SESSION

ONE HUNDRED AND SIXTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY THREE

An Act to Implement the Recommendations of the Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, it is estimated that as many as 136,300 Maine citizens lack health insurance and that over 200,000 of the State's citizens are underinsured; and

Whereas, the State's health spending per capita increased 150% from 1980 to 1990, ranking Maine 5th highest in the nation and per capita spending is expected to increase 2.3 times by the year 2000 if the current trend continues; and

Whereas, uncompensated care costs from the growing numbers of Maine's uninsured are being shifted onto a shrinking number of insured consumers, workers and businesses in Maine; and

Whereas, a disproportionate segment of health insurance costs and health care costs are directly attributable to administrative inefficiency, burdening Maine businesses, providers and consumers with avoidable costs; and

Whereas, the State's health care for all its citizens scores on quality indices below societies spending less and providing universal, comprehensive health insurance systems for all citizens; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

PART A

Sec. A-1. 24-A MRSA §2808, sub-§1, ¶A is amended to read:

A. The policyholder is a bona fide group ~~formed for purposes other than procurement of insurance~~;

Sec. A-2. 24-A MRSA §2808, sub-§ 5 and 6 is enacted to read:

5. A group formed pursuant to this section for the purpose of purchasing insurance is subject to the provisions of 24-A MRSA §2808-B.

6. A municipality may assist its residents in the formation of a group under this section and in the administrative work necessary to accomplish the ongoing purchase of the insurance.

PART B

Sec. B-1. 24-A MRSA §2736-C is enacted to read:

§2736-C. Community rating

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

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate

organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

B. "Community rate" means the rate to be charged to all eligible individuals for health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D.

C. "Premium rate" means the rate charged to an individual for a health plan.

D. "Health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. "Health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment; or

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance.

2. Rating practices. The following requirements apply to the rating practices of carriers providing health plans.

A. A carrier issuing a health plan after the effective date of this section must file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent for informational purposes prior to issuance of any health plan.

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the individual.

C. A carrier may vary the premium rate due to family status, smoking status and participation in wellness programs.

D. A carrier may vary the premium rate due to age, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands:

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and July 14, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1996 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1997, the premium rate may not deviate from the community rate filed by the carrier.

Unless continued or modified by law, this paragraph is repealed on July 15, 1994.

3. Guaranteed issuance and guaranteed renewal. Carriers providing health plans must meet the following requirements on issuance and renewal.

A. Coverage must be guaranteed to all individuals.

B. Renewal must be guaranteed to all individuals except:

(1) For nonpayment of the required premiums by the policyholder or contract holder;

(2) For fraud or material misrepresentation by the policyholder or contract holder;

(3) For fraud or material misrepresentation on the part of the individual or the individual's representative; and

(4) When the carrier ceases providing health plans in compliance with subsection 4.

4. Cessation of business. Carriers that provide health plans after the effective date of this section that plan to cease doing business in the health plan market must comply with the following requirements.

A. Notice of the decision to cease doing business in that market must be provided to the bureau and to the policyholder or contract holder 6 months prior to nonrenewal.

B. Carriers that cease to write new business in that market continue to be governed by this section with respect to business conducted under this section.

C. Carriers that cease to write new business in that market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent.

5. Fair marketing standards. Carriers providing health plans must meet the following standards of fair marketing.

A. Each carrier must actively market health plan coverage to individuals in this State.

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

(1) Encouraging or directing individuals to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; and

(2) Encouraging or directing individuals to seek coverage from another carrier because of any of the rating factors listed in subsection 2.

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of a health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2.

D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2.

E. Denial by a carrier of an application for coverage from an individual must be in writing and must state the reason or reasons for the denial.

F. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of health plans in this State.

G. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier.

6. Applicability. This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

Sec. B-2. 24-A §2808-B, sub-§1, ¶¶D and H are amended to read:

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that during at least 50% of its working days in the preceding calendar quarter employed fewer than ~~25~~ 50 eligible employees, the majority of whom are employed

within the State. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer. In the calculation of carrier percentage participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation.

H. "Subgroup" means an employer with fewer than ~~25~~ 50 employees within an association or a multiple employer trust or any similar subdivision of a larger group covered by a single group health policy or contract.

Sec. B-3. 24-A MRSA §2808-B, sub-§2 ¶¶ B and D are amended to read:

2. Rating practices. The following requirements apply to the rating practices of carriers providing small group health plans.

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the eligible group or members of the group.

D. A carrier may vary the premium rate due to age, ~~gender,~~ occupation or industry, and geographic area only under the following schedule and within the listed percentage bands:

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and July 14, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1996 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1997, the premium rate may not deviate from the community rate filed by the carrier.

Unless continued or modified by law, this paragraph is repealed on July 15, 1994.

PART C

Sec. C-1. 24-A MRSA §238 is enacted to read:

§238. Data collection

The Bureau of Insurance shall establish a data collection program to collect data on health insurance which will make possible the examination and analysis of information which distinguishes health, disability, medicare supplement and other policies, individual policies from group policies, policies issued to persons age 65 and older from other policies, policies which offer primary care case management from traditional policies, and Maine data from national data.

PART D

Sec. D-1. 24 MRSA §2347, sub-§1 is amended to read:

§2347. Continuity on replacement of group contract

1. Contracts subject to this section. Notwithstanding any other provision of law, this section applies to all individual and group contracts, except group long-term care policies as defined in Title 24-A, section 5051, issued by nonprofit hospital or medical service organizations to contract holders who are obtaining coverage individually or for a group or subgroup to replace coverage under a different contract or policy issued by any self-insurer, insurer, health maintenance organization or nonprofit hospital or medical service organization. For purposes of this section, the individual or

group contract issued to replace the prior contract or policy is the "replacement contract." The group contract or policy being replaced is the "replaced contract or policy."

Sec. D-2. 24 MRSA §2349 is amended to read:

§2349. Continuity of coverage for individual who changes groups

1. Contracts subject to this section. This section applies to all individual policies and group contracts issued by nonprofit hospital or medical service organizations, except group long-term care policies as defined in Title 24-A, section 5051.

2. Persons provided continuity of coverage. Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under an individual policy or group nonprofit hospital or medical service organization contract if:

A. That person was covered under an individual or group contract or policy issued by any self-insurer, insurer, health maintenance organization, nonprofit hospital or medical service organization, or governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, and the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072, Subsection 4. For purposes of this section, the individual policy or group contract under which the person is seeking coverage is the "succeeding contract." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding contract. A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. For purposes of this section, a "late enrollee" is a person who requests enrollment under an individual policy or in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or

policy and the individual did not request coverage initially under the succeeding contract because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment, termination of the individual or group policy or group contract under which the individual was covered, death of a spouse or divorce; or

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order.

4. Prohibition against discontinuity. Except as provided in this section, in an individual policy or a group contract subject to this section, a nonprofit hospital or medical service organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if that contract or policy were still in effect. The issuer of the succeeding contract is not required to duplicate any benefits covered by the issuer of the prior contract or policy.

5. Determination of benefits. When a determination of benefits under the prior contract or policy is required, the issuer of the prior contract or policy shall, at the request of the issuer of the succeeding contract, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the issuer of the succeeding contract. For purposes of this section, benefits of the prior contract or policy are determined in accordance with the definitions, conditions and covered expense provisions of that contract or policy rather than those of the succeeding contract. The benefit determination must be made as if coverage had not been replaced.

6. Limit on premium increase. For rating purposes, a nonprofit hospital or medical service organization may not charge claims for preexisting conditions of a person subject to this section, during the first 12 months of employment of that person, directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. Any additional claims may be pooled among all such groups and subgroups covered by that nonprofit hospital or medical service organization. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

7. Reinsurance, excess insurance or administrative services. A nonprofit hospital or medical service organization providing reinsurance, excess insurance coverage or administrative services to a plan for the payment of health services by an employer to a group of employees shall provide that the plan meet the requirements of continuity of coverage for a group health insurance policy in this section.

Sec. D-3. 24-A MRSA §2849 is amended to read:

§2849. Continuity on replacement of group policy

1. Policies subject to this section. Notwithstanding any other provision of law, this section applies to all individual and group medical insurance policies issued by insurers or health maintenance organizations to policyholders who are obtaining coverage individually or for a group or subgroup to replace coverage under a different contract or policy issued by any nonprofit hospital or medical service organization, self-insurer, insurer or health maintenance organization. For purposes of this section, the individual or group policy issued to replace the prior contract or policy is the "replacement policy." The group contract or policy being replaced is the "replaced contract or policy."

2. Persons provided continuity of coverage under this section. This section provides continuity of coverage to persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy.

3. Prohibition against discontinuity. In a replacement policy subject to this section, an insurer or health maintenance organization may not, for any person described in subsection 2:

A. Request that the person provide or otherwise seek to obtain evidence of individual insurability. This in no way limits the insurer's right to require information concerning the health of the individuals in the group to determine whether the group as a whole is insurable or to determine rates for the group as a whole;

B. Decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; or

C. Impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section.

4. Persons covered for fewer than 90 continuous days. Notwithstanding subsection 3, a person who was covered under the replaced contract or policy for fewer than 90 continuous days may be subject to a preexisting condition exclusion or waiting period in the replacement policy, provided the period is not longer than 90 days, and credit is given for satisfaction or partial satisfaction of the same or similar provisions under the replaced contract or policy.

5. Liability after discontinuance. The nonprofit hospital or medical service organization, self-insurer, insurer or health maintenance organization that issued the replaced contract or policy is liable after discontinuance of that contract or policy only to the extent of its accrued liabilities and extensions of benefits.

Sec. D-4. 24-A MRSA §2849-B is amended to read:

§2849-B. Continuity for individual who changes groups

1. Policies subject to this section. This section applies to all individual and group medical insurance policies issued by insurers or health maintenance organizations.

2. Persons provided continuity of coverage. Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under an individual or group self-insurance, insurance or health maintenance organization policy if:

A. That person was covered under an individual or group contract or policy issued by any nonprofit hospital or medical service organization, self-insurer, insurer, health maintenance organization, or governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, or the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072, Subsection 4. For purposes of this section, the individual or group policy under which the person is seeking coverage is the "succeeding policy." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding policy. A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. For purposes of this section, a "late enrollee" is a person who requests enrollment in an individual or group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract or policy because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment, termination of the individual or group policy or group contract under which the individual was covered, death of a spouse or divorce; or

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order.

4. Prohibition against discontinuity. Except as provided in this section, in an individual or group policy subject to this section, an self-insurer, insurer or health maintenance organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

5. Determination of benefits. When a determination of benefit under the prior contract or policy is required, the issuer of the prior contract or policy shall, at the request of the issuer of the succeeding policy, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the issuer of the succeeding policy. For purposes of this section, benefits of the prior contract or policy are determined in accordance with the definitions, conditions and covered expense provisions of that contract or policy rather than those of the succeeding policy. The benefit determination must be made as if coverage had not been replaced.

6. Limit on premium increase. For rating purposes, an insurer or health maintenance organization may not charge claims for preexisting conditions of any person subject to this section, during the first 12 months of employment of that

person, directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. The insurer or health maintenance organization may pool any additional claims among all such groups and subgroups covered by that insurer or health maintenance organization. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

7. Reinsurance, excess insurance or administrative services. An insurer providing reinsurance, excess insurance coverage or administrative services to a plan for the payment of health services by an employer to a group of employees shall provide that the plan meet the requirements of continuity of coverage for a group health insurance policy in this section.

PART E

Sec. E-1. 24 MRSA chapter 21, subchapter X, Health Care Providers is enacted to read:

Subchapter X
Health Care Providers

§2981. Health care fees

The charges for common office services provided by a health care provider must be posted in a conspicuous place in the office of the health care provider.

§2982. Referrals by physicians prohibited

1. Prohibited referrals. A physician who has an ownership or investment interest in a diagnostic laboratory or facility, clinical laboratory, physical therapy center or comprehensive rehabilitation center located outside the office of the physician may not refer patients to such laboratory, facility or center.

2. Ownership or investment interest. For the purposes of this section, an ownership or investment interest in a diagnostic laboratory or facility, clinical laboratory, physical therapy center or comprehensive rehabilitation center exists whenever, with regard to the laboratory, facility or center, a physician or a member of a physician's immediate family directly or indirectly:

A. Is a general partner, officer, director or employer;

B. Has contributed capital; or

C. Owns, controls or has power to vote.

§2983. Health provider bargaining

Notwithstanding any other provision of the law, health care providers who choose to participate may join together to negotiate the reimbursement rate for Medicaid services.

PART F

Sec. F-1. 22 MRSA §304-A, sub-§2, as amended by PL 1987, c. 363, §§1 and 2, is repealed and the following enacted in its place:

2. Acquisitions of certain major medical equipment. Acquisitions of major medical equipment with a cost of $1,000,000 or more. There is a waiver for the use of major medical equipment on a temporary basis as provided in section 308, subsection 4;

Sec. F-2. 22 MRSA §304-A, sub-§2-A is enacted to read:

2-A. Establishment of independent medical centers. Establishment of independent medical centers, acquiring major medical equipment with a cost in the aggregate of $1,000,000 or more, including, but not limited to, independent ambulatory surgical centers, independent catheterization centers and independent radiologic service centers;

Sec. F-3. 22 MRSA §396-K, sub-§3, as amended by PL 1991, c. 84, §3, is further amended to read:

3. Certificate of Need Development Account. For the 3rd and subsequent payment year cycles, the commission shall establish a ~~Hospital~~ Certificate of Need Development Account to support the development of hospital facilities and services and nonhospital facilities using major medical equipment that receive certificates of need pursuant to section 304-A. This account ~~shall~~ must be administered as follows.

A. The commission shall annually establish, by rule, the amount to be credited to the ~~Hospital~~ Certificate of Need Development Account. In establishing the amount of the credit, the commission shall, at a minimum, consider:

(1) The State Health Plan;

(2) The ability of the citizens of the State to underwrite the additional costs;

(3) The limitations imposed on payments for new facilities and services by the Federal Government pursuant to the United States Social Security Act, ~~Title~~ Titles XVIII and XIX;

(4) The special needs of small hospitals;

(5) The historic needs and experience of hospitals and other facilities subject to this account over the past 5 years;

(6) The amount in the account for the previous years and the level of utilization ~~by hospitals~~ in those years;

(7) Obsolescence of physical plants;

(8) Technological developments; and

(9) Management services or other improvements in the quality of care.

The commission shall report, no later than January 15th of each year, to the joint standing committee of the Legislature having jurisdiction over human resources regarding the rationale the commission used in establishing the amount credited to the ~~Hospital~~ Certificate of Need Development Account in the previous year.

The amount to be credited in a particular payment year cycle will be deemed credited to the ~~Hospital~~ Certificate of Need Development Account as of the first day of that payment year cycle.

B-1. On the basis of additional information received after an annual credit is established pursuant to paragraph A, including information provided by the department concerning the State Health Plan or projects then under review, the commission may by rule increase or decrease the amount of the annual credit during the course of the payment year cycle to which it applies. The commission may not act under this paragraph to decrease the credit below the amount that would, in combination with any amounts carried over from prior years, equal the total of any debits associated with projects approved on or before the date that the commission notifies the department of a proposed rule that would decrease the credit. For any payment year cycle in which the annual

credit is apportioned to "statewide" and "individual hospital" components, the increase or decrease authorized by this paragraph ~~shall apply~~ applies solely to the "statewide" component of the credit.

C. The commission shall approve an adjustment to a hospital's financial requirements under section 396-D, subsection 5, paragraph A, for a major or minor project if:

(1) The project was approved by the department under the Maine Certificate of Need Act; and

(2) The associated incremental annual capital and operating costs do not exceed the amount remaining in the ~~Hospital~~ Certificate of Need Development Account as of the date of approval of the project by the department, after accounting for previously approved projects.

F. Debits and carry-overs ~~are~~ must be determined as follows.

(1) Except as provided in subparagraph (2), the commission shall debit against the ~~Hospital~~ Certificate of Need Development Account the full amount of the incremental annual capital and operating costs associated with each project for which an adjustment is approved under paragraph C and with each project for which certificate of need approval has been granted pursuant to section 304-A, subsection 2. Incremental annual capital and operating costs ~~are~~ must be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 5, for the 3rd year of implementation of the ~~project~~ projects subject to such an adjustment. For acquisitions of equipment by persons other than hospitals, incremental annual capital and operating costs must be determined in a manner consistent with the manner in which project costs are determined for hospitals.

(2) In the case of a project ~~which~~ that is approved under paragraph C and ~~which~~ that involves extraordinary incremental annual capital and operating costs, the commission may, in accordance with duly promulgated rules, defer the debiting of a portion of the annual costs associated with the project until a subsequent payment year cycle or cycles.

(3) Amounts credited to the ~~Hospital~~ Certificate of Need Development Account for which there are no debits

~~are~~ must be carried forward to subsequent payment year cycles as a credit.

PART G

Sec. G-1. 5 MRSA §1543, first paragraph is amended to read:

~~No money shall~~ Money may not be drawn from the State Treasury, except in accordance with appropriations duly authorized by law. Every disbursement from the State Treasury ~~shall~~ must be upon the authorization of the State Controller and the Treasurer of State, as evidenced by their facsimile signatures, except that the Treasurer of State may authorize interbank and intrabank transfers for purposes of pooled investments. Disbursements ~~shall~~ must be in the form of a check or an electronic transfer of funds against a designated bank or trust company acting as a depository of the State Government.

PART H

Sec. H-1. 24 MRSA §2979 is enacted to read:

§2979. Expanded practice parameters; expanded risk management protocols

The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration may develop practice parameters and risk management protocols in the medical specialty areas not listed in section 2972. The practice parameters must define appropriate clinical indications and methods of treatment within that specialty. The risk management protocols must establish standards of practice designed to avoid malpractice claims and increase the defensibility of the malpractice claims that are pursued. The parameters and protocols must be consistent with appropriate standards of care and levels of quality. The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration shall review the parameters and protocols, approve the parameters and protocols appropriate for each medical specialty area and adopt them as rules in accordance with the Maine Administrative Procedure Act.

All practice parameters and risk management protocols adopted pursuant to this section are subject to the provisions of sections 2373 through 2378.

PART I

Sec. I-1. 20-A MRSA §12101, subsection 10 is repealed.

Sec. I-2. 20-A MRSA §12104, sub-§5, paragraph A is amended to read:

5. Loan agreement. The student shall enter into a loan agreement that provides for the following.

A. Upon completion of professional education the student shall repay the loan in accordance with the following schedule.

(1) A loan recipient who does not obtain loan forgiveness pursuant to this section shall repay the entire principal portion of the loan plus simple interest at a rate to be determined by rule of the authority. Interest does not begin to accrue until the loan recipient completes medical education, including residency and internship. The authority may establish differing interest rates to encourage loan recipients to practice primary health care medicine in the State.

(2) Primary health care physicians and dentists practicing in a designated health professional shortage area~~, any physician practicing in an underserved specialty~~ or any physician providing services to a designated underserved group are forgiven the larger of 25% of the original outstanding indebtedness plus any accrued interest or $7,500 for each year of practice.

(3) Veterinarians providing services to Maine residents with insufficient veterinary services are forgiven the larger of 25% of the original outstanding indebtedness plus any accrued interest or $7,500 for each year of practice.

(4) Any student electing to complete an entire residency at any family practice residency program in the State is forgiven 50% of the original outstanding indebtedness for each year of practice in a designated health professional shortage area ~~or as a physician practicing in an underserved specialty~~ or as a physician providing services to an underserved group.

Sec. I-3. 20-A MRSA §12107 is amended to read:

§12107. Rules

The authority shall establish rules necessary to implement this chapter. The Commissioner of Human Services shall develop rules for determining health professional shortage areas for the practice of primary health care medicine and dentistry, for determining the reasonableness of the service provided by loan recipients to Medicaid and Medicare patients and participation by loan recipients in public health clinics, and for determining underserved groups ~~and for determining underserved specialties~~. The Commissioner of Agriculture, Food and Rural Resources shall develop rules for the determination of insufficient veterinary services. The rules authorized by this section must be adopted in accordance with Title 5, chapter 375, subchapter II.

PART J

Sec. J-1. 32 MRSA §1082 is amended to read:

§1082. Qualifications

Before receiving a certificate to practice dentistry in this State, a person shall be at least 18 years of age and shall be a graduate of or have a diploma from an acceptable dental college, school or dental department of a domestic or foreign university approved by the board.

PART K

Sec. K-1. 22-B MRSA is enacted to read:

TITLE 22-B

HEALTH

PART 1

ADMINISTRATION AND ORGANIZATION

CHAPTER 1

DEPARTMENT OF HEALTH

§101. Definitions

As used in this Part, unless the context otherwise indicates, the following terms have the following meanings.

1. Commissioner. "Commissioner" means the Commissioner of Health.

2. Department. "Department" means the Department of Health within the executive branch responsible for administering multiple major programs and multimillion dollar budgets to provide health services pursuant to provisions of state and federal laws.

§102. Department established

The Department of Health is established within the executive branch to provide health services to the citizens in this State.

§103. Commissioner

1. Appointment. The department is administered by a commissioner who is appointed by the Governor subject to review by the joint standing committee of the Legislature having jurisdiction over health matters and confirmation by the Legislature. The commissioner serves at the pleasure of the Governor.

2. Qualifications. The commissioner must be qualified by postgraduate education and extensive experience in the fields of health and public administration, including public policy analysis and development, public financial and program administrative matters and legislative and executive branch relations.

3. Application. Notwithstanding the establishment of the department in this Part, the department may not undertake

administration of programs or services until the legislation developed by the Commission on the Establishment of the Department of Health is adopted.

Sec. K-2. Acting commissioners. Until the legislation proposed by the Commission on the Establishment of the Department of Health is enacted, the Commissioner of Human Services is the Acting Commissioner of Health.

Sec. K-3. Reorganization of health services. It is the intent of the Legislature that by July 1, 1994 the Department of Health be created, having as its jurisdiction health services currently performed by other state departments, including but not limited to the Department of Human Services, the Department of Mental Health and Mental Retardation and the Office of Substance Abuse. The establishment of this new department must be accomplished without diverting any direct service funds or incurring additional administrative costs.

Sec. K-4. Commission on the Establishment of the Department of Health.

1. Commission established. The Commission on the Establishment of the Department of Health, referred to in this section as the "commission," is established and consists of 13 members of the Legislature, including 3 Senators appointed by the President of the Senate and 10 members of the House of Representatives appointed by the Speaker of the House of Representatives as follows:

A. Two members of the Joint Standing Committee on Appropriations and Financial Affairs;

B. Two members of the Joint Standing Committee on Banking and Insurance

C. Four members of the Joint Standing Committee on Human Resources;

D. Two members of the Joint Standing Committee on State and Local Government; and

E. Three additional members of the Legislature.

Each appointing authority shall ensure that the composition of appointees from the authority's chamber reflects the proportion of majority and minority parties in that chamber. All members must be appointed by July 1, 1993. The commission is abolished on January 1, 1994.

2. Convening of commission; election of chair. The Chair of the Legislative Council shall call the first meeting of the

commission within 30 days of the appointment of all commission members and in no case later than August 1, 1993. At that meeting, the commission shall select a chair from among its members.

3. Working groups. The chair of the commission may form working groups on an ad hoc basis to develop legislative proposals to the full commission. A working group must consist of at least 3 members who are Legislators and who are members of the commission in addition to any other persons the chair may appoint as nonvoting members of the working group.

4. Staff. The commission may request staffing assistance within existing resources from the Legislative Council.

5. Cooperation from departments. All officials of the executive branch agencies affected by this Act shall provide information, advice and assistance to the commission upon request.

6. Compensation. The members of the commission are not entitled to the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2.

7. Budget. The Executive Director of the Legislative Council shall administer the commission's budget.

8. Commission charged. The commission shall develop, with the advice and assistance of officials of the executive branch, all legislation needed to implement the reorganization of services in accordance with this Act, including amendments to the statutes, reallocation of funds and transitional language as needed. The legislation, together with a report identifying specific positions that are added or deleted as a result of the reorganization, must be presented to the joint standing committee of the Legislature having jurisdiction over state and local government matters by November 1, 1993 for consideration during the Second Regular Session of the 116th Legislature.

9. Content of legislation. The legislation prepared by the commission must provide for at least the following:

A. Creation of the Department of Health with at least the following functional clusters: public health; medical care finance; substance abuse; mental health; developmental services and physical disability; and aging.

(1) The public health cluster includes, but is not limited to:

(a) All functions of the Department of Human Services, Bureau of Health;

(b) All functions of the Department of Human Services' division of health planning;

(c) All functions of the Department of Human Services, Office of Vital Statistics; and

(d) All AIDS case management and other AIDS-related services.

(2) The medical care finance cluster includes, but is not limited to:

(a) All functions of the Department of Human Services, Bureau of Medical Services

(3) The substance abuse cluster includes, but is not limited to:

(a) All functions of the Executive Department, Office of Substance Abuse.

(4) The mental health cluster includes, but is not limited to:

(a) All adult services provided by the Department of Mental Health and Mental Retardation, Bureau of Mental Health; and

(b) The Bangor Mental Health Institute and the Augusta Mental Health Institute.

(5) The developmental services and physical disability cluster includes, but is not limited to:

(a) All adult services provided by the Department of Mental Health and Mental Retardation, Bureau of Mental Retardation, except guardianship services;

(b) The Aroostook Residential Center and Pineland Center; and

(c) All services from the Department of Human Services, Bureau of Rehabilitation, except services for people with visual impairments, and services related to job training and placement.

(6) The aging cluster includes, but is not limited to:

(a) All functions of the Department of Human Services, Bureau of Elder and Adult Services; and

(b) All adult protection and adult guardianship functions;

B. Creation of a universal information and referral system for all health services to be phased in as funds become available; and

C. A single case management system responsive to unique consumer needs within the department.

PART L

Sec. L-1. Report on Multiple Employer Welfare Arrangements. The Bureau of Insurance shall study the regulation of fully and partially insured Multiple Employer Welfare Arrangements under section 514(b)(6)(A) of the Employment Retirement Income Security Act of 1974 and shall submit a report and implementing legislation to the joint standing committee having jurisdiction over banking and insurance matters on or before March 1, 1993.

Sec. L-2. Report on preexisting conditions exclusion periods. The Bureau of Insurance shall undertake a study and shall report to the joint standing committee having jurisdiction over banking and insurance matters on or before March 1, 1993 on the length of time of preexisting condition exclusion periods, including the option of making the period run for a minimum time period of 3 months and a maximum time period corresponding to the length of time a person is eligible to receive unemployment compensation.

Sec. L-3. State Medicaid Plan amendment. By July 1, 1993, the Department of Human Services shall submit for approval to the appropriate federal authorities an amendment to the State Medicaid Plan to provide Medicaid coverage to pregnant women and infants on a sliding fee scale from 185% to 285% of the Federal Poverty Level. The Department shall devise the sliding fee scale in a manner that raises sufficient funds from consumers to provide all of the State financial match for the services proposed under this section.

Sec. L-4. Standardized billing forms, instructions and procedures for completion. The Bureau of Insurance is directed to work cooperatively with the Department of Health and Human Services and agencies in other states toward the development of

standardized billing forms, instructions and procedures for completion of the forms.

Sec. L-5. Examination of barriers to electronic billing and payment. The Department of Human Services and the Bureau of Insurance are directed to examine the barriers to increasing the rate of standardized electronic billing and payment in the Medicaid, Maine Health Program and other programs administered by the Bureau of Medical Services.

Sec. L-6. Report on medical malpractice rate setting. The Superintendent of Insurance shall review and report to the joint standing committee having jurisdiction over banking and insurance matters on or before March 1, 1993 on the current rate setting procedures for medical malpractice insurance.

Sec. L-7. Report on medical malpractice screening panels and dispute resolution systems. The Superintendent of Insurance is directed to review the arbitration panels for medical malpractice established in Vermont in 12 V.S.A. §7001 et seq. and the mandatory prelitigation screening and mediation panels established in 24 MRSA §2852 et seq. The Superintendent of Insurance is directed to consult with interested parties, including but not limited to consumers, trial attorneys and physicians, to develop a proposal for a non-adversarial dispute resolution system for addressing smaller claims. A preliminary report must be submitted to the joint standing committee having jurisdiction over banking and insurance matters as soon as possible. A final report containing implementing legislation must be submitted by March 1, 1993.

Sec. L-8. Special Committee to Study Health Care Professions. There is established a special committee to study health care professions, composed of 6 legislators and 3 members of the public for the purpose of studying the allocation of human and financial resources in health care.

Membership. The Speaker of the House of Representatives shall appoint 3 members of the House of Representatives. The President of the Senate shall appoint 3 members of the Senate. The Governor shall appoint 3 members to represent the interests of the public. All appointments must be made within 30 days of the effective date of this section.

Meetings. The President of the Senate shall convene the first meeting of the committee, at which the members shall appoint a chair and vice-chair.

Duties and report. The committee shall complete a study and report back to the joint standing committee having jurisdiction over banking and insurance matters on or before January 1, 1994 on the issue of the qualifications and full

utilization of health care professionals, identifying the legal barriers to appropriate utilization and the extent to which health policies determine health care policy, the degree to which health care professionals drive the system and the effect of full and partial participation of health care professionals in health care programs funded by the public sector. The committee may request staff assistance as necessary from the Legislative Council.

Sec. L-9. Information on federal health insurance earned income tax credit. The Bureau of Insurance and the Department of Taxation are directed to work together to publish and distribute information for the public on the federal health insurance earned income tax credit.

Sec. L-10. Report on unification of administration of all publicly funded and publicly administered health insurance programs. The Department of Human Services is directed to report to the joint standing committee having jurisdiction over banking and insurance matters on or before March 1, 1993 on options for the unification of administration of all publicly funded and publicly administered health insurance programs.

Sec. L-11. Report on single point of entry/eligibility determinations. The Department of Human Services is directed to report to the joint standing committee having jurisdiction over banking and insurance matters on or before March 1, 1993 on single point of entry/eligibility determinations utilizing the FAMIS computer system.

Sec. L-12. Report on the feasibility of combining the medical portion of automobile insurance and health insurance. The Bureau of Insurance is directed to report to the joint standing committee having jurisdiction over banking and insurance matters on or before January 1, 1994 on the feasibility of combining the medical portion of automobile insurance and health insurance.

STATEMENT OF FACT

1. Part A allows groups to be formed to purchase health insurance and subjects such groups to the community rating law (PL 1991, c. 861). It allows municipalities to assist citizens in the purchase of health insurance.

2. Part B expands the community rating law (PL 1991, c. 861) by making it applicable to individual policies and to employee groups of fewer than 50 employees and by prohibiting gender-based rating.

3. Part C requires the Bureau of Insurance to collect insurance data which distinguishes health from other policies, policies sold to people age 65 and over from policies sold to people younger than 65, disability policies from other policies, policies offering primary care case management from other policies, individual policies from group policies and Maine data from national data.

4. Part D applies the continuity law (24-A MRSA c. 36) to persons moving from group to individual policies, to persons who are leaving their jobs with self-insured employers for new jobs, thus changing from the health plan of the self-insured employers to group or individual insurance policies and it applies the continuity law to persons moving from individual or group policies to self-insured employers with health plans that utilize reinsurance policies.

5. Part E requires health care providers to post in their offices the charges for common office services. It prohibits a physician who has an ownership or investment interest in a diagnostic laboratory or facility, clinical laboratory, physical therapy center or comprehensive rehabilitation center located outside the office of the physician from referring patients to the laboratory, facility or center. It allows health care providers to join together to negotiate the reimbursement rate for Medicaid services.

6. Part F expands the certificate of need (CON) requirements to physician offices for equipment of $1 million or more.

7. Part G amends the law that currently prohibits funds from being transmitted electronically to providers.

8. Part H authorizes the Board of Registration in Medicine and the Board of Osteopathic Examination and Registration to expand work on practice parameters, approving them and adopting them as rules. The new parameters and protocols are subject to the provisions of Title 24, sections 2373 to 2378.

9. Part I removes "underserved specialty" as eligible service and reemphasize primary care in underserved areas in the Health Professions Loan Program.

10. Part J allows the licensing of foreign-trained dentists by the Board of Dental Examiners.

11. Part K establishes a State of Maine Department of Health and establishes the Commission on the Establishment of the Department of Health to plan for the new agency.

12. Part L-1 Direct the Bureau of Insurance to study the feasibility of a regulatory scheme for Multiple Employer Welfare Arrangements (MEWA's) that are not fully insured and to submit its report, along with implementing legislation, to the Joint Standing Committee on Banking and Insurance by March 1, 1993.

13. Part L-2 directs the Bureau of Insurance and the Department of Labor to submit a report to the Banking and Insurance Committee by March 1, 1993, on the question of making the pre-existing condition exclusion period run for at least 3 months and up to the period of a person's eligibility for unemployment compensation.

14. Part L-3 directs the Department of Human Services to amend the State Medicaid Plan to cover pregnant women and children who are not receiving cash assistance on a sliding fee scale up to 285% of the federal poverty level.

15. Part L-4 directs the Superintendent of Insurance to work cooperatively with the federal government and other states toward the development of standardized billing forms, instructions and procedures for the completion of the forms.

16. Part L-5 directs the Department of Human Services and the Bureau of Insurance to examine barriers to increasing the rate of standardized electronic billing in the Medicaid, Maine Health Program and other programs administered by the Bureau of Medical Services.

17. Part L-6 directs the Superintendent of Insurance to examine Maine's current rate setting procedures for medical malpractice insurance and to report to the Joint Standing Committee on Banking and Insurance by March 1, 1993.

18. Part L-7 directs the Superintendent of Insurance to review Vermont's medical malpractice arbitration system and Maine's medical malpractice screening panels and propose a non-adversarial dispute resolution system for addressing smaller claims. The proposal must be developed in consultation with all interested parties, including but not limited to consumers, trial attorneys and physicians. A report to the Joint Standing Committee on Banking and Insurance is due March 1, 1993, containing the review and legislation. A preliminary report is due as soon as possible.

19. Part L-8 establishes a Special Committee to Study Health Care Professions, comprised of 6 legislators and 3 public members to study the allocation of human and financial resources in health care. The committee is charged with completing its study and reporting back to the Banking and Insurance Committee on January 1, 1994.

20. Part L-9 directs the Bureau of Insurance, in cooperation with the Department of Taxation, to put together information on the federal health insurance earned income tax credit for distribution to consumers.

21. Part L-10 directs the Department of Human Services to report by March 1, 1993 to the Banking and Insurance Committee the options for unifying the administration of all health insurance programs that are publicly funded or publicly administered.

22. Part L-11 directs the Department of Human Services to report by March 1, 1993 to the Banking and Insurance Committee on single point of entry/ eligibility determinations utilizing the FAMIS computer system.

23. Part L-12 directs the Bureau of Insurance to report to the joint standing committee having jurisdiction over banking and insurance matters on or before January 1, 1994 on the feasibility of combining the medical portion of automobile insurance and health insurance.

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