MAINE STATE LEGISLATURE

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State Of Maine
121st Legislature

First Regular Session

Bill Summaries

Joint Standing Committee on Insurance and Financial Services

July 2003

Members:
Sen. Lloyd P. LaFountain III, Chair
Sen. Neria R. Douglass
Sen. Arthur F. Mayo III

Rep. Christopher P. O'Neil, Chair
Rep. Marilyn E. Canavan
Rep. Joseph C. Perry
Rep. Bonita J. Breault
Rep. Anne C. Perry
Rep. Kevin J. Glynn
Rep. Florence T. Young
Rep. Lois A. Snowe-Mello
Rep. Michael A. Vaughan
Rep. Richard G. Woodbury

Staff:
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Maine State Legislature

Office Of Policy And Legal Analysis
Office Of Fiscal And Program Review

121st Maine Legislature
First Regular Session

Summary Of Legislation Before The Joint Standing Committees

Enclosed please find a summary of all bills, resolves, joint study orders, joint resolutions and Constitutional resolutions that were considered by the joint standing and joint select committees of the Maine Legislature this past session. The document is a compilation of bill summaries which describe each bill and relevant amendments, as well as the final action taken. Also included are statistical summaries of bill activity this session for the Legislature and each of its joint standing committees.

The document is organized for convenient reference to information on bills considered by the committees. It is arranged alphabetically by committee name and within committees by bill (LD) number. The committee report(s), prime sponsor for each bill and the lead co-sponsor(s), if designated, are listed below each bill title. All adopted amendments are listed by paper number. Two indices, a subject index and a numerical index by LD number are provided for easy reference to bills. They are located at the back of the document. A separate publication, History and Final Disposition of Legislative Documents, may also be helpful in providing information on the disposition of bills. These bill summaries also are available at the Law and Legislative Reference Library and on the Internet (www.state.me.us/legis/opla).

Final action on each bill is noted to the right of the bill title. The abbreviations used for various categories of final action are as follows:

CARRIED OVER PURSUANT TO HP 1212 .... *Bills carried over to the 2nd Regular Session*
CON RES XXX .... *Chapter # of Constitutional Resolution passed by both Houses*
CONF CMTE UNABLE TO AGREE .... *Committee of Conference unable to agree; bill died*
DIED BETWEEN BODIES .... *House & Senate disagree; bill died*
DIED IN CONCURRENCE .... *One body accepts ONTP report; the other indefinitely postpones the bill*
DIED ON ADJOURNMENT .... *Action incomplete when session ended; bill died*
EMERGENCY .... *Enacted law takes effect sooner than 90 days*
FAILED EMERGENCY ENACTMENT/FINAL PASSAGE .... *Emergency bill failed to get 2/3 vote*
FAILED ENACTMENT/FINAL PASSAGE .... *Bill failed to get majority vote*
FAILED MANDATE ENACTMENT .... *Bill imposing local mandate failed to get 2/3 vote*
NOT PROPERLY BEFORE THE BODY .... *Ruled out of order by the presiding officers; bill died*
INDEF PP .... *Bill Indefinitely Postponed*
ONTP .... *Ought Not To Pass report accepted*
OTP-ND .... *Committee report Ought To Pass In New Draft*
P&S XXX .... *Chapter # of enacted Private & Special Law*
PASSED .... *Joint Order passed in both bodies*
PUBLIC XXX .... *Chapter # of enacted Public Law*
RESOLVE XXX .... *Chapter # of finally passed Resolve*
UNSIGNED .... *Bill held by Governor*
VETO SUSTAINED .... *Legislature failed to override Governor's Veto*

Please note that the effective date for all non-emergency legislation enacted in the First Regular Session (unless otherwise specified in a particular law) is September 13, 2003.

David C. Elliott, Director
Offices located in Room 215 of the Cross Office Building

LD 1605 **An Act To Amend the Law Relating to Multiple-employer Welfare Arrangements** **PUBLIC 374 EMERGENCY**

Sponsor(s)	Committee Report	Amendments Adopted
LAFOUNTAIN	OTP	
BREAULT		

LD 1605 proposed to require that trust funds of a multiple-employer welfare arrangement be held in this State until disbursed by the trust. It also proposed to remove the requirement that a 3rd-party administrator of a multiple-employer welfare arrangement be domiciled in this State.

Enacted Law Summary

Public Law 2003, chapter 374 provides that trust funds of a multiple-employer welfare arrangement must be held in this State until disbursed by the trust and removes the requirement that a licensed 3rd-party administrator of a multiple-employer welfare arrangement be domiciled in this State.

Public Law 2003, chapter 374 was enacted as an emergency measure effective May 30, 2003.

LD 1611 **An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs** **PUBLIC 469**

Sponsor(s)	Committee Report	Amendments Adopted
O'NEIL	OTP-AM	H-565
TREAT		S-228

LD 1611 proposed to do the following:

Part A of the bill establishes Dirigo Health as an independent agency of State Government. It seeks to make affordable health insurance available to small businesses and individuals, provide additional assistance to employees and individuals with earnings below 300% of the federal poverty guidelines and establishes the Maine Quality Forum to improve the quality of care in this State.

Part B requires the Governor to issue a biennial State Health Plan and establishes an advisory council to assist in the development of the plan.

Part C ties the administration of the certificate of need process to the State Health Plan and the capital investment fund. It further seeks to strengthen the public database administered by the Maine Health Data Organization.
Part D requires insurers in the small group market to submit to the Superintendent of Insurance the same rate information that insurers in other markets are required to provide.

Part E requires certain health care providers to provide consumer information.

Part F establishes voluntary constraints on health care cost increases.

Part G requires the Governor to work to improve access to care for veterans and to improve Medicare reimbursements for Maine providers.

Committee Amendment "A" (H-565) proposed to replace the bill. In Part A, the amendment proposed to establish Dirigo Health as an independent executive agency to arrange for the provision of health coverage to small employers and their employees and dependents and to individuals on a voluntary basis. Dirigo Health is also required to monitor and improve the quality of health care in this State. Dirigo Health is governed by a board of directors. Five voting members must be appointed by the Governor and confirmed by the Legislature.

Under Part A, Dirigo Health must contract with health insurance carriers to offer health insurance to eligible small businesses and individuals through Dirigo Health Insurance. The health insurance benefits must be determined by the board and must comply with all statutory requirements of the Maine Insurance Code, including mandated benefits. The amendment also provides additional assistance through subsidies, based on a sliding scale, to employees and individuals with earnings below 300% of the federal poverty level who are enrolled in Dirigo Health. Employers who participate in Dirigo Health Insurance may be required to contribute up to 60% toward the cost of coverage for employees who work at least 20 hours per week and their dependents. The employer contribution rate for employees who work less than full time must be prorated.

In the first year of operation, funding for Dirigo Health is provided through the General Fund. After July 1, 2005, funding for subsidies and the Maine Quality Forum must be provided through savings offset payments paid by health insurance carriers, employee benefit excess insurance carriers and third-party administrators. The board of directors is required to establish the savings offset amount, not to exceed 4% of annual premium revenue or its equivalent, on an annual basis and those savings offset payments may not exceed the aggregate cost savings attributable to reductions in bad debt and charity care costs as a result of the operation of Dirigo Health and the expansion in MaineCare.

Part A proposed to expand MaineCare coverage for children and adults and provides coverage for expansion enrollees who enroll individually and who enroll through Dirigo Health as part of an employer group. The expansion of MaineCare eligibility may not become effective until Dirigo Health becomes operational. The amendment also requires monthly reporting of the noncategorical adult MaineCare expansion.

Within Dirigo Health, the amendment proposed to establish a high-risk pool for persons whose care costs are over $100,000 per year and for those with certain named diagnoses. It requires Dirigo Health to develop disease management protocols for persons in the high-risk pool. If after 3 years Dirigo Health underperforms relative to the trends in average premium rates and average rates of uninsured individuals compared to those trends in states with high-risk pools, Dirigo Health is charged with submitting legislation to create a high-risk pool on January 1, 2008.

Part A proposed to establish the Maine Quality Forum within Dirigo Health to collect and disseminate research, adopt quality and performance measures, coordinate quality data, issue quality reports in conjunction with the Maine Health Data Organization, conduct consumer education and technology assessment reviews, encourage the adoption of electronic technology, make recommendations for the biennial State Health Plan and issue an annual report. To assist the board and the forum, the amendment establishes the Maine Quality Forum Advisory Council.

Part B proposed to require the Governor to issue a biennial State Health Plan and establishes an advisory council to assist in the development of the plan. Part B also proposed to establish the capital investment fund, an annual limit for resources allocated under the certificate of need program. Within the capital investment fund, 12.5% of the total is required to be designated for nonhospital projects for a period of 3 years. The amendment specifies that a certificate of need or public financing that affects health care costs may not be provided unless it meets the goals and budgets in the State Health Plan.

Part C proposed to apply certificate of need (CON) requirements to the portions of an ambulatory surgical facility used by patients or to support ambulatory surgical care and to new technology that costs over $1,200,000 in the office of a private practitioner. It proposed to establish an automatic adjustment to the CON thresholds based on the Consumer Price Index, medical index. It would expand the bases on which the Commissioner of Human Services makes CON decisions, adding consistency with the State Health Plan, reference to quality outcomes, reference to inappropriate increases in service utilization and the limits of the capital investment fund. It would allow the Commissioner of Human Services to receive reports from a panel of experts on CON applications and requires evaluations from the Department of Human Services, Bureau of Health and the Superintendent of Insurance. It proposed to require hospitals and health care practitioners to make information on the charges for commonly offered health care services available to the public.

Part C proposed to require the Maine Health Data Organization to adopt rules to collect data on health care quality based on the quality measures adopted by the Maine Quality Forum. It also would require the Maine Health Data Organization to issue reports on health care services, costs and quality.

Part D proposed to require health care practitioners to submit claims to health insurance carriers in electronic format beginning October 16, 2003. Until October 16, 2005, health care practitioners with fewer than 10 full-time equivalent employees are not required to submit claims electronically. After that date, those practitioners may apply to the Superintendent of Insurance for an exemption from the electronic claims filing requirement.

Part E proposed to require the Superintendent of Insurance to adopt rules for the filing of annual report supplements by health insurers and health maintenance organizations. It would require small group health plans to submit rate filings to the Superintendent of Insurance and imposes rate hearings and rate reviews on those filings unless a carrier opts to guarantee a 78% loss ratio or refund excess premiums. It would require individual and small group health insurance rates to reflect savings offset payments and any recovery of those offsets in premium rates. It would require large group health carriers to file annually certification that rating practices and methods meet actuarial principles and that savings offset payments and recovery offsets have been properly included in the filing. It proposed to allow managed care health plans to apply to the Superintendent of Insurance for permission to offer health plans with financial incentive provisions to encourage the use of designated providers of specialty and hospital care if the plan does not exceed the Bureau of Insurance Rule Chapter 850 travel standards by 100% and meets quality criteria. The Superintendent of Insurance is required to adopt rules relating to quality criteria by January 1, 2004 and submit those rules for legislative review before final adoption. The provision regarding managed care plans offering health plans with financial incentive provisions is repealed on July 1, 2007 unless continued by the Legislature. It would require the Superintendent of Insurance to conduct a study of the impact of a cap of $250,000 on noneconomic damages in medical malpractice lawsuits on the cost of medical malpractice insurance.

Part F proposed to set voluntary constraints on financial growth for a period of one year by health care practitioners, hospitals and health insurance carriers. It also requires the Governor's Office of Health Policy and Finance and the Maine Hospital Association to agree on a timetable, format and methodology for reporting on hospital charges, cost efficiency and consolidated operating margins. It requires the Department of Human Services to conduct a comprehensive study of MaineCare reimbursement rates and to report by January 15, 2005. It establishes the Commission to Study Maine's Hospitals and requires that commission to report by November 1, 2004.

Part G proposed to require the Governor to work to improve access to care for veterans and to improve Medicare reimbursements for Maine providers and establishes a task force to study health care services provided to Maine veterans.

Part H proposed to restore $500,000 in General Fund money to restore the physician incentive payment program within the MaineCare program.

Part H proposed to authorize the State Controller to transfer $53,000,000 from the General Fund to Dirigo Health to support its operation in the first year.

Part H also proposed to add appropriations and allocations sections to the bill, as amended, as well as an emergency preamble and emergency clause.

Senate Amendment "B" to Committee Amendment "A" (S-288) proposed to remove the emergency preamble and emergency clause from Committee Amendment "A."

House Amendment "A" to Committee Amendment "A" (H-572) proposed to provide that if the average premium rates in the State and the rate of uninsured individuals exceed the relevant average, the board shall submit proposed legislation to include in the Dirigo Health product offerings a high-deductible medical savings account package. House Amendment "A" was not adopted.

House Amendment "B" to Committee Amendment "A" (H-573) replaced the bill and Committee Amendment. Part A proposed to create the Comprehensive Health Insurance Risk Pool Association to spread the cost of high-risk individuals among all health insurers. The high-risk pool is funded through an assessment on insurers. This Part requires the State to submit an application to the Federal Government for federal assistance to create a high-risk pool.

Part A also removed the guaranteed issuance requirement for individual health plans effective February 1, 2005.

Part B proposed to broaden the community rating bands in individual health insurance to allow increased variation of premium rates based on age and health status.

Part C proposed to direct the Department of Human Services to provide Medicaid-eligible individuals with premium subsidies so that the value of MaineCare benefits may be applied to the purchase of private health insurance through employers or a plan offered in the individual market. The department is further directed to seek any waivers needed from the Federal Government.

Part D proposed to provide that a health maintenance organization may furnish health care services through providers that exceed the standard geographic accessibility limits imposed by the Department of Professional and Financial Regulation, Bureau of Insurance by rule for specialty care and hospital services with the exception of hospital services for emergencies and maternity care.

Part E proposed to set a limit of $250,000 on noneconomic damages in medical liability actions. Under this Part, a plaintiff is still entitled to the full economic loss, including all medical expenses, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income and any other verifiable monetary losses. House Amendment "B" was not adopted.

House Amendment "C" to Committee Amendment "A" (H-574) proposed to limit the amount of savings offset payments to 75% of the savings resulting from decreasing rates of growth in the State's health care spending and bad debt and charity care costs. This amendment also proposed to require health insurance carriers and providers to use best efforts to ensure that health insurance premiums reflect the recovery of all the cost savings offset payments. House Amendment "C" was not adopted.

House Amendment "D" to Committee Amendment "A" (H-575) proposed to require that the Dirigo Health Insurance program will exist in only one county for its first year of operation. In order for the program to expand to a statewide program, the Board of Directors of Dirigo Health must report to the Legislature and receive its approval for expansion. The amendment replaces the fiscal information of the committee amendment. House Amendment "D" was not adopted.

House Amendment "E" to Committee Amendment "A" (H-577) proposed to place the Governor and State Legislators under the Dirigo Health Insurance plan. House Amendment "E" was not adopted.

House Amendment "F" to Committee Amendment "A" (H-578) proposed to require that the Board of Directors of Dirigo Health offer an optional plan for public school teachers. Under the optional plan, a teacher could elect coverage under Dirigo Health and that teacher's contribution to the Dirigo Health Fund would be 4% of the annual salary earned from teaching and the State's contribution would be 40% of the cost of health insurance coverage. House Amendment "F" was not adopted.

House Amendment "G" to Committee Amendment "A" (H-583) proposed to create the Comprehensive Health Insurance Risk Pool Association to spread the cost of high-risk individuals among all health insurers. The high-risk pool is funded through an assessment on insurers. This amendment proposed to require the State to submit an application to the Federal Government for federal assistance to create a high-risk pool.

This amendment also proposed to remove the guaranteed issuance requirement for individual health plans effective July 1, 2005. House Amendment "G" was not adopted.

House Amendment "H" to Committee Amendment "A" (H-584) proposed to remove the emergency preamble and the emergency clause from Committee Amendment "A". House Amendment "H" was not adopted.

House Amendment "I" to Committee Amendment "A" (H-586) proposed to remove the emergency preamble and emergency clause from Committee Amendment "A." House Amendment "I" was not adopted.

Senate Amendment "A" to Committee Amendment "A" (S-278) proposed to replace the bill and Committee amendment. Part A proposed to create the Comprehensive Health Insurance Risk Pool Association to spread the cost of high-risk individuals among all health insurers. The high-risk pool is funded through an assessment on insurers. This Part proposed to require the State to submit an application to the Federal Government for federal assistance to create a high-risk pool.

Part A also proposed to remove the guaranteed issuance requirement for individual health plans effective February 1, 2005.

Part B proposed to broaden the community rating bands in individual health insurance to allow increased variation of premium rates based on age and health status.

Part C proposed to direct the Department of Human Services to provide Medicaid-eligible individuals with premium subsidies so that the value of MaineCare benefits may be applied to the purchase of private health insurance through employers or a plan offered in the individual market. The department is further directed to seek any waivers needed from the Federal Government.
Part D proposed to provide that a health maintenance organization may furnish health care services through providers that exceed the standard geographic accessibility limits imposed by the Department of Professional and

Financial Regulation, Bureau of Insurance by rule for specialty care and hospital services with the exception of hospital services for emergencies and maternity care.

Part E proposed to set a limit of $250,000 on noneconomic damages in medical liability actions. Under this Part, a plaintiff is still entitled to the full economic loss, including all medical expenses, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income and any other verifiable monetary losses. Senate Amendment "A" was not adopted.

Enacted Law Summary

Public Law 2003, chapter 469 establishes Dirigo Health as an independent executive agency to arrange for the provision of health coverage to small employers and their employees and dependents and to individuals on a voluntary basis. Dirigo Health is also required to monitor and improve the quality of health care in this State. Dirigo Health is governed by a board of directors. Five voting members must be appointed by the Governor and confirmed by the Legislature.

Dirigo Health must contract with health insurance carriers to offer health insurance to eligible small businesses and individuals through Dirigo Health Insurance. The health insurance benefits must be determined by the board and must comply with all statutory requirements of the Maine Insurance Code, including mandated benefits. The law also provides additional assistance through subsidies, based on a sliding scale, to employees and individuals with earnings below 300% of the federal poverty level who are enrolled in Dirigo Health. Employers who participate in Dirigo Health Insurance may be required to contribute up to 60% toward the cost of coverage for employees who work at least 20 hours per week and their dependents. The employer contribution rate for employees who work less than full time must be prorated. Coverage through Dirigo Health Insurance must begin no later than October 1, 2004.

In the first year of operation, funding for Dirigo Health is provided through the General Fund. After July 1, 2005, funding for subsidies and the Maine Quality Forum must be provided through savings offset payments paid by health insurance carriers, employee benefit excess insurance carriers and third-party administrators. The board of directors is required to establish the savings offset amount, not to exceed 4% of annual premium revenue or its equivalent, on an annual basis and those savings offset payments may not exceed the aggregate cost savings attributable to reductions in bad debt and charity care costs as a result of the operation of Dirigo Health and the expansion in MaineCare.

The law expands MaineCare coverage for children and adults and provides coverage for expansion enrollees who enroll individually and who enroll through Dirigo Health as part of an employer group. The expansion of MaineCare eligibility may not become effective until Dirigo Health becomes operational. Monthly reporting on the noncategorical adult MaineCare expansion will be required to monitor enrollment.

Within Dirigo Health, the law establishes a high-risk pool for persons whose care costs are over $100,000 per year and for those with certain named diagnoses. It requires Dirigo Health to develop disease management protocols for persons in the high-risk pool. If after 3 years Dirigo Health underperforms relative to the trends in average premium rates and average rates of uninsured individuals compared to those trends in states with high-risk pools, Dirigo Health is charged with submitting legislation to create a high-risk pool on January 1, 2008.

The law establishes the Maine Quality Forum within Dirigo Health to collect and disseminate research, adopt quality and performance measures, coordinate quality data, issue quality reports in conjunction with the Maine Health Data Organization, conduct consumer education and technology assessment reviews, encourage the adoption

of electronic technology, make recommendations for the biennial State Health Plan and issue an annual report. The Maine Quality Forum Advisory Council is established to assist the board and the forum. The Maine Health Data Organization will adopt rules to collect data on health care quality based on the quality measures adopted by the Maine Quality Forum and issue reports on health care services, costs and quality.

The law requires the Governor to issue a biennial State Health Plan and establishes an advisory council to assist in the development of the plan. It also establishes the capital investment fund, an annual limit for resources allocated under the certificate of need program. Within the capital investment fund, 12.5% of the total is required to be designated for nonhospital projects for a period of 3 years. The law specifies that a certificate of need or public financing that affects health care costs may not be provided unless it meets the goals and budgets in the State Health Plan.

The law applies certificate of need (CON) requirements to the portions of an ambulatory surgical facility used by patients or to support ambulatory surgical care and to new technology that costs over $1,200,000 in the office of a private practitioner. It establishes an automatic adjustment to the CON thresholds based on the Consumer Price Index, medical index. It expands the bases on which the Commissioner of Human Services makes CON decisions, adding consistency with the State Health Plan, reference to quality outcomes, reference to inappropriate increases in service utilization and the limits of the capital investment fund. It allows the Commissioner of Human Services to receive reports from a panel of experts on CON applications and requires evaluations from the Department of Human Services, Bureau of Health and the Superintendent of Insurance. It requires hospitals and health care practitioners to make information on the charges for commonly offered health care services available to the public.

The law requires health care practitioners to submit claims to health insurance carriers in electronic format beginning October 16, 2003. Until October 16, 2005, health care practitioners with fewer than 10 full-time equivalent employees are not required to submit claims electronically. After that date, those practitioners may apply to the Superintendent of Insurance for an exemption from the electronic claims filing requirement.

The law requires the Superintendent of Insurance to adopt rules for the filing of annual report supplements by health insurers and health maintenance organizations. It requires small group health plans to submit rate filings to the Superintendent of Insurance and imposes rate hearings and rate reviews on those filings unless a carrier opts to guarantee a 78% loss ratio or refund excess premiums. It requires individual and small group health insurance rates to reflect savings offset payments and any recovery of those offsets in premium rates. It requires large group health carriers to file annually certification that rating practices and methods meet actuarial principles and that savings offset payments and recovery offsets have been properly included in the filing. It allows managed care health plans to apply to the Superintendent of Insurance for permission to offer health plans with financial incentive provisions to encourage the use of designated providers of specialty and hospital care if the plan does not exceed the Bureau of Insurance Rule Chapter 850 travel standards by 100% and meets quality criteria. The Superintendent of Insurance is required to adopt rules relating to quality criteria by January 1, 2004 and submit those rules for legislative review before final adoption. The provision regarding managed care plans offering health plans with financial incentive provisions is repealed on July 1, 2007 unless continued by the Legislature. It requires the Superintendent of Insurance to conduct a study of the impact of a cap of $250,000 on noneconomic damages in medical malpractice lawsuits on the cost of medical malpractice insurance.

The law sets voluntary constraints on financial growth for a period of one year by health care practitioners, hospitals and health insurance carriers. It also requires the Governor's Office of Health Policy and Finance and the Maine Hospital Association to agree on a timetable, format and methodology for reporting on hospital charges, cost efficiency and consolidated operating margins. It requires the Department of Human Services to conduct a comprehensive study of MaineCare reimbursement rates and to report by January 15, 2005. It establishes the Commission to Study Maine's Hospitals and requires that commission to report by November 1, 2004.

The law requires the Governor to work to improve access to care for veterans and to improve Medicare reimbursements for Maine providers and establishes a task force to study health care services provided to Maine veterans.

The law restores $500,000 in General Fund money to restore the physician incentive payment program within the MaineCare program.

HP 725 **JOINT STUDY ORDER – Relative to a Study to Examine Mandated Health Insurance Benefits and the Cost of Those Benefits to the Individual Insurance Consumer** **ONTP**

Sponsor(s)	Committee Report	Amendments Adopted
VAUGHAN	ONTP	

This joint study order proposed to require that the Joint Standing Committee on Insurance and Financial Services conduct a study to examine mandated health insurance benefits and the cost of those benefits to the individual insurance consumer. The joint order proposed that the committee report back to the Second Regular Session.