An Act To Amend MaineCare Benefits as Allowed by the Federal Deficit Reduction Act of 2005

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

Sec. 1. 22 MRSA §3173-C, as amended by PL 2003, c. 20, Pt. K, §§5 to 8 and c. 451, Pt. H, §1 and affected by §3, is further amended to read:

§ 3173-C. Copayments and premiums

1. Authorization required. The department may not require any MaineCare member, referred to in this section as "member," to make any payment toward the cost of a MaineCare service unless that payment is specifically authorized by this section, except that any copayment or premium expressly approved by the federal Secretary of the Department of Health and Human Services as part of a waiver must be implemented.

2. Prescription drug services. Except as provided in subsections 3 and 4, a payment of $2.50 for each drug is to be collected from the ~~MaineCare~~ member for each drug prescription that is an approved MaineCare service. Copayments must be capped at $25 per month per member. If a member is prescribed a drug in a quantity specifically intended by the provider or pharmacist, for the recipient's health and welfare, to last less than one month, only one payment for that drug for that month is required.

3. Exemptions. No copayment may be imposed with respect to the following services:

A. Family planning services;

B. Services furnished to individuals under 21 years of age;

C. Services furnished to any individual who is an inpatient in a hospital, nursing facility or other institution, if that individual is required, as a condition of receiving services in that institution, to spend for costs of care all but a minimal amount of income required for personal needs;

D. Services furnished to pregnant women, and services furnished during the post-partum phase of maternity care to the extent permitted by federal law;

E. ~~Emergency~~Except as applied to nonemergency use of emergency services, emergency services, as defined by the department;

F. Services furnished to an individual by a Health Maintenance Organization, as defined in the United States Social Security Act, Section 1903(m), in which ~~he~~the individual is enrolled; and

G. Any other service or services required to be exempt under the provisions of the United States Social Security Act, Title XIX and successors to it.

4. Persons in state custody. Any copayment imposed on a Medicaid recipient in the custody of the State is to be collected from the state agency having custody of the recipient.

~~7.~~ **Copayments.** ~~Notwithstanding any other provision of law, the following copayments per service per day are imposed and reimbursements are reduced, or both, to the following levels:~~

~~A. Outpatient hospital services, $3;~~

~~B. Home health services, $3;~~

~~C. Durable medical equipment services, $3;~~

~~D. Private duty nursing and personal care services, $5 per month;~~

~~E. Ambulance services, $3;~~

~~F. Physical therapy services, $2;~~

~~G. Occupational therapy services, $2;~~

~~H. Speech therapy services, $2;~~

~~I. Podiatry services, $2;~~

~~J. Psychologist services, $2;~~

~~K. Chiropractic services, $2;~~

~~L. Laboratory and x-ray services, $1;~~

~~M. Optical services, $2;~~

~~N. Optometric services, $3;~~

~~O. Mental health clinic services, $2;~~

~~P. Substance abuse services, $2;~~

~~Q. Hospital inpatient services, $3 per patient day;~~

~~R. Federally qualified health center services, $3 per patient day, effective July 1, 2004; and~~

~~S. Rural health center services, $3 per patient day.~~

~~The department may adopt rules to adjust the copayments set forth in this subsection. The rules may adjust amounts to ensure that copayments are deemed nominal in amount and may include monthly limits or exclusions per service category. The need to maintain provider participation in the Medicaid program to the extent required by 42 United States Code, Section 1392(a)(30)(A) or any successor provision of law must be considered in any reduction in reimbursement to providers or imposition of copayments.~~

8. Copayments. Notwithstanding any other provision of law, copayments to be paid by members are subject to the provisions of this subsection. In accordance with this subsection a provider may charge a copayment to a member and, if the member does not pay the copayment, the provider may refuse to provide the service or item for which the copayment was charged.

A. Copayments may not be charged to the following populations:

(1) Children who have not attained 6 years of age whose family incomes are below 133% of the nonfarm income official poverty line;

(2) Children 6 years of age and older and under 19 years of age whose family incomes are below 100% of the nonfarm income official poverty line;

(3) Pregnant women and women who are within 60 days of having delivered a child;

(4) Recipients of federal supplemental security income benefits;

(5) Women being treated for breast or cervical cancer;

(6) Children in foster care and adoption assistance programs under chapter 1071; and

(7) Members who reside in licensed residential facilities run by or contracted for by the State in which the residents are subject to a personal needs allowance under rules adopted by the department.

B. Copayments may not be charged for pregnancy-related services, family planning services, hospice care or preventive services for children who have not attained 18 years of age.

C. For members whose income is below 100% of the nonfarm income official poverty line, copayments are limited to nominal amounts as determined by rule adopted by the department and may not be required in order for the member to receive the service or item.

D. Except as otherwise provided in this paragraph, copayments must be charged by providers of services and items, and reimbursements are reduced as follows.

(1) For members whose income is between 100% and 150% of the nonfarm income official poverty line, except as otherwise provided in this subparagraph, copayments are set at 10% of the cost of the service or item. For nonemergency use of emergency services, copayments are set at twice the amount otherwise applicable to the emergency service. The hospital must first screen the member for the purposes of determining the member's health condition prior to

requiring payment of the nonemergency use copayment. The hospital must inform the member of the increased copayment applicable to the member's nonemergency use of emergency services and must provide information about nonemergency providers who could provide appropriate health care services to the member.

(2) For members whose income is above 150% of the nonfarm income official poverty line, except as otherwise provided in this subparagraph, copayments are set at 20% of the cost of the service or item. For nonemergency use of emergency services, copayments are set by rule adopted by the department. The hospital must first screen the member for the purposes of determining the member's health condition prior to requiring payment of the nonemergency use copayment. The hospital must inform the member of the increased copayment applicable to the member's nonemergency use of emergency services and must provide information about nonemergency providers who could provide appropriate health care services to the member.

E. Copayments for prescription and over-the-counter drugs that are subject to the formulary standards of section 3174-M, subsection 1-A are subject to the provisions of this subsection.

(1) For all members, copayments for preferred drugs are limited to the amounts determined by rule adopted by the department.

(2) For members whose family income is below 150% of the nonfarm income official poverty line, copayments for drugs are limited to nominal amounts.

(3) For members whose family income is at or above 150% of the nonfarm income official poverty line, copayments for drugs are set at 20% of the cost of nonpreferred drugs and 10% of the cost of preferred drugs.

(4) For all members, copayments at the higher rate applicable to nonpreferred drugs must be waived when the prescribing health care practitioner determines that the preferred drug is less effective for the member or will have an adverse health impact on the member and informs the department of that determination.

F. For all members, copayments and premiums are limited to an aggregate limit of 5% of family income over a 3-month period.

9. Premiums. Premiums for health coverage are subject to the provisions of this subsection.

A. Premiums may not be charged to the following populations:

(1) Children who have not attained 6 years of age whose family incomes are below 133% of the nonfarm income official poverty line;

(2) Children 6 years of age and older and under 19 years of age whose family incomes are below 100% of the nonfarm income official poverty line;

(3) Pregnant women and women who are within 60 days of having delivered a child;

(4) Recipients of federal supplemental security income benefits;

(5) Women being treated for breast or cervical cancer;

(6) Children in foster care and adoption assistance programs under chapter 1071;

(7) Members who reside in licensed residential facilities run by or contracted for by the State in which the residents are subject to a personal needs allowance under rules adopted by the department; and

(8) All members whose family income is below 150% of the nonfarm income official poverty line.

B. For all members whose family income is at or above 150% of the nonfarm income official poverty line, premiums are set at amounts to be determined by the department by rule.

C. For all members, copayments and premiums are limited to an aggregate limit of 5% of family income over a 3-month period.

D. The department shall suspend coverage for a member who is more than 60 days in arrears in the payment of premiums required by this subsection.

10. Nonemergency use of emergency services. As used in this section, "nonemergency use of emergency services" means use of emergency services in a hospital for care or treatment other than for an emergency medical condition, as defined in the federal Balanced Budget Act of 1997, Public Law 105-33, 111 Stat. 251.

11. Rulemaking. The department shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. Rulemaking. By January 1, 2008, the Department of Health and Human Services shall adopt rules to implement this Act.

Sec. 3. Effective date. This Act takes effect October 1, 2007.

SUMMARY

This bill imposes cost sharing in the form of premiums and copayments for services, items and prescription drugs in the MaineCare program consistent with the provisions of the federal Deficit Reduction Act of 2005.