STATE OF MAINE
HOUSE OF REPRESENTATIVES
108TH LEGISLATURE
FIRST REGULAR SESSION

(Filing No. H-753)

COMMITTEE AMENDMENT "B" to H.P. 1539, L.D. 1769, Bill, "AN ACT to Require Filing and Prior Approval of all Rates for Use by Nonprofit Hospital or Medical Organizations."

Amend the Bill by striking out all of the title and inserting in its place the following:

'AN ACT to Require Filing and Authority for Subsequent Disapproval of all Nongroup Rates Utilized by Health Insurance Companies and Nonprofit Hospital and Medical Service Organizations and to Clarify the Powers and Authority of Nonprofit Hospital Associations to Give or Deny Participating Hospital Status under their Hospitalization Plans.'

Further amend the Bill by striking out all of the emergency preamble.

Further amend the Bill by striking out everything after the enacting clause and inserting in its place the following:

'Sec. 1. 24 MRSA §2301, sub-§1, as repealed and replaced by PL 1971, c. 444, §1, is amended by adding at the end the following new paragraph:

any corporation so organized shall grant participating status under its programs to any hospital that is duly licensed by, and in good standing ~~under~~ with, applicable statutes and regulations, the Department of Human Services. A certificate issued by the commissioner of the department or his designee shall be conclusive evidence of such licensure and standing.

Sec. 2. 24 MRSA §2305, sub-§3 is repealed and the following enacted in its place:

3. Rates and benefits. The rates charged and benefits to be provided are as prescribed in sections 2316, 2321 and 2322.

Sec. 3. 24 MRSA §§2321, 2322 and 2323 are enacted to read:

§2321. Rate filings on individual subscriber and membership contracts

1. Filing of rate schedule. Every nonprofit hospital and medical service organization shall file with the superintendent, except as to group subscriber and membership contracts, every rate, rating formula and every modification of any of the foregoing which it proposes to use. Every such filing shall state the effective date thereof. Every such filing shall be made not less than 30 days in advance of the stated effective date unless such 30-day requirement is waived by the superintendent and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days.

2. Filing information. When a filing is not accompanied by the information upon which the organization supports such filing and the superintendent does not have sufficient information to determine whether such filing meets the requirements that the rates shall not be excessive, inadequate or unfairly discriminatory, he shall require the organization to furnish the information upon which it supports the filing. A filing and any supporting information shall be open to public inspection after the filing becomes effective. For the purpose of determining whether the filing produces rates that are not excessive, inadequate or unfairly discriminatory, the superintendent may employ a competent actuary and the reasonable

costs of the actuary shall be borne by the organization making such filing.

§2322. Disapproval of filing

If, at any time, the superintendent has reason to believe that a filing does not meet the requirements that rates shall not be excessive, inadequate or unfairly discriminatory and violates any of the provisions of Title 24-A, chapter 23, to the extent it is applicable pursuant to section 2317, he shall, after a hearing held upon not less than 10 days written notice to the organization making the filing specifying the matters to be considered at such hearing, issue an order specifying in what respects, if any, he finds that such filing fails to meet the requirements that rates shall not be excessive, inadequate or unfairly discriminatory and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. The superintendent shall have the burden of proof at any hearing concerning a determination that the rates are excessive, inadequate or unfairly discriminatory. Copies of the order shall be sent to the organization making the filing. The order shall not affect any individual subscriber or membership contract made or issued prior to the expiration of the effective period set forth in the order.

§2323. Appeals from order or decision of the superintendent

Any organization aggrieved by an order or decision of the superintendent may appeal therefrom as provided in Title 24-A, section 236.

Sec. 4. 24-A MRSA §2736, as amended by PL 1973, c. 585, §12, is repealed and the following enacted in its place:

§2736. Rate filings on individual health insurance policies

1. Insurer issuing individual health insurance policies. Every insurer issuing individual health insurance policies for delivery in this State shall file with the superintendent, every rate, rating formula and classification of risks pertaining to such policies, and every modification of any of the foregoing which it proposes to use. Every such insurer shall file with the superintendent, except as to group policy rates, every rate and rating formula, and every modification of any of the foregoing which it proposes to use. Every such filing shall state the effective date thereof. Every such filing shall be made not less than 30 days in advance of the stated effective date unless such 30-day requirement is waived by the superintendent and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days.

2. Accompanying information. When a filing is not accompanied by the information upon which the insurer supports such filing, and the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates shall not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. A filing and any supporting information shall be open to public inspection after the filing becomes effective.

Sec. 5. 24-A MRSA §2736-A is enacted to read:

§2736-A. Disapproval of filing

If, at any time, the superintendent has reason to believe that a filing does not meet the requirements that rates shall not be

excessive, inadequate or unfairly discriminatory and violates any of the provisions of chapter 23, he shall, after a hearing held upon not less than 10 days written notice to the insurer making the filing specifying the matters to be considered at such hearing, issue an order specifying in what respects, if any, he finds that such filing fails to meet the requirements that rates shall not be excessive, inadequate or unfairly discriminatory and stating when, within a reasonable time period thereafter, such filing shall be deemed no longer effective. The superintendent shall have the burden of proof at any hearing concerning a determination that the rates are excessive, inadequate or unfairly discriminatory. Copies of the order shall be sent to the insurer making the filing. The order shall not affect any policy issued prior to the expiration of the effective period set forth in the order.

Sec. 6. P&SL 1939, c. 24, §16 is enacted to read:

Sec. 16. Standards for granting participating status. This corporation shall grant participating status under its programs to any hospital that is duly licensed by, and in good standing under applicable statutes and regulations, with the Department of Human Services. A certificate issued by the commissioner of the department or his designee shall be conclusive evidence of such licensure and standing.'

Statement of Fact

This amendment proposes to clarify the existing laws under which the Superintendent of Insurance is permitted and required to review the rates of individual health insurance policies issued by insurance companies and the rates of individual subscriber and membership contracts issued by nonprofit hospital and medical service organizations.

This amendment also clarifies and specifies the powers and authority of nonprofit hospital associations, and particularly Associated Hospital Service of Maine, to give or deny status as participating hospitals under their hospitalization plans. In recent years Associated Hospital Service of Maine, through its Blue Cross program, has terminated the participating status of one Maine hospital and threatened to terminate the participating status of another. Its basis has been that under its own standards, the hospitals have not fully complied with applicable planning statutes. Those planning statutes are generally of federal origin and under the statutory scheme are administered by state agencies or nonprofit organizations. Those statutes have specific standards for compliance and are generally applicable to planning review for Medicare purposes. Under the planning structure, if a hospital desires to be reimbursed for certain expenditures, such as capital expenditures for Medicare purposes, it must submit to the planning process. There are instances where the planning process may not apply; where the planning agencies may

determine not to review; or where the hospital may decide on its own to absorb certain costs and not to pass them on to the Medicare program.

Blue Cross, however, has attempted to superimpose on the planning process more stringent standards than those contained in the statutes and to recognize that the hospitals abide by not only planning statutes but Blue Cross' own standards in order to get benefits under Blue Cross' contract. In many cases this has created financial hardships for hospitals because of the cost of the planning process. In one case Blue Cross' position has resulted in its insistence that the hospital go through the planning process twice and in another case, because of this and other reasons, the hospital closed and only recently has reopened. Blue Cross' present posture leaves it, and not the government, as the final arbiter of whether the planning process applies. That decision should be left up to the state and federal government and to the agencies charged with administering the statutes and not to Associated Hospital Service of Maine.

It should be noted that there is a consumer effect to Blue Cross' position caused by the fact that if a hospital goes through the planning process, at least in one of the cases contemplated above, the cost would be $50,000 to $100,000 which ultimately must be passed on to the consumer. This legislation then has two general thrusts. It permits hospitals to look forward to complying with existing statutory standards, whatever

those may be from time to time, and however they may be applicable. Hospitals which are duly licensed and in good standing should be able to afford Blue Cross subscribers use of their facilities when illness or injury strikes. Additionally, and importantly, the amendment relieves hospitals of the financial burden of going through the planning process simply for Blue Cross purposes and having to pass that cost on to the already overburdened consumer.

Reported by the Minority of theCommittee on Business Legisation.

Reproduced and distributed under the direction of the Clerk of the House.
6/20/77

(Filing No. H-753)