

MAINE STATE LEGISLATURE

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1 SECOND REGULAR SESSION
2

3 ONE HUNDRED AND TWELFTH LEGISLATURE
4

5 Legislative Document

No. 2068

7 H.P. 1466

House of Representatives, February 25, 1986

8 Reported by Representative Brannigan from the Committee on Business
9 and Commerce. Sent up for concurrence and ordered printed. Approved by
the Legislative Council on June 18, 1985.

EDWIN H. PERT, Clerk

10 Reported from the Joint Standing Committee on Business and Commerce
under Joint Rule 19.

11
12 STATE OF MAINE
13

14 IN THE YEAR OF OUR LORD
15 NINETEEN HUNDRED AND EIGHTY-SIX
16

17 AN ACT to Authorize Preferred Provider
18 Arrangements in Maine and to Establish
19 a Cash Reserve Requirement for Health
20 Maintenance Organizations.
21

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

24 Sec. 1. 24 MRSA c. 19, first 3 lines, are re-
25 pealed and the following enacted in its place:

26 CHAPTER 19

27 NONPROFIT HOSPITAL OR MEDICAL SERVICE
28 ORGANIZATIONS

29 SUBCHAPTER I

30 GENERAL PROVISIONS

31 Sec. 2. 24 MRSA c. 19, sub-c. II is enacted to
32 read:

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§2333. Short title

§2334. Definitions

1. Health care services. "Health care services" means health care services or products rendered or sold by a provider within the scope of the providers legal authorization.

2. Nonprofit service organization. "Nonprofit service organization" means a nonprofit hospital service corporation, nonprofit medical service corporation or nonprofit health care plan authorized in this State.

3. Preferred provider. "Preferred provider" means a provider of health care services who has entered into a contract with a nonprofit service organization to provide health care services to specified persons at a discounted rate.

4. Provider. "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

5. Subscriber. "Subscriber" means an individual entitled to certain specified health care under a contract issued by a nonprofit service organization.

6. Superintendent. "Superintendent" means the Superintendent of Insurance.

§2335. Discrimination

1 Before entering into any agreement under this
2 Act, a nonprofit service organization shall establish
3 terms and conditions that must be met by providers
4 wishing to enter into an agreement with the nonprofit
5 service organization. Neither differences in prices
6 among providers produced by a process of individual
7 negotiation nor price differences among other
8 providers in different geographical areas or differ-
9 ent specialties constitute unreasonable discrimina-
10 tion against or among providers.

11 §2336. Contracts; agreements or arrangements with
12 incentives or limits on reimbursement autho-
13 rized

14 1. Contracts, agreements or arrangements. Con-
15 tracts, agreements or arrangements issued under this
16 Act may not contain terms or conditions that will op-
17 erate unreasonably to restrict the access and availa-
18 bility of health care services for the subscriber.

19 2. Nonprofit service organizations. Nonprofit
20 service organizations may:

21 A. Enter into agreements with certain providers
22 of their choice relating to health care services
23 which may be rendered to subscribers of the non-
24 profit service organizations, including agree-
25 ments relating to the amounts to be charged the
26 subscribers for services rendered. These agree-
27 ments are not per se violations of antitrust pro-
28 visions; or

29 B. Issue or administer programs or contracts in
30 this State that include incentives for the sub-
31 scriber to use the services of a provider who has
32 entered into an agreement with the nonprofit ser-
33 vice organization pursuant to paragraph A. Where
34 such a program or contract is offered to an em-
35 ployee group, employees shall have the option an-
36 nually of participating in any other health in-
37 surance program or health care plan sponsored by
38 their employer.

39 §2337. Annual reporting

1 1. Disclosure. Any nonprofit service organiza-
2 tion which proposes to offer a preferred provider ar-
3 rangement authorized by this chapter shall disclose
4 in a report to the Superintendent of Insurance, prior
5 to its initial offering and prior to any change
6 thereafter, the following:

7 A. The name which the arrangement intends to use
8 and its business address;

9 B. The name, address and nature of any separate
10 organization which administers the arrangement on
11 the behalf of the nonprofit service organization;
12 and

13 C. The names and addresses of all providers des-
14 ignated by the nonprofit service organizations
15 under this section and the terms of the agree-
16 ments with designated health care providers.

17 The superintendent shall maintain a record of ar-
18 rangements proposed under this section, including a
19 record of any complaints submitted relative to the
20 arrangements.

21 2. If a nonprofit service organization offers an
22 arrangement with incentives or limits on reimburse-
23 ment consistent with this chapter as part of a group
24 health insurance contract or policy, the forms shall
25 disclose to subscribers:

26 A. Those providers with which agreements or ar-
27 rangements have been made to provide health care
28 services to the subscribers and a source for the
29 subscribers to contact regarding changes in those
30 providers;

31 B. The extent of coverage as well as any limita-
32 tions or exclusions of health care services under
33 the policy or contract;

34 C. The circumstances under which reimbursement
35 will be made to a subscriber unable to use the
36 services of a preferred provider;

37 D. A description of the process for addressing a
38 complaint under the policy or contract;

1 E. Deductible and coinsurance amounts charged to
2 any person receiving health care services from a
3 preferred provider; and

4 F. The rate of payment when health care services
5 are provided by a nonpreferred provider.

6 §2338. Risk-sharing and prepaid capitation rates

7 Any nonprofit service organization having formed
8 a preferred provider arrangement embodying risk-
9 sharing by providers and employing a prepaid capita-
10 tion rate shall file applicable provider agreements,
11 rates and other relevant material with the Superin-
12 tendent of Insurance for approval. The superintend-
13 ent shall disapprove any arrangement if it contains
14 any unjust, unfair or inequitable provisions. The
15 superintendent shall disapprove any charges which are
16 excessive, inadequate or unfairly discriminatory.

17 If the superintendent has not taken any action on
18 the forms filed within 30 days of receipt, the ar-
19 rangement shall be deemed approved. The superintend-
20 ent may extend, by not more than an additional 30
21 days, the period within which he may affirmatively
22 approve or disapprove any form, by giving notice to
23 the nonprofit service organization before expiration
24 of the initial 30-day period. At the expiration of
25 any extension, if the superintendent has not acted on
26 the forms, the arrangement shall be deemed approved.
27 The superintendent may at any time, after hearing and
28 for cause shown, withdraw any such approval.

29 §2339. Alternative health care benefits

30 A nonprofit service organization which makes a
31 preferred provider arrangement available shall pro-
32 vide for payment for health care services rendered by
33 providers who are not preferred providers, but that
34 payment need not be the same as for preferred
35 providers.

36 §2340. Utilization review

37 On or before April 1st of each year, a nonprofit
38 service organization which issues or administers a
39 program or contract in this State that includes in-

centives for the subscriber to use the services, or a provider who has entered into an agreement with the nonprofit service organization pursuant to section 2336, subsection 2, paragraph A, shall file a report of its activities for the preceding year with the superintendent and at a minimum shall contain the following:

1. Name, address and scope of license. Name, address and scope of license of each preferred provider; and

2. Claims experience. Claims experience for the following categories: Hospitalization; ambulatory surgical or other outpatient services; and professional services listed by specialty.

Sec. 3. 24-A MRSA §2159, sub-§2, as enacted by PL 1969, c. 132, §1, is amended to read:

2. No person ~~shall~~ may make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. Nothing in this provision prohibits an insurer from providing incentives for insureds to use the services of a particular hospital or person.

Sec. 4. 24-A MRSA c. 32 is enacted to read:

CHAPTER 32

PREFERRED PROVIDER ARRANGEMENT ACT OF 1986

§2670. Short title

This chapter may be cited as the "Preferred Provider Arrangement Act of 1986."

§2671. Definitions

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

1 1. "Administrator" means any person, partnership
2 or corporation, other than an insurer or nonprofit
3 health service organization, that arranges contracts
4 with or administers contracts with a provider whereby
5 beneficiaries are provided an incentive to use the
6 services of that provider.

7 2. "Beneficiary" means the individual entitled
8 to reimbursement for expenses of health care services
9 under a program where the beneficiary has an incen-
10 tive to use the services of a provider who has en-
11 tered into an agreement or arrangement with an admin-
12 istrator.

13 3. "Health care services" means health care ser-
14 vices or products rendered or sold by a provider
15 within the scope of the provider's legal authoriza-
16 tion.

17 4. "Insured" means an individual entitled to re-
18 imbursement for expenses of health care services un-
19 der a policy issued or administered by an insurer.

20 5. "Insurer" means an insurance company autho-
21 rized in this State to issue policies which reimburse
22 for expenses of health care services.

23 6. "Preferred provider" means a provider of
24 health care services who has entered into a contract
25 with an insurer or administrator to provide health
26 care services to specified persons at a discounted
27 rate.

28 7. "Provider" means an individual or entity duly
29 licensed or legally authorized to provide health care
30 services.

31 8. "Superintendent" means Superintendent of In-
32 surance.

33 §2672. Discrimination

34 Before entering into any agreement under this
35 chapter an insurer or administrator shall establish
36 terms and conditions that must be met by providers
37 wishing to enter into an agreement with the insurer
38 or administrator. Neither differences in prices

1 among providers produced by a process of individual
2 negotiation nor price differences among other
3 providers in different geographical areas or differ-
4 ent specialties constitute unreasonable discrimina-
5 tion against or among providers.

6 §2673. Policies, agreements or arrangements with in-
7 centives or limits on reimbursement autho-
8 rized

9 1. Policies, agreements or arrangements issued
10 under this chapter may not contain terms or condi-
11 tions that will operate unreasonably to restrict the
12 access and availability of health care services for
13 the insured or beneficiary.

14 2. An insurer or administrator may enter into
15 agreements with certain providers of its choice re-
16 lating to health care services which may be rendered
17 to insureds or beneficiaries, including agreements
18 relating to the amounts to be charged the insureds or
19 beneficiaries for services rendered. These agree-
20 ments are not per se violations of antitrust provi-
21 sions.

22 3. An insurer may issue policies in this State
23 or an administrator may administer programs in this
24 State that include incentives for the insured or ben-
25 eficiary to use the services of a provider who has
26 entered into an agreement with the insurer or admin-
27 istrator pursuant to subsection 2. Where such a pro-
28 gram or policy is offered to an employee group annu-
29 ally, employees shall have the option of participa-
30 ting in any other health insurance program or health
31 care plan sponsored by their employer.

32 §2674. Requirements applicable to administrators

33 1. All administrators of a preferred provider
34 program subject to this chapter shall register with
35 the Bureau of Insurance and pay an annual registra-
36 tion fee of \$20. The Bureau of Insurance shall by
37 rule establish criteria for the registration, includ-
38 ing minimum solvency requirements.

39 The Bureau of Insurance shall compile and maintain a
40 current listing of administrators and insurers offer-
41 ing agreements authorized under this chapter.

1 2. Each administrator who handles money for pur-
2 poses of payment for provider services subject to
3 this chapter shall establish and maintain a fiduciary
4 account, separate and apart from any and all other
5 accounts, for the receipt and disbursement of funds
6 for program reimbursement covered under this chapter
7 and post or cause to be posted, a surety bond in a
8 penal sum to be determined by the standards of a rule
9 to be established by the superintendent.

10 A. If a surety bond of indemnity is posted, it
11 shall be drawn in favor of the Treasurer of State
12 and held by the Superintendent of Insurance for
13 the benefit of parties in interest.

14 B. In the event of misappropriation of funds or
15 other violation of a fiduciary obligation, the
16 right of any administrator to enter agreements or
17 arrangements with incentives or limits on reim-
18 bursment consistent with this chapter may be re-
19 voked or suspended by the superintendent.

20 3. Each administrator shall provide to each ben-
21 eficiary of any program subject to this chapter a
22 document which:

23 A. Sets forth those providers with which agree-
24 ments or arrangements have been made to provide
25 health care services to the beneficiary; a source
26 for the beneficiary to contact regarding changes
27 in the providers and a clear description of any
28 incentives for the beneficiary to use the
29 providers;

30 B. Discloses the extent of coverage as well as
31 any limitations or exclusions of health care ser-
32 vices under the program;

33 C. Clearly sets out the circumstances under
34 which reimbursement will be made to a beneficiary
35 unable to use the services of a preferred
36 provider;

37 D. Sets out a description of the process for ad-
38 ressing a beneficiary complaint under the pro-
39 gram;

1 E. Discloses deductible and coinsurance amounts
2 charged to any person receiving health care ser-
3 vices from a preferred provider; and

4 F. Discloses the rate of payment when health
5 care services are provided by a nonpreferred
6 provider.

7 4. An administrator who operates more than one
8 such program shall establish and maintain a separate
9 fiduciary account or surety bond for each such pro-
10 gram.

11 5. The Superior Court shall assess a civil pen-
12 alty in an amount not to exceed \$3,000 for each vio-
13 lation, payable to the Bureau of Insurance, to be ap-
14 plied toward the administration of this Title,
15 against any corporation, entity or an individual vio-
16 lating any provision of this chapter, including fail-
17 ure to register or pay the required fee, misappropri-
18 ation of funds or other violation of fiduciary re-
19 sponsibility. Any person, whether director, office
20 manager, employee, representative of a corporation or
21 entity or otherwise, may also be punished by impris-
22 onment for less than one year for knowingly partici-
23 pating in or authorizing the misappropriation of
24 funds or other violation of fiduciary responsibility.

25 6. Nothing in this chapter affects any rights or
26 interest that any person other than the Bureau of In-
27 surance may possess.

28 §2675. Requirements applicable to insurers

29 1. Any insurer which proposes to offer a pre-
30 ferred provider arrangement authorized by this chap-
31 ter shall disclose in a report to the Superintendent
32 of Insurance prior to its initial offering and prior
33 to any charge thereafter the following:

34 A. The name which the arrangement intends to use
35 and its business address;

36 B. The name, address and nature of any separate
37 organization which administers the arrangement on
38 the behalf of the insurers; and

1 C. The names and addresses of all providers des-
2 ignated by the insurer under this clause and the
3 terms of the agreements with designated health
4 care providers.

5 The superintendent shall maintain a record of ar-
6 rangements proposed under this clause, including a
7 record of any complaints submitted relative to the
8 arrangements.

9 2. If an insurer offers an arrangement with in-
10 centives or limits on reimbursement consistent with
11 this chapter as part of a group health insurance con-
12 tract or policy, the forms shall disclose to insur-
13 eds:

14 A. Those providers with which agreements or ar-
15 rangements have been made to provide health care
16 services to the insureds; a source for the in-
17 sured to contact regarding changes in the
18 providers;

19 B. The extent of coverage as well as any limita-
20 tions or exclusions of health care services under
21 the policy or contract;

22 C. The circumstances under which reimbursement
23 will be made to an insured unable to use the ser-
24 vices of a preferred provider;

25 D. A description of the process for addressing a
26 complaint under the policy or contract;

27 E. Deductible and coinsurance amounts charged to
28 any person receiving health care services from a
29 preferred provider; and

30 F. The rate of payment when health care services
31 are provided by a nonpreferred provider.

32 §2676. Risk-sharing and prepaid capitation rates

33 Any administrator or insurer having formed a pre-
34 ferred provider arrangement embodying risk-sharing by
35 providers and employing a prepaid capitation rate
36 shall file applicable rates and other relevant mate-
37 rial with the Superintendent of Insurance for approv-

1 al. The superintendent shall disapprove any arrange-
2 ment if it contains any charges or provisions which
3 are excessive, inadequate or unfairly discriminatory.

4 If the superintendent has not taken any action on
5 the forms filed within 30 days of receipt, the ar-
6 rangement shall be deemed approved. The superintend-
7 ent may extend, by not more than an additional 30
8 days, the period within which he may affirmatively
9 approve or disapprove any form, by giving notice to
10 the administrator or insurer before expiration of the
11 initial 30-day period. At the expiration of any ex-
12 ension, if the superintendent has not acted on the
13 forms, the arrangement shall be deemed approved. The
14 superintendent may at any time, after hearing and for
15 cause shown, withdraw any such approval.

16 §2677. Alternative health care benefits

17 An insurer or administrator who makes a preferred
18 provider arrangement available shall provide for pay-
19 ment for health care services rendered by providers
20 who are not preferred providers, but the payment need
21 not be the same as for preferred providers.

22 §2678. Utilization review

23 On or before April 1st of each year, an
24 adminstrator or insurer who issues or administers a
25 program, policy or contract in this State that in-
26 cludes incentives for the insured or beneficiary to
27 use the services of a provider who has entered into
28 an agreement with the insurer or administrator, pur-
29 suant to section 2673, subsection 2, paragraph A,
30 shall file a report of its activities for the preced-
31 ing year with the superintendent. The report shall
32 be in the form prescribed by the superintendent and
33 at a minimum shall contain the following:

34 1. Name, address and scope of license of each
35 preferred provider; and

36 2. Utilization experience for the following cat-
37 egories: Hospitalization; ambulatory surgical or oth-
38 er outpatient services; and professional services.
39 Utilization of professional services is to be listed
40 by specialty.

1 §2679. Unaffected parties

2 The requirements of this chapter are not applica-
3 ble to self-insured employers, employee benefit trust
4 funds and other organizations regulated by the Em-
5 ployee Retirement Income Security Act of 1974.

6 Sec. 5. 24-A MRSA §2713, sub-§2, ¶B, as enacted
7 by PL 1969, c. 132, §1, is amended to read:

8 B. Subject to any written direction of the in-
9 sured in the application or otherwise all or a
10 portion of any indemnities provided by this poli-
11 cyl on account of hospital, nursing, medical or
12 surgical services may, at the insurer's option
13 and unless the insured requests otherwise in
14 writing not later than the time of filing proofs
15 of such loss, be paid directly to the hospital or
16 person rendering such services; but it is not re-
17 quired that the service be rendered by a particu-
18 lar hospital or person. Nothing in this provi-
19 sion prohibits an insurer from providing an in-
20 centive for insureds to use the services of a
21 particular hospital or person.

22 Sec. 6. 24-A MRSA §4204, sub-§2-A, ¶D, as en-
23 acted by PL 1981, c. 501, §51, is amended to read:

24 D. The health maintenance organization is finan-
25 cially responsible and shall, among other fac-
26 tors, reasonably be expected to meet its obliga-
27 tions to enrollees and prospective enrollees.
28 Each health maintenance organization shall estab-
29 lish and maintain an unimpaired appropriation of
30 surplus, represented by liquid assets consisting
31 of cash, prime commercial paper, marketable secu-
32 rities with maturities not exceeding 2 years' du-
33 ration and fully insured certificates of deposits
34 issued by banks and savings and loan associations
35 located within the United States. The value of
36 this appropriation of surplus shall be equal to
37 the organization's claims incurred, but not re-
38 ported, as determined monthly by methods of
39 claims valuation found acceptable by the superin-
40 tendent. Any nonprofit health maintenance orga-
41 nization employing fund accounts shall hold a re-
42 served portion of its General Fund balance in a

1 like manner. These funds shall be in addition to
2 and shall not be included as a part of other
3 working capital funds required by regulation of
4 the Bureau of Insurance.

5 In making this determination, the superintendent
6 may also consider:

7 (1) The financial soundness of the health
8 maintenance organization's arrangements for
9 health care services and the schedule of
10 charges used in connection therewith;

11 (2) The adequacy of working capital;

12 (3) Any agreement with an insurer, a non-
13 profit hospital or medical service corpora-
14 tion, a government or any other organization
15 for insuring or providing the payment of the
16 cost of health care services or the provi-
17 sion for automatic applicability of an al-
18 ternative coverage in the event of discon-
19 tinuance of the plan;

20 (4) Any agreement with providers for the
21 provision of health care services; and

22 (5) Any arrangements for insurance coverage
23 or an adequate plan for self-insurance to
24 respond to claims for injuries arising out
25 of the furnishing of health care services.

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STATEMENT OF FACT

2 This bill provides enabling legislation and regu-
3 lation for preferred provider organizations. Pre-
4 ferred provider organizations, also known as PPO's,
5 are organizations of health care providers who have
6 agreed to provide health care services at a dis-
7 counted rate for specified groups of people. Pre-
8 ferred provider organizations can be organized by in-
9 surance companies, nonprofit service organizations,
10 or other administrators. The bill defines them and
11 sets forth specific financial and reporting require-
12 ments. In addition, there are specific provisions
13 requiring utilization review, geographic accessibili-
14 ty, some level of reimbursement for nonpreferred
15 providers, and yearly options to choose between
16 health plans where more than one is offered. These
17 arrangements are exempt from per se state antitrust
18 laws under this bill.

19 This bill also has a provision requiring health
20 maintenance organizations to maintain a cash reserve
21 requirement. This bill will protect the members of
22 the health maintenance organizations, all of whom pay
23 a set fee for health care services in advance.

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