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SECOND REGULAR SESSION

ONE HUNDRED AND TWELFTH LEGISLATURE

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H.P. 1625 House of Representatives, March 31, 1986

Reported by Representative Aliberti from the Committee on Business and Commerce and printed under Joint Rule 2.

EDWIN H. PERT, Clerk

STATE OF MAINE

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

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

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

Sec. 1. 24 MRSA c. 19, first 3 lines, are repealed and the following enacted in their place:

CHAPTER 19

NONPROFIT HOSPITAL OR MEDICAL SERVICE ORGANIZATIONS

SUBCHAPTER I

GENERAL PROVISIONS

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

SUBCHAPTER II

NONPROFIT SERVICE ORGANIZATIONS PREFERRED PROVIDER ARRANGEMENT ACT OF 1986

§2333. Short title

This subchapter shall be known as the "Nonprofit Service Organizations Preferred Provider Arrangement Act of 1986."

§2334. Definitions

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

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 preferred provider arrangement with a nonprofit service organization.

4. Preferred provider arrangement. "Preferred provider arrangement" means a contract, agreement or arrangement consistent with section 2336.

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

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

7. Superintendent. "Superintendent" means the Superintendent of Insurance.

§2335. Selective contracting authorized

Nonprofit service organizations may enter into contracts with a limited number of preferred providers. In selecting preferred providers, nonprofit service organizations may consider, among other factors, price differences between or among providers, geographic accessibility, specialization and projected utilization by beneficiaries and insureds. Selective contracting does not constitute unreasonable discrimination against or among providers.

§2336. Contracts; agreements or arrangements with incentives or limits on reimbursement authorized

1. Contracts, agreements or arrangements. Contracts, agreements or arrangements issued under this Act may not contain terms or conditions that will operate unreasonably to restrict the access and availability of health care services for the subscriber.

2. Nonprofit service organizations. Nonprofit service organizations may:

A. Enter into agreements with certain providers of their choice relating to health care services which may be rendered to subscribers of the nonprofit service organizations, including agreements relating to the amounts to be charged by the provider to the subscriber for services rendered and amounts to be paid by the nonprofit service organization for services rendered; or

B. Issue or administer programs or contracts in this State that include incentives for the subscriber to use the services of a provider who has entered into an agreement with the nonprofit service organization pursuant to paragraph A. Where such a program or contract is offered to an employee group, employees shall have the option annually of participating in any other health insurance program or health care plan sponsored by their employer.

§2337. Reporting and disclosure

1. Disclosure. Any nonprofit service organization which proposes to offer a preferred provider arrangement authorized by this chapter shall disclose in a report to the Superintendent of Insurance, at least 30 days prior to its initial offering and prior to any change thereafter, the following:

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

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

C. The names and addresses of all providers designated by the nonprofit service organizations under this section and the terms of the agreements with designated health care providers.

The superintendent shall maintain a record of arrangements proposed under this section, including a record of any complaints submitted relative to the arrangements.

2. Certain arrangements with incentives or limits on reimbursement; disclosure. If a nonprofit service organization offers an arrangement with incentives or limits on reimbursement consistent with this subchapter as part of a group health insurance contract or policy, the forms shall disclose to subscribers:

A. Those providers with which agreements or arrangements have been made to provide health care services to the subscribers and a source for the subscribers to contact regarding changes in those providers;

B. The extent of coverage as well as any limitations or exclusions of health care services under the policy or contract;

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

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

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

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

3. Disapproval of arrangements. The superintendent shall disapprove any arrangement if it contains any unjust, unfair or inequitable provisions.

§2338. Risk-sharing and prepaid capitation rates

Preferred provider arrangements may embody risk sharing by providers. Any nonprofit service organization having formed a preferred provider arrangement by providers and employing a prepaid capitation rate shall file applicable provider agreements, rates and other relevant material with the Superintendent of Insurance for approval. The superintendent shall disapprove any rates which are excessive, inadequate or unfairly discriminatory.

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

§2339. Alternative health care benefits

A nonprofit service organization which makes a preferred provider arrangement available shall provide for payment for covered health care services rendered by providers who are not preferred providers. The payment shall be 80% of the amount that would have been charged by the preferred provider.

§2340. Utilization review

On or before April 1st of each year, a nonprofit service organization which issues or administers a program or contract in this State that includes incentives 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 provider.

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

2. "Beneficiary" means the individual entitled to reimbursement for expenses of health care services under a program where the beneficiary has an incentive to use the services of a provider who has entered into an agreement or arrangement with an administrator.

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

4. "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.

5. "Insurer" means an insurance company authorized in this State to issue policies which reimburse for expenses of health care services.

6. "Preferred provider" means a provider who enters into a preferred provider arrangement with an administrator or insurer.

7. "Preferred provider arrangement" means a contract, agreement or arrangement consistent with section 2673.

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

9. "Superintendent" means Superintendent of Insurance.

§2672. Selective contracting authorized

Insurers or administrators may enter into contracts with a limited number of preferred providers. In selecting preferred providers, insurers or administrators may consider, among other factors, price differences between or among providers, geographic accessibility, specialization and projected utilization by beneficiaries and insureds. Selective contracting does not constitute unreasonable discrimination against or among providers.

§2673. Policies, agreements or arrangements with incentives or limits on reimbursement authorized

1. Policies, agreements or arrangements issued under this chapter may not contain terms or conditions that will operate unreasonably to restrict the access and availability of health care services for the insured or beneficiary.

2. An insurer or administrator may enter into agreements with certain providers of its choice relating to health care services which may be rendered to insureds of the insurer or beneficiaries of the administrator, including agreements relating to the amounts to be charged by the provider to the insured or beneficiary for services rendered and the amounts to be paid by the insurer or administrator.

An administrator may market and otherwise make available preferred provider arrangements to licensed health maintenance organizations, insurance companies, health service corporations, fraternal benefit societies or self-insuring employers or health and welfare trust funds and to their subscribers provided that, in performing these functions, the administrator shall provide administrative services only and shall not accept underwriting risk in the form of a premium or capitation payment for its services. In performing functions consistent with this chapter, an administrator shall not accept any underwriting risk in the form of premium or capitation payment for its services.

3. An insurer may issue policies in this State or an administrator may administer programs in this State that include incentives for the insured or beneficiary to use the services of a provider who has entered into an agreement with the insurer or administrator pursuant to subsection 2. Where such a program or policy is offered to an employee group annually, employees shall have the option of participating in any other health insurance program or health care plan sponsored by their employer.

§2674. Requirements applicable to administrators

1. All administrators of a preferred provider program subject to this chapter shall register with the Bureau of Insurance and pay an annual registration fee of $20. The Bureau of Insurance shall by rule establish criteria for the registration, including minimum solvency requirements.

The Bureau of Insurance shall compile and maintain a current listing of administrators and insurers offering agreements authorized under this chapter.

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

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

B. In the event of misappropriation of funds or other violation of a fiduciary obligation, the right of any administrator to enter agreements or arrangements with incentives or limits on reimbursement consistent with this chapter may be revoked or suspended by the superintendent.

3. Unless the following information is provided by another entity, each administrator shall provide to each beneficiary of any program subject to this chapter a document which:

A. Sets forth those providers with which agreements or arrangements have been made to provide health care services to the beneficiary; a source for the beneficiary to contact regarding changes in the providers and a clear description of any incentives for the beneficiary to use the providers;

B. Discloses the extent of coverage as well as any limitations or exclusions of health care services under the program;

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

D. Sets out a description of the process for addressing a beneficiary complaint under the program;

E. Discloses deductible and coinsurance amounts charged to any person receiving health care services from a preferred provider; and

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

4. An administrator who operates more than one such program shall establish and maintain a separate fiduciary account for each such program.

5. The Superior Court shall assess a civil penalty in an amount not to exceed $3,000 for each violation, payable to the Bureau of Insurance, to be applied toward the administration of this Title, against any corporation, entity or an individual violating any provision of this chapter, including failure to register or pay the required fee, misappropriation of funds or other violation of fiduciary responsibility. Any person, whether director, office

manager, employee, representative of a corporation or entity or otherwise, may also be punished by imprisonment for less than one year for knowingly participating in or authorizing the misappropriation of funds or other violation of fiduciary responsibility.

6. Nothing in this chapter affects any rights or interest that any person other than the Bureau of Insurance or an administrator may possess.

§2675. Requirements applicable to insurers

1. Any insurer which proposes to offer a preferred provider arrangement authorized by this chapter shall disclose in a report to the Superintendent of Insurance at least 30 days prior to its initial offering and prior to any change thereafter the following:

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

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

C. The names and addresses of all providers designated by the insurer and the terms of the agreements with designated health care providers.

The superintendent shall maintain a record of arrangements proposed, including a record of any complaints submitted relative to the arrangements.

2. If an insurer offers an arrangement with incentives or limits on reimbursement consistent with this chapter as part of a group health insurance contract or policy, the forms shall disclose to insureds:

A. Those providers with which agreements or arrangements have been made to provide health care services to the insureds; a source for the insured to contact regarding changes in the providers;

B. The extent of coverage as well as any limitations or exclusions of health care services under the policy or contract;

C. The circumstances under which reimbursement will be made to an insured unable to use the services of a preferred provider;

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

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

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

3. The superintendent shall disapprove any arrangement if it contains any unjust, unfair or inequitable provisions.

§2676. Risk-sharing and prepaid capitation rates

Any insurer having formed a preferred provider arrangement employing a prepaid capitation rate shall file applicable rates and other relevant material with the Superintendent of Insurance for approval. The superintendent shall disapprove any rates which are excessive, inadequate or unfairly discriminatory.

If the superintendent has not taken any action on the forms filed within 30 days of receipt, the arrangement shall be deemed approved. The superintendent may extend, by not more than an additional 30 days, the period within which he may affirmatively approve or disapprove any form, by giving notice to the administrator or insurer before expiration of the initial 30-day period. At the expiration of any extension, if the superintendent has not acted on the forms, the arrangement shall be deemed approved. The superintendent may at any time, after hearing and for cause shown, withdraw any such approval.

§2677. Alternative health care benefits

An insurer or administrator who makes a preferred provider arrangement available shall provide for payment for covered health care services rendered by providers who are not preferred providers. The payment shall be 80% of the amount that would have been charged by the preferred provider.

§2678. Utilization review

On or before April 1st of each year, an administrator or insurer who issues or administers a program, policy or contract in this State that includes incentives for the insured or beneficiary to use the services of a provider who has entered into an agreement with the insurer or administrator, pursuant to section 2673, subsection 2, shall file a report of its activities for the preceding year with the superintendent. The report shall be in the form prescribed by the superintendent and at a minimum shall contain the following:

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

2. Utilization experience for the following categories: Hospitalization; ambulatory surgical or other outpatient services; and professional services. Utilization of professional services is to be listed by specialty.

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

B. Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person. Nothing in this provision prohibits an insurer from providing an incentive for insureds to use the services of a particular provider.

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

D. The health maintenance organization is financially responsible and shall, among other factors, reasonably be expected to meet its obligations to enrollees and prospective enrollees. Each health maintenance organization shall establish and maintain an unimpaired appropriation of surplus, represented by liquid assets consisting of cash, prime commercial paper, marketable securities with maturities not exceeding 2 years' duration and fully insured certificates of deposits issued by banks and savings and loan associations located within the United States. The value of this appropriation of surplus shall be equal to the organization's claims incurred, but not reported, as determined monthly by methods of claims valuation found acceptable by the superintendent. Any nonprofit health maintenance organization employing fund accounts shall hold a reserved portion of its General Fund balance in a like manner. These funds shall be in addition to and shall not be included as a part of other working capital funds required by regulation of the Bureau of Insurance.

In making this determination, the superintendent may also consider:

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

(2) The adequacy of working capital;

(3) Any agreement with an insurer, a nonprofit hospital or medical service corporation, a government or any other organization for insuring or providing the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

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

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

Sec. 7. 24-A MRSA §4223, as enacted by PL 1975, c. 503, is amended to read:

§4223. Filings and reports as public documents

All applications, filings and reports required under this chapter shall be treated as public documents subject to limitations and exceptions provided in Title 1, chapter 13, subchapter I.

Sec. 8. 24-A MRSA §4227 is enacted to read:

§4227. Dual choice

Any employer of more than 25 employees who offers a health maintenance organization, as defined in section 4202, shall also offer its employees, at the time of offering and renewal of the health maintenance organization, the option of selecting alternative health benefits coverage which does not restrict the ability of the covered person to obtain health care services from the provider of their choice.

Any employer subject to this section shall contribute to the alternative health benefits coverage to the same extent as it contributes to the health maintenance organization.

No employer may be required to pay more for health benefits as a result of the application of this section than would otherwise be paid.

STATEMENT OF FACT

This new draft makes some substantive changes to the bill, as well as many technical changes. The exemption from antitrust provisions was deleted because the committee decided it was unnecessary. A provision setting the level for reimbursement for nonpreferred providers at 80% was added instead of allowing this to be negotiated. A new section was added to require employers with 25 or more employees who offer a health maintenance organization as a health plan to also offer a traditional plan.

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