

MAINE STATE LEGISLATURE

The following document is provided by the
LAW AND LEGISLATIVE DIGITAL LIBRARY
at the Maine State Law and Legislative Reference Library
<http://legislature.maine.gov/lawlib>



Reproduced from scanned originals with text recognition applied
(searchable text may contain some errors and/or omissions)

1 (New Draft of H.P. 1466, L.D. 2068)
2 SECOND REGULAR SESSION
3

4 ONE HUNDRED AND TWELFTH LEGISLATURE
5

6 Legislative Document

No. 2290

7
8 H.P. 1625

House of Representatives, March 31, 1986

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

11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
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 re-
pealed and the following enacted in their place:

CHAPTER 19

NONPROFIT HOSPITAL OR MEDICAL SERVICE
ORGANIZATIONS

SUBCHAPTER I

GENERAL PROVISIONS

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

3 SUBCHAPTER II

4 NONPROFIT SERVICE ORGANIZATIONS PREFERRED
5 PROVIDER ARRANGEMENT ACT OF 1986

6 §2333. Short title

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

10 §2334. Definitions

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

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

18 2. Nonprofit service organization. "Nonprofit
19 service organization" means a nonprofit hospital ser-
20 vice corporation, nonprofit medical service corpora-
21 tion or nonprofit health care plan authorized in this
22 State.

23 3. Preferred provider. "Preferred provider"
24 means a provider of health care services who has en-
25 tered into a preferred provider arrangement with a
26 nonprofit service organization.

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

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

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

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

3 §2335. Selective contracting authorized

4 Nonprofit service organizations may enter into
5 contracts with a limited number of preferred
6 providers. In selecting preferred providers, nonprofit
7 service organizations may consider, among other
8 factors, price differences between or among
9 providers, geographic accessibility, specialization
10 and projected utilization by beneficiaries and insureds.
11 Selective contracting does not constitute unrea-
12 sonable discrimination against or among providers.

13 §2336. Contracts; agreements or arrangements with
14 incentives or limits on reimbursement autho-
15 riized

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

21 2. Nonprofit service organizations. Nonprofit
22 service organizations may:

23 A. Enter into agreements with certain providers
24 of their choice relating to health care services
25 which may be rendered to subscribers of the non-
26 profit service organizations, including agree-
27 ments relating to the amounts to be charged by
28 the provider to the subscriber for services ren-
29 dered and amounts to be paid by the nonprofit
30 service organization for services rendered; or

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

1 §2337. Reporting and disclosure

2 1. Disclosure. Any nonprofit service organiza-
3 tion which proposes to offer a preferred provider ar-
4 rangement authorized by this chapter shall disclose
5 in a report to the Superintendent of Insurance, at
6 least 30 days prior to its initial offering and prior
7 to any change thereafter, the following:

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

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

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

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

22 2. Certain arrangements with incentives or lim-
23 its on reimbursement; disclosure. If a nonprofit ser-
24 vice organization offers an arrangement with incen-
25 tives or limits on reimbursement consistent with this
26 subchapter as part of a group health insurance con-
27 tract or policy, the forms shall disclose to sub-
28 scribers:

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

34 B. The extent of coverage as well as any limita-
35 tions or exclusions of health care services under
36 the policy or contract;

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

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

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

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

8 3. Disapproval of arrangements. The superintend-
9 ent shall disapprove any arrangement if it contains
10 any unjust, unfair or inequitable provisions.

11 §2338. Risk-sharing and prepaid capitation rates

12 Preferred provider arrangements may embody risk
13 sharing by providers. Any nonprofit service organiza-
14 tion having formed a preferred provider arrangement
15 by providers and employing a prepaid capitation rate
16 shall file applicable provider agreements, rates and
17 other relevant material with the Superintendent of
18 Insurance for approval. The superintendent shall
19 disapprove any rates which are excessive, inadequate
20 or unfairly discriminatory.

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

33 §2339. Alternative health care benefits

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

1 §2340. Utilization review

2 On or before April 1st of each year, a nonprofit
3 service organization which issues or administers a
4 program or contract in this State that includes in-
5 centives for the subscriber to use the services, or a
6 provider who has entered into an agreement with the
7 nonprofit service organization pursuant to section
8 2336, subsection 2, paragraph A, shall file a report
9 of its activities for the preceding year with the su-
10 perintendent and at a minimum shall contain the fol-
11 lowing:

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

15 2. Claims experience. Claims experience for the
16 following categories: Hospitalization; ambulatory
17 surgical or other outpatient services; and profes-
18 sional services listed by specialty.

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

21 2. No person ~~shall~~ may make or permit any unfair
22 discrimination between individuals of the same class
23 and of essentially the same hazard in the amount of
24 premium, policy fees, or rates charged for any policy
25 or contract of health insurance or in the benefits
26 payable thereunder, or in any of the terms or condi-
27 tions of such contract, or in any other manner what-
28 ever. Nothing in this provision prohibits an insurer
29 from providing incentives for insureds to use the
30 services of a particular provider.

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

32 CHAPTER 32

33 PREFERRED PROVIDER ARRANGEMENT ACT OF 1986

34 §2670. Short title

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

1 §2671. Definitions

2 As used in this chapter, unless the context indi-
3 cates otherwise, the following terms have the follow-
4 ing meanings.

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

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

17 3. "Health care services" means health care ser-
18 vices or products rendered or sold by a provider
19 within the scope of the provider's legal authoriza-
20 tion.

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

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

27 6. "Preferred provider" means a provider who en-
28 ters into a preferred provider arrangement with an
29 administrator or insurer.

30 7. "Preferred provider arrangement" means a con-
31 tract, agreement or arrangement consistent with sec-
32 tion 2673.

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

36 9. "Superintendent" means Superintendent of In-
37 surance.

1 §2672. Selective contracting authorized

2 Insurers or administrators may enter into con-
3 tracts with a limited number of preferred providers.
4 In selecting preferred providers, insurers or admin-
5 istrators may consider, among other factors, price
6 differences between or among providers, geographic
7 accessibility, specialization and projected utiliza-
8 tion by beneficiaries and insureds. Selective con-
9 tracting does not constitute unreasonable discrimina-
10 tion against or among providers.

11 §2673. Policies, agreements or arrangements with in-
12 centives or limits on reimbursement autho-
13 riized

14 1. Policies, agreements or arrangements issued
15 under this chapter may not contain terms or condi-
16 tions that will operate unreasonably to restrict the
17 access and availability of health care services for
18 the insured or beneficiary.

19 2. An insurer or administrator may enter into
20 agreements with certain providers of its choice re-
21 lating to health care services which may be rendered
22 to insureds of the insurer or beneficiaries of the
23 administrator, including agreements relating to the
24 amounts to be charged by the provider to the insured
25 or beneficiary for services rendered and the amounts
26 to be paid by the insurer or administrator.

27 An administrator may market and otherwise make avail-
28 able preferred provider arrangements to licensed
29 health maintenance organizations, insurance compa-
30 nies, health service corporations, fraternal benefit
31 societies or self-insuring employers or health and
32 welfare trust funds and to their subscribers provided
33 that, in performing these functions, the administra-
34 tor shall provide administrative services only and
35 shall not accept underwriting risk in the form of a
36 premium or capitation payment for its services. In
37 performing functions consistent with this chapter, an
38 administrator shall not accept any underwriting risk
39 in the form of premium or capitation payment for its
40 services.

1 3. An insurer may issue policies in this State
2 or an administrator may administer programs in this
3 State that include incentives for the insured or ben-
4 eficiary to use the services of a provider who has
5 entered into an agreement with the insurer or admin-
6 istrator pursuant to subsection 2. Where such a pro-
7 gram or policy is offered to an employee group annu-
8 ally, employees shall have the option of participa-
9 ting in any other health insurance program or health
10 care plan sponsored by their employer.

11 §2674. Requirements applicable to administrators

12 1. All administrators of a preferred provider
13 program subject to this chapter shall register with
14 the Bureau of Insurance and pay an annual registra-
15 tion fee of \$20. The Bureau of Insurance shall by
16 rule establish criteria for the registration, includ-
17 ing minimum solvency requirements.

18 The Bureau of Insurance shall compile and maintain a
19 current listing of administrators and insurers offer-
20 ing agreements authorized under this chapter.

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

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

34 B. In the event of misappropriation of funds or
35 other violation of a fiduciary obligation, the
36 right of any administrator to enter agreements or
37 arrangements with incentives or limits on reim-
38 bursement consistent with this chapter may be re-
39 voked or suspended by the superintendent.

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

5 A. Sets forth those providers with which agree-
6 ments or arrangements have been made to provide
7 health care services to the beneficiary; a source
8 for the beneficiary to contact regarding changes
9 in the providers and a clear description of any
10 incentives for the beneficiary to use the
11 providers;

12 B. Discloses the extent of coverage as well as
13 any limitations or exclusions of health care ser-
14 vices under the program;

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

19 D. Sets out a description of the process for ad-
20 dressing a beneficiary complaint under the pro-
21 gram;

22 E. Discloses deductible and coinsurance amounts
23 charged to any person receiving health care ser-
24 vices from a preferred provider; and

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

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

31 5. The Superior Court shall assess a civil pen-
32 alty in an amount not to exceed \$3,000 for each vio-
33 lation, payable to the Bureau of Insurance, to be ap-
34 plied toward the administration of this Title,
35 against any corporation, entity or an individual vio-
36 lating any provision of this chapter, including fail-
37 ure to register or pay the required fee, misappropri-
38 ation of funds or other violation of fiduciary re-
39 sponsibility. Any person, whether director, office

1 manager, employee, representative of a corporation or
2 entity or otherwise, may also be punished by impris-
3 onment for less than one year for knowingly partici-
4 pating in or authorizing the misappropriation of
5 funds or other violation of fiduciary responsibility.

6 6. Nothing in this chapter affects any rights or
7 interest that any person other than the Bureau of In-
8 surance or an administrator may possess.

9 §2675. Requirements applicable to insurers

10 1. Any insurer which proposes to offer a pre-
11 ferred provider arrangement authorized by this chap-
12 ter shall disclose in a report to the Superintendent
13 of Insurance at least 30 days prior to its initial
14 offering and prior to any change thereafter the fol-
15 lowing:

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

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

21 C. The names and addresses of all providers des-
22 ignated by the insurer and the terms of the
23 agreements with designated health care providers.

24 The superintendent shall maintain a record of ar-
25 rangements proposed, including a record of any com-
26 plaints submitted relative to the arrangements.

27 2. If an insurer offers an arrangement with in-
28 centives or limits on reimbursement consistent with
29 this chapter as part of a group health insurance con-
30 tract or policy, the forms shall disclose to insur-
31 eds:

32 A. Those providers with which agreements or ar-
33 rangements have been made to provide health care
34 services to the insureds; a source for the in-
35 sured to contact regarding changes in the
36 providers;

1 B. The extent of coverage as well as any limita-
2 tions or exclusions of health care services under
3 the policy or contract;

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

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

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

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

14 3. The superintendent shall disapprove any ar-
15 rangement if it contains any unjust, unfair or ineq-
16 uitable provisions.

17 §2676. Risk-sharing and prepaid capitation rates

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

24 If the superintendent has not taken any action on
25 the forms filed within 30 days of receipt, the ar-
26 rangement shall be deemed approved. The superintend-
27 ent may extend, by not more than an additional 30
28 days, the period within which he may affirmatively
29 approve or disapprove any form, by giving notice to
30 the administrator or insurer before expiration of the
31 initial 30-day period. At the expiration of any ex-
32 ension, if the superintendent has not acted on the
33 forms, the arrangement shall be deemed approved. The
34 superintendent may at any time, after hearing and for
35 cause shown, withdraw any such approval.

36 §2677. Alternative health care benefits

1 An insurer or administrator who makes a preferred
2 provider arrangement available shall provide for pay-
3 ment for covered health care services rendered by
4 providers who are not preferred providers. The pay-
5 ment shall be 80% of the amount that would have been
6 charged by the preferred provider.

7 §2678. Utilization review

8 On or before April 1st of each year, an adminis-
9 trator or insurer who issues or administers a pro-
10 gram, policy or contract in this State that includes
11 incentives for the insured or beneficiary to use the
12 services of a provider who has entered into an agree-
13 ment with the insurer or administrator, pursuant to
14 section 2673, subsection 2, shall file a report of
15 its activities for the preceding year with the super-
16 intendent. The report shall be in the form pre-
17 scribed by the superintendent and at a minimum shall
18 contain the following:

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

21 2. Utilization experience for the following cat-
22 egories: Hospitalization; ambulatory surgical or oth-
23 er outpatient services; and professional services.
24 Utilization of professional services is to be listed
25 by specialty.

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

28 B. Subject to any written direction of the in-
29 sured in the application or otherwise all or a
30 portion of any indemnities provided by this poli-
31 cy on account of hospital, nursing, medical or
32 surgical services may, at the insurer's option
33 and unless the insured requests otherwise in
34 writing not later than the time of filing proofs
35 of such loss, be paid directly to the hospital or
36 person rendering such services; but it is not re-
37 quired that the service be rendered by a particu-
38 lar hospital or person. Nothing in this provi-
39 sion prohibits an insurer from providing an in-
40 centive for insureds to use the services of a
41 particular provider.

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

3 D. The health maintenance organization is finan-
4 cially responsible and shall, among other fac-
5 tors, reasonably be expected to meet its obliga-
6 tions to enrollees and prospective enrollees.
7 Each health maintenance organization shall estab-
8 lish and maintain an unimpaired appropriation of
9 surplus, represented by liquid assets consisting
10 of cash, prime commercial paper, marketable secu-
11 rities with maturities not exceeding 2 years' du-
12 ration and fully insured certificates of deposits
13 issued by banks and savings and loan associations
14 located within the United States. The value of
15 this appropriation of surplus shall be equal to
16 the organization's claims incurred, but not re-
17 ported, as determined monthly by methods of
18 claims valuation found acceptable by the superin-
19 tendent. Any nonprofit health maintenance orga-
20 nization employing fund accounts shall hold a re-
21 reserved portion of its General Fund balance in a
22 like manner. These funds shall be in addition to
23 and shall not be included as a part of other
24 working capital funds required by regulation of
25 the Bureau of Insurance.

26 In making this determination, the superintendent
27 may also consider:

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

32 (2) The adequacy of working capital;

33 (3) Any agreement with an insurer, a non-
34 profit hospital or medical service corpora-
35 tion, a government or any other organization
36 for insuring or providing the payment of the
37 cost of health care services or the provi-
38 sion for automatic applicability of an al-
39 ternative coverage in the event of discon-
40 tinuance of the plan;

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

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

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

7 §4223. Filings and reports as public documents

8 All applications, filings and reports required
9 under this chapter shall be treated as public docu-
10 ments subject to limitations and exceptions provided
11 in Title 1, chapter 13, subchapter I.

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

13 §4227. Dual choice

14 Any employer of more than 25 employees who offers
15 a health maintenance organization, as defined in sec-
16 tion 4202, shall also offer its employees, at the
17 time of offering and renewal of the health mainte-
18 nance organization, the option of selecting alterna-
19 tive health benefits coverage which does not restrict
20 the ability of the covered person to obtain health
21 care services from the provider of their choice.

22 Any employer subject to this section shall con-
23 tribute to the alternative health benefits coverage
24 to the same extent as it contributes to the health
25 maintenance organization.

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

1

STATEMENT OF FACT

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

12

6996032786