115th MAINE LEGISLATURE

FIRST REGULAR SESSION-1991

Legislative Document **No. 1122**

H.P. 790 House of Representatives, March 13, 1991

Reference to the Committee on Human Resources suggested and ordered printed.

Ed Pert

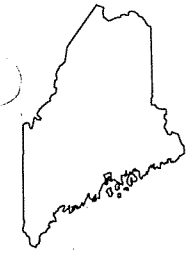
EDWIN H. PERT, Clerk

Presented by Representative MANNING of Portland.
Cosponsored by Representative GWADOSKY of Fairfield and Senator THERIAULT of Aroostook.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

An Act to Encourage Medical Cost Containment Measures by Enabling the Establishment of Preferred Provider Arrangements.



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

Sec. 1. 24-A MRSA §2673, sub-§§2 and 3, as repealed and replaced by PL 1989, c. 588, Pt. A, §49, are amended to read:

2. Terms governing preferred provider arrangements and assuring access or availability. Policies, agreements or arrangements issued under this ~~chapter~~ provision may not contain terms or conditions that ~~will~~ operate unreasonably to restrict the access and availability of health care services. ~~The superintendent shall adopt rules setting forth criteria for determining when a term or condition operates unreasonably to restrict access and availability of health care services. The rules shall include criteria for evaluating the reasonableness of the distance to be travelled by insureds or beneficiaries for particular services and may prohibit the insurer or administrator from applying a benefit level differential to individual insureds or beneficiaries who must travel an unreasonable distance to obtain the service. The criteria shall also include the effect of the arrangement on noninsureds and nonbeneficiaries in the communities affected by the arrangement, including, but not limited to, the ability of nonpreferred providers to continue to provide health care services if all nonemergency services were provided by a preferred provider.~~ However, no restrictions may result in a required payment to a nonpreferred provider at a benefit level equal to that of a preferred provider, unless specified in this chapter.

A. The superintendent shall adopt rules relating to capitated preferred provider arrangements, to require filing of the following information:

(1) The name and business address used for the arrangement or of any separate organization that administers an arrangement;

(2) A general statement of the health care services offered, including the method of program marketing and the geographic area being served;

(3) The names and addresses of all providers participating in an arrangement;

(4) Prototype copies of any contracts used with employers or other purchasers, providers and administrators;

(5) Procedures, if any, for referral of covered persons to nonpreferred providers by a preferred provider or by the health service organization, insurer or administrator and the conditions under which referral occurs;

(6) Procedures for assuring reasonable availability of health care services, maintaining and monitoring quality health care and for controlling cost of health care services and utilization of services including an explanation of the provisions holding covered persons financially harmless for payment denials;

(7) Copies of booklet certificates or contracts to be given to the covered persons;

(8) Rates charged to employers or other purchasers relating to the preferred provider arrangement;

(9) A description of benefit differentials; and

(10) Procedures to resolve complaints and grievances in a timely manner.

B. The superintendent shall adopt rules relating to noncapitated preferred provider arrangements to require filing of the following information:

(1) The name and business address used for the arrangement or of any separate organization that administers an arrangement;

(2) The names and addresses of all providers participating in an arrangement;

(3) Prototype copies of any contracts used with employers or other purchasers, providers and administrators;

(4) Procedures for controlling cost of health care services and utilization of services;

(5) Copies of booklet certificates or contracts to be given to the covered persons;

(6) A description of benefit differentials; and

(7) Procedures to resolve complaints and grievances in a timely manner.

3. Length of contract. Contracts for preferred provider arrangements ~~shall~~ must not exceed a term of 3 years. A ~~preferred provider arrangement for all insureds or beneficiaries of an insurer must be awarded on the basis of an open bidding process after invitation to all providers of that service in the State. Each preferred provider arrangement affecting all~~

~~insureds and beneficiaries must be bid and contracted for as separate services. Each service on the list set forth in section 2677 shall constitute a separate service.~~

Sec. 2. 24-A MRSA §2675, sub-§1-A, ¶A, as enacted by PL 1989, c. 588, Pt. A, §51, is amended to read:

A. The superintendent shall disapprove any arrangement if it contains any unjust, unfair or inequitable provisions or fails to meet the standards ~~set forth in~~ under section 2673, or those ~~set forth in~~ established by rules adopted pursuant to section 2673. ~~The superintendent shall also adopt rules setting forth the criteria to be used in determining what constitutes an unjust, unfair or inequitable provision.~~

Sec. 3. 24-A MRSA §2676, as repealed and replaced by PL 1989, c. 588, Pt. A, §53, is amended to read:

§2676. Risk sharing

Preferred provider arrangements may embody risk sharing by providers. Capitation is one form of permitted risk sharing and may be based upon a fixed per member per month payment or percentage of premium payment pursuant for which the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided.

Sec. 4. 24-A MRSA §2678, sub-§2, as enacted by PL 1985, c. 704, §4, is amended to read:

2. Utilization experience in aggregate dollars spent for the following categories: ~~Hospitalization~~ 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 §2679, sub-§1, ¶¶A and B, as enacted by PL 1987, c. 168, §3, are amended to read:

A. The ~~number and~~ type of evaluations performed.

(1) For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service;

~~B. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or benefits paid for the service were reduced by the administrator or insurer;~~

STATEMENT OF FACT

This bill enables the use of managed care techniques as a means to contain medical costs. Specifically, the bill amends current law to differentiate between types of preferred provider arrangements, simple reimbursement mechanisms as contrasted to capitated arrangements that may be based upon a fixed per member per month payment structure. As proposed, capitated arrangements are required to file more detailed information with the Bureau of Insurance than is required of a simple reimbursement plan.