L.D. 2129

(Filing No. H-988)

STATE OF MAINE
HOUSE OF REPRESENTATIVES
115TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 1517, L.D. 2129, Bill, "An Act to Amend the Maine Insurance Code"

Amend the bill by striking out everything after the enacting clause and before the statement of fact and inserting in its place the following:

'**Sec. 1. 24-A MRSA §4202,** as amended by PL 1989, c. 842, §§1 to 3, is repealed.

Sec. 2. 24-A MRSA §4202-A is enacted to read:

§4202-A. Definitions

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

1. Basic health care services. "Basic health care services" means health care services that an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, emergency care, inpatient hospital care, inpatient-outpatient physician services, x-ray services and laboratory services.

2. Capitated basis. "Capitated basis" has the following meanings.

A. "Capitated basis" means fixed per-member, per-month payments or percentage-of-premium payments pursuant to which the provider assumes full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

B. "Capitated basis," in the context of a point-of-service option plan, means prepayment that considers provision of in-plan covered services as described in paragraph A and that considers out-of-plan indemnity benefits reimbursed pursuant to the terms of a point-of-service product approved pursuant to section 4207-A.

3. Carrier. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital, a medical service corporation or any other entity responsible for the payment of benefits or provision of services under a group contract.

4. Copayment. "Copayment" means an amount an enrollee must pay in order to receive a specific service that is not fully prepaid.

5. Deductible. "Deductible" means the amount an enrollee is responsible to pay out of pocket before a health maintenance organization begins to pay the costs associated with treatment.

6. Enrollee. "Enrollee" means an individual who is enrolled in a health maintenance organization.

7. Evidence of coverage. "Evidence of coverage" means any certificate, agreement or contract issued to a group contract holder or an enrollee setting out the coverage to which an enrollee is entitled.

8. Group contract holder. "Group contract holder" means an entity or person that has purchased coverage from a health maintenance organization that provides, at a minimum, basic health care services to enrollees.

9. Health care services. "Health care services" means any services included in the furnishing of medical care, dental care or hospitalization to an individual, or any services incident to the furnishing of that care or hospitalization, as well as the furnishing of any other services to an individual to prevent, alleviate, cure or heal human illness or injury.

10. Health maintenance organization. "Health maintenance organization" means a public or private organization that is organized under the laws of the Federal Government, this State, another state or the District of Columbia and that:

A. Provides, arranges or pays for, or reimburses the cost of, health care services, including, at a minimum, basic health care services to enrolled participants;

B. Is compensated, except for reasonable copayments, for basic health care services to enrolled participants solely on a predetermined periodic rate basis;

C. Provides physicians' services primarily directly through physicians who are either employees or partners of that organization or through arrangements with individual physicians or one or more groups of physicians organized on a group-practice or individual-practice basis under which those physicians or groups are provided effective incentives to avoid unnecessary or unduly costly utilization, regardless of whether a physician is individually compensated primarily on a fee-for-service basis or otherwise. The organization may discharge its obligation through a point-of-service option product by reimbursing out-of-plan providers pursuant to the terms contained in the group contract holder's group contract. Receipt of out-of-plan covered services by an enrollee does not obligate the organization for an enrollee's responsibilities to meet copayments or deductibles; and

D. Ensures the availability, accessibility and quality, including effective utilization, of the health care services that it provides or makes available through clearly identifiable focal points of legal and administrative responsibility.

Nothing in this subsection prevents a health maintenance organization from providing fee-for-service health care services as well as health maintenance organization services.

11. In-plan covered services. "In-plan covered services" means covered health care services obtained from providers who are employed by, under contract with, referred by or otherwise affiliated with the health maintenance organization. "In-plan covered services" includes emergency services.

12. Nonprofit hospital or medical service organization. "Nonprofit hospital or medical service organization" means any organization defined in and authorized to act under Title 24, chapter 19.

13. Out-of-plan covered services. "Out-of-plan covered services" means nonemergency, covered health care services obtained without a referral from providers who are not otherwise employed by, under contract with or otherwise affiliated with the health maintenance organization or from affiliated specialists.

14. Participating provider. "Participating provider" means a provider as defined in subsection 18 that, under an express or implied contract with a health maintenance organization, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment, directly or indirectly from the health maintenance organization.

15. Person. "Person" means an individual, firm, partnership, corporation, association, syndicate, organization, society, business trust, attorney-in-fact or any legal entity.

16. Point-of-service option. "Point-of-service option" means a health maintenance organization product that allows an enrollee to select either the comprehensive health care benefits of the health maintenance organization or care from a provider of the enrollee's choice outside the health maintenance organization network with traditional indemnity benefits. A point-of-service option in which the risk for out-of-plan covered services of a health maintenance organization is shared with a reinsurer must meet the requirements of this chapter applicable to the indemnity benefits provided by a health maintenance organization.

17. Point-of-service product. "Point-of-service product" means a product that includes both in-plan covered services and out-of-plan covered services.

18. Provider. "Provider" means a physician, hospital or person that is licensed or otherwise authorized in this State to furnish health care services.

19. Superintendent. "Superintendent" means the Superintendent of Insurance.

20. Uncovered expenditures. "Uncovered expenditures" means costs to a health maintenance organization for health care services that are the obligation of the health maintenance organization for which an enrollee may also be liable.

Sec. 3. 24-A MRSA §4204, sub-§2-A, ¶C, as enacted by PL 1981, c. 501, §51, is amended to read:

C. The health maintenance organization conforms to the definition under section ~~4202~~ 4202-A, subsection ~~5~~ 10.

Sec. 4. 24-A MRSA §4204-A, sub-§2-A is enacted to read:

2-A. Additional surplus. A health maintenance organization that otherwise possesses surplus funds as required under this section shall also maintain surplus in a reasonable amount as determined by the superintendent in relation to indemnity risks assumed through the issuance of a point-of-service product, net of any applicable reinsurance.

Sec. 5. 24-A MRSA §4207-A is enacted to read:

§4207-A. Point-of-service products

1. Product design; mandatory requirements. A point-of-service product, filed and approved for use subject to the requirements of section 4207, subsection 4, at a minimum must:

A. Provide all services required by law to be provided by health maintenance organizations as in-plan covered services, including emergency services;

B. Provide incentives for enrollees to use in-plan covered services; and

C. Offer out-of-plan covered services only if those services are provided by the point-of-service product on an in-plan basis.

2. Product design; optional provisions. A point-of-service product may:

A. Limit or exclude specific types of services from coverage when obtained out of plan;

B. Include annual out-of-pocket limits and annual and lifetime maximum benefit allowances for out-of-plan covered services that are separate from any limits and allowances applied to in-plan covered services;

C. Limit the groups to which the point-of-service product is offered. If the point-of-service product is offered to a group, it must be offered to all eligible members of that group; and

D. Include those services that an enrollee obtains from a participating physician for which proper authorization was not given.

3. Product limitations and exclusions. A health maintenance organization is subject to the following requirements as to its point-of-service product.

A. A health maintenance organization may not expend more than 20% of its total annual health care expenditures for out-of-plan covered services.

B. If compliance with the amount specified in paragraph A is not demonstrated on a quarterly basis in a health maintenance organization's quarterly financial report, the superintendent may prohibit the health maintenance organization from offering a point-of-service product for new issues or for the renewal of existing contracts until compliance has been demonstrated.

4. Plan requirements. A health maintenance organization may not issue a point-of-service product until it has filed and has had approved by the superintendent a plan to comply with this section, including, in addition to any other requirements of this section, group contracts, subscriber contracts and other materials used by enrollees.

A. Marketing materials must be filed upon request of the superintendent. Member handbooks must be filed for approval only when the initial point-of-service plan is filed and when substantial modifications are made in the point-of-service plan that change policy terms respecting benefits or change the manner in which enrollees may access provider services.

B. The plan must include, but is not limited to, provisions demonstrating that the health maintenance organization will:

(1) Design the benefit levels for in-plan covered services and out-of-plan covered services to achieve the desired level of in-plan utilization; and

(2) Provide or arrange for the provision of adequate systems to:

(a) Process and pay claims for out-of-plan covered services;

(b) Meet the requirements of a point-of-service product as set by this section or by rule of the superintendent; and

(c) Generate accurate financial and regulatory reports on a timely basis in order for the superintendent to evaluate experience with the point-of-service product and monitor compliance with point-of-service product provisions.

5. Claims processing. Explanation of benefits given to an enrollee of a point-of-service plan must contain an explanation of coverage for self-referral health care services that is adequate to permit an enrollee to determine claims liability under the plan.

6. Disclosure. All marketing materials, subscriber contracts, member handbooks or other material used by enrollees must contain a clear and concise explanation of point-of-service health care services. The explanation must include:

A. The method of reimbursement;

B. Applicable copayments and deductibles;

C. Other uncovered costs or charges;

D. The services that an enrollee is permitted to obtain on a self-referral basis; and

E. Instructions regarding submission of claims for self-referred health care services.

Sec. 6. 24-A MRSA §4208, sub-§1, as enacted by PL 1975, c. 503, is amended to read:

1. Every health maintenance organization shall annually, on or before the first day of April, file a report verified by at least 2 principal officers with the superintendent with a copy to the Commissioner of Human Services, covering the preceding calendar year. The superintendent may by rule or order require the filing of quarterly or more frequent reports, which may be required to include liability for uncovered expenditures as well as an audit opinion.

Sec. 7. 24-A MRSA §4224, as enacted by PL 1975, c. 503, is repealed and the following enacted in its place:

§4224. Confidentiality; liability; access to records

1. Confidentiality. Any data or information pertaining to the diagnosis, treatment or health of an enrollee or applicant obtained from that enrollee or applicant or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except: to the extent that it may be necessary to carry out the purposes of this chapter; upon the express consent of the enrollee or applicant; pursuant to statute or court order for the production of evidence or the discovery of evidence; or in the event of claim or litigation between that enrollee or applicant and the health maintenance organization when such data or information is pertinent. A health maintenance organization is entitled to claim any statutory privileges against such disclosure that the provider who furnished such information to the health maintenance organization is entitled to claim.

2. Liability. A person who, in good faith and without malice, as a member, agent or employee of a quality assurance committee, assists in the origination, investigation or preparation of a report or information related to treatment previously rendered, submits that report or information to a health maintenance organization or appropriate state licensing board, or assists the committee in carrying out any of its duties under this chapter is not subject to civil liability for damages as a consequence of those actions, nor is the health maintenance organization that established that committee or the officers, directors, employees or agents of that health maintenance organization liable for the activities of that person. This section may not be construed to relieve any person of liability arising from treatment of a patient.

A. The information considered by a quality assurance committee and the records of its actions and proceedings are confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal, if permitted, from the findings or recommendations of the committee. A member of a quality assurance committee or an officer, director, staff person or other member of a health maintenance organization engaged in assisting the committee or any person assisting or furnishing information to the committee may not be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on these activities.

B. Information considered by a quality assurance committee and the records and proceedings of that committee used pursuant to paragraph A by a state licensing or certifying

agency or in an appeal must be kept confidential and are subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of the health care review committee.

3. Access to records. To fulfill the obligations of a health maintenance organization under section 4204, subsection 2-A, paragraph B, a health maintenance organization must have access to treatment records and other information pertaining to the diagnosis, treatment and health status of any enrollee.

Sec. 8. 24-A MRSA §4227, as enacted by PL 1985, c. 704, §8, is amended to read:

§4227. Choice of alternative coverage

Any employer of more than ~~25~~ 50 employees who offers a health maintenance organization, as defined in section ~~4202~~ 4202-A, 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~~ that does not restrict the ability of the covered ~~person~~ persons to obtain health care services from the ~~provider~~ providers 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~~ An employer may not be required to pay more for health benefits as a result of the application of this section than would otherwise be paid.

An employer may satisfy the requirements of this section by offering a point-of-service option.

FISCAL NOTE

The Bureau of Insurance will incur some minor additional administrative costs to adopt rules regarding reporting by health maintenance organizations. These costs can be absorbed within the bureau's existing budgeted resources.'

STATEMENT OF FACT

This amendment replaces the original bill. The amendment adds necessary terms to the list of definitions for health

maintenance organizations, or HMO's. It requires HMO's to maintain surplus funds to cover indemnity obligations, allows point-of-service options and establishes requirements on point-of-service options for HMO's. It tracks the confidentiality and limited liability provisions applicable to other health care providers. It changes the law so that an employer of 50, rather than 25, employees who offers an HMO shall offer its employees the option of selecting alternative health benefits coverage. The amendment also adds rulemaking power for the Superintendent of Insurance so that written reports may be required from the HMO's to ensure compliance with the law.

This amendment also adds a fiscal note.

Reported by the Committee on Banking and Insurance
Reproduced and distributed under the direction of the Clerk of the House
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