116th MAINE LEGISLATURE

FIRST REGULAR SESSION-1993

Legislative Document **No. 1491**

H.P. 1104 House of Representatives, May 11, 1993

An Act Concerning Preferred Provider Arrangements.

Reference to the Committee on Banking and Insurance suggested and ordered printed.

JOSEPH W. MAYO, Clerk

Presented by Representative DAGGETT of Augusta.

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

Sec. 1. 24-A MRSA c. 32, as amended, is repealed.

Sec. 2. 24-A MRSA c. 32-A is enacted to read:

CHAPTER 32-A

PREFERRED PROVIDER ARRANGEMENT ACT OF 1993

§2680. Short title

This chapter is known and may be cited as the "Preferred Provider Arrangement Act of 1993."

§2681. Definitions

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

1. Administrator. "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 by which beneficiaries are provided an incentive to use the services of that provider.

2. Beneficiary. "Beneficiary" means an individual entitled to reimbursement for expenses of health care services under a program in which 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. "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. "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.

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

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

7. Preferred provider arrangement. "Preferred provider arrangement" means a contract, agreement or arrangement consistent with section 2683.

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

9. Superintendent. "Superintendent" means the Superintendent of Insurance.

§2682. Selective contracting authorized

1. Contracting authorized. This Act authorizes selective contracting by insurers or administrators with a limited number of preferred providers to provide health care services to insureds of the insurer or beneficiaries of the administrator in a cost-effective way.

2. Contracting not discrimination. 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.

§2683. Policies, agreements or arrangements with incentives or limits on reimbursement authorized

1. Arrangements with preferred providers permitted. Subject to this section and to the approval of the superintendent, an insurer or administrator may enter into agreements with certain providers of the insurer's or administrator's choice relating to health care services that 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 amounts to be paid by the insurer or administrator.

A. An administrator may market or make preferred provider arrangements available to licensed health maintenance organizations, insurance companies, health service corporations, fraternal benefit societies, self-insuring employers or health and welfare trust funds and their subscribers. In performing these functions, the administrator must provide administrative services only and may not accept underwriting risk in the form of a premium or capitation payment for services rendered.

B. 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 this subsection. When such a program or policy is offered to an employee group, employees have the annual option of participating in any other health insurance program or health care plan sponsored by their employer.

2. Terms restricting access or availability prohibited. Policies, agreements or arrangements issued under this Act may not contain terms or conditions that will operate to restrict unreasonably the access and availability of health care services. The superintendent shall adopt rules setting forth criteria for determining when a term or condition operates to restrict unreasonably access and availability of health care services. The rules must 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 must 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 services were provided by a preferred provider.

3. Presumption of restricted access and availability. It is presumed that the proposed preferred provider arrangement operates to restrict unreasonably access and availability of health care services when the type of care contemplated is addressed by preexisting mandated benefit legislation. The superintendent shall adopt rules setting forth criteria for determining when a term or condition operates to restrict unreasonably access and availability of health care services. The rules must include criteria for evaluating the reasonableness of the distance to be traveled 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 must also include the effect of the arrangement on noninsureds and nonbeneficiaries in the community affected by the arrangement, including, but not limited to, the ability of nonpreferred providers to continue to provide health care services.

4. Length of contract; contracting process. Contracts for preferred providers arrangements may 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. Providers must be given an adequate opportunity to respond to the open bidding process, but in any event, they must have at least 30 calendar days to respond. 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 2685 constitutes a separate service.

§2684. Requirements applicable to administrators

1. Registration. All administrators of a preferred provider program subject to this Act shall register with the Bureau of Insurance and pay an annual registration fee of $2500. 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 Act.

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

A. If a surety bond of indemnity is posted, it must be drawn in favor of the Treasurer of State and held by the superintendent 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 Act may be revoked or suspended by the superintendent.

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

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

5. Penalties. 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 Act, including failure to register or pay the required fee, misappropriation of funds or other violation of fiduciary responsibility. Any person, whether a director, office manager, employee, representative of a corporation or entity or other person, may also be punished by imprisonment for less than one year for knowingly participating in or authorizing the misappropriation of funds or another violation of fiduciary responsibility.

6. Rights not impaired. Nothing in this Act affects any rights or interests possessed by any person other than the Bureau of Insurance or an administrator.

§2685. Requirements applicable to insurers

1. Approval of arrangements. An insurer or administrator that proposes to offer a preferred provider arrangement authorized by this Act shall file with the superintendent

proposed agreements, rates and other materials relevant to the proposed arrangement, in the time period and the manner established by rule by the superintendent. The insurer or administrator proposing the arrangement shall file with the superintendent a list of practitioners and agencies who are providers of the type of care contemplated under the arrangement. An arrangement may not be offered until the superintendent has approved the arrangement. The superintendent shall include in the rules the number of days within which the superintendent must approve or disapprove a proposed arrangement.

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 section 2683 or those set forth in rules adopted pursuant to section 2683. The superintendent shall also adopt rules setting forth the criteria to be used in determining what constitutes an unjust, unfair or inequitable provision.

B. The superintendent shall disapprove any arrangement if it contains health care provider credential requirements that exceed the existing credential or licensing requirements under state law or regulation.

C. The superintendent shall disapprove any arrangement if it contains in-service training requirements for health care providers in excess of existing requirements adopted by a governmental agency or standards adopted by the appropriate professional organization.

D. The superintendent shall disapprove any arrangement if it contains provisions that will cause existing health care providers to suffer substantial revenue losses resulting in reduction of services or if they are otherwise required, because of the effect of the arrangement, to reduce services available to nonbeneficiary clients or patients. The superintendent shall adopt rules setting forth criteria to be used in determining when existing health care providers will suffer substantial revenue losses or reduction of services, including, but not limited to, consideration of the following:

(1) The effect the reduction of services will have on the level of benefits made available to residents of this State by this Act to be provided by a wide variety of health care providers pursuant to Title 24, chapter 19;

(2) The negative effect the reduction of services will have on the orderly, efficient and cost-effective provision of health care services in the State; and

(3) The aggregate social costs attending the reduction of services in terms of mortality, violent crime and untreated substance abuse.

E. The superintendent shall disapprove any arrangement if it otherwise exceeds any existing regulatory requirements.

2. Notice. Within 5 days of filing a proposed arrangement, the administrator or insurer proposing the arrangement shall:

A. Mail notice of the proposal to all persons who have requested notice of preferred provider arrangement proposals in advance from the superintendent;

B. Publish notice of the preferred provider arrangement in the legal advertisement section of at least one newspaper published in each county of the State at least once a week for 8 consecutive weeks;

C. Mail notice of the preferred provider arrangement to all persons listed as providers of that type of care in the filing required under subsection 1;

D. Publish notice of the preferred provider arrangement in an appropriate professional journal for at least 2 months; and

E. Ensure that the notices invite written comments from interested persons and inform interested persons of their right to request a public hearing.

3. Public hearing. The superintendent may hold a public hearing on approval of a preferred provider arrangement and shall hold a public hearing if an interested person requests a public hearing and the request meets the criteria set forth in this section and in the rules adopted under this section. The superintendent shall hold a public hearing upon request of an interest person when:

A. The interested person makes a written request to the superintendent:

(1) Within the time period established by rule by the superintendent;

(2) Stating briefly the respects in which that person is interested or affected; and

(3) Stating the grounds on which that person relies and the relief to be demanded at the hearing; and

B. The superintendent finds that:

(1) The request is timely and made in good faith; and

(2) The interested person would be aggrieved if the stated grounds were established and the grounds otherwise justify the hearing.

The superintendent shall adopt rules to implement the hearing requirement, including rules setting forth the time period within which a public hearing will be held on the superintendent's initiative and the time period within which an interested person must file a request for a public hearing. If the superintendent finds that a public hearing is justified at the request of an interested person, the public hearing must be held within 30 days after the filing of the request by an interested person, unless the hearing is postponed by consent of the interested person, the superintendent and the insurer or administrator filing the arrangement. The hearing must be held in accordance with the provisions of the Maine Administrative Procedure Act, including the provision permitting intervention of interested persons.

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

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

§2686. Risk sharing

Preferred provider arrangements may embody risk sharing by providers.

§2687. Alternative health care benefits

An insurer or administrator who makes a preferred provider arrangement available shall provide for payment of covered health care services rendered by providers who are not preferred providers. The benefit level differential for all services rendered is limited to a maximum of 20% of the allowable charge. For the purposes of this section, the term "allowable charge" means the amount that would be payable for services under the preferred provider arrangement prior to the application of any deductible and coinsurance.

§2688. 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 2683, subsection 2, shall file a report of its activities for the preceding year with the superintendent. The report must be in the form prescribed by the superintendent and at a minimum must contain the following:

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

2. Utilization experience. Utilization experience for the following categories: hospitalization, ambulatory surgical or other outpatient services and professional services. Utilization of professional services must be listed by specialty.

§2689. Annual report

In addition to the utilization reports required by section 2688, each insurer or administrator shall file a report with the joint standing committee of the Legislature having jurisdiction over insurance matters by January 1st of each year, setting forth its activities for the past year with respect to preferred

provider arrangements, its plans to develop arrangements in the future, the effects of the preferred provider arrangements on insurance costs and services and insured and employer satisfaction with the arrangement. The superintendent shall also file a report with the joint standing committee of the Legislature having jurisdiction over insurance matters by January 1st of each year on the activities of insurers with respect to preferred provider arrangements, any complaints received by the Bureau of Insurance concerning these arrangements and the effects of preferred provider arrangements.

§2690. Utilization review data

1. Report required. 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 contains a provision by which, in nonemergency cases, the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening procedure prior to the delivery of nonemergency contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed in ordered by a duly licensed physician shall file a report on the results of the evaluation for the preceding year with the superintendent. The report must contain the following:

A. The number and type of evaluations performed.

(1) As used in 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;

C. The number and result of any appeals by patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and

D. Any complaints filed in a court of competent jurisdiction and served upon an administrator or insurer filing under this section stating a course of action against the administrator or insurer on the basis of damages to patients alleged to have been proximately caused by a delay, reduction or denial of medical benefits by the administrator

or insurer, as determined through prospective evaluations and the determination of liability or other disposition of the complaint.

2. State residents. This section applies only to evaluations, appeals and complaints relating to residents of the State.

3. Confidentiality. Information provided pursuant to this section may not identify the names of patients.

§2691. Retroactivity; reapproval required

The requirements contained in this Act are effective retroactively to September 23, 1992. Any preferred provider arrangement approved subsequent to September 23, 1992 pursuant to the provisions of chapter 32 must be reapproved pursuant to the provisions of this Act.

STATEMENT OF FACT

This bill repeals the Preferred Provider Arrangement Act of 1986 and enacts a replacement act which is intended to address certain issues created by a recent Bureau of Insurance action with respect to preferred providers in the substance abuse field. The bill does not adversely affect current mandated benefits. It addresses the ability of nonpreferred providers to continue to provide health care services if other key services are provided by other preferred providers. It also addresses a number of procedural aspects having to do with notice to providers and provider opportunity to respond. It also requires the filing of lists of possible preferred providers with the Superintendent of Insurance. It increases the filing fee from $20 to $2,500 reflecting the great amount of processing work necessary.

The bill provides that no preferred provider arrangement may be approved by the Superintendent of Insurance when an arrangement requires exceeding existing credentials or licensing statutes or regulations; requires in-service training in excess of statutory or regulatory requirements; has the effect of causing losses of service or revenues to key current providers; or exceeds the requirements of any existing statutory or regulatory provisions having to do with the operation of agencies or the exercise of licensure by individual providers.

The bill contains a retroactivity clause requiring the superintendent to reopen proceedings in which preferred providers

had been approved under the Preferred Provider Arrangement Act of 1986.