L.D. 1596

DATE: 3/23/94 (Filing No. S- 502)

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BANKING & INSURANCE

Reported by: Senator McCormick of Kennebec

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STATE OF MAINE
SENATE
116TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to S.P. 560, L.D. 1596, Bill, "An Act to Promote Managed Care and to Otherwise Facilitate the Cost-effective Delivery of Health Care in the State"

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

'**Emergency preamble. Whereas,** Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, it has become apparent that the laws relating to managed health care plans are restricting the ability of such plans to negotiate reductions in costs; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

PART A

Sec. A-1. 22 MRSA §396-I, sub-§4, as amended by PL 1991, c. 786, §2, is repealed and the following enacted in its place:

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4. Negotiated discounts. A hospital participating in the rate per case system may negotiate discounts to charges with payors or purchasers. A hospital participating in the total revenue system may negotiate discounts with the approval of the commission according to standards adopted by rule of the commission. The revenue losses resulting from negotiated discounts may not be reflected in the computation of a hospital's revenue limit. Negotiated discounts may include capitation arrangements for hospital and other services and other contracts in which an agreed payment amount may, in individual cases, be more or less than the established charge for the services rendered.

Sec. A-2. 22 MRSA §1829, sub-§2, ¶B, as repealed and replaced by PL 1991, c. 548, Pt. A, §17, is amended to read:

B. Covered under an insurance policy or contract that is not subject to Title 24, section 2302-B, Title 24-A, section 2749-A or Title 24-A, section ~~2848~~ 2847-A.

Sec. A-3. 24-A MRSA §2736-C, sub-§3, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

B. Renewal must be guaranteed to all individuals except:

(1) For nonpayment of the required premiums by the policyholder or contract holder;

(2) For fraud or material misrepresentation by the policyholder or contract holder;

(3) For fraud or material misrepresentation on the part of the individual or the individual's representative; ~~and~~

(4) When the carrier ceases providing individual health plans in compliance with subsection 4~~.~~ ; or

(5) When the carrier ceases offering a product and replaces it with a product that complies with the requirements of this section, including renewability.

Sec. A-4. 24-A MRSA §2808-B, sub-§4, ¶B, as enacted by PL 1991, c. 861, §2, is amended to read:

B. Renewal must be guaranteed to all eligible groups, to all eligible employees and their dependents in those groups except:

(1) For nonpayment of the required premiums by the policyholder, contract holder or employer;

(2) For fraud or material misrepresentation by the policyholder, contract holder or employer or;

(3) With respect to coverage of eligible individuals, for fraud or material misrepresentation on the part of the individual or the individual's representative;

(4) For noncompliance with the carrier's minimum participation requirements, which may not exceed 75%; and

(5) When the carrier ceases providing small group health plans in compliance with subsection 5.; or

(6) When the carrier ceases offering a product and replaces it with a product that complies with the requirements of this section, including renewability.

Sec. A-5. 24-A MRSA §4202-A, sub-§10, as enacted by PL 1991, c. 709, §2, is amended to read:

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 or a component of such an organization, 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, except that the organization is not prohibited from having a provision in a group contract allowing an adjustment of premiums based upon the actual health services utilization of the enrollees covered under the contract, and except that such a contract may not be sold to an eligible group subject to the community rating requirements of section 2808-B;

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

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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. A health care provider or affiliated entity that does not offer health insurance or health benefit plans may not be or become a health maintenance organization subject to this chapter solely by reason of arrangements with insurers or hospital or medical service organizations for reimbursement in whole or in part on a capitated basis, the financial risk to the provider or affiliated entity associated with reimbursement arrangements with such 3rd-party payors or the furnishing by the provider or affiliated entity of utilization or case management services.

Sec. A-6. 24-A MRSA §4207, sub-§5, as enacted by PL 1975, c. 503, is repealed and the following enacted in its place:

5. A schedule or an amendment to a schedule of charge for enrollee health coverage for health care services may not used by any health maintenance organization unless it complies with section 2736 or 2839, whichever is applicable.

Sec. A-7. Reconsideration and amendment of Bureau of Insurance Rule Chapter 750. The Superintendent of Insurance shall reconsider and amend, in accordance with the Bureau of Insurance Rule Chapter 750 regarding benefits in the standard and basic plans for small group health insurance, the Maine Revised Statutes, Title 24-A, section 2808-B, subsection 8, to ensure that the benefits and benefit limitations do not discriminate against chiropractors whose services are mandated by law. The superintendent shall report to the joint standing committee of the Legislature having jurisdiction over banking and insurance

matters by October 1, 1994, on the reconsideration and amendment of Bureau of Insurance Rule Chapter 750.

PART B

Sec. B-1. 24 MRSA §2302-B is enacted to read:

§2302-B. Penalty for noncompliance with utilization review programs

A contract issued or renewed by a nonprofit service organization after the effective date of this section may not contain a provision that establishes a penalty of more than $500 for failure to provide notification under a utilization review program.

Sec. B-2. 24-A MRSA §2736-C, sub-§8 is enacted to read:

8. Authority of the superintendent. The superintendent may by rule define one or more standardized individual health plans that must be offered by all carriers offering individual health plans in the State.

Sec. B-3. 24-A MRSA §2749-B is enacted to read:

§2749-B. Penalty for noncompliance with utilization review programs

A health insurance policy issued or renewed in this State after the effective date of this section may not contain a provision that establishes a penalty of more than $500 for failure to provide notification under a utilization review program.

Sec. B-4. 24-A MRSA §2772, sub-§5 is enacted to read:

5. Penalty for noncompliance with utilization review programs. A medical utilization review program may not recommend or implement a penalty of more than $500 for failure to provide notification.

Sec. B-5. 24-A MRSA §2847-D is enacted to read:

§2847-D. Penalty for noncompliance with utilization review programs

A policy or certificate issued or renewed after the effective date of this section may not contain a provision that establishes a penalty of more than $500 for failure to provide notification under a utilization review program.

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Sec. B-6. 24-A MRSA §2860-A, as enacted by PL 1993, c. 208, §3, is amended to read:

§2860-A. Commissions

A commission not exceeding 5% of credit life and health insurance premiums, as set forth by rules adopted by the superintendent, may be paid to any creditor who is a licensed credit insurance agent. This section does not prohibit fees paid to a lender for handling or processing credit life or health insurance not exceeding 10% of prima facie premiums as set forth by rules adopted by the superintendent.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved.'

Further amend the bill by inserting at the end before the statement of fact the following:

'FISCAL NOTE

The Bureau of Insurance will incur some minor additional costs to adopt or amend rules pertaining to health insurance and to submit a required report to the Legislature. These costs can be absorbed within the bureau's existing budgeted resources.'

STATEMENT OF FACT

This amendment adds an emergency preamble to the bill. It divides the bill into Part A, derived from the original bill and Part B, which is new.

In Part A the amendment corrects a cross-reference to the insurance provision on penalties for failure to notify of hospitalization. It deletes sections 2 and 3 of the bill. It deletes the words "has substantially similar benefits" from the provision on product discontinuance in the exceptions to guaranteed renewal in the small group market. It deletes sections 5 and 6 of the bill. It adds a provision allowing health maintenance organizations to experience rate their groups unless they are subject to the small group community rating law. It deletes section 8. It adds an exception for product discontinuance to the individual health insurance provisions. It requires the Superintendent of Insurance to reconsider and amend Bureau of Insurance Rule Chapter 750 regarding benefits in the basic and standard health plans in the small group market.

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In Part B the amendment allows penalties for noncompliance with medical utilization review program notification requirements up to $500. It allows the Superintendent of Insurance to define by rule one or more standardized individual health plans that must be offered by all carriers. It corrects a reference to premiums in the insurance commission provisions.

This amendment also adds a fiscal note to the bill.

COMMITTEE AMENDMENT