116th MAINE LEGISLATURE

SECOND REGULAR SESSION-1993

Legislative Document **No. 1596**

S.P. 560 In Senate, December 27, 1993

An Act to Promote Managed Care and to Otherwise Facilitate the Cost-effective Delivery of Health Care in the State.

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 26. Received by the Secretary of the Senate on December 27, 1993. Referred to the Committee on Banking and Insurance and 1200 ordered printed pursuant to Joint Rule 14.

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator CONLEY of Cumberland.

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

Sec. 1. 22 MRSA §396-I, sub-§4, as amended by PL 1991, c. 786, §2, is repealed and the following enacted in its place:

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. 2. 24-A MRSA §2736-C, sub-§2, ¶D, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

D. A carrier may vary the premium rate due to age, smoking status, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and July 14, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued

or renewed in this State between July 15, 1996 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1997, the premium rate may not deviate from the community rate filed by the carrier.

~~Unless--continued--or--modified--by--law,--this--paragraph--is repealed-on-July-15,-1994.~~

Sec. 3. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 1993, c. 477, Pt. B, §1 and affected by Pt. F, §1, is further amended to read:

D. A carrier may vary the premium rate due to age, smoking status, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and July 14, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1996 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1997, the premium rate may not deviate from the community rate filed by the carrier.

~~Unless--continued--or--modified--by--law,--this--paragraph--is repealed-on-July-15,-1994.~~

Sec. 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 has substantially similar benefits and complies with the requirements of this section, including renewability.

Sec. 5. 24-A MRSA §2808-B, sub-§8, as enacted by PL 1991, c. 861, §2, is amended to read:

8. Standardized plans. The superintendent shall by rule define 2 standardized small group health plans that must be offered by all carriers offering small group health plans in the State. An association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 may offer one or both plans to its subgroups. The plans must consist of a standard plan and a basic plan. Both plans must meet the requirements for mandated coverage for specific health services,

specific diseases and for certain providers of health services under Title 24 and this Title applicable to small group health plans. As used in this subsection:

A. "Standard plan" means a plan that is similar to those plans typically sold to small employers; and

B. "Basic plan" means a plan that emphasizes preventative care and that contains reasonable but lesser benefits than the standard plan to the extent necessary to reduce the anticipated cost of the plan by 20%.

The premium rate charged by a carrier for the basic plan may not exceed 80% of the corresponding premium rate charged by that carrier for the standard plan. A carrier may satisfy the requirements of this subsection, however, by offering standard and basic versions of a managed care product that may utilize a gatekeeper physician, networks of participating providers and other care management techniques. Benefits offered under these managed care standardized plans need not provide for covered services to the extent required by rules adopted pursuant to this subsection.

Sec. 6. 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 or a component of such an 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, 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;

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.

Sec. 7. 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 2327, 2736 or 2839, whichever is applicable.

Sec. 8. 24-A MRSA §4227, as amended by PL 1991, c. 709, §8, is repealed.

STATEMENT OF FACT

The purpose of this bill is to remove the statutory barriers to the formation of managed care health care plans. The bill makes the following changes.

1. It allows satisfaction of the standard and basic plan requirements in the small group market with a managed care product to reflect movement of that market to such products.

2. It provides that an employer may offer a health maintenance organization to employees as its sole health benefit plan option.

3. It clarifies that health maintenance organizations can utilize alternative financing mechanisms in group contracts.

4. It amends rate-filing requirements to be consistent with other group plans.

5. It amends the hospital discounting laws to allow more flexible risk-sharing with hospitals.

6. It preserves a carrier's flexibility to remove obsolete products from the market by providing that a carrier can replace a guaranteed renewable policy with a substantially similar policy that is also guaranteed renewable and complies with the other requirements of the law.

7. It repeals the sunset of the phase-in of the community rating law in the small group and individual markets.

This document has not yet been reviewed to determine the need for cross-reference, stylistic and other technical amendments to conform existing law to current drafting standards.