MAINE STATE LEGISLATURE

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117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document **No. 1512**

S.P. 553 In Senate, May 9, 1995

An Act to Ensure Fairness and Choice to Patients and Providers under Managed Health Care.

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

MAY M. ROSS
Secretary of the Senate

Presented by Senator McCORMICK of Kennebec.
Cosponsored by Senator AMERO of Cumberland, Representative LIBBY of Buxton and Senators: BUSTIN of Kennebec, BUTLAND of Cumberland, CAREY of Kennebec, CLEVELAND of Androscoggin, GOLDTHWAIT of Hancock, LONGLEY of Waldo, PARADIS of Aroostook, PENDEXTER of Cumberland, PINGREE of Knox, RAND of Cumberland, RUHLIN of Penobscot, SMALL of Sagadahoc, STEVENS of Androscoggin, Representatives: AHEARNE of Madawaska, AULT of Wayne, BARTH of Bethel, BRENNAN of Portland, CHARTRAND of Rockland, CHASE of China, CLOUTIER of South Portland, DONNELLY of Presque Isle, DORE of Auburn, ETNIER of Harpswell, FITZPATRICK of Durham, GATES of Rockport, JOYNER of Hollis, KILKELLY of Wiscasset, LEMAIRE of Lewiston, MADORE of Augusta, MITCHELL of Vassalboro, MITCHELL of Portland, MORRISON of Bangor, MURPHY of Berwick, O'GARA of Westbrook, OTT of York, PLOWMAN of Hampden, POVICH of Ellsworth, RICHARDSON of Portland, SAXL of Bangor, SAXL of Portland, SHIAH of Bowdoinham, SIROIS of Caribou, THOMPSON of Naples, TOWNSEND of Portland, TREAT of Gardiner, VIGUE of Winslow, WATSON of Farmingdale, WINN of Glenburn.

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

Sec. 1. 24-A MRSA c. 81 is enacted to read:

CHAPTER 81

PATIENT AND PROVIDER PROTECTION ACT OF 1995

§6651. Short title

This chapter may be known and cited as the "Patient and Provider Protection Act of 1995."

§6652. Purpose

The Legislature hereby finds and declares that:

1. Vital governmental function. As the State's population increasingly is enrolled in health plans that utilize managed care techniques that include decisions regarding coverage and the appropriateness of health care, it is a vital state governmental function to protect patients and providers through ensuring quality managed care practices;

2. Ensure fairness; necessary protections. While recognizing that managed care has many beneficial aspects, insurance companies and other managed care organizations increasingly are selectively contracting with health care providers to join their plans and are discontinuing providers from their networks, which restricts a patient's ability to make choices concerning the patient's health care providers, and are making decisions to refuse or terminate health care or other decisions that can negatively affect a patient's health. It is essential to ensure fairness in managed care plans and provide a mechanism for delineating necessary protections for both providers and patients; and

3. Appropriate utilization review. The State, through the Bureau of Insurance, shall undertake steps to ensure patient protection, provider fairness and coverage options for all patients to ensure patients have access to services for which they are covered and to encourage cost containment by requiring appropriate utilization review, including the use of provider practice guidelines.

§6653. Definitions

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

1. Direct service ratio. "Direct service ratio" means the ratio of benefits returned to policyholders or contract holders, not including refunds or credits, to premiums collected.

2. Emergency medical condition. "Emergency medical condition" means:

A. A medical condition manifesting itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or the unborn child in serious jeopardy;

(2) Serious impairment to bodily function; or

(3) Serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman who is having contractions:

(1) That there is inadequate time to effect a safe transfer from one hospital to another hospital before delivery; or

(2) That the transfer from one hospital to another hospital may pose a threat to the health or safety of the woman or the unborn child.

3. Emergency services. "Emergency services" means those covered health care services provided after the sudden onset of an emergency medical condition.

4. Managed care contractor. "Managed care contractor" means a person, entity or 3rd-party administrator that:

A. Establishes, operates or maintains a network of participating providers;

B. Arranges for or conducts utilization review activities; and

C. Contracts with an insurance company, a managed care entity, an employer or employee organization, or any other entity providing coverage for health care services, to operate a managed care plan.

5. Managed care entity. "Managed care entity" includes a licensed insurance company licensed in accordance with this Title, a health maintenance organization licensed pursuant to chapter 56, a preferred provider organization licensed pursuant to chapter 32, a physician-hospital organization, a nonprofit hospital or medical service organization organized pursuant to Title 24, an employer or employee organization, a managed care contractor, or any other risk-bearing entity.

6. Managed care plan. "Managed care plan" means a plan operated by a managed care entity, a managed care contractor or any other risk-bearing entity that provides for the financing or delivery of health care services to persons enrolled in the plan through:

A. Arrangements with selected providers to furnish health care services;

B. Explicit standards for the selection of participating providers;

C. Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan; or

D. Arrangements that share risks with providers.

7. Participating provider. "Participating provider" means a licensed or certified provider of health care services, including mental health services, or health care supplies that has entered into an agreement with a managed care entity to provide those services or supplies to a patient enrolled in a managed care plan.

8. Plan sponsor. "Plan sponsor" is any employer, association, public agency or any other entity providing a plan.

9. Point-of-service plan or out-or-network plan. "Point-of-service plan" or "out-of-network plan" means a plan that offers services to enrollees through a provider network and in addition offers services or access to care by network and nonnetwork providers.

10. Provider network. "Provider network" means those providers who have entered into a contract or agreement with a plan under which such providers are obligated to provide items and services to eligible enrollees in the plan or have an agreement to provide services on a fee-for-service basis.

11. Superintendent. "Superintendent" means the Superintendent of Insurance.

§6654. Construction; protection of consumer choice

Nothing in this chapter may be construed as prohibiting:

1. Purchase services with own funds. An individual from purchasing any health care services with that individual's own funds, whether such services are covered within the individual's benefit package or from another health care provider or plan, except as otherwise provided by federal or state law; or

2. Additional benefits. Any plan sponsor from providing additional coverage for benefits, rights or protections not set out in this chapter.

§6655. Reporting requirements

To operate in this State, a managed care plan must comply with the following requirements.

1. Description of plan. A managed care plan shall provide to prospective enrollees, and to members of the public and nonparticipating providers upon their request, information on the terms and conditions of the plan to enable those persons to make informed decisions regarding their choice of plan. A managed care plan shall provide this information annually to current enrollees, participating providers and the superintendent. This information must be presented in a format acceptable to the superintendent. All written and oral descriptions of a plan must be truthful and must use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII. Descriptions of plans under this subsection must be standardized so that enrollees may compare the attributes of the plans. After a plan has provided the required information, a plan can satisfy the annual information requirement by providing any amendments to the materials on an annual basis. Specific items that must be included in a description are:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

(1) Health care services not provided;

(2) Health care services requiring copayments or deductibles paid by enrollees;

2 (3) The fact that access to health care services does not guarantee access to a particular provider type; and

4 (4) Health care services that are or may be provided only by referral;

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B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may lead the patient to be denied coverage or not be provided a particular service;

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C. Financial arrangements or contractual provisions with hospitals, review companies, physicians and any other provider of health care services that could potentially limit the services offered, restrict referral or treatment options or negatively affect the provider's fiduciary responsibility to the provider's patients, including, but not limited to, financial incentives not to provide medical services or other services;

22 D. An explanation of how plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other noncovered or out-of-plan services and limits on preexisiting conditions and waiting periods;

28 E. The terms under which the plan may be renewed by the plan member or enrollee, including any reservation by the plan of any right to increase premiums;

32 F. A statement as to when benefits cease in the event of nonpayment of the prepaid or periodic premium and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition;

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G. A description of the enrollee's right to appropriate and accessible care in a timely fashion, an effective and timely grievance process, timely determinations of coverage issues, confidentiality of medical records, written copies of coverage decisions that are not explicit in the plan agreement and 2nd opinions when used in grievance procedures as outlined in section 6660. The description must also include the enrolles' right not to be discriminated against based on health status and the right to refuse treatment without jeopardizing future treatment;

48 H. The toll-free number and address of the consumer and provider ombudsman named pursuant to section 6662; and

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I. A description of the plan's credentialing standards for providers.

2. Schedule of revenue costs and expenses. A managed care plan shall provide the following information annually to the superintendent:

A. A schedule of revenues and expenses, including direct service ratios;

B. Plan revenue, including:

(1) Premium revenue;

(2) Income from investment; and

(3) All other income;

C. Plan administrative costs, including:

(1) Marketing and advertising costs, including sales costs and commissions;

(2) Total compensation from the managed care entity, including bonuses, stock options and incentive pay for officers and directors of the managed care entity who are compensated;

(3) Shareholder dividend payments, if applicable;

(4) Underwriting costs;

(5) Legal expenses; and

(6) All other expenses; and

D. Plan costs of medical services, including, but not limited to, costs for:

(1) Physician services;

(2) Hospital services, including, but not limited to, both inpatient and outpatient services;

(3) Chiropractic services;

(4) Other professional services;

(5) Pharmacy services, excluding pharmaceutical products dispensed in a provider's office;

2 (6) Health education;

4 (7) Substance abuse services; and

6 (8) Mental health services.

8 **3. Plan complaint, adverse decisions and prior authorization statistics.** A managed care plan shall provide
10 annually to the superintendent information on plan complaints, adverse decisions and prior authorization statistics. This
12 statistical information must contain, at a minimum:

14 A. The ratio of the number of complaints received to the total number of covered persons, reported by category;
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B. The ratio of the number of adverse decisions issued to
18 the number of complaints received, reported by category;

20 C. The ratio of the number of prior authorizations denied to the number of prior authorizations requested, reported by
22 category;

24 D. The ratio of the number of successful enrollee appeals to the total number of appeals filed;
26
E. The percentage of disenrollments by enrollees and
28 providers from the managed care plan within the previous 12 months and the reasons for the disenrollments. With respect
30 to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary
32 disenrollments;

34 F. Enrollee satisfaction statistics, including complaints received, provider-to-enrollee ratio by geographic region
36 and medical specialty and a report on what actions, if any, the managed care entity has taken to improve complaint
38 handling and eliminate the causes of valid complaints; and

40 G. Data regarding reasonable standards of quality of care as required by the superintendent. Such quality indicators
42 must be based on factors such as age, gender, geographic area, income and access to providers.
44
4. Acceptable methods of providing information. A managed
46 care plan may meet any of the reporting requirements set forth in this section by providing information in conformity with the
48 requirements of the federal Health Maintenance Organization Act of 1973 or any other applicable state or federal law or any
50 accrediting organization recognized by the superintendent, as

long as the superintendent finds that the information is substantially similar to the information required by this section and is presented in a format that provides a meaningful comparison between plans. When the superintendent determines that the information required by this section is feasible and appropriate, this information must be provided by geographic region, age, gender and employer or group. With respect to geographical breakdown, the information must be provided in a manner that permits comparisons between urban and rural areas.

The superintendent shall compile information relevant to a meaningful comparison of plans from the information reported according to this section into an annual report on managed care plans and shall make the report available to the public and other interested persons. The report must be presented in a format that provides a meaningful comparison between plans. The report must also include a description of the data reported as well as a disclaimer regarding any limitations on the use of the data.

§6656. Plan requirements

A managed care plan operating in this State must meet the following requirements.

1. Demonstration of adequate access to providers. A plan shall demonstrate reasonable access to health care providers within the geographic area covered by the plan and ensure that all covered health care services are provided in a timely fashion in accordance with standards developed by the superintendent. These standards must address, but are not limited to:

A. Access to emergency services;

B. Access to urgent care services;

C. Access to primary care services;

D. Access to specialty services;

E. Average waiting times for primary care;

F. Average waiting times for specialty care, for in-plan specialists or out-of-plan specialists for covered services;

G. Average time for telephone contacts between enrollees and the managed care entity;

H. Geographic accessibility;

I. Appropriate linguistic communication;

J. Ratio of enrollees to providers; and

K. Assisting enrollees in accessing necessary services.

2. Physician and enrollee input. A managed care plan shall establish a mechanism, with defined rights, under which enrollees and participating providers may provide input into the plan's medical policy, including coverage of new technology and procedures, utilization review criteria and procedures, quality and credentialing criteria and health care management procedures.

3. Provider participation; credentials. The participation of providers and the granting of credentials is governed by the following.

A. A managed care plan shall establish credentials for participating providers and allow all providers within the plan's geographic service area to apply for such credentials, if those providers provide services covered by the plan.

B. The credential-granting process begins upon application of a provider to a managed care plan, except that if a plan demonstrates that the plan's provider panel is full, the plan need not undertake the credential-granting process. To qualify for this exception, the plan must demonstrate, to the superintendent's satisfaction, that it satisfies all of the access standards set forth in this chapter. If a plan's provider panel is full, the plan shall retain all provider applications submitted to the plan and notify providers of the opportunity to apply for credentials when the plan is open to their specialty.

C. If a managed care plan is accepting applications and a provider is denied participation, that provider's application must be reviewed by a credential-granting committee, which must contain appropriate representation of the applicant's specialty.

D. The granting of credentials must be based on objective standards of quality with input from providers granted credentials by the managed care plan. A description of these standards must be made available to applicants and enrollees.

E. A physician may not be denied participation in a plan based solely on board certification.

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F. If a graduate medical education is a consideration in granting credentials, equal recognition must be given to training programs accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

G. With respect to nonphysician providers, a managed care plan may not restrict access and availability by requiring appropriately licensed or certified providers, in order to be granted credentials, to have education, training, experience or professional qualifications, other than requiring that a specialist provider be certified or otherwise recognized as qualified to practice in that specialty area, according to professional standards adopted by a national organization representing that profession that is recognized by the superintendent.

H. When economic considerations, including providers' patterns of expenditures per patient, are a consideration in granting credentials, objective criteria must be used and must be made available to applicants, participating providers and enrollees. Any economic profiling of a provider must be adjusted, when applicable, to recognize case mix, severity of illness, age of patient and other features of a provider's practice that may account for costs that are higher or lower than expected costs. Profiles must be made available to those providers that are profiled, with an opportunity to review and dispute.

I. A managed care plan may not discriminate against enrollees based on health status by excluding providers with practices containing a substantial number of patients with chronic or disabling medical conditions.

J. All decisions regarding the granting of credentials must be in writing. The applicant must be provided with all reasons for the denial of an application or nonrenewal of a contract.

K. A managed care plan may not include any clause in a provider's contract that allows the plan to terminate the contract without cause. Nothing in this subsection prohibits a plan from terminating a provider on the grounds of excess capacity when the plan demonstrates, to the superintendent's satisfaction, that the plan complies with the access standards set out in this section.

L. A managed care plan may not terminate, or restrict in any way, a provider's contract because the provider advocates for medically appropriate health care.

(1) For the purposes of this paragraph, "to advocate for medically appropriate health care" means to appeal a managed care plan's decision to deny payment for a service pursuant to a reasonable grievance or appeal procedure, or to protest a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by reputable providers practicing in the same or similar locality under similar circumstances, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients.

(2) Nothing in this paragraph may be construed to prohibit a plan from making a determination not to pay for a particular medical treatment or service or to prohibit a plan from enforcing reasonable peer review or utilization review protocols or determining whether a provider has complied with those protocols.

M. A managed care plan may not include a clause in a provider's contract that restricts a provider's right to free speech. A plan may not terminate a provider who expresses an opinion regarding the plan or any of its affiliates.

N. There must be an appeal process available for all adverse decisions. The bureau shall determine whether the process provided by a managed care plan is consistent with due process, using as a standard the due process provisions contained in the federal Health Care Quality Improvement Act of 1986, 42 United States Code, Sections 11101 to 11152.

O. The same standards and procedures used to determine credentials must also be used in those cases where a managed care plan seeks to reduce or withdraw such credentials. Prior to initiation of a proceeding leading to termination of a contract for cause, the provider must be provided notice, an opportunity for discussion and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by a state licensing board that effectively impairs the provider's ability to practice within the jurisdiction.

P. Nothing in this subsection precludes a managed care plan from denying participation in the plan to a provider or providers based upon criteria consistent with this chapter.

4. Confidentiality. A managed care plan shall establish procedures to ensure that all applicable federal and state laws

designed to protect the confidentiality of provider and individual medical records are followed.

5. Maintenance of medical records. A managed care plan shall ensure that medical records are maintained in conformity with good professional medical practice and appropriate health management and that the records are dated, contain the most current information and identify the author.

6. Financial reserve requirements. A managed care plan must meet all applicable state or federal statutory or regulatory financial reserve requirements to ensure proper payment for health care services provided under the plan. Stop-loss or reinsurance coverage must be established to provide for plan failures even when a plan has met the reserve requirements.

7. Grievance procedures. All plans must have a grievance procedure as set out in section 6660.

§6657. Utilization review

A managed care plan operating in this State shall comply with chapter 34 and any applicable rules in conducting utilization reviews. In addition to the requirements of chapter 34 and the bureau's rules, a managed care plan shall comply with the following requirements.

1. Requirements for medical review or utilization review practices. A managed care plan shall appoint a medical director who is responsible for all clinical decisions by the plan and shall provide assurances that the medical review or utilization review practices it uses, and the medical review or utilization review practices of payors or reviewers with whom it contracts, comply with the following requirements.

A. Screening criteria, weighing elements and computer algorithms utilized in the review process and their method of development must be released, upon request, to providers and the public. Such criteria must be based on sound scientific principles and developed in cooperation with providers.

B. Any person who recommends denial of coverage or payment, or determines that a service should not be provided, based on medical necessity standards, must have training and expertise that is comparable to the treating provider.

2. Same-day telephone responses. Qualified personnel must be available for same-day telephone responses to inquiries about medical necessity, including approval of continued length of

stay. If review personnel are not available, medical services provided are considered approved.

3. Prior authorization of nonemergency services. Provider requests for prior authorization of a nonemergency service must be answered within 2 business days. If the information submitted is insufficient to make a decision, the provider must be apprised within 2 business days of the additional information necessary to render a decision. If the plan determines that outside consultation is necessary, the plan shall inform the provider and the enrollee for whom the service was requested within 2 business days. The plan must make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable.

4. Prior approval considered approval for all purposes. When prior approval for a service or other covered item is obtained, it is considered approval for all services related to the original approval and the service is considered to be covered unless there was fraud or incorrect information provided at the time the prior approval was obtained.

5. Medical information release consent forms. When prior authorization is a condition to coverage of a service, a managed care plan shall ensure that an enrollee signs a medical information release consent form upon enrollment.

6. Reimbursement for emergency services. A managed care plan shall reimburse a participating provider for emergency services and care provided to an enrollee, as required by federal or state law, until the care results in stabilization of the enrollee. Payment for emergency services and care required by federal law may be denied only if the managed care plan reasonably determines that the emergency services and care were never performed.

A managed care plan may not require prior authorization for an emergency medical condition, including a medical screening exam and stabilizing treatment as defined in the United States Social Security Act, Section 1867. Any prior authorization requirements for medically necessary services arising from such a screening exam or stabilizing treatment are deemed to be approved unless a request for authorization of those services is denied within 30 minutes of the time the request is made.

§6658. Quality of care

A managed care plan shall ensure that the health care services provided to enrollees is rendered under reasonable

standards of quality of care consistent with the prevailing standards of medical practice in the community.

1. Internal quality assurance program. A managed care plan shall have an ongoing internal quality assurance program for its health care services.

2. Written standards. The standards of quality of care must be described in a written document, which must be available for examination by the superintendent or by the Department of Human Services. The document must include, but is not limited to, the following:

A. A written statement of goals and objectives that stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to enrollees;

B. A written statement describing how state-of-the-art methodology is incorporated into an ongoing system for monitoring of care that is individual case-oriented and, when implemented, provides interpretation and analysis of patterns of care rendered to individual patients by individual providers;

C. Written procedures for taking appropriate remedial action whenever inappropriate or substandard services have been provided or services that should have been furnished have not been provided, as determined under the quality assurance program; and

D. A written plan for providing review of providers, including ongoing review within the managed care plan.

§6659. Patient choice of provider

1. Services outside provider network. A managed care plan that restricts access to providers shall offer enrollees the opportunity to obtain coverage through a point-of-service plan for out-of-network services or in-network services without a referral.

A. Except as otherwise provided by state law or any waiver granted by the federal Department of Health and Human Services for the operation of the Medicaid program in the State, a point-of-service plan may require payment for an out-of-network item or service. Any such payment, whether in the form of premiums, copayments, coinsurance, deductibles or any other form of payment, must be reasonably related to the costs of providing the item or service. The superintendent shall adopt rules regulating such charges and, in adopting such rules, must ensure that the charges do

not unreasonably restrict access to out-of-network items or services.

B. All sponsors of point-of-services plans and physicians and other professionals participating in such plans, upon request, must disclose their fees, applicable payment schedules, coinsurance requirements, or any other financial requirements that affect patient payment levels.

2. Choice of provider. A managed care plan shall allow enrollees to choose their own participating providers, to change providers without good cause at least once annually and to change providers with good cause as necessary.

3. Chronic disease or condition. When the enrollee has a chronic disabling disease or condition and it is in the enrollee's best interest to continue an existing provider-patient relationship with a nonparticipating provider or establish a new provider-patient relationship with a nonparticipating provider, that provider must be permitted to enroll as a participating provider, even if it is only to continue caring for that particular patient. The provider must meet the objective standards of quality set by the plan.

§6660. Grievance procedure

1. Statement of reasons for denial. An enrollee or a provider who has had a claim denied or is otherwise aggrieved by any decision of a managed care plan must be provided a written statement of reasons for the decision, which must be clearly documented in the permanent case record, whether such record is automated or manual. The written statement must include a general description of the reason the service was denied or a description of the grievance, an explanation of both the enrollee's and the provider's appeal rights and instructions for both the enrollee and the provider to appeal pursuant to the grievance process described in subsection 2.

2. Grievance process. A managed care plan must have a grievance process that meets the requirements established by the superintendent. The grievance process described in this subsection may not be construed as mandatory for the enrollee or the provider, nor is exhaustion of the grievance process or administrative remedies to be construed as being a prerequisite to civil action against the managed care plan. The superintendent's rules governing the grievance process must provide for, at a minimum, the following:

A. Timelines within which grievances must be processed, including expedited processing for exigent circumstances;

B. The right of the aggrieved party to counsel, to present and cross-examine witnesses and to be heard by an impartial decision maker;

C. The right of the aggrieved party to have access to and copies of records and other information necessary to pursue the grievance; and

D. The right of the aggrieved party to a written decision setting forth findings of fact and the reasons for the decision and informing the aggrieved party of the right to pursue the claim with the ombudsman described in section 6662 or through a civil action.

3. Appeal process. An enrollee or a provider, upon assignment of an enrollee, who has had a claim denied as not medically necessary must be provided an opportunity for a due process appeal to a medical consultant or peer review group. The independent medical consultant or peer review group must be agreed upon by the appealing party and the managed care plan and may not be affiliated with the organization that performed the initial review. This subsection applies only to claims for services for life-threatening conditions or conditions likely to lead to a permanent impairment.

4. Independent 2nd opinion. In any appeal where a professional opinion regarding health condition is a material issue in the dispute, the appealing party is entitled to an independent 2nd opinion paid for by the managed care plan.

§6661. Cost containment

1. Practice guidelines. A managed care plan shall work with its participating providers to establish a quality-based, cost-effective practice guidelines.

2. Data. A managed care plan shall supply any available data to a participating provider comparing the provider's practice profile with that of other providers practicing in the same specialty area.

3. Maintenance of direct service ratio. A managed care plan shall maintain direct service ratios as follows.

A. Notwithstanding any law to the contrary relating to loss ratios, health care policies or contracts may not be delivered or executed in the State unless those policies or contracts are expected to return to policyholders and contract holders in the form of aggregate health care

benefits, not including refunds or credits, the amounts set out in paragraph B, as estimated for the entire period for which rates are computed to provide coverage;

B. For all policies and contracts delivered, issued for delivery or executed on or after January 1, 1996, the superintendent shall disapprove any premium rates filed by any managed care entity, whether initial or revised, unless it is anticipated that the aggregate benefits estimated to be paid under all such policies or contracts maintained in force by the managed care entity for the period for which coverage is provided will return to policyholders or contract holders direct service ratios of:

(1) At least 85% of the aggregate premiums collected for a group health policy or contract;

(2) At least 85% of the aggregate premiums collected for small group health policies or contracts;

(3) At least 85% of the aggregate premiums collected for an individual health policy or contract; and

(4) At least 85% for all policies or contracts referred to in section 2413, subsection 1, paragraph G, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums.

C. The applicable percentages for each of the policies and contracts set out in paragraph B must increase by one percentage point on January 1st of each year, beginning January 1, 1997, until a 90% direct service ratio is reached on January 1, 2001.

D. A managed care entity that enters the market after January 1, 1996 does not start at the beginning of the phase-in schedule set out in paragraphs B and C and shall instead comply with the direct service ratio requirements applicable to other managed care entities in that market for each time period. All filing of rates and rating schedules must demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings for rate revisions must also demonstrate that the anticipated direct service ratio over the entire future period for which revised rates are computed to provide coverage can be expected to meet the appropriate direct service ratio standard, and the aggregate direct service ratio from the

inception of a policy or contract must equal or exceed the appropriate direct service ratio standard.

§6662. Ombudsman

The superintendent shall hire or enter into a contract for a consumer and provider ombudsman to receive and monitor complaints and assist enrollees and participating providers in resolution of complaints. The ombudsman shall report to the superintendent at least annually regarding systemic problems or issues affecting the quality, cost, access or delivery of service. The superintendent shall investigate such problems or issues, make findings and recommend a course of action to solve the problems identified.

§6663. Enforcement by enrollees or participating providers

Enrollees and participating providers have the right to bring a private action at law or equity to enforce any of the standards, rights or requirements of this chapter in a court of law and to be awarded costs and legal fees, if successful.

§6664. Construction

Nothing in this chapter may be construed to permit any provider willing to abide by the terms and conditions of a plan to be admitted to the plan.

§6665. Liability

1. Indemnification. A contract between a managed care entity and a provider for the provision of services to patients may not require the provider to indemnify the managed care entity for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with any claim or action brought against the managed care plan based on the managed care entity's management decisions, utilization review provisions or other actions that caused the provider's decisions and actions in providing or withholding treatment to or from any patient.

2. Immunity from liability. A participating provider is immune from civil liability based on a claim alleging a patient's injury as the result of a negligent decision made by a managed care plan or its agents, when the participating provider appeals the decision pursuant to rules adopted by the superintendent. In such an instance, the managed care plan may be civilly liable to the patient.

§6666. Advisory board

2 Each managed care entity licensed to operate in the State shall establish an enrollee advisory board in accordance with
4 rules adopted by the superintendent. The purpose of the enrollee advisory board is to advise the board of directors of the managed
6 care entity, the superintendent and the consumer and provider ombudsman established pursuant to section 6662 on plan policies
8 and priorities in identifying and addressing community health needs and health outcomes; ensuring access, quality and
10 reasonable costs to all enrollees; and protecting and advocating for the rights of enrollees. Rules adopted by the superintendent
12 must define the purpose, functions, composition, areas for input and rights and responsibilities of an enrollee advisory board.

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§6667. Adoption of rules

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The superintendent shall adopt rules and establish standards
18 of compliance and penalties for noncompliance for managed care entities in order to carry out the purposes of this chapter.

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§6668. Effective date

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This chapter takes effect January 1, 1996.

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STATEMENT OF FACT

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The purpose of this bill is to provide fundamental
28 protection to patients and providers in managed care health plans. This bill enacts provisions to ensure that:

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1. Patients understand the coverages and incentives in such
32 plans;

34 2. Providers receive due process relative to plan selection and denial of participation;

36

3. Patients have access to the services for which they are
38 covered and are provided with due process;

40 4. Patients and purchasers are given the opportunity to compare one plan with another, financially and otherwise;

42

5. Patients are given as many options as possible,
44 consistent with cost-containment strategies; and

46 6. Providers, patients and the managed care plans work together to contain costs.