117th MAINE LEGISLATURE

SECOND REGULAR SESSION-1996

Legislative Document **No. 1882**

S.P. 769 In Senate, March 28, 1996

An Act to Create the Maine Health Care Reform Act of 1996.

Reported by Senator ABROMSON from the Committee on Banking and Insurance pursuant to Joint Order S.P. 750 and printed under Joint Rule 2.

MAY M. ROSS
Secretary of the Senate

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

PART A

Sec. A-1. 24-A MRSA §1901, sub-§1, ¶¶M and N, as enacted by PL 1989, c. 846, Pt. D, §2 and affected by Pt. E, §4, are amended to read:

M. A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney and who does not collect charges or premiums in connection with life or health insurance coverage; ~~and~~

N. A person acting as a trustee, named fiduciary or plan official of an employee benefit plan within the meaning of the federal Employee Retirement Income Security Act of 1974, as amended, 29 United States Code, Section 1001, et seq.; and

Sec. A-2. 24-A MRSA §1901, sub-§1, ¶O is enacted to read:

O. A private purchasing alliance licensed in accordance with chapter 18-A.

Sec. A-3. 24-A MRSA c. 18-A is enacted to read:

CHAPTER 18-A

PRIVATE PURCHASING ALLIANCES

§1951. Definitions

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

1. Carrier. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue health plans in this State. For the purposes of this chapter, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this chapter apply as if all health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this chapter, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

2. Private purchasing alliance. "Private purchasing alliance" or "alliance" means a nonprofit corporation licensed pursuant to this section established under Title 13-B to provide

health insurance to its members through multiple unaffiliated participating carriers.

§1952. Licensure

A person or entity may not market, sell, offer or arrange for a package of one or more health benefit plans underwritten by 2 or more carriers without first being licensed by the superintendent. The superintendent shall specify by rule standards and procedures for the issuance and renewal of licenses for private purchasing alliances. A rule may require an application fee of not more than $400 and an annual license fee of not more than $100. A license may not be issued until the rulemaking required by this chapter has been undertaken and all required rules are in effect.

§1953. Powers

In addition to the powers granted in Title 13-B, an alliance may do any of the following:

1. Membership fees. Set reasonable fees for membership in the alliance for financing reasonable and necessary costs incurred in administering the alliance;

2. Premium collection. Provide premium collection services for health benefit plans offered through the alliance if the insurer or health maintenance organization offering the plan gives express written authorization to the alliance or any other person or entity acting on behalf of the alliance to act as the insurer's or the health maintenance organization's agent for that purpose;

3. Contracts. Contract with qualified independent 3rd parties for any service necessary to carry out the powers and duties authorized or required by this chapter;

4. Standards. Exclude a carrier or freeze enrollment in a carrier for failure to achieve established quality, access or information reporting standards of the alliance;

5. Data collection. Develop uniform standards for data to be provided by participating carriers and providers. The alliance may collect data necessary for evaluation of the performance of participating carriers and their provider networks by consumers, providers, employers and the superintendent;

6. Negotiation. Negotiate with participating carriers the premium rates charged for coverage offered through the alliance, consistent with rules adopted by the superintendent; or

7. Risk adjustment. Establish procedures, subject to approval by the superintendent, for adjusting payments within each risk pool to participating carriers if the alliance finds that some carriers have a significantly disproportionate share of high-risk or low-risk enrollees.

§1954. Duties

An alliance shall:

1. Carrier eligibility. Develop and make available a list of objective criteria, subject to rules adopted by the superintendent, that participating carriers must meet in order to be eligible to participate in the alliance;

2. Enrollee choice. Ensure that enrollees have a choice among a reasonable number of competing carriers and types of health benefit plans in accordance with the following.

A. In every portion of the alliance's service area, the alliance must offer at least 3 different carriers. When 3 participating carriers are not reasonably available in some or all of the alliance's service area, the superintendent may waive this requirement in accordance with standards and procedures established by rule pursuant to this chapter.

B. Notwithstanding any other provision of this Title or Title 24 that requires coverage for outpatient benefits, the alliance shall offer at least one health plan providing catastrophic coverage for inpatient hospital benefits only, in accordance with rules developed by the superintendent. This paragraph is repealed on January 1, 2000;

3. Enrollment. Develop standard enrollment procedures in accordance with rules adopted by the superintendent;

4. Plan descriptions. Publish educational materials, plan descriptions and comparison sheets describing participating carriers and the health benefit plans available through the alliance for use in enrolling eligible members. The information may include an assessment of utilization management procedures and the level of quality and cost-effective care;

5. Enrollee eligibility. Establish eligibility standards for membership in accordance with rules adopted by the superintendent. Eligibility standards may not relate to health status;

6. Acceptance of enrollees. Accept all applicants for membership that meet the alliance's eligibility standards;

7. Risk pools. Develop standards for classifying groups of participating members into risk pools. The risk pools may include one or more risk pools for enrolled employees and their dependents and a risk pool for enrolled individuals and their dependents;

8. Annual report. Prepare an annual report on the operations of the alliance to the superintendent, which must include an accounting of all outside revenues received by the alliance and internal and independent audits and any other information the superintendent may require;

9. Trust account. Maintain a trust account or accounts for deposit of all money received and collected for the operation of the alliance. An alliance and its board members, employees and agents have a fiduciary duty with respect to all money received or owed to it to ensure payments of its obligations and a full accounting to its members and the superintendent; and

10. Violations. Report to the superintendent any suspected or alleged law violations.

The superintendent may specify further duties by rule.

§1955. Restrictions

1. Restricted activities. An alliance may not purchase health care services, assume risk for the cost or provision of health services or otherwise contract with health care providers for the provision of health care services to enrollees.

2. Licensing. A person who solicits applications for insurance, negotiates insurance contracts or takes applications for insurance from enrollees on behalf of an alliance or on behalf of insurance carriers or health maintenance organizations that have contracted with the alliance must be licensed with the bureau in compliance with chapter 17.

3. Conflict of interest. A person may not be a board member, officer or employee of an alliance if that person is employed as or by, is a member of the board of directors of, is an officer of, or has a material direct or indirect ownership interest in a carrier, health care provider or insurance agency or brokerage. A person may not be a board member or officer of an alliance if a member of that person's household is a member of the board of directors of, is an officer of or has a material direct or indirect ownership interest in a carrier, health care

provider or insurance agency or brokerage. A board member, officer or employee of an alliance who is licensed as an agent, broker or consultant may act under that license only on behalf of the alliance and only within the scope of that person's duties as a board member, officer or employee.

4. Commissions. All commissions or other payments to the alliance from or on behalf of carriers must inure to the benefit of the alliance and alliance members. An employee of an alliance may not receive compensation that is contingent upon the amount of coverage sold or upon the health carrier that is chosen. This subsection does not prohibit an alliance from arranging coverage through an unaffiliated agent or broker who is paid on a commission basis in the ordinary course of business.

5. Rulemaking. The superintendent may specify further restrictions by rule.

§1956. Authority of superintendent

1. Alliance conduct. The superintendent has the authority to regulate the establishment and conduct of alliances as set forth in this chapter.

2. Representations. A person or entity not licensed by the superintendent as a private purchasing alliance and engaged in the purchase, sale, marketing or distribution of health insurance or health care benefit plans may not represent itself as an alliance, health insurance purchasing alliance, purchasing alliance, health insurance purchasing cooperative or purchasing cooperative, or otherwise use a confusingly similar name.

3. Conflict. Nothing in this chapter may be considered in conflict with or limit the duties and powers granted to the superintendent under the laws of this State.

4. Penalties. Violations of this chapter are subject to the penalties contained in section 12-A.

§1957. Rulemaking

The superintendent shall adopt rules necessary to carry out the requirements of this chapter before January 1, 1997. All rules adopted pursuant to this chapter are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. A-4. 24-A MRSA §2804-A is enacted to read:

§2804-A. Private purchasing alliances

A group of individuals may be insured under a policy issued to a private purchasing alliance meeting the requirements of chapter 18-A.

Sec. A-5. 24-A MRSA §2808-B, sub-§1, ¶H, as enacted by PL 1991, c. 861, §2, is amended to read:

H. "Subgroup" means an employer with fewer than 25 employees within an association ~~or~~, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract.

Sec. A-6. 24-A MRSA §2808-B, sub-§2, ¶F is enacted to read:

F. Premium rates charged to a private purchasing alliance, as defined by chapter 18-A, may be reduced in accordance with rules adopted pursuant to that chapter.

PART B

Sec. B-1. 24 MRSA §2349, sub-§2, ¶B, as enacted by PL 1989, c. 867, §1 and affected by §10, is repealed and the following enacted in its place:

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within 3 months before the date the person enrolls or is eligible to enroll in the succeeding contract.

A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within a time period specified under this section.

Sec. B-2. 24-A MRSA §707, sub-§3, as amended by PL 1995, c. 375, Pt. C, §4, is further amended to read:

3. An insurer other than a casualty insurer may transact employee benefit excess insurance only if that insurer is authorized to insure the class of risk assumed by the underlying benefit plan. Employee benefit excess insurance, even if written by a life or health insurer, is not subject to chapters 29 and 31 to 37, except to the extent that particular provisions are made expressly applicable by rule or law. ~~The~~ No later than July 1, 1997, the superintendent ~~may~~ shall by rule set standards distinguishing excess insurance from basic insurance. In developing these standards, the superintendent may consider the analysis supporting the recommendations of the National Association of Insurance Commissioners.

Sec. B-3. 24-A MRSA §2849-B, sub-§2, ¶B, as amended by PL 1993, c. 666, Pt. D, §4, is repealed and the following enacted in its place:

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within 3 months before the date the person enrolls or is eligible to enroll in the succeeding contract.

A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within a time period specified under this section; and

PART C

Sec. C-1. 24-A MRSA, c. 56-A is enacted to read:

CHAPTER 56-A

HEALTH PLAN IMPROVEMENT ACT

§4301. Definitions

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

1. Carrier. "Carrier" means an 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 or a nonprofit hospital or medical service organization licensed pursuant to Title 24. An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

2. Enrollee. "Enrollee" means an individual who is enrolled in a health plan or a managed care plan.

3. Health plan. "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan.

4. Managed care plan. "Managed care plan" means a plan offered or administered by a carrier 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; and

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

A return to work program developed for the management of workers' compensation claims may not be considered a managed care plan.

5. 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 carrier to provide those services or supplies to an individual enrolled in a managed care plan.

6. Plan sponsor. "Plan sponsor" means an employer, association, public agency or any other entity providing a health plan.

§4302. Reporting requirements

To offer a health plan in this State, a carrier must comply with the following requirements.

1. Description of plan. A carrier shall provide to prospective enrollees and participating providers, and to members of the public and nonparticipating providers upon request, information on the terms and conditions of the plan to enable those persons to make informed decision regarding their choice of plan. A carrier shall provide this information annually to current enrollees, participating providers and the superintendent. This information must be presented in a standardized format acceptable to the superintendent. In adopting rules or developing standardized reporting formats, the superintendent shall consider the nature of the health plan and the extent to which rules or standardized formats are appropriate to the plan. All written and oral descriptions of the health 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, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of plans under this subsection must be standardized so that enrollees may compare the attributes of the plans. After a carrier has provided the required information, the annual information requirement under this subsection may be satisfied by the provision of any amendments to the materials on an annual basis. Specific items that must be included in a description are as follows:

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 excluded from coverage;

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

(3) Restrictions on access to a particular provider type; and

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

B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may result in the enrollee being denied coverage or not being provided a particular service;

C. A general description of the methods used to compensate providers, including capitation and methods in which providers receive compensation based upon referrals, utilization or cost criteria;

D. An explanation of how health 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 preexisting conditions and waiting periods;

E. The terms under which the health plan may be renewed by the plan members or enrollees, including any reservation by the health plan of any right to increase premiums;

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 the enrollees who are hospitalized or undergoing treatment for an ongoing condition;

G. A description of the manner in which the plan addresses the following: the provision of appropriate and accessible care in a timely fashion; an effective and timely grievance process and the circumstances in which an enrollee may obtain a 2nd opinion; timely determinations of coverage issues; confidentiality of medical records; and written copies of coverage decisions that are not explicit in the health plan agreement. The description must also include a statement explaining the circumstances under which health status may be considered in making coverage decisions in accordance with state and federal laws and that enrollees may refuse particular treatments without jeopardizing future treatment;

H. Procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or plan formulary, if any; a description of the formulary; and a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on a plan list or plan formulary. Enrollees may request additional information related to specific drugs that are not on the drug formulary; and

I. Information on where and in what manner health care services may be obtained.

2. Plan complaint; adverse decisions; prior authorization statistics. A carrier shall provide annually to the superintendent information for each health plan that it offers on plan complaints, adverse decisions and prior authorization statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received to the total number of enrollees, reported by type of complaint and category of enrollee;

B. The ratio of the number of adverse decisions issued to the number of complaints received, reported by category;

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

D. The ratio of the number of successful enrollee appeals to the total number of appeals filed;

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and

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

3. Acceptable methods of providing information. A carrier may meet any of the reporting requirements set forth in this section by providing information in conformity with the requirements of the federal Health Maintenance Organization Act of 1973, 42 United States Code, Sections 280c and 300e to 300e-17 (1988), or any other applicable state or federal law or any 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 health plans. When the superintendent determines that it is feasible and appropriate, the information required by this section must be provided by geographic region,

age, gender and type of employer or group. With respect to geographical breakdown, the information must be provided in a manner that permits comparisons between urban and rural areas.

§4303. Plan requirements

A carrier offering a health plan in this State must meet the following requirements.

1. Demonstration of adequate access to providers. A carrier offering a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the superintendent before January 1, 1997. These standards must consider the geographical and transportational problems in rural areas.

2. Credentialling. The credentialling of providers by a carrier offering a managed care plan is governed by this subsection.

A. The granting of credentials must be based on objective standards that are available to providers upon application for credentialling.

B. All decisions regarding the granting of credentials, including a decision to deselect a provider, must be in writing. The provider must be provided with all reasons for the denial of an application, nonrenewal of a contract or termination of a contract.

C. A carrier shall establish and maintain an appeal procedure, including the provider's right to a hearing, for dealing with provider concerns relating to the denial of credentialling for not meeting the objective credentialling standards of the plan and the contractual relationship between the carrier and the provider. The superintendent shall determine whether the process provided by a carrier is fair and reasonable. This procedure must be specified in every contract between a carrier and a provider.

3. Provider's right to advocate for medically appropriate care. A carrier offering a managed care plan may not terminate or otherwise discipline a participating provider because the provider advocates for medically appropriate health care. A carrier may not restrict a provider from disclosing to any enrollee any information the provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, the availability of other therapy, consultations or tests or the decision of any plan to authorize or deny health care services or benefits.

A. For the purposes of this section, "to advocate for medically appropriate health care" means to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service pursuant to an established 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, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients.

B. Nothing in this subsection may be construed to prohibit a plan from making a determination not to pay for a particular medical treatment or service or to enforce reasonable peer review or utilization review protocols.

4. Grievance procedure for enrollees. A carrier offering a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following:

(1) Notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed;

(2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly;

(3) Procedures for the submission of relevant information and enrollee participation;

(4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal rights within the plan, the procedure and time limitations for taking such an appeal, notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; and

(5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance.

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the plan, of a provider of the same specialty participating in the plan. If a provider of the same specialty does not participate in the plan, then the 2nd opinion must be given by a nonparticipating provider.

§4304. Utilization review

The following requirements apply to health plans in this State that require prior authorization of health care services or otherwise subject payment of health care services to review for clinical necessity, appropriateness, efficacy or efficiency. A carrier offering a health plan subject to this section that contracts with other entities to perform utilization review on the carrier's behalf is responsible for ensuring compliance with this section and chapter 34.

1. Requirements for medical review or utilization review practices. A carrier must appoint a medical director who is responsible for reviewing and approving the carrier's policies governing the clinical aspects of coverage determinations by any health plan that it offers.

2. Prior authorization of nonemergency services. Requests by a provider for prior authorization of a nonemergency service must be answered by a carrier within 2 business days. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

3. Background information; affirmative duty of provider. A provider has an affirmative duty to submit to the carrier the background information necessary for the carrier to complete its review and render a decision within the time period required in

subsection 2. If the provider needs additional time to submit that required information, the provider must inform the carrier in a timely manner. Nothing in this section requires a provider to submit confidential information without a signed consent from the enrollee.

4. Revocation of prior authorization. When prior approval for a service or other covered item is granted, a carrier may not retrospectively deny coverage or payment for the originally approved service unless fraudulent or materially incorrect information was provided at the time prior approval for the service was granted.

§4305. Quality of care

A carrier must meet the following requirements relating to quality of care.

1. Internal quality assurance program. A health plan must have an ongoing quality assurance program for the health care services provided or reimbursed by the health plan.

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.

3. Coverage decisions. Following a determination that a particular service is covered, a carrier may not deny payment for that service based on the enrollee's age, nature of disability or degree of medical dependency.

§4306. Enrollee choice of primary care physician

A carrier offering a managed care plan shall allow enrollees to choose their own primary care physicians, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A managed care plan must allow enrollees to change primary care physicians without good cause at least once annually and to change with good cause as necessary. When an enrollee fails to choose a primary care physician, the managed care plan may assign the enrollee a primary care physician located in the same geographic area in which the enrollee resides.

§4307. Construction

Nothing in this chapter may be construed to:

1. Purchase services with own funds. Prohibit an individual from purchasing any health care services with that individual's own funds, whether these 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;

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

3. Provider participation. Require a carrier to admit to a managed care plan a provider willing to abide by the terms and conditions of the managed care plan.

§4308. Liability

1. Indemnification. A contract between a carrier and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier 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 health plan based on the carrier's own fault. Nothing in this subsection may be construed to remove responsibility of a carrier or provider for expenses or liabilities caused by the carrier's or provider's own negligent acts or omissions or intentional misconduct.

§4309. Adoption of rules

The superintendent shall adopt rules and establish standards for health plans in order to carry out the purposes of this chapter. Rules adopted pursuant to this chapter are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. C-2. Effective date. This Part takes effect January 1, 1997.

PART D

Sec. D-1. 24-A MRSA §4202-A, sub-§10, ¶A, as enacted by PL 1991, c. 709, §2, is amended to read:

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, except that health maintenance organizations contracting with the State

Government or the Federal Government to service Medicaid or Medicare populations may limit the services they provide under the contracts consistent with the terms of those contracts if such basic health care services are provided to those populations by other means;

Sec. D-2. 24-A MRSA §4203, sub-§3, ¶L, as enacted by PL 1975, c. 503, is amended to read:

L. A description of the complaint and grievance procedures to be utilized as required under section 4303, subsection 4 and section 4211;

Sec. D-3. 24-A MRSA §4204, sub-§2-A, ¶L, as enacted by PL 1993, c. 702, Pt. B, §1, is repealed and the following enacted in its place:

L. The health maintenance organization meets the requirements of section 4303, subsection 1.

Sec. D-4. 24-A MRSA §4209, sub-§1, ¶B, as enacted by PL 1989, c. 842, §15, is amended to read:

B. A description of the organizational structure and operation of the health maintenance organization, including the kind and extent of enrollee participation, and a summary of any material changes since the issuance of the last report; and

Sec. D-5. 24-A MRSA §4209, sub-§1, ¶C and ¶D, as enacted by PL 1989, c. 842, §15, are repealed.

Sec. D-6. 24-A MRSA §4209, sub-§1, ¶E is enacted to read:

E. A description of the plan as required under section 4302, subsection 1.

Sec. D-7. 24-A §4222-B, sub-§9 is enacted to read:

9. The requirements of chapter 56-A and any rules adopted pursuant to that chapter apply to health maintenance organizations.

Sec. D-8. 24-A MRSA §4234-A, sub-§11, as enacted by PL 1995, c. 407, §10, is amended to read:

11. Application. Except as otherwise provided, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on and after July 1, 1996. Contracts

entered into with the State Government or the Federal Government to service Medicaid or Medicare populations may limit the services provided under such contracts consistent with the terms of those contracts if mental health services are provided to these populations by other means. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

Sec. D-9. Allocation. The following funds are allocated from the Insurance Regulatory Fund to carry out the purposes of this Act.

	1996-97
PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF	
Bureau of Insurance	
All Other	$15,000
Allocates funds for the costs of adopting rules pertaining to certain changes in health care insurance regulatory requirements.	

FISCAL NOTE

	1996-97
APPROPRIATIONS/ALLOCATIONS	
Other Funds	$15,000
REVENUES	
Other Funds	$15,000

The Bureau of Insurance within the Department of Professional and Financial Regulation will require an Insurance Regulatory Fund allocation of $15,000 in fiscal year 1996-97 for the cost of adopting certain rules pertaining to changes in health care insurance law. The bureau has adequate room under its statutory assessment cap to collect the revenues necessary to cover this increased cost.

This bill may increase the number of civil suits filed in the court system. The additional workload and administrative

costs associated with the minimal number of new cases filed can be absorbed within the budgeted resources of the Judicial Department. The collection of additional filing fees may also increase General Fund revenue by minor amounts.

STATEMENT OF FACT

This bill is reported out by the Joint Standing Committee on Banking and Insurance and is the result of the committee's deliberations on the legislation proposed in Legislative Document 1512, "An Act to Ensure Fairness and Choice to Patients and Providers under Managed Health Care," and Legislative Document 1753, "An Act to Control Health Care Costs and Improve Access to Health Care." This bill is the majority report of the committee.

In Part A, the bill creates a licensing and regulatory process to allow the establishment of private purchasing alliances. Private purchasing alliances are nonprofit corporations licensed by the Bureau of Insurance to provide health insurance to members through multiple unaffiliated participating carriers. When established, an alliance must offer a range of health plans from at least 3 different carriers within the alliance's service area. One of the health plans that must be offered through the alliance is a catastrophic plan providing coverage for inpatient hospital benefits only.

In Part B, the bill extends the continuity of coverage protection for persons eligible for unemployment compensation from 90 days to 180 days and requires the Bureau of Insurance to set standards distinguishing excess insurance from basic insurance.

In Part C, the bill requires health plans operating in this State to meet certain requirements regarding reporting and disclosure, utilization review, grievance procedures and quality of care criteria. The bill requires managed care plans to demonstrate adequate access to providers and health care services within the plan in accordance with standards developed by the Bureau of Insurance. Managed care plans must also use objective standards for the credentialling of providers, provide written statements of all decisions regarding credentialling and maintain an appeals process for providers. Managed care plans are prohibited from terminating, refusing to contract with or otherwise disciplining providers participating in the plan when the provider advocates for medically appropriate care for plan enrollees. Part C has an effective date of January 1, 1997.

In Part D, the bill repeals sections of current law applying to health maintenance organizations that are redundant with the

statutory provisions in Part C and makes appropriate cross references in the Maine Revised Statutes, Title 24-A, chapter 56 to the relevant statutory provisions in Part C.

This bill also has an allocation section and a fiscal note.