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L.D. 2029

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BANKING AND INSURANCE

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
119TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 1422, L.D. 2029, Bill, "An Act to Update and Amend the Preferred Provider Arrangement Act"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

'**Sec. 1. 24-A MRSA §601, sub-§20,** as amended by PL 1993, c. 637, §13, is further amended to read:

20. Preferred provider arrangement administrator. Preferred provider ~~organization~~ arrangement administrator fees are:

A. Original registration issuance fee	$100; and
B. Annual renewal fee	$100.

Sec. 2. 24-A MRSA §1901, sub-§1, as amended by PL 1997, c. 457, §28, is further amended by adding at the end a new blocked paragraph to read:

Notwithstanding any other provision of this subsection, "administrator" includes any administrator of a preferred provider arrangement required to register under this chapter pursuant to section 2674-A.

Sec. 3. 24-A MRSA c. 32, as amended, is further amended by repealing the chapter headnote and enacting the following in its place:

CHAPTER 32

PREFERRED PROVIDER ARRANGEMENT ACT

Sec. 4. 24-A MRSA §2670, as enacted by PL 1985, c. 704, §4, is amended to read:

§2670. Short title

This chapter may be cited as the "Preferred Provider Arrangement Act ~~of 1986~~."

Sec. 5. 24-A MRSA §2671, as amended by PL 1995, c. 332, Pt. P, §1, is further amended to read:

§2671. Definitions

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

1. "Administrator" means any person, ~~partnership, or corporation,~~ other than ~~an insurer, health maintenance organization or nonprofit health service organization~~ a carrier, that ~~arranges, contracts with or~~ administers ~~contracts with a provider in which beneficiaries are provided an incentive to use the services of that~~ a preferred provider arrangement. An administrator does not include a health maintenance organization licensed pursuant to chapter 56 or a nonprofit health care plan regulated by the superintendent pursuant to Title 24. An employer exempt 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 an administrator.

1-A. "Capitation" has the same meaning as defined in section 4331, subsection 2.

~~**2.** "Beneficiary" means the individual entitled to reimbursement for expenses of health care services under a program where the beneficiary has an incentive to use the services of a provider who has entered into an agreement or arrangement with an administrator.~~

2-A. "Carrier" means an insurance company licensed in accordance with this Title, a fraternal benefit society authorized pursuant to chapter 55 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-B. "Enrollee" means an individual entitled to reimbursement for expenses of health care services under a health plan.

3. "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's legal authorization.

3-A. "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.** "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.~~

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

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

7. "Preferred provider arrangement" means a contract, agreement or arrangement ~~consistent with section 2673~~ between a carrier or administrator and a provider in which the provider agrees to provide services to a health plan enrollee whose plan benefits include incentives for the enrollee to use the services of that provider.

8. "Provider" means an individual or entity duly licensed or otherwise legally authorized to provide health care services, including, but not limited to, the treatment of physical health and mental health and provision for medical supplies and pharmaceutical supplies.

9. "Superintendent" means the Superintendent of Insurance.

Sec. 6. 24-A MRSA §2672, as enacted by PL 1985, c. 704, §4, is amended to read:

§2672. Selective contracting authorized

~~Insurers~~ Carriers or administrators may enter into ~~contracts with a limited number of~~ preferred ~~providers~~ provider

arrangements with providers of their choice. In selecting preferred providers, ~~insurers~~ carriers or administrators may consider, among other factors, price differences between or among providers, geographic accessibility, specialization and projected utilization by ~~beneficiaries and insureds~~ enrollees. Selective contracting does not constitute unreasonable discrimination against or among providers.

Sec. 7. 24-A MRSA §2673, as repealed and replaced by PL 1989, c. 588, Pt. A, §49, is repealed.

Sec. 8. 24-A MRSA §2673-A is enacted to read:

§2673-A. Preferred provider arrangements

1. Filing with superintendent; disapproval. A carrier or administrator who proposes to offer a preferred provider arrangement shall file with the superintendent proposed agreements, rates, geographic service areas, provider networks and other materials relevant to the proposed arrangement. The superintendent shall disapprove any preferred provider arrangement if the arrangement contains any unjust, unfair or inequitable provisions; unreasonably restricts access and availability of health care services; or fails to comply with other requirements of this chapter, chapter 56-A or rules adopted by the superintendent.

2. Considered separate preferred provider arrangements. If health plans offered by the same carrier have different geographic service areas, or if there are preferred providers in one health plan who are nonpreferred providers in another health plan offered by the same carrier or administered by the same administrator or who are in a different preference tier if the plan is a multitier plan, then the plans represent different preferred provider arrangements and must be separately filed and approved.

3. Rules. Preferred provider arrangements offered by carriers that are subject to chapter 56-A must be in compliance with applicable provisions of that chapter and any rules adopted under that chapter. Employer-sponsored plans that are exempt from this chapter pursuant to federal law and administrators offering preferred provider arrangements to employer-sponsored plans are not subject to the provisions of chapter 56-A or rules adopted under that chapter, provided either the administrator or any other participating entity, other than the self-insured employer, does not undertake insurance risk. The superintendent may adopt rules establishing procedures for filing and approval of preferred provider arrangements, including the time period within which the superintendent must act on a completed

application; specific criteria for determining when a term or condition is unjust, unfair or inequitable or has the effect of unreasonably restricting access and availability to health care services; and standards consistent with this chapter and chapter 56-A for the ongoing operation and oversight of approved provider arrangements. The rules may prohibit the carrier from applying a benefit level differential to enrollees who must travel an unreasonable distance to obtain the service. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

Sec. 9. 24-A MRSA §2674, as enacted by PL 1985, c. 704, §4, is repealed.

Sec. 10. 24-A MRSA §2674-A is enacted to read:

§2674-A. Requirements for administrators and carriers

1. Registration fee. All administrators of a preferred provider arrangement shall register with the superintendent and pay an annual registration fee pursuant to section 601, subsection 20. The superintendent shall by rule establish criteria for the registration, including minimum solvency requirements. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

2. Compilation of current listing. The bureau shall compile and maintain a current listing of administrators and carriers offering preferred provider arrangements authorized under this chapter.

3. Prohibition against insurance risk. Except as specifically authorized in section 2676, an administrator may provide administrative services only and may not accept insurance risk.

4. Approval required before marketing or making available. A carrier may not issue a health plan incorporating a preferred provider arrangement and an administrator may not market or otherwise make available a preferred provider arrangement until the superintendent pursuant to section 2673-A has approved the arrangement.

5. Registration as insurance administrator. In addition to meeting the requirements of the preferred provider arrangement, each preferred provider administrator who directly or indirectly transfers funds, manages funds, adjusts claims or asserts control over the transfer of funds for the purpose of payment of provider

services shall register with the superintendent as an insurance administrator pursuant to chapter 18.

6. Provision of document to beneficiary. Each preferred provider administrator shall inform all carriers that the carriers must provide to each enrollee of any health plan subject to this chapter a plan description that complies with the requirements of and rules adopted under chapter 56-A, subchapter I.

Sec. 11. 24-A MRSA §2675, as amended by PL 1989, c. 588, Pt. A, §§50 to 52, is repealed.

Sec. 12. 24-A MRSA §2676, as repealed and replaced by PL 1989, c. 588, Pt. A, §53, is amended to read:

§2676. Risk transfer

Preferred provider arrangements may ~~embody risk sharing by providers~~ include capitated payments that are limited to the health services provided by the provider.

Preferred provider arrangements may embody risk transfer between carriers and providers in accordance with the provisions of chapter 56-A, subchapter III. Any other acceptance of insurance risk by a person that does not hold a valid certificate of authority or license and is not exempt by law from licensure constitutes the unauthorized transaction of insurance within the meaning of section 404 and chapter 21.

Sec. 13. 24-A MRSA §2677, as amended by PL 1993, c. 600, Pt. B, §19, is repealed.

Sec. 14. 24-A MRSA §2677-A is enacted to read:

§2677-A. Payment for nonpreferred providers

1. Nonpreferred providers. A carrier incorporating a preferred provider arrangement into a health plan shall provide for payment of covered health care services rendered by providers that are not preferred providers.

2. Benefit level. The benefit level differential between services rendered by preferred providers and nonpreferred providers may not exceed 20% of the allowable charge for the service rendered. Compliance with this requirement for a given benefit plan may be demonstrated on an aggregate basis. This demonstration of compliance must be based on a reasonably anticipated mix of claims certified by a qualified actuary who is a member of the American Academy of Actuaries or a successor

organization. As used in this subsection, "allowable charge" means the amount that would be payable for services under the preferred provider arrangement including deductible and coinsurance amounts.

Sec. 15. 24-A MRSA §2678, as enacted by PL 1985, c. 704, §4, is amended to read:

§2678. Annual experience report

On or before April 1st of each year, an administrator or ~~insurer~~ carrier who issues or administers a program, policy or contract in this State that includes incentives for the ~~insured or beneficiary~~ enrollee to use the services of a provider who has entered into an agreement with the ~~insurer~~ carrier or administrator, ~~pursuant to section 2673, subsection 2,~~ shall file a report of its activities for the preceding year with the superintendent. The report ~~shall~~ must be in the form prescribed by the superintendent and at a minimum ~~shall~~ must contain the following:

1. Name A provider directory that includes the name, address and scope of license of each preferred provider; and

~~2. Utilization experience for the following categories: Hospitalization; ambulatory surgical or other outpatient services; and professional services. Utilization of professional services is to be listed by specialty.~~

3. Annual information specified in chapter 56-A or rules adopted under that chapter. Annual information reported to the superintendent pursuant to chapter 56-A under another license must be referenced in the report and not reported in a duplicate manner.

Sec. 16. 24-A MRSA §2678-A, as enacted by PL 1989, c. 588, Pt. A, §55, is repealed.

Sec. 17. 24-A MRSA §2679, as enacted by PL 1987, c. 168, §3, is repealed.

Sec. 18. 24-A MRSA §2680, as enacted by PL 1993, c. 477, Pt. D, §9 and affected by Pt. F, §1, is repealed and the following enacted in its place:

§2680. Standardized claim form

Administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician, chiropractor or licensed hospital shall

accept the current standardized claim form approved by the federal Health Care Financing Administration.

Sec. 19. 24-A MRSA §4301, sub-§1, as amended by PL 1999, c. 256, Pt. A, §1, is further amended to read:

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~~ arrangement administrator licensed pursuant to chapter 32, a fraternal benefit society licensed pursuant to chapter 55, a nonprofit hospital or medical service organization licensed pursuant to Title 24 or a multiple-employer welfare arrangement licensed pursuant to chapter 81. 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.

Sec. 20. 24-A MRSA c. 56-A, sub-c. III is enacted to read:

SUBCHAPTER III

DOWNSTREAM RISK

§4331. Definitions

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

1. Bonus. "Bonus" means a payment a carrier makes to a downstream entity beyond any salary, fee-for-service payment, capitation or returned withhold.

2. Capitation. "Capitation" means a set dollar payment per patient per unit of time, usually per month, that a carrier pays a health care practitioner, institutional provider or downstream entity to cover a specified set of services and administrative costs without regard to the actual number or nature of services provided. The services covered may include the downstream entity's own services, referral services or all medical services.

3. Downstream entity. "Downstream entity" means a person other than a carrier that has assumed all or part of the insurance risk of one or more health plans under a contractual relationship with a carrier or another downstream entity. An employer exempt 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 downstream entity.

4. Downstream risk arrangement. "Downstream risk arrangement" means any compensation arrangement between a carrier and a downstream entity that may directly or indirectly have the effect of reducing or limiting services furnished to enrollees of the carrier.

5. Payments. "Payments" means any amounts the carrier pays the downstream entity for services the downstream entity furnishes directly, plus amounts paid for administration and amounts paid in whole or in part based on use and costs of referral services such as withhold amounts, bonuses based on referral levels and any other compensation to the downstream entity to influence the use of referral services. Bonuses and other compensation that are not based on referral levels, such as bonuses based solely on quality of care furnished, patient satisfaction and participation on committees, are not considered payments for purposes of this subchapter.

6. Physician group. "Physician group" means a partnership, association, corporation, individual practice association or other group of physicians that distributes income from the practice among members. An individual practice association is a physician group only if the association is composed of individual physicians and has no subcontracts with physician groups.

7. Potential payments. "Potential payments" means the maximum anticipated total amount, based on the most recent year's utilization and experience and any current or anticipated factors that may affect costs, to be paid for a defined set of referral services for the carrier's subscribers and for which the downstream entity assumes by contract financial risk, to some extent, for the costs of such services. The methodology for determining potential payments must be filed by the carrier with the bureau.

8. Referral services. "Referral services" means any specialty, inpatient, outpatient or laboratory services that a downstream entity orders or arranges, but does not furnish directly.

9. Risk-sharing arrangement. "Risk-sharing arrangement" means an arrangement between a carrier and a downstream entity in which the carrier continues to pay providers for a defined set of services subject to an annual reconciliation process in which costs incurred by the carrier are compared with budgeted or targeted amounts for such services and that may, if payments are different than the budgeted amount, create financial liability of the downstream entity to the carrier or the carrier to the downstream entity provided the carrier holds or retains control of any funds in excess of those required to satisfy current

claims obligations or direct payment to providers for services rendered pending reconciliation.

10. Risk threshold. "Risk threshold" means the maximum risk, if the risk is based on referral services, to which a downstream entity may be exposed under a downstream risk arrangement without being at substantial financial risk.

11. Withhold. "Withhold" means a percentage of payments or set dollar amounts that a carrier deducts from a downstream entity's service fee, capitation or salary payment and that may or may not be returned to the downstream entity, depending on specific predetermined factors.

§4332. Safe harbor and waiver

1. Authority for safe harbor. Notwithstanding any other provisions of this Title or Title 24, including, without limitation, sections 4341 and 4342, an arrangement between a carrier and a downstream entity with which the carrier has contracted to provide or arrange for the provision of services that allows the downstream entity to accept a limited degree of insurance risk is permitted and such a risk arrangement is deemed not to be engaging in the business of insurance by the downstream entity if:

A. The arrangement does not involve substantial insurance risk or substantial enrollment risk as described in section 4334; and

B. The arrangement meets the requirements of sections 4335 and 4336.

2. Waiver for downstream risk arrangements that exceed risk threshold described in section 4334. Carriers and downstream entities that wish to develop downstream risk arrangements that exceed the risk threshold described in section 4334 may jointly request that the superintendent grant a waiver that allows the downstream entity to accept a limited degree of insurance risk without being licensed as an insurer, a health maintenance organization or an insurance administrator. The joint request for a waiver must include a plan for managing financial exposure, based upon reasonable enrollment and utilization projections and upon the contracts, parties and features proposed, sufficient to quantify in dollars per quarter and per annum all elements of downstream risk to be assumed by the downstream entity. All other risk arrangements are prohibited unless the arrangements meet the appropriate licensing standards or are expressly permitted by the superintendent.

3. Continuing obligation to subscribers. A carrier contracting with a downstream entity remains obligated to its subscribers for the delivery of health care benefits consistent with existing state law. The carrier remains responsible for compliance with all applicable laws.

4. Certain incentives prohibited. A downstream risk arrangement may not contain incentives for the downstream entity or participating provider to limit or deny medically necessary care to enrollees.

5. Requirements still applicable. The application of the safe harbor provisions in subsection 1 or a waiver of licensing requirements granted pursuant to this section does not exempt the downstream entity from any other licensure or prior approval requirements applicable to activities conducted by the downstream entity, including, but not limited to, utilization review licensure, insurance administrator licensure or preferred provider arrangement registration.

§4333. Requirements for downstream risk arrangements

1. Permissible downstream risk arrangements. Downstream entities that do not exceed the risk threshold described in section 4334 may enter into downstream risk arrangements only if:

A. The requirements of section 4332, subsection 1 and sections 4335 and 4336 are met; and

B. No specific payment is made directly or indirectly under the plan to a provider as an inducement to reduce or limit medically necessary services furnished to an enrollee.

2. Prohibited downstream risk payments. A specific payment of any kind may not be made directly or indirectly under the incentive plan to a downstream entity as an inducement to reduce or limit covered medically necessary services under the carrier's contract furnished to an enrollee. Indirect payments include offerings of monetary value such as stock options or waivers of debt measured in the present or future.

3. Applicability. This section applies to risk arrangements between carriers and downstream entities with which they contract to provide medical services to enrollees. This section also applies to subcontracting arrangements.

§4334. Substantial insurance risk; substantial enrollment risk

1. Substantial insurance risk. Substantial insurance risk is risk based on the use or costs of referral services only, when the downstream entity is at risk for more than 25% of potential payments by the carrier to the downstream entity.

2. Substantial enrollment risk. Substantial enrollment risk exists when a carrier enters into a risk arrangement with a downstream entity involving more than 25% of the enrollees served by the carrier in the State unless the risk arrangement is a risk-sharing arrangement.

§4335. Contractual provisions

Full copies of contracts and summary descriptions of contracts must be provided to the superintendent. The following provisions must be included in contracts between a carrier and a downstream entity:

1. Enrollee not liable. A provision in all relevant contracts between a carrier and a downstream entity or between a downstream entity and a participating provider of health care services stating that if the carrier fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the carrier;

2. Maintenance of books, accounts and records. A provision for the maintenance of books, accounts and records by the downstream entity and the carrier to verify that transactions, including the risk transfer, are clearly, accurately and completely recorded, in accordance with generally accepted accounting principles and disclosed in writing;

3. Prohibition on assignment of rights or obligations. A provision prohibiting the assignment of any rights or obligations under the contract in the absence of the consent of the carrier;

4. Right to object to subcontractor. A provision granting the carrier the right to be advised of and the right to object to any subcontractor with whom the downstream entity proposes to contract with respect to services required to be performed by the downstream entity under its contract with the carrier;

5. Termination of contract. A provision for the termination of the contract, including the right to immediately terminate the contract upon a valid order issued by the superintendent or another lawful authority;

6. Compliance with utilization review laws, rules and licensing requirements. A provision requiring the downstream entity to comply with utilization review laws, rules and

licensing requirements appropriate to the functions the downstream entity has contracted to undertake on behalf of the carrier;

7. Ability to perform. A provision requiring the downstream entity to advise the carrier in a timely manner of relevant matters that may have a material effect on the downstream entity's ability to perform under the contract, including, but not limited to:

A. Whether the downstream entity or participating provider is subject to an administrative order, a cease and desist order, a fine or a license suspension; and

B. Whether legal action has been taken that may have a material effect on the downstream entity's financial condition or the downstream entity's ability to perform under the contract; and

8. Incorporation by reference. A provision requiring the contract between a carrier and a downstream entity to be attached to all contracts between the downstream entity and those of the entity's participating providers contractually obligated to provide services to the carrier's enrollees under the contract between the carrier and the downstream entity.

§4336. Disclosure requirements for organizations with downstream risk arrangements

1. Disclosure to superintendent. Each carrier shall provide information concerning the carrier's downstream risk arrangements as required or requested by the superintendent. The disclosure must contain the following information in sufficient detail to enable the superintendent to determine whether the risk arrangement complies with the following requirements:

A. Whether services not furnished by the downstream entity are covered by the risk arrangement. If the services furnished by the downstream entity are covered by the risk arrangement, disclosure of other aspects of the plan need not be made;

B. The type of risk arrangement; for example, withhold, bonus, capitation;

C. If the risk arrangement involves a withhold or bonus, the percent of the withhold or bonus;

D. The panel size, the number of enrollees covered by the downstream entity and the total number of enrollees covered by the carrier in the State; and

E. In the case of capitated downstream entities, capitation payments paid to primary care providers for the most recent year broken down by percent for primary care services, referral services to specialists, hospital services and other types of provider services, including, but not limited to, nursing home and home health agency services.

2. Annual disclosure. A carrier shall provide this information to the superintendent at least annually. A carrier shall provide the capitation data required under subsection 1 for the previous calendar year to the superintendent by April 1st of each year.

3. Disclosure to enrollees. A carrier shall provide the following information to any enrollee upon request:

A. Whether the prepaid plan uses a downstream risk arrangement that affects the use of referral services; and

B. The type of risk arrangement.

§4337. Requirements related to subcontracting arrangements

1. Physician groups. A carrier that contracts with a downstream entity that places the individual physician members at substantial financial risk for services they do not furnish shall disclose to the superintendent any incentive plan between the downstream entity and the entity's individual physicians that bases compensation to the physician on the use or cost of services furnished to enrollees. The disclosure must include the information specified in section 4336, subsection 1.

2. Intermediate entities. A carrier that contracts with a downstream entity, other than a physician group, for the provision of services to enrollees shall disclose to the superintendent any risk arrangement between the entity and a physician or physician group that bases compensation to the physician or physician group on the use or cost of services furnished to enrollees. The disclosure must include the information required to be disclosed under section 4336, subsection 1.

3. Sanctions against the carrier. The superintendent may apply intermediate sanctions if the superintendent determines that a carrier fails to comply with the requirements of this section.

§4338. Downstream risk arrangements that exceed risk threshold described in section 4334

The superintendent may waive downstream risk arrangements from licensure requirements that exceed the risk threshold described in section 4334 if the downstream risk arrangement meets the contractual and disclosure requirements established under section 4332 and the criteria set forth in sections 4339 to 4342 and is determined by the superintendent not to prejudice enrollee interests.

§4339. Contractual provisions to demonstrate financial viability

If a carrier applies for a waiver under section 4332, subsection 2, the carrier may demonstrate the financial viability and condition of the downstream entity through the terms of the contract, including one or more of the following:

1. Books, accounts and records. A contractual provision authorizing the carrier to access the downstream entity's books, accounts and records according to terms and conditions on which the carrier and the downstream entity agree;

2. Financial statements. A contractual provision requiring the downstream entity to provide to the carrier interim unaudited financial statements on a regular and ongoing basis as well as an annual financial statement, accompanied by a certified public accountant's opinion, appropriate to the magnitude of risk involved;

3. Reserves. A contractual provision authorizing the carrier to receive information regarding the downstream entity's reserves;

4. Letter of credit. A contractual provision requiring the downstream entity to post a letter of credit or other acceptable financial security;

5. Fees. A contractual provision under which the carrier withholds fees payable to the downstream entity or to the providers for which it acts;

6. General liability insurance. A contractual provision requiring the downstream entity to carry general liability insurance and requiring participating providers to carry professional liability insurance in an amount and from an insurer mutually acceptable to the carrier and the downstream entity;

7. Surety bond. A contractual provision requiring the downstream entity to secure a surety bond to cover the downstream entity's performance under the contract; or

8. Excess of loss insurance. A contractual provision requiring the downstream entity to secure excess of loss insurance or reinsurance in an amount and from an insurer mutually acceptable to the carrier and the downstream entity.

§4340. Financial viability

Each carrier and downstream entity requesting a waiver shall file with the superintendent a plan for managing financial exposure under those downstream risk arrangement contracts and thereafter operate in substantial conformance with the terms of that plan and of the corresponding waiver. At least 60 days before any material change in a filed and approved exposure management plan, the carrier and downstream entity shall file for the superintendent's review and approval a modified plan, along with any changes in related contracts.

§4341. Limitations on premium transfer

The superintendent may deny a request for waiver based on any of the following characteristics:

1. Transfer of 30% of annual aggregate premium. A contract by which 30% or more of the carrier's annual aggregate premium with respect to a contract, plan or product is transferred to a single downstream entity. This transfer is the sum of capitated payments plus the sum of amounts returnable to the carrier through incentive payments or other risk adjustments; or

2. Transfer of 75% of annual aggregate premium. Multiple contracts by which 75% or more of the carrier's annual aggregate premium with respect to a contract, plan or product is transferred to one or more downstream entities. This transfer is the sum of capitated payments plus the sum of amounts returnable to the carrier through incentive payments or other risk adjustments.

§4342. Related provisions

The superintendent may deny a request for waiver based on any of the following characteristics:

1. Carrier controlled. An arrangement with a downstream entity that has control of the carrier. "Control" has the same meaning as defined in section 222, subsection 2, paragraph B;

2. Transfer of claims processing, payment or adjudication. An arrangement by which the claims processing, claims payment or claims adjudication functions are transferred to the downstream

entity from the carrier. This section may not be construed to authorize the superintendent to deny a request based on the transfer of utilization review functions from the carrier to the downstream entity;

3. Transfer of managerial control. An arrangement by which managerial control of the carrier's information system is transferred to the downstream entity;

4. Overlap between officers or directors. An arrangement in which there is overlap between the officers or directors of the downstream entity and the carrier; or

5. Transfer of more than 1/12 of annual capitated payments. An arrangement that transfers more than 1/12 of the annual capitated payments at one time to the downstream entity.

§4343. Rules

The superintendent may adopt rules establishing application procedures and specific standards for meeting the requirements pursuant to this subchapter. Rules adopted pursuant to this subchapter are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

Sec. 21. Transition. Within 180 days after the effective date of this Act, all carriers with existing downstream risk arrangements shall file applications for waivers from licensure with the Superintendent of Insurance consistent with the requirements of this Act. The superintendent may grant waivers on a provisional basis, retroactive to the effective date of this Act, while a full review of the application is pending. Any arrangement in which the superintendent expressly approves the risk transfer before the effective date of this Act is deemed approved if the carrier files a plan for managing financial exposure within 180 days after the effective date of this Act. The superintendent may rescind or modify any waiver granted pursuant to this section if the downstream risk arrangement is not in compliance with the requirements of this Act or if the carrier does not provide the superintendent with the information necessary to determine whether the arrangement is in compliance with the requirements of this Act.'

Further amend the bill by inserting at the end before the summary the following:

COMMITTEE AMENDMENT "A" to H.P. 1422, L.D. 2029

FISCAL NOTE

The Bureau of Insurance within the Department of Professional and Financial Regulation will incur some minor additional costs to adopt rules and issue waivers. These costs can be absorbed within the bureau's existing budgeted resources.

This bill is not expected to affect the costs of the state employee health insurance program or the State's share of retired teachers' health insurance.'

SUMMARY

This amendment replaces the bill. It accomplishes the following.

Preferred provider arrangements, PPAs, include a contract, agreement or arrangement between a carrier or administrator and a provider in which the provider agrees to provide health care services to a health plan enrollee whose plan benefits include incentives, typically a discount, for the enrollee to use the services of that provider. PPAs often serve as the provider network for carriers offering discount arrangements. In some instances, a PPA is the provider network for health maintenance organizations, HMOs. A gatekeeper PPA mirrors an HMO point-of-service product. Because of the similarities between a PPA and an HMO, this amendment proposes to standardize the reporting and filing requirements.

This amendment clarifies definitions in the PPA statute and makes the definitions consistent with the HMO statute. The amendment makes the accessibility and reporting standards for PPAs and HMOs consistent. The amendment clarifies the information that PPAs must file with the Superintendent of Insurance to be registered in the State. The bill requires preferred provider administrators who transfer funds, manage funds or adjust claims to register as insurance administrators. The amendment requires that carriers offering more than one health plan with different provider networks must register each arrangement as a separate PPA with the superintendent. The amendment clarifies that the rules adopted pursuant to the Maine Revised Statutes, Title 24-A, chapter 56-A are applicable to PPAs.

This amendment requires providers that enter into limited risk arrangements to meet certain criteria to protect enrollees from financial risk. Carriers that enter into downstream risk arrangements with downstream entities must acknowledge responsibility for providing services to enrollees in the event a

downstream entity fails financially. Title 24-A, chapter 56-A, subchapter III allows the waiver of licensure requirements for downstream risk arrangements that meet safe harbor provisions or meet additional contractual and disclosure requirements specified by the superintendent. This subchapter establishes a risk threshold under which a downstream entity may operate without licensure. Specific contractual and disclosure provisions are established that downstream entities must comply with to meet safe harbor standards. Additionally, the superintendent may waive licensing requirements for downstream entities that exceed the risk threshold if they meet specific contractual and disclosure conditions.

The amendment also adds a fiscal note to the bill.