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H.P. 1422 House of Representatives, March 24, 1999

An Act to Update and Amend the Preferred Provider Arrangement Act.

Submitted by the Department of Professional and Financial Regulation pursuant to Joint Rule 204.

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

JOSEPH W. MAYO, Clerk

Presented by Representative SAXL of Bangor.
Cosponsored by Senator ABROMSON of Cumberland.

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

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 section, "administrator" includes any administrator of a preferred provider organization required to register under this chapter pursuant to section 2674-A.

Sec. 3. 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. 4. 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.

1-A. "Capitation" means a method of payment for health services in which the health care practitioner, institutional provider or downstream risk entity is paid in whole or part a fixed dollar amount for each person served, without regard to

the actual number or nature of services provided to each person in a set period of time.

~~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 health maintenance organization licensed pursuant to chapter 56, 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. "Provider" does not include physician hospital organizations.

9. "Superintendent" means the Superintendent of Insurance.

Sec. 5. 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~~ preferred 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. 6. 24-A MRSA §2673, as repealed and replaced by PL 1989, c. 588, Pt. A, §49, is repealed.

Sec. 7. 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 area, provider network and other materials relevant to the proposed arrangement. The superintendent shall disapprove any preferred provider arrangement if it 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 2 health plans 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 multilevel plan, then the 2 plans represent different preferred provider arrangements and must be separately filed and approved.

3. Rules. Preferred provider arrangements authorized under this chapter are subject to the requirements of rules adopted pursuant to chapter 56-A. 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 individual enrollees or beneficiaries who must travel an unreasonable distance to obtain the service, and may take into account the effect of the arrangement on noninsureds and nonbeneficiaries in the communities affected by the arrangement, including, but not limited to, the ability of nonpreferred providers to continue to provide health care services if all nonemergency services were provided by a preferred provider. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

Sec. 8. 24-A MRSA §2674, as enacted by PL 1985, c. 704, §4, is repealed.

Sec. 9. 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 subject to this chapter 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. No arrangement may be offered until the superintendent has approved the arrangement.

2. Compilation of current listing. The Bureau of Insurance shall compile and maintain a current listing of administrators and carriers offering agreements 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. An administrator may not market or otherwise make available a

preferred provider arrangement to carriers, nor may a carrier issue a health plan incorporating a preferred provider arrangement until the arrangement has been approved by the superintendent pursuant to section 2673-A.

5. Registration as insurance administrator. Each 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 Bureau of Insurance as an insurance administrator pursuant to chapter 18.

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

Sec. 10. 24-A MRSA §2675, as amended by PL 1989, c. 588, Pt. A, §§50 to 52, is repealed.

Sec. 11. 24-A MRSA §2676, as repealed and replaced by PL 1989, c. 588, Pt. A, §53, is amended to read:

§2676. Risk sharing

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

Parties to preferred provider arrangements may receive capitated payments directly or indirectly from a licensed carrier to the extent authorized by the superintendent pursuant to chapter 56-A, subchapter III. Any other transfer of insurance risk to a person that does not hold a valid certificate of authority and is not exempt by law from licensure constitutes the unauthorized transaction of insurance within the meaning of section 404 and chapter 21.

Sec. 12. 24-A MRSA §2677, as amended by PL 1993, c. 600, Pt. B, §19, is repealed.

Sec. 13. 24-A MRSA §2677-A is enacted to read:

§2677-A. Payment for 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 who are not preferred providers.

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

Sec. 14. 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 to include 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~~ Annual information specified in chapter 56-A.

Sec. 15. 24-A MRSA §2678-A, as enacted by PL 1989, c. 588, Pt. A, §55, is repealed.

Sec. 16. 24-A MRSA §2679, as enacted by PL 1987, c. 168, §3, is repealed.

Sec. 17. 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 must accept the current standardized claim form approved by the Federal Government.

Sec. 18. 24-A MRSA §2681 is enacted to read:

§2681. Public notice

Within 10 days of receipt of a report of a proposed preferred provider arrangement, the superintendent shall mail notice of the proposal to all persons who have requested notice of preferred provider arrangement proposals in advance from the superintendent.

Sec. 19. 24-A MRSA §4301, sub-§1, as amended by PL 1997, c. 604, 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 or 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. 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 benefit plans under a contractual relationship with a carrier or another downstream entity.

§4332. Waiver of licensure requirements

1. Authority to grant waiver. Notwithstanding any other provisions of this Title or Title 24, the superintendent, at the request of a carrier, may grant a waiver from licensure to a downstream entity with whom the carrier has contracted to provide services that allow the downstream entity to accept a limited degree of insurance risk without being licensed as an insurer or as a health maintenance organization.

2. Continuing obligation to subscribers. A carrier receiving a waiver remains obligated to its subscribers for the delivery of health care benefits and the quality of services provided. The carrier remains responsible for compliance with all applicable laws.

3. Assumption of risk. A downstream entity may only assume risk within the terms of the waiver granted by the superintendent. A downstream entity may assume risk from more than one carrier only if a separate waiver has been granted to each carrier.

4. Certain incentives prohibited. A financial arrangement may not contain incentives for the downstream risk entity or participating providers to limit or deny medically necessary care to individual subscribers.

5. Plan for managing financial exposure. Each carrier receiving one or more waivers pursuant to this subchapter must file with the superintendent a plan for managing its financial exposure under those contracts and remain in substantial conformance with the terms of that plan. At least 60 days before any material change in a filed and approved exposure management plan, the carrier shall file for the superintendent's review and approval a modified plan, along with any changes in its standard contracts.

6. Requirements still applicable. A waiver from certificate of authority requirements granted pursuant to this section does not exempt the downstream entity from any other licensure or prior approval requirements applicable to the kinds of activities conducted by the downstream entity, including, but not limited to, utilization review licensure, insurance administrator licensure or preferred provider arrangement registration.

7. Rules. The superintendent may adopt rules establishing application procedures and specific standards for waivers granted and exposure management plans filed pursuant to this subchapter. Within 60 days under an expedited review, the

superintendent shall grant or deny a carrier's request to use a previously approved downstream risk contractual agreement. The superintendent may develop financial and other criteria to establish model contractual language that a carrier may use in a generic filing. A carrier's generic filing with model contractual language is subject to an expedited review. Rules adopted pursuant to this subchapter are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

§4333. Contractual provisions

The superintendent may not issue a waiver until the carrier has demonstrated that its contractual arrangement with the downstream entity is sufficient to ensure adequate consumer protections, the financial solvency of the downstream entity and its ability to provide health care services on a continuing basis, and the ability of the superintendent to regulate the downstream entity indirectly through the carrier. In determining whether to grant a request for waiver, the superintendent shall consider the following contractual provisions:

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 accounts. A provision for the maintenance of books, accounts and records by the downstream entity and the carrier to ensure that transactions, including the risk transfer, are clearly, accurately and completely disclosed;

3. Ensuring financial viability. Appropriate terms permitting the carrier to ensure the financial viability and condition of the downstream entity through the term of the contract, including one or more of the following:

A. A 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;

B. A 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 audited financial statement;

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

D. A provision for the downstream entity to post a letter of credit or other acceptable financial security;

E. A provision under which the carrier withholds fees payable to the downstream entity;

F. A provision for the downstream entity to carry general liability insurance and for participating providers to carry professional liability insurance in an amount and from a carrier that is mutually acceptable to the carrier and the downstream entity;

G. A provision for the downstream entity to secure a surety bond to cover the downstream entity's performance under the contract; or

H. A provision for the downstream entity to secure excess of loss insurance in an amount and from another carrier that is mutually acceptable to the carrier and the downstream entity;

4. 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;

5. 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;

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

7. Institution of financial monitoring plan. A provision setting forth the circumstances under which the carrier may institute financial monitoring plan of the downstream entity;

8. Compliance with utilization review and licensing requirements. A provision requiring the downstream entity to comply with utilization review, 3rd-party administrator or other licensing requirements triggered by the functions it has contracted to undertake on behalf of the carrier;

9. Ability to perform. A provision requiring the downstream entity to timely advise the carrier 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

10. Incorporation by reference. Whether a contract between a carrier and a downstream entity is incorporated by reference and is attached to all contracts between the downstream entity and those of its participating providers contractually obligated to provide services to the carrier's enrollees under the carrier-downstream entity contract.

§4334. Limitations on risk 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 is transferred to a single downstream entity;

2. Transfer of 75% of annual aggregate premium. Multiple contracts by which 75% or more of the carrier's annual aggregate premium is transferred to one or more downstream entities;

3. Carrier controlled. A contract with the downstream entity that has control of the carrier. "Control" has the same meaning as defined in section 222, subsection 2, paragraph B;

4. Transfer of claims processing, payment or adjudication. A contract by which the claims processing, claims payment or claims adjudication functions are transferred to the downstream entity from the carrier. Nothing in this subparagraph may 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;

5. Transfer of managerial control. A contract by which managerial control of the carrier's information system is transferred to the downstream entity;

6. Overlap between officers or directors. A contract in which there is overlap between the officers or directors of the downstream entity and the carrier; or

7. Transfer of more than 1/12 of annual capitated payments. A contract that transfers more than 1/12 of the annual capitated payments at one time to the downstream entity.

Sec. 21. Transition. Within 90 days after the effective date of this Act, all carriers with existing downstream risk transfer 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 an exposure management plan within 90 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.

SUMMARY

This bill accomplishes the following:

1. It makes definitions in the Maine Revised Statutes, Title 24-A, chapter 32 more consistent with those in Title 24-A, chapter 56-A;

2. It adds geographic accessibility standards for preferred provider arrangements, consistent with those of health maintenance organizations;

3. It provides for the incorporation of downstream risk arrangements;

4. It requires a preferred provider administrator who handles money to be licensed as a 3rd-party administrator, rather than being subject to separate standards as they are currently; and

5. It requires registered preferred provider arrangements to generate annual reports consistent with existing law.