125th MAINE LEGISLATURE

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Legislative Document **No. 496**

H.P. 389 House of Representatives, February 10, 2011

An Act To Amend the Laws Governing Financial Incentives and Geographic Accessibility of Services Covered by Health Insurance Providers

Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

HEATHER J.R. PRIEST
Clerk

Presented by Representative McKANE of Newcastle.
Cosponsored by Senator THOMAS of Somerset and
Representatives: MALABY of Hancock, PICCHIOTTI of Fairfield, RICHARDSON of Warren, WEAVER of York, Senators: HASTINGS of Oxford, McCORMICK of Kennebec, SNOWE-MELLO of Androscoggin.

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

Sec. 1. 24-A MRSA §2673-A, sub-§3, as enacted by PL 1999, c. 609, §8, is amended to read:

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~~ 2-A.

Sec. 2. 24-A MRSA §4203, sub-§3, ¶S, as amended by PL 2003, c. 469, Pt. E, §18, is further amended to read:

S. A list of the names and addresses of all physicians and facilities with which the health maintenance organization has or will have agreements. If products are offered that pay full benefits only when providers within a subset of the contracted physicians or facilities are utilized, a list of the providers in that limited network must be included, as well as a list of the geographic areas where the products are offered. This paragraph may not be construed to prohibit a health maintenance organization from offering a health plan that includes financial provisions designed to encourage members to use designated providers in a network in accordance with section 4303, subsection 1, paragraph ~~A~~ D.

Sec. 3. 24-A MRSA §4303, sub-§1, as amended by PL 2009, c. 652, Pt. A, §33, is further amended to read:

1. Demonstration of adequate access to providers. Except as provided in ~~paragraphs B and C~~ paragraph D, a carrier offering or renewing 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. These standards must consider the geographical and transportational problems in rural areas. All managed care plans covering residents of this State must provide reasonable access to providers consistent with the access-to-services requirements of any applicable bureau rule.

~~B. Upon approval of the superintendent, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:~~

~~(1) The entire network meets overall access standards pursuant to Bureau of Insurance Rule Chapter 850;~~

~~(2) The health plan is consistent with product design guidelines for Bureau of Insurance Rule Chapter 750, but only if the health plan is offered by a health maintenance organization;~~

~~(3) The health plan does not include financial provisions designed to encourage members to use designated providers of primary, preventive, maternity, obstetrical, ancillary or emergency care services, as defined in Bureau of Insurance Rule Chapter 850;~~

~~(4) The financial provisions may apply to all of the enrollees covered under the carrier's health plan;~~

~~(5) The carrier establishes to the satisfaction of the superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The superintendent may consult with other state entities, including the Department of Health and Human Services, Bureau of Health and the Maine Quality Forum established in section 6951, to determine whether the carrier has met the requirements of this subparagraph. The superintendent shall adopt rules regarding the criteria used by the superintendent to determine whether the carrier meets the quality requirements of this subparagraph; and~~

~~(6) The financial provisions may not permit travel at a distance that exceeds the standards established in Bureau of Insurance Rule Chapter 850 for mileage and travel time by 100%.~~

~~C. A carrier may develop and file with the superintendent for approval a pilot program that allows carriers to reward providers for quality and efficiency through tiered benefit networks and providing incentives to members. The upper tier, or the upper tiers if there are 3 or more tiers, under a pilot program approved pursuant to this paragraph is exempt from geographic access requirements set forth in this subsection or in rules adopted by the superintendent. Any carrier offering a health plan under the pilot program must collect data on the impact of the pilot program on premiums paid by enrollees, payments made to providers, quality of care received and access to health care services by individuals enrolled in health plans under the pilot program and must submit that data annually to the superintendent. The superintendent shall report annually beginning January 15, 2010 to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on any approval of a pilot program pursuant to this paragraph.~~

~~The basis for tiering benefits under a pilot program must be to provide incentives for higher-quality care, improved patient safety or improved efficiency or a combination~~

~~of those factors. The superintendent shall consult with the Maine Quality Forum under section 6951 in assessing quality. The superintendent shall disapprove or withdraw approval of a pilot program if the superintendent finds that approval or continued operation would cause undue hardship to enrollees in the pilot program or reduce their quality of care.~~

~~The superintendent shall consider the experience of approved pilot programs, including consumer complaints and examinations, provider behavior and efficiency, in determining whether or not to reapprove subsequent pilot program applications.~~

D. In addition to a managed care plan offered by a carrier in accordance with this subsection and standards developed by rule by the superintendent, a carrier shall offer a health plan with financial provisions to encourage use of designated providers that is exempt from geographic access requirements set forth in this subsection or in rules adopted by the superintendent.

SUMMARY

This bill removes provisions in current law prohibiting health insurance carriers from applying benefit differentials based on travel and repeals the provision authorizing pilot projects that are exempt from geographic access requirements. In its place, the bill requires health insurance carriers to offer a health plan with financial provisions to encourage use of designated providers that is exempt from geographic access requirements established in current law and in rules adopted by the Department of Professional and Financial Regulation, Bureau of Insurance.