MAINE STATE LEGISLATURE

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125th MAINE LEGISLATURE

FIRST REGULAR SESSION-2011

Legislative Document **No. 1333**

H.P. 979 House of Representatives, March 29, 2011

An Act To Modify Rating Practices for Individual and Small Group Health Plans and To Encourage Value-based Purchasing of Health Care Services

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

HEATHER J.R. PRIEST
Clerk

Presented by Representative RICHARDSON of Warren.
Cosponsored by Representatives: BLACK of Wilton, DOW of Waldoboro, FITZPATRICK of Houlton, McKANE of Newcastle, PICCHIOTTI of Fairfield, Senator: WHITTEMORE of Somerset.

Printed on recycled paper

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

Sec. 1. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2007, c. 629, Pt. A, §4, is repealed and the following enacted in its place:

D. A carrier may vary the premium rate due to age and geographic area in accordance with the limitations set out in this paragraph.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2012 and December 31, 2012, for each health benefit plan offered by a carrier, the highest premium rate for each rating tier may not exceed 2 times the premium rate that could be charged to an eligible individual with the lowest premium rate for that rating tier in a given rating period.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2013 and December 31, 2013, for each health benefit plan offered by a carrier, the highest premium rate for each rating tier may not exceed 2.5 times the premium rate that could be charged to an eligible individual with the lowest premium rate for that rating tier in a given rating period.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014, for each health benefit plan offered by a carrier, the highest premium rate for each rating tier may not exceed 3 times the premium rate that could be charged to an eligible individual with the lowest premium rate for that rating tier in a given rating period.

For purposes of this paragraph, "rating tier" means each category of individual or family composition for which a carrier charges separate rates.

Sec. 2. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 2001, c. 410, Pt. A, §4 and affected by §10, is repealed and the following enacted in its place:

D. A carrier may vary the premium rate due to age, occupation or industry and geographic area in accordance with the limitations set out in this paragraph.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2012 and December 31, 2012, for each small group health plan offered by a carrier, the highest premium rate for each rating tier may not exceed 2 times the premium rate that could be charged to an eligible group with the lowest premium rate for that rating tier in a given rating period.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2013 and December 31, 2013, for each small group health plan offered by a carrier, the highest premium rate for each rating tier may not exceed 2.5 times the premium rate that could be charged to an eligible group with the lowest premium rate for that rating tier in a given rating period.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014, for each small group health plan offered by a carrier, the highest premium rate for each rating tier may not exceed 3 times the premium rate that could be charged to an eligible group with the lowest premium rate for that rating tier in a given rating period.

For purposes of this paragraph, "rating tier" means each category of small group for which a carrier charges separate rates.

Sec. 3. 24-A MRSA §2808-B, sub-§2, ¶D-1, as amended by PL 2001, c. 410, Pt. A, §5 and affected by §10, is repealed.

Sec. 4. 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, a~~ 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~~ transportation 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; and

(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 financial 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~~ 2012 to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on ~~any approval of a pilot program~~ the impact of the financial incentives on cost, quality of care and access to health care services 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.~~

Sec. 5. Application. The requirements of this Act apply to all policies, contracts and certificates subject to this Act that are executed, delivered, issued for delivery, continued or renewed on or after January 1, 2012. For the purposes of this Act, contracts are deemed to be renewed no later than the next anniversary of the contract date.

Sec. 6. Effective date. Those sections of this Act that repeal and replace the Maine Revised Statutes, Title 24-A, section 2736-C, subsection 2, paragraph D and section 2808-B, subsection 2, paragraph D take effect January 1, 2012.

SUMMARY

This bill gradually modifies the community rating provisions for individual and small group health plans. It expands in 3 increments the rating bands from the current ratio of 1.5:1 to 3:1 by January 1, 2014.

The bill allows financial incentives except for emergency care services. It maintains the requirement that plans must provide reasonable access to services for all members. It allows plans to provide financial incentives to members to reward providers for quality and efficiency. A carrier must submit annual data to the Superintendent of Insurance showing the impact of such financial incentives 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.