L.D. 1006

Date: 6/14/13 (Filing No. H-502)

INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

126TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 704, L.D. 1006, Bill, "An Act To Clarify Transparency of Medical Provider Profiling Programs Used by Insurance Companies and Other Providers of Health Insurance"

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

'**Sec. 1. 5 MRSA §285, sub-§15** is enacted to read:

15. Provider profiling programs. Notwithstanding subsection 10, the requirements of Title 24-A, sections 2694-A and 4303-A apply to any provider profiling program, as defined in Title 24-A, section 4301-A, subsection 16-A, developed by the commission.

Sec. 2. 24-A MRSA §2694-A, sub-§1, as enacted by PL 2009, c. 350, Pt. B, §1, is amended to read:

1. Performance measurement, reporting and tiering programs. An insurer delivering or issuing for delivery within the State any individual health insurance policy or group health insurance policy or certificate shall annually file with the superintendent on or before October 1, 2010 and annually by October 1st in subsequent years a full and true statement of its criteria, standards, practices, procedures and programs that measure ~~physician performance~~ or tier ~~physician~~ health care provider performance with respect to quality, cost or cost-efficiency. The statement must be on a form prepared by the superintendent and may be supplemented by additional information required by the superintendent. The statement must be verified by the oath of the insurer's president or vice-president, and secretary or chief medical officer. A filing and supporting information are public records notwithstanding Title 1, section 402, subsection 3, paragraph B.

Sec. 3. 24-A MRSA §4301-A, sub-§16-A, as enacted by PL 2009, c. 439, Pt. B, §1, is amended to read:

16-A. Provider profiling program. "Provider profiling program" means a program that uses provider data in order to rate or rank provider quality, cost or efficiency of care by the use of a grade, star, tier, rating or any other form of designation that provides an

enrollee with an incentive to use a designated provider based on quality, cost or efficiency of care.

Sec. 4. 24-A MRSA §4303, sub-§2, ¶E, as enacted by PL 2009, c. 439, Pt. B, §5, is repealed.

Sec. 5. 24-A MRSA §4303-A is enacted to read:

§4303-A. Provider profiling programs

1. Disclosure. At least 60 days prior to using or publicly disclosing the results of the provider profiling program, a carrier with a provider profiling program shall disclose to providers the methodologies, criteria, data and analysis used to evaluate provider quality, performance and cost, including but not limited to unit cost, price and cost-efficiency ratings. For the purposes of this subsection, the disclosure of data is satisfied by the provision by a carrier of a description of the data used in the evaluation, the source of the data, the time period subject to evaluation and, if applicable, the types of claims used in the evaluation including any adjustments to the data and exclusion from the data.

2. Provider profile. A carrier shall create and share with providers their provider profile at least 60 days prior to using or publicly disclosing the results of the provider profiling program.

3. Request for data. A provider may request a copy of its data within 30 days of the carrier's disclosure to a provider as required by subsection 2, and, upon request from a provider, a carrier shall provide to that provider the data associated with the requesting provider and all adjustments to the data used to evaluate that provider as part of the carrier's provider profiling program. The bureau shall adopt rules to establish requirements for the disclosure of data by a carrier to a provider in accordance with this subsection. The bureau shall provide in the rules for a time and manner of disclosure consistent with a carrier's ability to adopt, revise and develop an effective provider profiling program.

4. Appeals. A carrier shall establish a process that affords a provider the opportunity to review and dispute its provider profiling result within 30 days of being provided with its provider profile pursuant to subsection 2. The appeal process must:

A. Afford the provider the opportunity to correct material errors, submit additional information for consideration and seek review of data and performance ratings;

B. Afford the provider the opportunity to review any information or evaluation prepared by a 3rd party and used by the carrier as part of its provider profiling program; however, if the 3rd party provides the right to review and correct that data, any appeal pursuant to this paragraph is limited to whether the carrier accurately portrayed the information and not to the underlying determination made by the 3rd party; and

C. Allow the provider to request reconsideration of its provider profiling result and submit supplemental information, including information demonstrating any computational or data errors.

5. Out-of-network providers. If a carrier has a provider profiling program that includes out-of-network providers, a carrier must meet the requirements of this section with regard to an out-of-network provider as well as for a provider in a carrier's network.

6. Rules. The bureau shall adopt rules necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.'

SUMMARY

This amendment replaces the bill. The amendment requires that any cost metric used by insurance carriers in a provider profiling program be covered by the existing transparency provisions in the health plan improvement laws. The amendment also requires carriers to provide copies of the data and methodology used in the metric to affected providers.

FISCAL NOTE REQUIRED

(See attached)

Revised: 06/13/13 mac

126th MAINE LEGISLATURE

LD 1006 **LR 1402(02)**

An Act To Clarify Transparency of Medical Provider Profiling Programs Used by Insurance Companies and Other Providers of Health Insurance

Fiscal Note for Bill as Amended by Committee Amendment "A" (H-502)
Committee: Insurance and Financial Services
Fiscal Note Required: Yes

Fiscal Note

Potential current biennium cost increase - Internal Service Fund
Minor cost increase - Other Special Revenue Funds

Fiscal Detail and Notes

Assumes the potential cost to the State Employee Health Plan from the requirement to provide data if requested by providers will be absorbed within existing budgeted resources. Additional costs to the Department of Professional and Financial Regulation are assumed to be minor and can be absorbed within existing budgeted resources.