L.D. 1466

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INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

SENATE

126TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to S.P. 540, L.D. 1466, Bill, "An Act To Amend the Law Governing Provider Contracts with Insurance Companies"

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

'**Sec. 1. 24-A MRSA §4303, sub-§18** is enacted to read:

18. Provider contract requirements. A carrier offering a health plan must meet the requirements of this subsection with respect to a contract offered by the carrier to a provider, including a contract offered through a preferred provider arrangement, as defined in section 2671, subsection 7. This subsection does not apply to dental or vision plans.

A. If the contract for a preferred provider arrangement includes a reference to policies or procedures to which a contracting provider would be bound, all such policies and procedures must be provided to the provider for review in an easily accessible manner upon the provider's request at the time the contract is offered.

B. Upon the provider's request at the time a contract for a preferred provider arrangement is offered, the following must be provided to a provider for review:

(1) The fee schedule or, if there is not a fee schedule for one or more of the services covered under the contract, the terms under which payment is determined. A carrier may require a provider to execute a nondisclosure agreement covering the information provided under this subparagraph; and

(2) The identity of all carriers for which the provider is agreeing to provide services to health plan enrollees.

C. As a condition of participation in one of the carrier's preferred provider arrangements, a contract offered by a carrier may not require a provider to participate in any other carrier's network subsequently offered by the carrier or by a carrier's preferred provider arrangement.

D. Without the provider's prior written consent, a provider's contractual participation in a carrier's preferred provider arrangement may not:

(1) Subject the provider to health plan payor requirements or fee schedules that materially differ from the terms of the provider's contract with the carrier, unless those materially different terms are set out in writing in a separate section of the contract, such as an exhibit or amendment; or

(2) Permit the terms of the provider's existing preferred provider arrangement contract to be superseded by a carrier's subsequent contract with a health plan payor.

E. A preferred provider arrangement contract may not require a provider providing a service to an enrollee under a health plan included in the provider's contract to obtain preauthorization if the enrollee's health plan does not require prior authorization as a condition of coverage.

F. Explanation of remittance advices or comparable documents, whether in paper or electronic form, that accompany and identify payment of a provider's claims under a carrier's contract, including contracts offered through a preferred provider arrangement, must identify the administrator and payor of the provider's claims and include contact information.

The requirements of this subsection do not apply to a carrier offering a health plan with respect to preferred provider arrangement contracts with a hospital or pharmacy.'

SUMMARY

This amendment replaces the bill. The amendment places certain requirements on contracts for preferred provider arrangements, which are contracts between a health insurance carrier and a health care 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. The amendment imposes requirements and restrictions on these contracts, including:

1. Requiring a carrier who offers the contract to a health care provider to include in the contract a fee schedule and to provide any policies or procedures referred to in the contract to the provider, upon request by the provider;

2. Requiring the approval of a provider, in writing, of an amendment to the contract that materially differs from the terms of the provider's contract and of any provision that would permit the provider's existing contract to be superseded by a carrier's subsequent contract with a health plan payor;

3. Prohibiting a carrier from requiring a provider, as a condition of participation in one of the carrier's preferred provider arrangements, to participate in any other carrier's network subsequently offered by the carrier or by a carrier's preferred provider arrangement;

4. Prohibiting a carrier from subjecting providers under health plans included in the contract to preauthorization requirements if the enrollee's health plan does not require prior authorization as a condition of coverage; and

5. Requiring remittance advices that identify payment of a provider's claims under a carrier's contract to identify the administrator and payor of the provider's claims and include contact information.

The amendment provides that the requirements do not apply to dental or vision plans or to a carrier offering a health plan with respect to preferred provider arrangement contracts with a hospital or pharmacy.