ALTERNATIVE METHODS OF PAYMENT FOR HEALTH CARE IN MAINE

Report of a Study by the
JOINT STANDING COMMITTEE ON
BUSINESS & COMMERCE
2nd Regular Session of the
112th Maine Legislature

January, 1986

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SUMMARY

The Joint Standing Committee on Business and Commerce undertook a study in the health care area on alternate delivery systems, mandated benefits, and licensing allied health professionals because of the many concerns regarding escalating health care and health insurance costs. Summarized below are the findings and recommendations contained in the study report and transmitted to the Second Regular Session of the 112th Legislature.

Findings

Health care and health insurance costs are rapidly rising in Maine and across the nation. One way to help slow this climb is through alternate delivery systems, HMO's and PPO's. These should be regulated to protect the people of Maine but not so much as to inhibit their growth. Some members of the Committee believe that mandating benefits are a cause in the rise of health care and health insurance costs, while other members believe that they may be a cause. Before mandating any future benefits, the Legislature should carefully consider certain criteria involving social and economic impact. Licensing many groups of allied health professionals may also be a cause in the rise in health care costs. The Legislature should carefully consider certain criteria before licensing groups in the future according to specific public and regulatory concerns.

Recommendations

I. Legislation should be enacted in the area of HMO's and PPO's including:

1. A cash reserve requirement for HMO's.

2. Enabling legislation for PPO's.

3. Specific provisions for PPO's concerning utilization review, geographic accessibility, some level of reimbursement for non-providers, yearly option to choose between plans and exemptions from per se state antitrust laws.

4. Financial and reporting requirements for PPO's.

II. Criteria in this report regarding mandating benefits should be adopted as guidelines, but not placed in the statutes.

III. Criteria in this report regarding licensing allied health professionals should be adopted as guidelines, but not placed in the statutes.

INTRODUCTION

During the first regular session of the 112th Legislature, the Business and Commerce Committee heard several bills relating to the method of payment used to provide health care to Maine people. At the same time people in Maine and across the country have been demanding quality health care at a reasonable price even though health care costs have been rapidly escalating. Because of this trend, consumers, health care providers, insurers, hospital and medical service organizations, and employers have put pressure on lawmakers to ensure that care is available at an affordable price to all concerned. In addition, various groups have come to the Legislature in recent years asking that certain health benefits be mandated or that certain groups be licensed. The Committee decided that it needed to study the impact of alternate delivery systems, licensing health professionals, and mandating certain benefits in health insurance plans on health care costs, health insurance costs, quality of care, and availability of care.

The Committee divided the study into three categories:

1. Alternate Delivery Systems- Health Maintenance Organizations (HMO'S) and Preferred Provider Organizations (PPO'S);

2. Mandated Benefits; and

3. Licensing Allied Health Professionals.

The subcommittee held four day-long public hearings in October, November, and December of 1985. During those hearings the subcommittee heard from representatives of Blue Cross Blue Shield , Union Mutual, various employers, the Chamber of Commerce, social worker groups, alcoholism treatment providers, nurses, nurse practitioners, nurse midwives, chiropractors, dentists, physicians, psychologists, hospital administrators, Maine Employee's Health Insurance Program and the Bureau of Insurance.

FINDINGS

I. Alternative Delivery Systems

A. Generally:

Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPO's) are the two main types of alternate delivery systems. An HMO is an organization which contracts to accept responsibility for providing a specified range of health services to a voluntarily enrolled specific population for a fixed, periodic prepayment (capitation). An HMO and often the physicians

assume all or part of the financial risk of providing services. There are four basic types of HMO's:

- Staff Model. Participating physicians are salaried employees of the HMO who see only HMO patients. Usually out-patient services are delivered at HMO-owned ambulatory care centers on a capitation basis.

- Group Models. HMO contracts with multi-specialty group(s) on a capitation basis. The group is responsible for paying its members out of this amount. Under this model, the physicians usually have other patients who are not members of the HMO.

- Primary Care Providers Model ("Gate Keeper" Model). HMO contracts with groups or individual physicians for primary care.

- IPA's. (Individual Practice Association.) HMO contracts on a fee-for service basis or on a capitation basis with a number of independent physicians or with an IPA. If the contract is the fee-for service model, the HMO retains a portion of the fees to guard against losses or to use as bonuses for physicians. According to "Legislative Briefing Paper on HMO's and PPO's", Center for Health Studies, Nashville, Tennessee, IPA's have suffered more operating problems because of the fee-for service aspect and the loose organization. IPA's generally have higher costs than the other models of HMO's.

A PPO can be an organization, a delivery system, or an arrangement between providers and third-party payers. Generally, PPO's are a group of health care providers who agree to provide services to a specific group of patients on a discounted fee-for-service basis. PPO's can be sponsored by providers, self-insured employers, union trust funds, insurance companies, insurance brokers, or other third-party administrators. Provider groups are the major sponsors of PPO's. Providers receive an increased pool of payments and more rapid payment of claims in return for the discount. Since PPO's have been largely unregulated, PPO's have been developed to fit a variety of situations. Even though PPO's vary widely in types of organizations, they generally have the following in common:

(1) limited panel of physicians and other providers

(2) some contracting arrangements

(3) negotiated payment rates

(4) utilization control mechanisms (pre-admission review, monitoring patients, review of charts, authorization of procedures, etc.).

Employers across the nation have been hit hard by rapidly rising health insurance costs. Many employers believe that HMO's and PPO's are an important way to save money while still delivering quality health care to their employees. For example, Chrysler was faced with extremely high health care costs for its employees, but was able to cut $58 million from its health care bill by using utilization reviews and HMO's. Both HMO's and PPO's can be more efficient and less costly by using utilization control mechanisms such as pre-admission review, monitoring patients, review of charts, and authorization of procedures.

Because of this ability to cut health care costs, HMO's and PPO's are growing nationwide. Although only one HMO and one PPO are operating at present in Maine, most people testifying agreed that there will be more. Maine's HMO law is ten years old, but there is no law regulating PPO's specifically. PPO's and PPO legislation are fairly new. Six states were regulating PPO's in March, 1984. This number has now grown to 14. The legislatures in at least ten other states are considering PPO legislation this year.

B. Types of PPO Laws:

There are several different types of laws regarding PPO's:

- EPO laws. Some states prohibit and others allow EPO's, exclusive provider organizations, where subscribers are precluded indefinitely from obtaining health services from other sources. The two states which allow EPO's generally regulate them to protect beneficiaries by setting standards which assure quality of care and subscriber access to service.

- Freedom of choice laws. Freedom of choice laws generally prevent an insurer from restricting or influencing an insured's choice of a health care provider. Therefore, any incentives given to encourage the use of preferred providers could be in violation of these provisions. These types of provisions generally inhibit PPO growth because incentives are necessary where there is a dual choice to promote the use of PPO's. According to Jonathan Sprague, Northland Health Group, free choice of any provider is expensive and has been a factor in rising health care costs.

- Payment. Nondiscrimination in payment laws prohibit reimbursement amounts to vary among providers and prohibit unequal benefits to be paid among insureds of the same class. These provisions are generally considered to inhibit PPO growth because they eliminate an essential element of a PPO - financial incentives to encourage use of more cost effective providers.

Payment is also regulated in a few states by specifying the amount or "disincentive rate" to be paid to non-preferred providers. Since the PPO's incentive to charge less is based on increased volume, latitude to negotiate a more cost effective program could be hampered under this provision.

- Willing Provider Provisions. Such a provision requires inclusion of any provider in a PPO who meets the requirements set by the PPO. There are possible anti-trust problems where a PPO has a large market share and refuses to include providers unless there is a reasonable basis for the exclusion.

- Inclusion of allied Health Professionals. This type of law mandates the inclusion of allied health professionals in PPO's. At the hearing on November 15, 1985, Jonathan Sprague said that some HMO's are using various professionals, such as social workers, because there is the incentive to use the best possible people at the best cost. It is possible that this would apply to PPO's as well and that to mandate inclusion would be less cost effective. If mandated, a PPO may be forced to have people on its staff who are not needed for that particular PPO.

- Enabling Legislation. Enabling legislation is varied. Some provisions merely authorize or encourage PPO's. Others amend the Insurance Codes to permit insurance companies to organize PPO's and to require non-insurance groups that sponsor PPO's to come under the Insurance Code. Other provisions such as registration, reporting, and financial requirements are often included.

C. Possible National Legislation:

The federal government is also interested in PPO legislation. Representative Donald Wyder (D-OR) has introduced a bill which addresses the concern of many legislators that existing state laws are inhibiting PPO growth. This bill (HR 733) is currently pending before the House Committee on energy and Commerce. This is similar to HR 2956 proposed in 1983. According to a bulletin

published by the National Center for Health Services Research and Health Care Technology Assessment (NCHSR & HCTA) Spring, 1985, members of both political parties have introduced legislation in the U.S. Congress that would override State insurance laws that inhibit the establishment of PPO's. The Federal Trade Commission is currently studying state legal barriers to PPO's, but the results are not expected until late spring of 1986.

D. Antitrust Concerns:

Antitrust laws do apply to PPO's, but PPO's can be designed to avoid accusations of price fixing or restraint of trade. The fundamental purpose of antitrust laws is to protect free competition. The paradox is that when PPO's set prices they are being competitive. Such price-fixing by a "joint venture" (individuals unable to undertake the project independently) is permitted under antitrust laws. Exclusion of providers is, also, permitted where the PPO has a small market share. The FTC found no unlawful price fixing in a New Jersey case because the providers set their prices independently and no more than 15% of the area providers were enrolled in the plan. Another PPO in California was disbanded because it signed up 90% of the physicians in the area and forbade the physicians from contracting with other PPO's. This inhibited the development of competing PPO's. California recently passed a law which would give PPO's limited exemptions from standard antitrust law. Although antitrust laws are a concern for PPO's which are improperly designed, no further regulation is needed.

E. Various Positions on PPO Legislation:

- Insurance Companies. According to Jim DiVirgilio, Blue Cross Blue Shield, insurers would like to see some basic enabling legislation, permitting and defining PPO's, because at present there is no set standard and no meaning to the consumer. It is their position that enabling legislation would give protections to consumers and allow the state to be in control, while PPO's develop in an orderly fashion. They would like to see all PPO's "playing by the same rules". They advocate a basic statute like the Minnesota statute which allows group health insurers to pay differing amounts of reimbursement to insureds who select preferred providers and requires that certain financial and contractual information be filed. They also like the Illinois statute which allows insurers to form PPO's and offer incentives, but which also requires that all PPO's be registered and have a utilization review process.

- American Hospital Association. The American Hospital Association asserts that because PPO's can be designed to fit the situation, they need the flexibility to

operate essentially without regulation. In Maine, if a PPO takes on the economic risk of the illness of their subscribers, they will be regulated as an insurer. If a PPO fits the definition of a Health Plan or an HMO, it will be regulated accordingly.

- Department of Insurance. The Bureau of Insurance presented a set of proposals for PPO regulation at the last public hearing in December. The proposal was to add certain restrictions and financial requirements for PPO's. The suggested restrictions included a "willing provider" provision, a "disincentive rate" provision, accessibility and option to participate provisions, utilization review requirement, requirements to include pharmacies and vision care centers, a provision not to require a primary care physician referral, and a provision to avoid conflict with anti-trust legislation regarding "alternate rate".

F. HMO Regulation:

Since HMO's have been regulated both on the federal level and on the state level for some time, the subcommittee sought to discover whether any further regulation was needed at this time, especially in light of the near failure of the Farmington HMO. The Farmington HMO was recently taken over by Blue Cross Blue Shield.

Because HMO's have an incentive to practice preventive medicine and avoid unnecessary tests, surgery, admittance to the hospital, and prolonged hospitalization, members of the Committee had questions and concerns regarding quality of care, premature discharge from the hospital, and consumer satisfaction. Two researchers compiled the findings of 17 studies addressing such concerns. These findings were summarized by the Wisconsin Legislative Council Staff in 1983. These results support the generally accepted contention that HMO's are able to deliver quality care with patient satisfaction at lower overall costs and lower costs to individuals and employers. Additionally, a study team from the Office of Health Maintenance Organizations, Department of Health, Education, and Welfare compiled results of 25 relevant studies and found that in 19 studies, quality in HMO's was superior to other settings and that in no study was quality of an HMO considered to be inferior. One reason for this result, even though doctors are given incentives to spend less, is that quality of care probably is improved through the utilization review process because the providers are being watched carefully by other physicians. The theory is that most people do their work more carefully when they know that someone is waiting to give it careful scrutiny.

The Commitee also had questions and concerns regarding the feasiblity of HMO's in Maine since several people at

the hearings stated that Maine does not have a large enough population to support an HMO. Douglas Cranshaw, Health Plans, Inc., Worcester, MA wrote to the Committee in disagreement with this position. He explained that feasibility is not dependent upon population alone but is also affected by utilization levels, benefit programs, supply of physicians, attitude of the business community, and presence of multi-hospital communities. He has been involved with rural HMO's around the country including a successful one in Rugby, North Dakota, population 3200. Inter Study, a "think tank" in Minnesota which is in the process of studying feasibility of HMO's in rural areas, asserts that HMO's can definitely survive in rural areas.

Regarding the failure of the Farmington HMO, Douglas Cranshaw stated that the failure was due in part to mismanagement and lack of risk sharing by physicians. Jonathan Sprague explained that there were no incentives for physicians to minimize costs and that many patients were seeing specialists unnecessarily. Dr. Daniel Onion, who was associated with the Farmington HMO, believes that a rural HMO can work if the patients are willing to seek care coordinated by primary care physicians, if physicians share the risks, and if there is a network of HMO's that share information and management. The Bureau of Insurance would like to see a requirement of a capital base or restricted cash balance because of the Farmington experience.

II. Mandated Benefits

A. In General:

Since the sixties there has been a national trend for state legislatures to mandate various forms of additional health insurance coverage. Many factors are responsible for this trend including the following: incomplete health insurance coverage, expanded definition of health, anti-physician sentiment, expanded number and types of practitioners, changing values and expectations of society, and pressure to reduce taxpayers' burden. Because of this trend several states have studied the impact of mandated benefits on health care costs. These studies indicate that mandating benefits may be one factor in rapidly escalating health care and health insurance costs. But market forces cannot be relied upon exclusively to supply needed benefits since consumers are not informed, rational buyers of health insurance. In Maine, no one could produce data to show that the previously mandated benefits were the only cause of rising health insurance premiums, although there is some evidence to show that many employers are now self-insuring in order to avoid the state mandated benefits.

Since there is great concern about rising costs but knowledge that some needed benefits were brought about only through mandation, many states are adopting criteria to use before any further benefits are mandated. The Committee reviewed criteria from several states and other associations and decided to adopt criteria from the Washington law, the Insurance Association of Connecticut, the National Association of Insurance Commissioners, and from the public in Maine since both social and economic considerations were included. The Committee also decided that since most benefits, once mandated, would probably remain due to public pressure, it would not be useful to try to secure more data concerning benefits already mandated.

B. Compilation of Criteria:

1. Social Considerations

a. Unmet Need

(a) If coverage is generally unavailable to what extent does lack of coverage result in unreasonable financial hardship in order to purchase such services or in persons avoiding necessary health care treatments? Has there been an injustice or discrimination?

(b) To what extent is the treatment or service generally utilized by a significant portion of the population?

(c) To what extent is the insurance coverage already available? How is the service being paid for now?

(d) What is the public demand for insurance coverage for the treatment or service? What is the level of interest of collective bargaining agents in negotiating for the treatment or service? Can the market be relied upon to meet the need?

(e) What is the evidence from other states that demonstrate the likelihood of achieving the stated objectives of meeting a consumer need?

b. Nature of the benefit

(a) Who is demanding the coverage? Who benefits from the coverage, receivers or providers?

(b) Does the benefit relate to the purposes of insurance? Is it one that is normally covered by insurance? Is this a medical or a broader social need and does it fit in with the role of the health insurance?

(c) What is the availability of the service? What is the current geographical distribution of pertinent providers/health care personnel or necessary equipment?

(d) Are there alternatives to meeting the identified need?

(e) Is there a social stigma attached to the benefit which will prevent the market from controlling?

(f) Is the quality of services proposed to be offered by non-physician practitioners an acceptable substitute for, or better than, that delivered by a physician? Will professional organizations enforce high standards?

c. Social Impact

(a) Will mandating this benefit result in other benefits being dropped?

(b) How will this mandate, together with other mandates, affect the decision of an employer to shift to no insurance or to a self-insured plan which is not subject to State regulation or taxation? How will self-insurance affect employees?

(c) How will the proposed benefit contribute to the quality of patient care and health status of the populace? What are the findings, if any, of State agencies?

(d) Will there be provisions to assure quality of care?

2. Economic Considerations

a. What is the estimated increase in insurance premiums for the proposed benefit over the next five years? The following must be considered:

-increased administration expenses of insurance agencies

-the extent that coverage will increase the cost of the treatment or service

-will coverage increase the appropriate or inappropriate use of the treatment or service?

-to what extent will the mandated treatment or service be a substitute for more expensive treatment or service?

b. Using the same considerations as above, what will be the impact of this coverage on the total cost of health care? Will the benefit be cost effective over time?

c. Will there be provisions to control utilization, costs, and fees?

d. How will non-physicians be reimbursed: fee-for-service, costs, or other; and which one minimizes costs?

e. What are the effects on employers and employees if premiums rise? Will employees end up paying more for their own or family's coverage?

3. Balancing Social and Economic Considerations

a. Does the need for coverage outweigh the costs of mandating coverage for all policyholders?

b. Can the problem be solved by mandating availability of the coverage, rather than mandating inclusion of the coverage in all plans?

III. Licensing Allied Health Professionals

The purpose of state licensing laws is to protect the health, safety and welfare of consumers. Professional groups frequently seek licensure giving the reason as a need for public protection. However, consumers rarely ask for or support licensure of a group. Government regulation often results in increased charges to consumers, decrease in availability of the services, and restrictive standards of admission into the profession which can be discriminatory. There is also little evidence to show that regulation actually ensures public safety. Professional boards in Maine seldom revoke a license.

Because of these concerns several states have enacted specific criteria which must be met by all groups asking to be licensed. In addition, several states require a specific process of evaluation with the burden on the group to prove that they meet the criteria. The process called sunrise often includes detailed application forms, public forums, technical committee reviews, and large filing fees.

The subcommittee reviewed criteria from several sources and had suggestions from the public and decided that the following would be important guidelines to follow in licensing any group of health professionals that apply:

A. Public Concerns:

(1) Will the unlicensed practice of an occupation harm or endanger the public?

(2) Are potential users of the occupational service able to properly evaluate the qualifications of those offering services without licensure?

(3) Is there a less restrictive method, such as certification by a professional association, which would protect the public?

(4) Will licensure result in higher costs to consumers or a decrease in the availability of services and practitioners?

(5) Will licensure primarily benefit the particular occupation, such as an increase in wages?

(6) What will the benefits to the public be if the group is licensed? Do these benefits outweigh any increased costs or reduction in availability of services?

(7) Will licensure raise overall health care costs?

(8) How will licensure affect the labor market?

B. Regulatory Concerns:

(1) Does the occupational group have an established method of ensuring competence of its members?

(2) Will the State have the resources to investigate or keep control? Are there enough members in the group to support licensure?

(3) Is the requesting occupational group clearly definable?

RECOMMENDATIONS:

1. HMO's and PPO's

A. Cash Reserve Requirement for HMO's:

The Committee recommends that all HMO's be required to have a cash reserve requirement as long as the initial amount would not be excessive for an HMO starting up. The HMO statute should be amended to reflect this change.

B. PPO Legislation:

Since the members of the Committee either want to promote the growth of PPO's or are resigned to the fact that they are going to develop, they agreed that some basic legislation allowing PPO's to develop in Maine would be appropriate. The Committee decided on the following:

1. Write legislation enabling PPO's to operate in the state.

2. Amend 24-A MRSA §2159 which deals with unfair discrimination to make this section inapplicable to PPO's since it could possibly be interpreted to prohibit PPO's.

3. Have the Bureau of Insurance write provisions regarding financial responsibility and reporting of PPO's.

4. Include a provision requiring utilization review.

5. Include a provision requiring that contract preferred providers be geographically accessible to subscribers.

6. Include a provision requiring that any plan include a provision giving some level of reimbursement for non-preferred providers which can be negotiated. One member of the Committee would prefer to set a "disincentive rate".

7. Include a provision allowing a subscriber, where two or more plans are offered, to have the option on a yearly basis of choosing any of the plans.

8. Include a provision giving PPO's an exemption from per se violations of state antitrust laws.

Several members of the Committee wanted to see some type of anti-discrimination clause written in because of the concern that a person could not go to a particular type of provider, such as a chiropractor or social worker, without paying the

non-preferred provider rate or the full cost. This takes the control of the decision away from the patient in some situations. However, the Committee decided not to recommend a provision requiring "inclusion of allied health professionals" since such mandation might handicap a PPO so that it could not compete. The problem might also be solved by economic incentives to provide the best care at the lowest cost.

A "dual choice" provision was also discussed by the Committee. Several members wanted to include such a provision to guarantee the right of an employee to be able to choose a traditional health plan where a PPO is offered. There was concern that an employer might force his employees to be in a PPO or pay the full cost of choosing a provider. The Committee decided not to recommend such a provision, however, because of the high cost to employers if they are required to offer 2 plans whenever they offer a PPO. This might add unreasonably to the cost of doing business in Maine. Employers are not required to offer any health plan, and such a provision might force many employers not to offer any plan who might otherwise offer one.

II. Mandated Benefits

The Committee decided to adopt the list of criteria in this report as guidelines to be used in the future, since further mandated benefits are or may be a cause in rising health care costs and because there is some evidence to show that mandating benefits cause employers to self-insure to avoid the benefits. However, the Committee did not want to put these criteria in the statutes for utilitarian reasons. Choosing which benefits should be mandated is a matter of judgment and guidelines only are necessary.

The Committee also wanted to state in this report as a matter of social policy that our society should be "wellness oriented" rather than "illness oriented". The Committee would like to see a basic health plan defined in the future.

III. Licensing Allied Health Professionals

The Committee decided to adopt the list of criteria in this report to use as guidelines when deciding whether to license a group of health professionals in the future. The Committee did not want to put these criteria in the statutes generally for the same reasons as stated in the previous section.

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PROPOSED LEGISLATION

SECOND REGULAR SESSION

ONE HUNDRED AND TWELFTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY SIX

AN ACT to Authorize Preferred Provider Arrangements in Maine and to Establish a Cash Reserve Requirement for Health Maintenance Organizations

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

Sec. 1. 24-A MRSA §2159, ¶2 is amended to read:

2. No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. Nothing in this provision shall prohibit an insurer from providing incentives for insureds to use the services of a particular hospital or person.

Sec. 2. 24-A MRSA §2713, ¶2, sub-¶B is amended to read:

B. Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person. Nothing in this provision shall prohibit an insurer from providing an incentive for insureds to use the services of a particular hospital or person.

Sec. 3. 24-A MRSA Chapter 32 is enacted:

§2670. Short title

This chapter may be cited as the "Preferred Provider Arrangement Act of 1986:

§2671. Definitions. As used in this chapter, the following definitions apply:

1. "Health care services" means health care services or products, rendered or sold by a provider within the scope of the provider's legal authorization.

2. "Insurer" means an insurance company authorized in this State to issue policies which reimburse for expenses of health care services.

3. "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.

4. "Preferred provider" means a provider of health care services who has entered into a contract with an insurer or administrator to provide health care services to specified persons at a discounted rate.

5. "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

6. "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.

7. "Administrator" means any person, partnership or corporation, other than an insurer or non-profit health service organization that arranges contracts with or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.

8. "Superintendent" means Superintendent of Insurance.

Sec. 3. 24-A MRSA §2672

Discrimination: Before entering into any agreement under this chapter an insurer or administrator shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer or administrator. Neither differences in prices among providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties shall constitute unreasonable discrimination against or among providers.

Sec. 4. 24-A MRSA §2673

Policies, agreements or arrangements with incentives or limits on reimbursement authorized.

1. Policies, agreements or arrangements issued under this Chapter may not contain terms or conditions that would operate unreasonably to restrict the access and availability of health care services for the insured or beneficiary.

2. An insurer or administrator may enter into agreements with certain providers of its choice relating to health care services which may be rendered to insureds or beneficiaries, including agreements relating to the amounts to be charged the insureds or beneficiaries for services rendered. These agreements are not per se violations of antitrust provisions.

3. An insurer may issue policies in this State or an administrator may administer programs in this State that include incentives for the insured or beneficiary to use the services of a provider who has entered into an agreement with the insurer or administrator pursuant to paragraph (2) above. Where such a program or policy is offered to an employee group annually, employees shall have the option of participating in any other health insurance program or health care plan sponsored by their employer.

§2674. Requirements Applicable to Administrators:

1. Registration. All administrators of a preferred provider program subject to this Article shall register with the Bureau of Insurance and pay an annual registration fee of $20. The Bureau of Insurance shall by rule establish criteria for such registration including minimum solvency requirements.

The Bureau of Insurance shall compile and maintain a current listing of administrators and insurers offering agreements authorized under this Chapter.

2. Fiduciary and Bonding Requirements. Each administrator who handles money for purposes of payment for provider services subject to this Chapter shall (1) establish and maintain a fiduciary account, separate and apart from any and all other accounts, for the receipt and disbursement of funds for program reimbursement covered under this Article, and (2) post or cause to be posted, a surety bond in a penal sum to be determined by the standards of a rule to be established by the Superintendent.

A. If a surety bond of indemnity is posted, it shall be drawn in favor of the Treasurer of the State and held by the Superintendent of Insurance for the benefit of parties in interest.

B. In the event of misappropriation of funds or other violation of a fiduciary obligation, the right of any administrator to enter agreements or arrangements with incentives or limits on reimbursement consistent with this chapter may be revoked or suspended by the Superintendent.

3. Program Requirements. Each administrator shall provide to each beneficiary of any program subject to this Chapter a document which (1) sets forth those providers with which agreements or arrangements have been made to provide health care services to such beneficiary; a source for the beneficiary to contact regarding changes in such providers and a clear description of any incentives for the beneficiary to use such providers, (2) discloses the extent of coverage as well as any limitations or exclusions of health care services under the program, (3) clearly sets out the circumstances under which reimbursement will be made to a beneficiary unable to use the services of a preferred provider, (4) a description of the process for addressing a beneficiary complaint under the program, (5) discloses deductible and coinsurance amounts charged to any person receiving health care services from a preferred provider, and (6) discloses the rate of payment when health care services are provided by a non-preferred provider.

4. Subject to this Chapter - An administrator who operates more than one such program shall establish and maintain a separate fiduciary account or surety bond for each such program.

5. Penalty. The Superior Court shall assess a civil penalty in an amount not to exceed $3,000 per violation, payable to the Bureau of Insurance to be applied toward the administration of this Title, against any corporation, entity, or individual violating any provision of this Chapter, including failure to register or pay the required fee, misappropriation of funds or other violation of fiduciary responsibility. Any person, whether director, office manager, employee, representative of a corporation or entity or otherwise may also be punished by imprisonment for less than one year for knowingly participating in or authorizing the misappropriation of funds or other violation of fiduciary responsibility.

6. Nothing in this Chapter shall affect any rights or interest that any person other than the Bureau of Insurance may possess.

§2675. Requirements Applicable to Insurers

1. Any insurer which proposes to offer a preferred provider arrangement authorized by this chapter shall disclose in a report to the Superintendent of Insurance prior to its initial offering and prior to any charge thereafter the following:

A. The name which the arrangement intends to use and its business address;

B. The name, address and nature of any separate organization which administers the arrangement on the behalf of the insurers; and

C. The names and addresses of all providers designated by the insurer under this clause and the terms of the agreements with designated health care providers.

The Superintendent shall maintain a record of arrangements proposed under this clause, including a record of any complaints submitted relative to the arrangements.

2. If an insurer offers an arrangement with incentives or limits on reimbursement consistent with this Chapter as part of a group health insurance contract or policy, such forms shall disclose to insureds: (1) those providers with which agreements or arrangements have been made to provide health care services to such insureds; a source for the insured to contact regarding changes in such providers, (2) the extent of coverage as well as any limitations or exclusions of health care services under the policy or contract, (3) the circumstances under which reimbursement will be made to an insured unable to use the services of a preferred provider, (4) a description of the process for addressing a complaint under the policy or contract, (5) deductible and coinsurance amounts charged to any person receiving health care services from a preferred provider, and (6) the rate of payment when health care services are provided by a non-preferred provider.

§2676. Risk Sharing and Prepaid Capitation Rates

1. Any administrator or insurer having formed a preferred provider arrangement embodying risk sharing by providers and employing a prepaid capitation rate shall file applicable rates and other relevant material with the Superintendent of Insurance for approval. The Superintendent shall disapprove any arrangement if it contains any charges or provisions which are excessive, inadequate or unfairly discriminatory.

If the Superintendent has not taken any action on the forms filed within 30 days of receipt, the arrangement shall be deemed approved. The Superintendent may extend by not more than an additional 30 days the period within which he may affirmatively approve or disapprove any form, by giving notice to the administrator or insurer before expiration of the initial 30 day period. At the expiration of any extension, if the Superintendent has not acted on the forms, the arrangement shall be deemed approved. The Superintendent may at any time, after hearing and for cause shown, withdraw any such approval.

§2677. Alternative Health Care Benefits

An insurer or administrator who makes a preferred provider arrangement available shall provide for payment for health care services rendered by providers who are not preferred providers but such payment need not be the same as for preferred providers.

§2678. Utilization Review

Experience report. On or before April first of each year an adminstrator or insurer who issues or administers a program, policy or contract in this state that includes incentives for the insured or beneficiary to use the services of a provider who has entered into an agreement with the insurer or administrator pursuant to Section 2673, subsection 2, paragraph A, shall file a report of its activities for the preceding year with the Superintendent. The report shall be in the form prescribed by the Superintendent and at a minimum shall contain the following:

1. Name, address and scope of license of each preferred provider,

2. Utilization experience for the following categories: hospitalization, ambulatory surgical or other out-patient services, and professional services. Utilization of professional services is to be listed by specialty.

§2679. Unaffected parties. The requirements of this chapter are not applicable to self-insured employers, employee benefit trust funds and other organizations regulated by the Employee Retirement Income Security Act of 1974 (ERISA).

Sec. 4. 24 MRSA §2333 is enacted.

§2333. Short Title

This section and section 2334 to 2340 shall be known as the "Nonprofit Service Organizations Preferred Provider Arrangement Act of 1986".

§2334. Definitions

As used in the Nonprofit Service Organizations Preferred Provider Arrangement Act of 1986, the following definitions apply.

1. "Health Care Services" means health care services or products rendered or sold by a provider within the scope of the providers legal authorization.

2. "Preferred provider" means a provider of health care services who has entered into a contract with an non-profit service organization to provide health care services to specified persons at a discounted rate.

3. "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

4. "Non-profit Service Organization" means a non-profit hospital service corporation, non-profit medical service corporation or non-profit health care plan authorized in this state.

5. "Subscriber" means an individual entitled to certain specified health care under a contract issued by a non-profit service organization.

6. "Superintendent" means Superintendent of Insurance.

§2335. Discrimination. Before entering into any agreement under this Act a non-profit service organization shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the non-profit service organization. Neither differences in prices among providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties shall constitute unreasonable discrimination against or among providers.

§2336. Contracts, agreements or arrangement with incentives or limits on reimbursement authorized.

1. Contracts agreements or arrangements issued under this Act may not contain terms or conditions that would operate unreasonably to restrict the access and availability of health care services for the subscriber.

2. A non-profit service organization may:

A. Enter into agreements with certain providers of its choice relating to health care services which may be rendered to subscribers of the non-profit service organizations, including agreements relating to the amounts to be charged the subscribers for services rendered. These agreements are not per se violations of antitrust provisions.

B. Issue or administer programs or contracts in this State that include incentives for the subscriber to use the services of a provider who has entered into an agreement with the non-profit service organization pursuant to paragraph (A) above. Where such a program or contract is offered to an employee group, employees shall have the option annually of participating in any other health insurance program or health care plan sponsored by their employer.

§2337. Annual Reporting

1. Any non-profit service organization which proposes to offer a preferred provider arrangement authorized by this chapter shall disclose in a report to the Superintendent of Insurance prior to its initial offering and prior to any change thereafter, the following:

A. The name which the arrangement intends to use and its business address;

B. The name, address and nature of any separate organization which administers the arrangement on the behalf of the non-profit service organization; and

C. The names and addresses of all providers designated by the non-profit service organizations under this clause and the terms of the agreements with designated health care providers.

The Superintendent shall maintain a record of arrangements proposed under this clause, including a record of any complaints submitted relative to the arrangements.

2. If a non-profit service organization offers an arrangement with incentives or limits on reimbursement consistent with this Chapter as part of a group health insurance contract or policy, such forms shall disclose to subscribers: (1) those providers with which agreements or arrangements have been made to provide health care services such subscribers and a source for the subscribers to contact regarding changes in such providers, (2) the extent of coverage as well as any limitations or exclusions of health care services under the policy or contract, (3) the circumstances under which reimbursement will be made to a subscriber unable to use the services of a preferred provider, (4) a description of the process for addressing a complaint under the policy or contract, (5) deductible and coinsurance amounts charged to any person receiving health care services from a preferred provider, and (6) the rate of payment when health care services are provided by a non-preferred provider.

§2338. Risk Sharing and Prepaid Capitation Rates

1. Any non-profit service organization having formed a preferred provider arrangement embodying risk sharing by providers and employing a prepaid capitation rate, shall file applicable provider agreements, rates and other relevant material with the Superintendent of Insurance for approval. The Superintendent shall disapprove any arrangement if it contains any unjust, unfair, or inequitable provisions. The Superintendent shall disapprove any charges which are excessive, inadequate or unfairly discriminatory.

If the Superintendent has not taken any action on the forms filed within 30 days of receipt, the arrangement shall be deemed approved. The Superintendent may extend by not more than an additional 30 days the period within which he may affirmatively approve or disapprove any form, by giving notice to the non-profit service organization before expiration of the initial 30 day period. At the expiration of any extension, if the Superintendent has not acted on the forms, the arrangement shall be deemed approved. The Superintendent may at any time, after hearing and for cause shown, withdraw any such approval.

§2339. Alternative Health Care Benefits

A non-profit service organization which makes a preferred provider arrangement available shall provide for payment for health care services rendered by providers who are not preferred providers, but such payment need not be the same as for preferred providers.

§2340. Utilization Review

Experience Report. On or before April first of each year a nonprofit service organization which issues or administers a program or contract in this state that includes incentives for the subscriber to use the services or a provider who has entered into an agreement with the nonprofit service organization pursuant to Section 2336, subsection 2, paragraph A, shall file a report of its activities for the preceding year with the Superintendent and at a minimum shall contain the following:

1. Name, address and scope of license of each preferred provider, and

2. Claims experience for the following categories: hospitalization, ambulatory surgical or other outpatient services, and professional services. Utilization of professional services listed by specialty.

Title 24-A MRSA §4204 2-A)(D) as amended in PL 1981, chapter 501, is amended to read:

2-A. The superintendent shall issue or deny a certificate of authority to any person filing an application pursuant to section 4203 within 50 business days of receipt of the notice from the Department of Human Services that the applicant has been granted a certificate of need or, if a certificate of need is not required, within 50 business days of receipt of notice from the Department of Human Services that the applicant is in compliance with the requirements of paragraph B. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 4220 if the superintendent is satisfied that the following conditions are met.

A. The Commissioner of Human Services certifies that the health maintenance organization has received a certificate of need or that a certificate of need is not required pursuant to Title 22, chapter 103.

B. If the Commissioner of Human Services has determined that a certificate of need is not required, the commissioner makes a determination and provides a certification to the superintendent whether the following requirements have been met.

(1) The applicant has demonstrated the willingness and potential ability to assure that the health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility and continuity of service.

(2) The applicant has arrangements, established in accordance with regulations promulgated by the Commissioner of Human Services with the advice of the Maine Health Systems Agency or any successor agency, for an ongoing quality of health care assurance program concerning health care processes and outcomes.

(3) The applicant has a procedure, established in accordance with regulations of the Commissioner of Human Services, to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services and such other matters as may be reasonably required by the commissioner.

The Commissioner of Human Services shall make the certification required by this paragraph within 60 days of the date of the written decision that a certificate of need was not required. If the commissioner certifies that the health maintenance organization does not meet all of the requirements of this paragraph, he shall specify in what respects it is deficient.

C. The health maintenance organization conforms to the definition under section 4202, subsection 5.

D. The health maintenance organization is financially responsible and shall, among other factors, reasonably be expected to meet its obligations to enrollees and prospective enrollees. Each health maintenance organization shall establish and maintain an unimpaired appropriation of surplus, represented by liquid assets consisting of cash, prime commercial paper, marketable securities with maturities not exceeding two years duration and fully insured certificates of deposits issued by banks and savings and loan associations located within the United

States. The value of this appropriation of surplus shall be equal to the organization's claims incurred but not reported as determined monthly by methods of claims valuation found acceptable by the Superintendent. Any non-profit health maintenance organization, employing fund accounts, shall hold a reserved portion of its general fund balance in a like manner. These funds shall be in addition to and shall not be included as a part of other working capital funds required by regulation of the Bureau of Insurance.

In making this determination, the superintendent may also consider:

(1) The financial soundness of the health maintenance organization's arrangements for health care services and the schedule of charges used in connection therewith;

(2)The adequacy of working capital;

(3) Any agreement with an insurer, a nonprofit hospital or medical service corporation, a government or any other organization for insuring or providing the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

(4) Any agreement with providers for the provision of health care services; and

(5) Any arrangement to claims for injuries arising out of the furnishing of health care services.

E. The enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to section 4206.

F. Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 4203 or by independent investigation, is contrary to the public interest.

The applicant shall furnish, upon request of the superintendent, any information necessary to make any determination required pursuant to this subsection.

STATEMENT OF FACT

This bill provides enabling legislation and regulation for preferred provider organizations. Preferred provider organizations (PPO's) are organizations of health care providers who have agreed to provide health care services at a

discounted rate for specified groups of people. PPO's can be organized by insurance companies, nonprofit service organizations, or other administrators. The bill defines them and sets forth specific financial and reporting requirements. In addition, there are specific provisions requiring utilization review, geographic accessibility, some level or reimbursement for non-preferred providers, and yearly options to choose between health plans where more than one is offered. These arrangements are exempt from per se state anti-trust laws under this bill.

This bill also has a provision requiring Health Maintenance Organizations (HMO's) to maintain a cash reserve requirement. This provision will protect the members of the HMO, all of whom pay a set fee for health care services in advance.

JG/elk/4557