128th MAINE LEGISLATURE

FIRST REGULAR SESSION-2017

Legislative Document **No. 1030**

S.P. 337 In Senate, March 14, 2017

An Act To Require Nondiscrimination Policies in Providing Health Care Services

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

HEATHER J.R. PRIEST
Secretary of the Senate

Presented by Senator CHENETTE of York.
Cosponsored by Representative CASÁS of Rockport and
Representative: BEEBE-CENTER of Rockland.

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

Sec. 1. 24-A MRSA §2385-G is enacted to read:

§2385-G. Nondiscrimination; prohibited practices

1. Covered providers. An insurer may not discriminate against a health care provider who is licensed, registered or certified by the State in providing covered services under a workers' compensation insurance policy or contract as long as the provider is acting within the scope of the provider's license, registration or certification.

2. Prohibited practices. An insurer offering a workers' compensation insurance policy or contract in this State may not engage in the following practices in order to limit the implementation of nondiscrimination policies:

A. Lower reimbursement rates for certain categories of providers who are delivering the same services as other provider types, as defined by procedural codes;

B. Apply limits to the number of allowable visits to some types of providers and not others;

C. Limit the amount of payment for a service provided by a licensed, registered or certified provider acting within the provider's scope of practice;

D. Limit the number of providers in the insurer's network;

E. Eliminate or restrict integrative or naturopathic services that are otherwise within the provider's scope of practice;

F. Restrict current procedural terminology codes, commonly referred to as "CPT codes," by provider type;

G. Exclude coverage for diagnosis and treatment of a condition or illness by a licensed, registered or certified provider who is acting within the provider's scope of practice if the insurer covers diagnosis and treatment of the condition or illness by a licensed physician or osteopathic physician;

H. Make access to providers difficult by implementing cumbersome approval processes; or

I. Implement exclusionary language in provider contracts that references "not medically necessary," "not clinically efficacious" or "experimental" solely to deny coverage for services.

3. Variable reimbursement methods. The provisions in subsection 2 do not prohibit an insurer from offering variable reimbursement methods based on quality and performance measures as long as the standard measures used are applied uniformly across provider types.

4. Deductible. Prior to meeting any deductible threshold, if applicable, the expense of any service paid by the policyholder that is rendered by a licensed provider must be applied to the deductible. When attributing the expense of services paid for by the

policyholder to the deductible, there may not be any differentiation between in-network and out-of-network providers until the point at which the deductible is met.

5. Conformity with federal law. An insurer shall comply with:

A. The federal Affordable Care Act, Sections 1251, 1252 and 1304;

B. 42 United States Code, Section 300gg et seq.;

C. 42 United States Code, Section 300gg-11 et seq.; and

D. 42 United States Code, Section 300gg-94.

Sec. 2. 24-A MRSA §2910-B is enacted to read:

§2910-B. Nondiscrimination; prohibited practices

1. Covered providers. An insurer may not discriminate against a health care provider who is licensed, registered or certified by the State in providing covered services under an automobile liability insurance policy or contract as long as the provider is acting within the scope of the provider's license, registration or certification.

2. Prohibited practices. An insurer offering an automobile liability insurance policy or contract in this State may not engage in the following practices in order to limit the implementation of nondiscrimination policies:

A. Lower reimbursement rates for certain categories of providers who are delivering the same services as other provider types, as defined by procedural codes;

B. Apply limits to the number of allowable visits to some types of providers and not others;

C. Limit the amount of payment for a service provided by a licensed, registered or certified provider acting within the provider's scope of practice;

D. Limit the number of providers in the insurer's network;

E. Eliminate or restrict integrative or naturopathic services that are otherwise within the provider's scope of practice;

F. Restrict current procedural terminology codes, commonly referred to as "CPT codes," by provider type;

G. Exclude coverage for diagnosis and treatment of a condition or illness by a licensed, registered or certified provider who is acting within the provider's scope of practice if the insurer covers diagnosis and treatment of the condition or illness by a licensed physician or osteopathic physician;

H. Make access to providers difficult by implementing cumbersome approval processes; or

I. Implement exclusionary language in provider contracts that references "not medically necessary," "not clinically efficacious" or "experimental" solely to deny coverage for services.

3. Variable reimbursement methods. The provisions in subsection 2 do not prohibit an insurer from offering variable reimbursement methods based on quality and performance measures as long as the standard measures used are applied uniformly across provider types.

4. Deductible. Prior to meeting any deductible threshold, if applicable, the expense of any service paid by the policyholder that is rendered by a licensed provider must be applied to the deductible. When attributing the expense of services paid for by the policyholder to the deductible, there may not be any differentiation between in-network and out-of-network providers until the point at which the deductible is met.

5. Conformity with federal law. An insurer shall comply with:

A. The federal Affordable Care Act, Sections 1251, 1252 and 1304;

B. 42 United States Code, Section 300gg et seq.;

C. 42 United States Code, Section 300gg-11 et seq.; and

D. 42 United States Code, Section 300gg-94.

Sec. 3. 24-A MRSA §4320-K is enacted to read:

§4320-K. Nondiscrimination; prohibited practices

1. Covered providers. A carrier may not discriminate against a health care provider who is licensed, registered or certified by the State in providing covered services to plan enrollees as long as the provider is acting within the scope of the provider's license, registration or certification. A carrier shall maintain network adequacy by ensuring a sufficient number of health care providers to serve the number of enrollees. Copayments, deductibles, conversion factors and covered essential health benefits under health plans must apply equally to all covered providers and not differ based solely on category or professional title of the provider or by licensure, registration or certification of the provider.

2. Prohibited practices. A carrier offering a health plan in this State may not engage in the following practices in order to limit the implementation of nondiscrimination policies:

A. Lower reimbursement rates for certain categories of providers who are delivering the same services as other provider types, as defined by procedural codes;

B. Apply limits to the number of allowable visits to some types of providers and not others;

C. Limit the amount of payment for a service provided by a licensed, registered or certified provider acting within the provider's scope of practice;

D. Limit the number of providers in the health plan's network;

E. Eliminate or restrict integrative or naturopathic services that are otherwise within the provider's scope of practice;

F. Restrict current procedural terminology codes, commonly referred to as "CPT codes," by provider type;

G. Exclude coverage for diagnosis and treatment of a condition or illness by a licensed, registered or certified provider who is acting within the provider's scope of practice if the health plan covers diagnosis and treatment of the condition or illness by a licensed physician or osteopathic physician;

H. Make access to providers difficult by implementing cumbersome approval processes; or

I. Implement exclusionary language in provider contracts that references "not medically necessary," "not clinically efficacious" or "experimental" solely to deny coverage for services.

3. Variable reimbursement methods. The provisions in subsection 2 do not prohibit a carrier from offering variable reimbursement methods based on quality and performance measures as long as the standard measures used are applied uniformly across provider types.

4. Deductible. Prior to meeting any deductible threshold, if applicable, the expense of any service paid by the policyholder that is rendered by a licensed provider must be applied to the deductible. When attributing the expense of services paid for by the policyholder to the deductible, there may not be any differentiation between in-network and out-of-network providers until the point at which the deductible is met.

5. Requirements if service determined experimental or not medically necessary. A carrier that limits coverage of experimental treatment or treatment determined to be not medically necessary shall:

A. Define the limitation and disclose the limits in any agreement, policy or certificate of coverage. The disclosure must include the following:

(1) Who is authorized to make the determination on limiting coverage; and

(2) The criteria the plan uses to determine whether a treatment, procedure, drug or device is experimental; and

B. If the carrier includes in the disclosure under paragraph A all of the information required to make a decision, issue, within 5 business days after receiving a request for coverage, a coverage decision. If coverage is denied, the carrier shall provide the insured a denial letter that includes:

(1) A statement of the specific medical and scientific factors considered in making a decision; and

(2) A notice of the insured's right to appeal and an explanation of the appeal process.

6. Conformity with federal law. A carrier shall comply with:

A. The federal Affordable Care Act, Sections 1251, 1252 and 1304;

B. 42 United States Code, Section 300gg et seq.;

C. 42 United States Code, Section 300gg-11 et seq.; and

D. 42 United States Code, Section 300gg-94.

SUMMARY

This bill prohibits health insurance carriers, automobile insurers and workers' compensation insurers from discriminating against health care providers who are licensed, registered or certified by the State in providing covered services as long as the providers are acting within the scope of their licenses, registrations or certifications. The bill also prohibits certain practices that may limit implementation of nondiscrimination policies.