# **02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**031 BUREAU OF INSURANCE**

**Chapter 360: REQUIREMENTS APPLICABLE TO PREFERRED PROVIDER ARRANGEMENTS**

**Section 1. Authority**

This rule is promulgated by the Superintendent pursuant to 24-A M.R.S.A. §212 and 24‑A M.R.S.A. Chapter 32 and 24-A M.R.S.A. Chapter 56-A, Subchapter III, §4343.

**Section 2. Purpose**

The purpose of this rule is to clarify the requirements applicable to preferred provider arrangements and to establish criteria for registration and approval of such arrangements.

**Section 3. Definitions**

A. “Administrator” means any person, other than a carrier, that administers a preferred provider arrangement.

B. "Copy" of any document to be filed with the Superintendent means a draft copy if a final copy is not reasonably available at the time of filing.

C. "Emergency services" means those health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:

(1) Serious jeopardy to the enrollee’s physical and/or mental health;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

D. “Health care services” means health care services or products rendered or sold by a provider within the scope of the provider’s legal authorization.

E. "Health Maintenance Organization" means an organization of the kind defined at 24-A M.R.S.A. §4202-A(10).

F. “Medically necessary health care” means health care services or products provided to an enrollee for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

(1) Consistent with generally accepted standards of medical practice;

(2) Clinically appropriate in terms of type, frequency, extent, site, and duration;

(3) Demonstrated through scientific evidence to be effective in improving health outcomes;

(4) Representative of “best practices” in the medical profession; and

(5) Not primarily for the convenience of the enrollee or physician or other health practitioner.

G. “Preferred provider arrangement” means a contract, agreement, or arrangement between a carrier or administrator and a 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.

H. “Special condition” means a condition or disease that is life-threatening, degenerative, or disabling and requires specialized medical care over a prolonged period of time.

**Section 4. Registration of a preferred provider arrangement**

A. No person, partnership, carrier, or corporation shall commence offering a preferred provider arrangement after the effective date of this rule, until the person, partnership, carrier or corporation has registered with the Superintendent as required by this rule.

B. A carrier or administrator registering a preferred provider arrangement must complete an initial registration on a form prescribed by the Superintendent.

C. Registrants are required to submit information in this initial registration in compliance with M.R.S.A. Title 24-A Chapter 56-A and Rule 850. Information previously reported to the Superintendent pursuant to Chapter 56-A and Rule 850 must be referenced in the registration materials and not reported in a duplicate manner.

D. Carriers that offer plans in different geographic service areas or having preferred providers in one plan who are nonpreferred providers in another plan offered by the same carrier must separately file and obtain approval for each arrangement. Plans that offer multi-tier preference tiers for preferred providers must also be registered as separate provider arrangements.

E. Preferred provider administrators who directly or indirectly transfer funds, manage funds, adjust claims, or assert control over the transfer of funds for the purpose of payment of provider services are required to be licensed as insurance administrators pursuant to Chapter 18, in addition to registering as a preferred provider arrangement.

F. Each registered carrier and administrator must keep current the information required to be disclosed in its registration statement by reporting all material changes or additions to the Superintendent within 30 days after the end of the month during which the material event occurs.

**Section 5. Procedures for review and approval of preferred provider arrangements**

A. Unless a hearing is scheduled pursuant to Section 6, the Superintendent will approve or disapprove the filing within 60 days of receipt of a complete filing.

B. **Filing requirements**. Applicants for preferred provider arrangements must comply with the following submission requirements:

(1) Complete an initial registration form;

(2) Provide a general statement of the health care services to be offered and the geographic area proposed to be served by the arrangement;

(3) Provide the name, address, and nature of any separate organization that administers the arrangement on behalf of the carrier or administrator;

(4) Describe the arrangement's relationship to existing health plans, specifying whether the arrangement will be offered as an alternative to coverage currently offered or as a replacement or modification of coverage currently offered, and explaining the reasons if certain classes of potential enrollees will be affected differently than others;

(5) Provide a list/directory of participating providers;

(6) Provide sample copies of provider contracts;

(7) Describe procedures, if any, for referral of enrollees to nonpreferred providers by a preferred provider, or by the carrier or administrator, including the conditions under which such referral will occur;

(8) Provide copies of contracts used involving a separate organization administering the arrangement on behalf of the carrier or administrator;

(9) Provide sample copies of contracts used with employers or other purchasers;

(10) Provide sample copies of contracts, certificates, or descriptive literature to be given to enrollees or to prospective enrollees;

(11) Describe the financial or other incentives for enrollees to use the services of a preferred provider or penalties for using nonpreferred providers;

(12) Describe provisions regarding payment for improper utilization of covered health services in situations where the enrollee has used the services of a preferred provider in compliance with the terms of the arrangement;

(13) Describe standing referral procedures regarding an enrollee with a special condition requiring ongoing care from a specialist;

(14) Describe procedures regarding coverage of the services of a nonpreferred provider if a preferred provider is not reasonably accessible;

(15) Describe utilization review procedures if review and authorization are required for health care services or for payment for those services, either by the carrier itself or by another entity contracted to perform utilization review on the carrier’s behalf;

(16) Describe procedures related to the development and use of a formulary, if the carrier provides coverage for prescription drugs but limits that coverage to drugs included in a formulary;

(17) Describe procedures related to enrollees who wish to participate in clinical trials;

(18) Provide other information that the applicant may wish to submit which reasonably relates to its ability to establish, operate, maintain, or underwrite a preferred provider organization; and

(19) Provide such other information as the Superintendent may reasonably request.

C. Criteria for approval

The Superintendent will disapprove any arrangement that contains unfair, unjust, or inequitable provisions, including, but not limited to:

(1) Any arrangement in which certain classes of current or potential enrollees will be affected differently than other classes of current or potential enrollees if that effect is determined to be unfair, unjust, or inequitable;

(2) Inability to demonstrate reasonable access to providers in the arrangement’s proposed geographic area;

(3) Provider contract provisions that offer any type of material inducement, bonus, or other financial incentive to a participating provider to deny, reduce, withhold, limit, or delay specifically medically necessary and appropriate health care services covered under the arrangement to an enrollee;

(4) Financial penalties to an enrollee for improper utilization of covered health services in situations where the enrollee has used the services of a preferred provider in compliance with the terms of the arrangement;

(5) Financial penalties to an enrollee for receiving emergency services from a nonpreferred provider if the care could not have been obtained from a preferred provider in a timely manner;

(6) The application of a benefit level differential for the services of a nonpreferred provider if a preferred provider is not reasonably accessible, unless the Superintendent waives the prohibition of this differential;

(7) Benefit level differentials between services rendered by preferred providers and nonpreferred providers exceeding twenty percent (20%) of the allowable charge for the service rendered, unless the Superintendent waives this requirement for a given benefit plan;

(8) Any arrangement that does not allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier’s network for treatment of that condition or, if a specialist able to treat the enrollee’s special condition does not participate in the carrier’s network, does not allow the enrollee to receive a standing referral to a nonparticipating specialist;

(9) Utilization review procedures (if required for health care services or for payment for those services), either by the carrier itself or by another entity contracted to perform utilization review on the carrier’s behalf that do not meet the requirements of Rule 850;

(10) The use of a formulary which does not ensure the participation of participating physicians and pharmacists in its development, or does not provide exceptions to the formulary limitation when a nonformulary alternative is medically indicated;

(11) Denial of qualified enrollee participation in approved clinical trials or denial, limitation, or imposition of additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in a clinical trial.

**Section 6. Public hearing**

A. Any person wishing to be notified of proposals for preferred provider arrangements must notify the Superintendent in writing.

B. All persons who request notification will be mailed notice within ten days of receipt of any filing made pursuant to Section 4 above. Other information contained in the filing will be available for inspection at the Bureau of Insurance except for any portions deemed confidential pursuant to 1 M.R.S.A. §402(3)(A) or (B). It is the responsibility of the filing party to identify any portions of the application materials or other filings for which confidential treatment is sought at the time of the filing of those materials. The filing party shall also submit a statement of the legal grounds, upon which the claim for confidentiality is based, which shall be specific to the materials identified; blanket assertions of confidentiality are not sufficient. Determination of confidentiality will be within the Superintendent’s discretion.

C. Any interested or affected person may make a written request for a public hearing to the Superintendent within 40 days after the filing. If the person requesting the hearing has made a timely request for notification, but timely notice was not sent pursuant to Subsection (B), the deadline shall be extended if fairness so requires.

D. If the Superintendent finds that a person requesting a hearing pursuant to Subsection (C) would be aggrieved if the stated grounds were established, and the grounds otherwise justify a hearing, then the Superintendent will hold a public hearing within 30 days after receipt of the request, or at a later date set by the Superintendent.

E. The Superintendent may convene a public hearing on the filing on his or her own initiative within 60 days after receiving a complete filing or at a later date set by the Superintendent.

F. Public hearings pursuant to Subsections (D) and (E) shall be held in accordance with 5 M.R.S.A. Chapter 375, Subch. IV (§§ 9051-9064) and Chapter 350 of the Bureau of Insurance rules. The Superintendent will issue a decision within 30 days after the close of the hearing.

**Section 7. Approved preferred provider arrangements**

A. The Superintendent may from time to time require an evaluation of the quality assurance program by a professionally recognized, independent third party at the expense of the carrier or administrator.

B. The Superintendent may convene a public hearing at any time if he or she has reason to believe that the requirements of this rule or any statutory requirement may not be met.

**Section 8. Solvency**

The administrator shall at all times maintain a current minimum equity of $10,000.

**Section 9. Annual registration fee and report**

Each administrator registered under this rule shall pay to the Superintendent a registration fee pursuant to 24-A M.R.S.A. §601 subsection 20 and annually thereafter on or before March 1st of each succeeding year so long as such registration is maintained. Annual registration reports in a format prescribed by the Superintendent must be filed with the Superintendent no later than March 1st of each year.

**Section 10. Examination of administrators who handle money**

A. The Superintendent or a designee may examine an administrator who directly or indirectly transfers funds, manages funds, adjusts claims, or asserts control over the transfer of funds for the purpose of payment of provider services for compliance with the requirements of this rule, 24-A M.R.S.A. §§ 2674-A and 1911.

B. Any administrator being examined shall provide to the examiner convenient and free access, at all reasonable hours at its offices, to all books, records, documents, and other papers relating to its business affairs. The examiner shall not have access to beneficiary medical records that are protected by state statute.

C. The examiners designated by the Superintendent pursuant to this Section may make reports to the Superintendent. Any report alleging substantive violations of this rule, or any applicable provisions of the Maine Insurance Code, shall be in writing and be based upon facts obtained by the examiners. The report shall be verified by the examiner(s).

D. If a report is made, the Superintendent shall either deliver a duplicate thereof to the administrator being examined or send such duplicate by certified or registered mail to the administrator's address specified in the records of the Bureau. The Superintendent shall afford the administrator an opportunity to request a hearing to object to the report. As a result of the findings of the report, the Superintendent may initiate a hearing concerning revocation or suspension of registration if the findings of the report so indicate.

**Section 11. Marketing**

A. An administrator may market and otherwise make available preferred provider arrangements to licensed health maintenance organizations, carriers, fraternal benefit societies, or self-insuring employers or health and welfare trust funds, and to their subscribers, provided that, in performing these functions, the administrator shall provide administrative services only and shall not accept underwriting risk in the form of a premium or capitation payment for its services except as provided for in 24-A M.R.S.A. Chapter 56-A Subchapter III.

B. In those cases where an administrator makes a preferred provider arrangement available to a health maintenance organization, the health maintenance organization shall continue to market and offer health care services, including at a minimum basic health care services as defined at 24-A M.R.S.A. §4202-A(1). All such services, to the extent otherwise consistent with this rule and other applicable law, may be offered through a preferred provider arrangement, or through a combination of arrangements including a preferred provider arrangement.

(1) No schedule of charges, including an amended schedule, for enrollee coverage for health care services, including services provided through a preferred provider arrangement, may be used by a health maintenance organization until a copy of the schedule, or amended schedule, has been filed with and approved by the Superintendent.

(2) The charges for the enrollee coverage for health care services including services provided through a preferred provider arrangement will be subject to the review required by 24-A M.R.S.A. §4207.

C. In those cases where an administrator makes a preferred provider arrangement available to a fraternal benefit society which provides for payment of hospital, medical, or nursing benefits due to sickness or bodily infirmity or accident, the fraternal benefit society must comply with all provisions of 24-A M.R.S.A. Chapter 55 (§§ 4101-4143) prior to marketing and offering the preferred provider arrangement to its members and their beneficiaries.

**Section 12. Severability**

If any provision or application of this rule shall be judged invalid for any reason, such judgment shall not affect, impair, or invalidate any other provision or application of this rule, and the remaining provisions and applications shall continue in full force and effect.

**Section 13. Effective date**

This rule, as amended, shall be effective September 15, 2002.

STATUTORY AUTHORITY: 24 M.R.S.A. Chap. 19, subchapter II (§§ 2333-2341);

24-A M.R.S.A. §212 and Chapter 32 (§§ 2670-2679).

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