FIRST REGULAR SESSION

ONE HUNDRED AND THIRTEENTH LEGISLATURE

Legislative Document NO. 974

H.P. 723 House of Representatives, March 26, 1987

Reference to the Committee on Banking and Insurance suggested and ordered printed.

EDWIN H. PERT, Clerk

Presented by Speaker MARTIN of Eagle Lake.

Cosponsored by Senators KERRY of York, KANY of Kennebec and Representative RYDELL of Brunswick.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-SEVEN

AN ACT to Provide Health Care Benefits to Uninsured Individuals.

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

Sec. 1. 5 MRSA §12004, sub-§8, ¶A, sub-¶¶(15-A) and (15-B) are enacted to read:

(15-A) Insurance	Maine High-Risk Insurance Organization	Not Authorized	24-A MRSA §6052
(15-B) Insurance	Special Select Commission on Access to Health Care	Expenses Only	24-A MRSA §6071

Sec. 2. 22 MRSA §396-F, sub-§1, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

1. Charity care. The commission shall make provision for a reasonable amount of revenue deduction attributable to charity care. For purposes of this section, the amount of revenue deduction attributable to charity care shall be defined as the amount of revenue, net of recoveries, which is expected to be written off as a result of a determination that the patient is unable to pay for the hospital services received, provided that the hospital's determination is made pursuant to a policy which was adopted by the hospital and filed with the commission and which is consistent with reasonable guidelines established by the commission in accordance with this section. The guidelines and policies shall include the requirement that upon admission, or in cases of emergency admission, before discharge of a patient, hospitals shall investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. If the hospitals' services to the patient are not covered by insurance or a medical assistance program, and the patient meets the financial requirements of the medically needy program pursuant to section 3174, the cost of hospital services which is not covered by another payor and, which is greater that the patients' spend-down, would be pursuant to section 3174 and implementing regulations shall be provided as charitable care. This section shall not prevent a hospital from establishing a policy of charitable care which includes services not included in this subsection, if permitted by the commissions' guidelines. In no event may hospital services to a person who meets the financial eligibility requirements of the medically needy program with respect to those services be billed to the patient or to a municipality.

Sec. 3. 22 MRSA §4313, sub-§1, as enacted by PL 1983, c. 577, §1, is repealed and the following enacted in its place:

1. Emergency care. In the event of an admission of an eligible person to the hospital, the hospital shall notify the overseer of the liable municipality

within 5 business days of the person's admission. In no event may hospital services to a person who meets the financial eligibility requirements of the medically needy program established pursuant to section 3174 with respect to those services be billed to the patient or to a municipality.

Sec. 4. 24-A MRSA cc. 71 and 72 are enacted to read:

CHAPTER 71

MAINE HIGH-RISK INSURANCE ORGANIZATION

§6051. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Benefit plan. "Benefit plan" means the coverages to be offered by the organization to eligible persons pursuant to section 6057.

2. Board. "Board" means the board of directors of the organization.

3. Bureau. "Bureau" means the Bureau of Insurance.

4. Health insurance. "Health insurance" means any hospital and medical expense incurred policy, nonprofit hospital and medical service plan contract and health maintenance organization subscriber contract. The term does not include short-term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

5. Health maintenance organization. "Health maintenance organization" means an organization authorized in chapter 56.

6. Insurance arrangement. "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or 3rd-party administrator, health care services or benefits other than through an insurer.

7. Insured. "Insured" means any individual of this State who is eligible to receive benefits from the organization.

8. Insurer. "Insurer" means any insurance company authorized to transact health insurance business in this State and any nonprofit hospital and medical service corporation.

9. Medicaid. "Medicaid" means coverage under the United States Social Security Act, Title XIX and successors to it.

10. Medicare. "Medicare" means coverage under the United States Social Security Act, Title XVIII.

11. Organization. "Organization" means the Maine High-Risk Insurance Organization.

12. Plan or plan of operation. "Plan" or "plan of operation" means the plan of operation of the organization, including articles, bylaws and operating rules, adopted by the board.

13. Superintendent. "Superintendent" means the Superintendent of Insurance.

§6052. Creation of the organization and board of directors

1. Organization established. The nonprofit entity to be known as the Maine High-Risk Insurance Organization, as established by Title 5, chapter 379, shall provide health insurance to persons who are otherwise unable to obtain health insurance for medical reasons, as determined by this chapter.

2. Reserve fund. A reserve fund shall be established to pay any expenses and claims above premium

income. This reserve shall be funded by an assessment on all revenues of all hospitals in the State. The amount of the assessment shall be determined and adjusted annually by the board.

3. Board of directors established. The Governor shall appoint a board of directors for the organization. The board shall be composed of 7 members. Five of those members shall represent the following interests: Two members shall represent consumers of health insurance; one member shall represent domestic commercial insurers; one member shall represent hospital and medical service corporations; and one member shall be the Superintendent of Insurance or his designee. Appointments shall be for 5-year terms, except that no more than 2 members' terms may expire in any one calendar year. Appointments for terms of less than 5 years may be made initially and to replace vacancies, if necessary, to maintain the appropriate staggered terms of office. The Governor shall designate the chairman of the board. The chairman of the board shall schedule an organizational meeting within 60 days of appointment.

§6053. Duties of the board of directors; reporting requirements

The board of directors shall:

1. Establish a plan of operation. Establish a plan of operation for the organization to assure the fair, reasonable and equitable administration of the organization, which may be amended as necessary;

2. Establish procedures. Establish procedures for the handling and accounting of assets and money of the organization;

3. Determine annual assessment. Determine the amount of the annual assessment and any adjustment needed at the end of each fiscal year;

4. Establish rates. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas and any other actuarial function appropriate to the operation of the organization;

5. Select administering insurer. Select an administering insurer;

6. Develop and implement a program. Develop and implement a program to publicize the existence of the organization, the eligibility requirements and procedures for enrollment and to maintain public awareness of the organization, including furnishing all insurance agents licensed in this State with a written explanation of the organization and its operation; and

7. Report. Report to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs, insurance and human resources by February 1st of each year. The report shall include the following:

A. Experience under the funding plan and recommendations for further funding;

B. Experience regarding administrative costs and recommendations regarding an amount of or the need for a statutory cap;

C. Experience regarding the subsidy program and recommendations for future aspects of the subsidy program; and

D. An annual audited financial statement certified by an independent certified public accountant.

§6054. The authority of the organization

The organization shall have the general powers and authority granted under the laws of this State to insurance companies licensed to transact health insurance business and specific authority to:

1. Enter into contracts. Enter into contracts as are necessary or proper to carry out the purposes of this chapter, including the authority to enter into contracts with similar agencies of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions or for technical assistance;

2. Sue. Sue or be sued;

3. Take legal action. Take such legal action as necessary to avoid the payment of improper claims against the organization or the coverage provided by or through the organization;

4. Receive premiums and assessments. Receive premiums and assessments from hospital revenues; and

5. Issue insurance policies. Issue policies of insurance in accordance with the requirements of this chapter.

§6055. Administering insurer

1. Selection process. The board shall select an insurer or insurers authorized to write health insurance through a competitive bidding process to administer the organization. The board shall evaluate bids submitted based on criteria established by the board which includes:

A. The insurer's proven ability to handle individual accident and health insurance;

B. The efficiency of the insurer's claim paying procedures;

C. An estimate of total charges for administering the plan; and

D. The insurer's ability to administer the plan in a cost efficient manner.

2. Term and subsequent appointment. Term and subsequent appointment shall be structured as follows.

A. The administering insurer shall serve for a period of 3 years, subject to removal for cause.

B. At least one year prior to the expiration of the 3-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer

for the succeeding 3-year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.

3. Duties. The administering insurer shall:

A. Perform all eligibility and administrative claims payment functions relating to the organization;

B. Establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board;

C. Perform all necessary functions to assure timely payment of benefits to covered persons under the organization, including:

(1) Making available information relating to the proper manner of submitting a claim for benefits to the organization and distributing forms upon which submission shall be made; and

(2) Evaluating the eligibility of each claim for payment by the organization;

D. Submit regular reports to the board regarding the operation of the organization, the frequency, content and form which shall be determined by the board;

E. Following the close of each calendar year, determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board on a form as prescribed by the board; and

F. Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

§6056. Assessments

Each hospital's assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the hospital with it.

If assessments exceed actual losses and administrative expenses, the excess shall be held at interest and used by the board to offset future losses or to reduce premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

§6057. Eligibility

1. Eligibility. Any individual person who is a resident of this State shall be eligible for organization coverage, except the following:

A. Persons eligible for health care under Medicare or Medicaid;

B. Persons who have terminated coverage in the organization, unless 12 months have elapsed;

C. Persons who have been paid the maximum lifetime benefit established pursuant to section 6058;

D. Inmates of public institutions;

E. Persons terminated for coverage of any insurance plan because of nonpayment of premium; or

F. Persons eligible for conversion at a cost less than the cost of the organization premium.

2. Termination. Any person who ceases to meet eligibility requirements may be terminated at the end of the policy period.

§6058. Benefits

1. General benefits. The organization shall offer major medical expense coverage to every eligible person. Major medical expense coverage offered by the organization shall pay an eligible and enrolled person's covered expenses, subject to limits on the

deductible and coinsurance payments authorized in subsection 3 up to a lifetime limit of not less than $500,000 a covered individual.

The coverage offered by the organization shall not be less than the benefits in a standard group plan and shall include:

A. All benefits required by state law with respect to group health policies subject to chapter 35;

B. Alternative care; and

C. Managed care, as defined by the board.

2. Factors affecting benefits. In establishing the organization coverage, the board shall take into consideration the levels of health insurance provided in the State, medical economic factors as may be deemed appropriate and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the State.

3. Deductibles and coinsurance. The organization coverage shall provide a deductible or a choice of deductibles of not less than $500 nor more than $1,000 a year per individual and coinsurance of 20%. The coinsurance and deductibles, in the aggregate, shall not exceed $1,500 per individual nor $3,000 a family per year.

4. Preexisting conditions. Organization coverage excludes charges or expenses, except as allowed in paragraph A, B or C, incurred during the first 90 days following the effective date of coverage as to any condition, which during the 90-day period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received as to that condition.

A. The preexisting condition exclusions shall be waived for those persons who enroll in the plan during the first 6 months of the plan's operation. Persons enrolling after the first 6 months will be subject to preexisting condition exclusions.

B. The preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, provided that:

(1) Application for organization coverage is made not later than 31 days following that involuntary termination; and

(2) The individual is not eligible for a conversion plan at a cost equal to or less than the organization premium.

Coverage in the organization shall be effective from the date on which the prior coverage was terminated.

C. If an insured has paid out $3,500 for uncovered medical expenses, exclusive of the deductible, during the 90-day waiting period, then the remainder of the waiting period will be waived for that insured.

5. Nonduplication of benefits. Benefits otherwise payable under organization coverage shall be reduced by all amounts paid or payable through any other health insurance or insurance arrangement and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program, except Medicaid.

The insurer or the organization shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the organization may be

reduced or refused as a setoff against any amount recoverable under this subsection.

§6059. Premiums

1. Reasonableness. Premiums charged for coverages issued by the organization may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

2. Separate schedules. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Rates and rate schedules may be adjusted for appropriate risk factors, such as age and area variation in claim cost, and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

3. Standard risk rate. The board shall determine the standard risk rate by calculating the average individual standard rate charged by the 5 largest insurers offering coverages in the State comparable to the organization coverage. In the event 5 insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage. In no event may organization rates exceed 150% of rates applicable to the standard risk rate.

4. Premium subsidy. The board shall make available a plan to subsidize premiums for those individuals who have been denied health insurance because of a health condition and who meet income eligibility requirements set by the board. The subsidy plan shall not exceed $50,000 in costs during the first 2 years of operation.

No subsidy may be given to a person if the premium amount, after deducting the subsidy, is less than the premium of any comparable individual health insurance policy currently available to that person in the State.

The board shall relate the experience of the subsidy plan to the Legislature in the annual report and shall make recommendations regarding the subsidy plan.

§6060. Duty of health insurance agents and brokers or insurers

1. Written notice. Any agent or broker licensed to sell health insurance pursuant to chapter 17 shall furnish written notification of the organization to any individual:

A. Who has sought health insurance through the agent; and

B. Who is not eligible for adequate health insurance other than through the organization.

Delivery to the individual of the written explanation furnished by the board pursuant to section 6053 shall satisfy this requirement. When coverage is sought other than through an agent or broker, the insurer shall provide the certification required by this section.

2. Rules; penalties. Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent shall adopt rules regarding the notification process and penalties for violations of this section.

CHAPTER 72

SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

§6071. Commission established.

There is established a Special Select Commission on Access to Health Care that shall investigate and make proposals to assure access to adequate health care for persons without adequate health insurance or other coverage.

§6072. Membership; appointment; duties

1. Membership. The commission shall have 11 members as follows: One Senator; 2 Representatives; one member representing providers of direct medical care; one member representing health care institutions; one member representing the health insurance industry; one member representing employers; one member representing labor; and 3 members representing consumers of health care who are currently inadequately covered by insurance or medical assistance programs.

2. Appointment. The members of the commission shall be appointed by the Speaker of the House and the President of the Senate.

3. Duties. The commission shall investigate and make recommendations to the Governor, the Commissioner of Human Services and the Legislature to assure access to adequate health care for all citizens. The commission's investigation shall include, but not be limited to, a review of all Medicaid options in which the State does not presently participate, and the possibilities of private and public medical insurance programs for people who cannot purchase their own insurance.

4. Staff and assistance. The Maine High-Risk Insurance Organization shall make available $50,000 to the commission to carry out its duties. The department of Human Services and the Bureau of Insurance shall provide research, clerical and computer assistance to the commission and give unrestricted access to its records, rules, policies and data, except for those items which the bureau is legally obligated to keep confidential.

Sec. 5. Effective date. This Act shall take effect 90 days after adjournment of the Legislature. The sale of policies under this Act shall take effect July 1, 1988.

STATEMENT OF FACT

This bill establishes the Maine High-Risk Insurance Organization which will make health insurance available for individuals who are unable to obtain adequate health insurance because of existing health conditions. Those persons enrolling in the plan during the first 6 months of the plan's operation would not be subject to any waiting period for any preexisting condition. After that time, the preexisting condition waiting period would be 90 days. An insured who pays out $3,500 for uncovered medical expenses during the waiting period would also be eligible to have the remainder of the waiting period waived.

Losses from the plan would be funded by an assessment on hospital revenues. The amount would be adjusted annually by the board of directors of the organization.

Additionally, the bill provides for a board of directors, appointed by the Governor, to select an administering insurer, establish a plan of operation, establish a subsidy program and set premium rates and schedules. The bill also provides guidelines for benefits, deductibles, copayments, maximum out-of-pocket expenses, premium rates and eligibility.

Sections 2 and 3 provide that the Health Care Finance Commission shall define as charitable care all hosptial services to individuals who would meet the financial eligibility guidelines of the medically needy program and that the costs may not be charged to either the individual or the individual's municipality.

Section 4 establishes a Select Commission on Access to Health Care to investigate and recommend ways to assure access to adequate health care for all citizens.

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