L.D. 2274

(Filing No. H-1090)

STATE OF MAINE
HOUSE OF REPRESENTATIVES
114TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 1641, L.D. 2274, Bill, "An Act to Ensure Continuity of Health Insurance Coverage"

Amend the bill by striking out everything after the enacting clause and before the statement of fact and inserting in its place the following:

'**Sec. 1. 24 MRSA c. 19, sub-c. II-B** is enacted to read:

SUBCHAPTER II-B

CONTINUITY OF HEALTH INSURANCE COVERAGE

§2346. Definitions

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

1. Group. "Group" means any of the types of groups under Title 24-A, sections 2804 to 2808.

2. Preexisting condition exclusion. "Preexisting condition exclusion" means an exclusion of benefits for a specified or indefinite period of time on the basis of one or more physical or mental conditions for which, before the effective date of enrollment:

A. A person experienced symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

B. A provider of health care services recommended or provided medical advice or treatment to the person.

3. Subgroup. "Subgroup" means an employer covered under a contract issued to a multiple employer trust or to an association.

4. Waiting period. "Waiting period" means a period of time after the effective date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of one or more medical conditions.

§2347. Continuity on replacement of group contract

1. Contracts subject to this section. Notwithstanding any other provision of law, this section applies to all group contracts, except group long-term care policies as defined in Title 24-A, section 5051, issued by nonprofit hospital or medical service organizations to contract holders who are obtaining coverage to replace coverage under a different contract or policy issued by any insurer, health maintenance organization or nonprofit hospital or medical service organization. For purposes of this section, the group contract issued to replace the prior contract or policy is the "replacement contract." The group contract or policy being replaced is the "replaced contract or policy."

2. Persons provided continuity of coverage under this section. This section provides continuity of coverage to persons who were covered under a replaced contract or policy at any time during the 90 days before discontinuance of the replaced contract or policy.

3. Prohibition against discontinuity. In a replacement contract subject to this section, a nonprofit hospital or medical service organization may not, for any person described in subsection 2:

A. Request that the person provide or otherwise seek to obtain evidence of insurability;

B. Decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; or

C. Impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section.

4. Persons covered for fewer than 90 continuous days. Notwithstanding subsection 3, any person who was covered under the replaced contract or policy for fewer than 90 continuous days may be subject to a preexisting condition exclusion or waiting

period in the replacement contract, provided the period is not longer than 90 days and credit is given for satisfaction or partial satisfaction of the same or similar provisions under the replaced contract or policy.

5. Liability after discontinuance. The nonprofit hospital or medical service organization, insurer or health maintenance organization that issued the replaced contract or policy is liable after discontinuance of that contract or policy only to the extent of its accrued liabilities and extensions of benefits.

§2348. Extension of benefits for disabled persons

1. Contracts subject to this section. This section applies to group contracts that provide hospital or medical expense coverage, except group long-term care policies as defined in Title 24-A, section 5051 and group contracts providing only coverage for dental expense.

2. Requirement. Every group contract subject to this section must provide a reasonable extension of benefits for a person who is totally disabled on the date the group contract is discontinued, or on the date coverage for a subgroup in the contract is discontinued. A premium may not be charged during the period of extension. An extension of benefits provision is reasonable if it provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance.

3. Description of benefit extension. The extension of benefits provision must be described in all contracts and group certificates. The benefits payable during any period of extension are subject to the regular benefit limits under the contract.

4. Liability after discontinuance. After discontinuance of a contract, the nonprofit hospital and medical service organization remains liable only to the extent of its accrued liabilities and extensions of benefits. The liability of the nonprofit hospital or medical service organization is the same whether the group contract holder or other entity secures replacement coverage from any insurer, nonprofit hospital or medical service organization or health maintenance organization, self-insures or foregoes the provision of coverage.

5. Rules. The superintendent shall adopt rules to define the term "total disability" for purposes of this section. The definition must identify persons who are unable, as a result of disability, to obtain comparable alternative coverage through comparable employment or otherwise.

§2349. Continuity of coverage for individual who changes groups

1. Contracts subject to this section. This section applies to all group contracts issued by nonprofit hospital or medical service organizations, except group long-term care policies as defined in Title 24-A, section 5051.

2. Persons provided continuity of coverage. Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under a group nonprofit hospital or medical service organization contract if:

A. That person was covered under an individual or group contract or policy issued by any insurer, health maintenance organization, nonprofit hospital or medical service organization, or governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, and the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072, Subsection 4. For purposes of this section, the group contract under which the person is seeking coverage is the "succeeding contract." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding contract. A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment, death of a spouse or divorce; or

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and

the request for coverage is made within 30 days after issuance of the court order.

4. Prohibition against discontinuity. Except as provided in this section, in a group contract subject to this section, a nonprofit hospital or medical service organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if that contract or policy were still in effect. The issuer of the succeeding contract is not required to duplicate any benefits covered by the issuer of the prior contract or policy.

5. Determination of benefits. When a determination of benefits under the prior contract or policy is required, the issuer of the prior contract or policy shall, at the request of the issuer of the succeeding contract, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the issuer of the succeeding contract. For purposes of this section, benefits of the prior contract or policy are determined in accordance with the definitions, conditions and covered expense provisions of that contract or policy rather than those of the succeeding contract. The benefit determination must be made as if coverage had not been replaced.

6. Limit on premium increase. For rating purposes, a nonprofit hospital or medical service organization may not charge claims for preexisting conditions of a person subject to this section, during the first 12 months of employment of that person, directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. Any additional claims may be pooled among all such groups and subgroups covered by that nonprofit hospital or medical service organization. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

§2350. Limitations on exclusion and waiting periods

1. Application. For purposes of this section, "individual contract" means a nongroup contract, other than a long-term care policy as defined in Title 24-A, section 5051.

2. Limitation. An individual contract between a subscriber and a nonprofit hospital or medical service organization may not impose a preexisting condition exclusion period of more than 6 months, except that the contract may exclude coverage for up to 24 months for any preexisting condition that, as of the effective

date of the coverage, requires ongoing medical observation or treatment.

Sec. 2. 24-A MRSA §2804, sub-§3, as repealed and replaced by PL 1981, c. 147, §2, is amended to read:

3. An Except as provided in chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 3. 24-A MRSA §2805, sub-§3, as repealed and replaced by PL 1981, c. 147, §3, is amended to read:

3. An Except as provided in chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 4. 24-A MRSA §2805-A, sub-§4, as enacted by PL 1981, c. 147, §4, is amended to read:

4. An Except as provided in chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 5. 24-A MRSA §2806, sub-§3, as repealed and replaced by PL 1981, c. 147, §5, is amended to read:

3. An Except as provided in chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 6. 24-A MRSA §2807-A, sub-§3, as enacted by PL 1981, c. 147, §7, is amended to read:

3. An Except as provided in chapter 36, an insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 7. 24-A MRSA §2808, sub-§4, as enacted by PL 1981, c. 147, §8, is amended to read:

4. An Except as provided in chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 8. 24-A MRSA c. 36 is enacted to read:

CHAPTER 36

CONTINUITY OF HEALTH INSURANCE COVERAGE

§2848. Definitions

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

1. Group. "Group" means any of the types of groups under sections 2804 to 2808.

2. Preexisting condition exclusion. "Preexisting condition exclusion" means an exclusion of benefits for a specified or indefinite period of time on the basis of one or more physical or mental conditions for which, preceding the effective date of enrollment:

A. A person experienced symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

B. A provider of health care services recommended or provided medical advice or treatment to the person.

3. Subgroup. "Subgroup" means an employer covered under a contract issued to a multiple employer trust or to an association.

4. Waiting period. "Waiting period" means a period of time after the effective date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of any or all medical conditions.

§2849. Continuity on replacement of group policy

1. Policies subject to this section. Notwithstanding any other provision of law, this section applies to all group policies, except group long-term care policies as defined in section 5051 or group long-term disability policies, issued by insurers or health maintenance organizations to policyholders who are obtaining coverage to replace coverage under a different contract or policy issued by any nonprofit hospital or medical service organization, insurer or health maintenance organization. For purposes of this section, the group policy issued to replace the prior contract or policy is the "replacement policy." The group contract or policy being replaced is the "replaced contract or policy."

2. Persons provided continuity of coverage under this section. This section provides continuity of coverage to persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy.

3. Prohibition against discontinuity. In a replacement policy subject to this section, an insurer or health maintenance organization may not, for any person described in subsection 2:

A. Request that the person provide or otherwise seek to obtain evidence of insurability;

B. Decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; or

C. Impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section.

4. Persons covered for fewer than 90 continuous days. Notwithstanding subsection 3, a person who was covered under the replaced contract or policy for fewer than 90 continuous days may be subject to a preexisting condition exclusion or waiting period in the replacement policy, provided the period is not longer than 90 days, and credit is given for satisfaction or partial satisfaction of the same or similar provisions under the replaced contract or policy.

5. Liability after discontinuance. The nonprofit hospital or medical service organization, insurer or health maintenance organization that issued the replaced contract or policy is liable after discontinuance of that contract or policy only to the extent of its accrued liabilities and extensions of benefits.

§2849-A. Extension of benefits for disabled persons

1. Policies subject to this section. This section applies to group policies that provide hospital or medical expense coverage and group policies that provide benefits for loss of time from work or specific indemnity during hospital confinement. This section does not apply to group policies providing coverage only for dental expense or to group long-term care policies as defined in section 5051 or group long-term disability policies.

2. Requirement. Every group policy subject to this section must provide a reasonable extension of benefits for a person who is totally disabled on the date the group policy is discontinued, or on the date coverage for a subgroup in the policy is discontinued. A premium may not be charged during the period of extension. For a policy providing hospital or medical expense coverage, an extension of benefits provision is reasonable if it

provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance. For a policy providing benefits for loss of time from work or specific indemnity during hospital confinement, extension of benefits means that discontinuance of the policy during a disability has no effect on benefits payable for that disability or confinement.

3. Description of benefit extension. The extension of benefits provision must be described in all policies and group certificates. The benefits payable during any period of extension are subject to the regular benefit limits under the policy.

4. Liability after discontinuance. After discontinuance of a policy, the insurer or health maintenance organization remains liable only to the extent of its accrued liabilities and extensions of benefits. The liability of the insurer or health maintenance organization is the same whether the group policyholder or other entity secures replacement coverage from any insurer, nonprofit hospital or medical service organization or health maintenance organization, self-insures or foregoes the provision of coverage.

5. Rules. The superintendent shall adopt rules to define the term "total disability" for purposes of this section. The definition must identify persons who are unable, as a result of disability, to obtain comparable alternative coverage through comparable employment or otherwise.

§2849-B. Continuity for individual who changes groups

1. Policies subject to this section. This section applies to all group policies issued by insurers or health maintenance organizations, except group long-term care policies as defined in section 5051 and group long-term disability policies.

2. Persons provided continuity of coverage. Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under a group insurance or health maintenance organization policy if:

A. That person was covered under an individual or group contract or policy issued by any nonprofit hospital or medical service organization, insurer, health maintenance organization, or governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, or the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072,

Subsection 4. For purposes of this section, the group policy under which the person is seeking coverage is the "succeeding policy." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding policy. A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding policy because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment, death of a spouse or divorce; or

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order.

4. Prohibition against discontinuity. Except as provided in this section, in a group policy subject to this section, an insurer or health maintenance organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

5. Determination of benefits. When a determination of benefit under the prior contract or policy is required, the issuer of the prior contract or policy shall, at the request of the issuer of the succeeding policy, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination

itself by the issuer of the succeeding policy. For purposes of this section, benefits of the prior contract or policy are determined in accordance with the definitions, conditions and covered expense provisions of that contract or policy rather than those of the succeeding policy. The benefit determination must be made as if coverage had not been replaced.

6. Limit on premium increase. For rating purposes, an insurer or health maintenance organization may not charge claims for preexisting conditions of any person subject to this section, during the first 12 months of employment of that person, directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. The insurer or health maintenance organization may pool any additional claims among all such groups and subgroups covered by that insurer or health maintenance organization. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

§2850. Limitations on exclusion and waiting periods

1. Application. This section applies to individual policies subject to chapter 33, except long-term care policies defined in section 5051, long-term disability policies, Medicare supplement policies and policies designed to cover specific diseases, hospital indemnity or accidental injury only.

2. Limitation. An individual policy issued by an insurer may not impose a preexisting condition exclusion period of more than 6 months, except that the policy may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation or treatment.

Sec. 9. 24-A MRSA §4210-A is enacted to read:

§4210-A. Continuity of health insurance coverage

Notwithstanding section 4210, the provisions of chapter 36 apply to health maintenance organizations.

Sec. 10. Application. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 1990. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Sec. 11. Health insurance continuity task force. As soon as practicable after passage of this Act, the Superintendent of Insurance shall convene a task force to study all reasonable proposals to ensure continuous health insurance coverage for as many citizens of this State as possible.

1. The health insurance continuity task force shall consist of 14 members as follows:

A. Four Legislators to be selected by the President of the Senate and the Speaker of the House of Representatives;

B. A representative of the Bureau of Insurance;

C. One representative of consumers, to be selected by the Consumers for Affordable Health Care;

D. One representative of employers, to be selected by the Maine Chamber of Commerce and Industry;

E. One employer that receives insurance through a multiple employer trust, to be selected by the Maine Chamber of Commerce and Industry;

F. One small business employer, to be selected by the Maine Merchants Association;

G. One representative of labor, to be selected by the Maine AFL-CIO;

H. One representative of commercial health insurers, to be selected by the Health Insurance Association of America;

I. One representative of nonprofit hospital or medical service organizations, to be selected by Blue Cross and Blue Shield of Maine;

K. One independent insurance agent with experience selling health insurance, to be selected jointly by the Independent Insurance Agents Association of Maine, the Professional Insurance Agents of New England and the Maine Association of Life Underwriters; and

L. One member of the Special Select Commission on Access to Health Care, to be selected by the members of that commission.

Organizations that are required to select members for the task force shall submit their selections to the superintendent as soon as possible after passage of this Act. The superintendent shall

appoint those persons to the task force and shall convene the first meeting of the task force as soon as possible after receiving the selections from the organizations.

2. Members of the task force are not entitled to compensation, except that, if authorized by the Legislative Council, legislative members of the task force may receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for expenses.

3. The issues to be addressed by the task force include, but are not limited to:

A. Rights of continuity for individual health insurance policyholders;

B. Limits on preexisting condition exclusions, riders, medical underwriting, and waiting periods;

C. Pooling, reinsurance and community rating for small business group and individual policies for spreading the costs of high-risk individuals who are provided continuous coverage;

D. Exclusions by industry or occupation; and

E. The economic impact of the proposed changes, including actuarial projections that account for reserve policies, costs of underwriting, administration, legal costs, marketing costs such as advertising and sales commissions, investment income and profit margins by product line, company and by industry.

4. The Bureau of Insurance shall provide staff assistance to facilitate the work of the task force and the collection of appropriate and necessary data from insurers and to draft any recommended legislation of the task force.

5. The task force shall submit any recommended legislation to the Joint Standing Committee on Banking and Insurance by January 1, 1991.

FISCAL NOTE

The Bureau of Insurance can absorb the costs associated with rulemaking and with the staffing and miscellaneous expenses of the task force.

The costs associated with Legislators' per diem and expenses are expected to be funded within the existing resources of the legislative budget. If the Legislative Council does not approve these expenses, the Legislators serving on the task force will not receive compensation and reimbursement of expenses.'

STATEMENT OF FACT

The bill, as amended, provides continuity of health benefits coverage for people who may otherwise be denied coverage or excluded from coverage for certain health conditions when their group plan changes insurers, or when they as individuals change coverage, for example, when they change jobs and seek coverage under a new employer's group plan. Currently, in these situations, the new contract or policy frequently permits "medical underwriting"; it permits the issuer of the contract or policy to deny coverage to persons otherwise eligible to join the plan because they have a medical condition or have characteristics that make them more likely to develop a medical condition. Alternatively, the issuer may agree to cover the person, but exclude coverage of a preexisting condition, a condition that the person has when applying for coverage, even though the person had coverage for that condition under the prior plan. The amendment protects individuals against breaks in coverage in these situations as follows.

In the first situation, when an employer or other holder of a group contract or policy changes to a different contract or policy issued by any insurer, nonprofit service organization or health maintenance organization, the replacement contract or policy may not deny coverage or exclude coverage of preexisting conditions to any person who was covered under the replaced contract or policy. A short exclusion period may be applied, however, to any person who was not covered for at least 90 continuous days under the replaced contract or policy.

In the 2nd situation, the amendment provides continuity of coverage for persons who move from coverage under a group or individual contract or governmental program into coverage by a group contract, by requiring the insurer, nonprofit hospital or medical service organization or health maintenance organization that issues the succeeding contract or policy to waive preexisting condition exclusions and medical underwriting to the extent the benefit would have been covered by the prior contract or policy. The amendment limits to 10% the premium increase that may be imposed on a group of fewer than 100 insured employees as a result of claims for preexisting conditions of those persons during their first year of employment. The insurer, nonprofit

hospital or medical service organization or health maintenance organization may spread any additional cost among other similar groups it covers.

The amendment also provides an extension of coverage in a 3rd situation. If a person is totally disabled on the date a group contract or policy is discontinued, the contract or policy must extend benefits for a reasonable period under the contract or policy for that person, regardless of subsequent coverage. No premium may be charged for the extension.

The continuity requirements do not generally apply to persons obtaining coverage under individual contracts or policies. With respect to individual contracts or policies, the amendment limits the preexisting condition exclusion period that may be imposed to 6 months, unless the condition requires ongoing medical observation and treatment in which case the benefits for that condition may be excluded for up to 24 months.

Finally, the amendment creates a task force to study additional health insurance continuity issues.

Reported by the Committee on Banking and Insurance
Reproduced and distributed under the direction of the Clerk of the House
4/5/90 (Filing No. H-1090)