L.D. 701

(Filing No. H-1007)

STATE OF MAINE
HOUSE OF REPRESENTATIVES
115TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 507, L.D. 701, Bill, "An Act to Provide Community Rating of Health Insurance Providers"

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 §2327-A,** as enacted by PL 1989, c. 422, §1, is amended to read:

§2327-A. Rating practices in group health insurance

Title 24-A, ~~section~~ sections 2808-A and 2808-B~~,~~ ~~shall~~ apply to nonprofit hospital corporations, nonprofit medical service corporations and nonprofit health care plans to the extent not inconsistent with this chapter.

Sec. 2. 24 MRSA §2808-A, as amended by PL 1991, c. 353, is further amended to read:

§2808-A. Rating practices in group health insurance

1. Groups with fewer than 25 members. Except as provided in subsection 3, no insurer may ~~increase~~ charge group health insurance premium rates for ~~a group~~ groups with fewer than 25 insured members, excluding dependents, ~~on the basis of~~ that vary based on the claims experience of ~~that~~ the group.

2. Subgroups; rate differentiation. Except as provided in subsection 3, no insurer may ~~increase~~ charge group health insurance premium rates on a basis ~~which~~ that discriminates between different subgroups of a group according to the claims

experience of the subgroup. The term "subgroup," as used in this section, refers to an employer with fewer than 25 insured employees within a multiple employer trust, or to any similar subdivision of a larger group covered by a single group health insurance policy or contract.

3. Tiers of rates allowed. ~~Groups~~ Except as provided in paragraph C, groups or subgroups subject to subsection 1 or 2 may be divided into 2 or more tiers for rating purposes based on the experience of the group or subgroup provided that the following conditions are satisfied.

A. The rates for the highest tier may not exceed the average rate for all tiers by more than 20%.

B. At the time of application, the insurer must provide to the prospective policyholder a prominent disclosure indicating that premium rates may change based on the claims experience of the group or subgroup. If the policyholder is a multiple employer trust, the policyholder must provide this disclosure to each employer at the time of application to the trust. For multiple employer trusts in existence on January 1, 1990, this disclosure procedure must be completed prior to the first subsequent renewal.

C. Exceptions to subsections 1 and 2 do not apply to policies executed, delivered, issued for delivery, continued or renewed on or after January 1, 1993.

4. Applicability. This section applies to all policies executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1990. It applies to any certificates delivered to residents of this State under a group health insurance policy described in section 2805-A, 2806 or 2808 and executed, continued or renewed on or after January 1, 1990. For purposes of this section, all contracts ~~shall be~~ are deemed ~~to be~~ renewed no later than the next yearly anniversary of the contract date.

5. Sunset. ~~Unless continued or modified by law, this~~ This section is repealed on ~~October 1, 1992~~ July 1, 1993.

Sec. 3. 24-A MRSA §2808-B is enacted to read:

§2808-B. Small group health plans

1. **Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue small group health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all small group health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

B. "Community rate" means the rate to be charged to all eligible groups for small group health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D.

C. "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not include employees who work on a part-time, temporary or substitute basis.

D. "Eligible group" means any person, firm, corporation, partnership or association engaged actively in a business that during at least 50% of its working days in the preceding calendar quarter employed fewer than 25 eligible employees, the majority of whom are employed within the State. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer. In the calculation of carrier percentage participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation.

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not

considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A or B.

F. "Premium rate" means the rate charged to an eligible group or eligible individual for a small group health plan.

G. "Small group health plan" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract. "Small group health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment; or

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance.

2. Rating practices. The following requirements apply to the rating practices of carriers providing small group health plans.

A. A carrier issuing a small group health plan after the effective date of this section must file the carrier's community rate and any formulas and factors used to adjust

that rate under paragraphs C and D with the superintendent for informational purposes prior to issuance of any small group health plan.

B. A carrier may not vary the premium rate due to the health status, claims experience or policy duration of the eligible group.

C. A carrier may vary the premium rate due to family status, smoking status, participation in wellness programs and group size.

D. A carrier may vary the premium rate due to age, gender, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands:

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 1993 and June 30, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 1994 and June 30, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 1995 and June 30, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996, the premium rate may not deviate from the community rate filed by the carrier.

E. The superintendent may exempt from the requirements of this section an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 that offers a small group health plan that complies with the premium rate requirements of this section

and guarantees issuance and renewal to all persons and their dependents within the association or trustee group.

3. Coverage for late enrollees. In providing coverage to late enrollees, small group health plan carriers are allowed to exclude a late enrollee for 18 months or provide coverage subject to an 18-month preexisting conditions exclusion.

4. Guaranteed issuance and guaranteed renewal. Carriers providing small group health plans must meet the following requirements on issuance and renewal.

A. Coverage must be guaranteed to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups.

B. Renewal must be guaranteed to all eligible groups, to all eligible employees and their dependents in those groups except:

(1) For nonpayment of the required premiums by the policyholder, contract holder or employer;

(2) For fraud or material misrepresentation by the policyholder, contract holder or employer or;

(3) With respect to coverage of eligible individuals, for fraud or material misrepresentation on the part of the individual or the individual's representative;

(4) For noncompliance with the carrier's minimum participation requirements, which may not exceed 75%; and

(5) When the carrier ceases providing small group health plans in compliance with subsection 5.

5. Cessation of business. Carriers that provide small group health plans after the effective date of this section that plan to cease doing business in the small group health plan market must comply with the following requirements.

A. Notice of the decision to cease doing business in that market must be provided to the bureau and to the policyholder or contract holder 6 months prior to nonrenewal.

B. Carriers that cease to write new business in that market continue to be governed by this section with respect to business conducted under this section.

C. Carriers that cease to write new business in that market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent.

6. Fair marketing standards. Carriers providing small group health plans must meet the following standards of fair marketing.

A. Each carrier must actively market small group health plan coverage to eligible groups in this State.

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

(1) Encouraging or directing eligible groups to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; and

(2) Encouraging or directing eligible groups to seek coverage from another carrier because of any of the rating factors listed in subsection 2.

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of a small group health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2.

D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2.

E. A carrier or representative of the carrier may not induce or otherwise encourage an eligible group to separate or otherwise exclude an employee from small group health plan coverage or benefits.

F. Denial by a carrier of an application for coverage from an eligible group must be in writing and must state the reason or reasons for the denial.

G. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of small group health plans in this State.

H. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of small group health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier.

7. Applicability. This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

Sec. 4. 24-A MRSA §4222, sub-§4 is enacted to read:

4. Section 2808-B applies to health maintenance organizations except that a health maintenance organization is not required to offer coverage or accept applications from an eligible group located outside the health maintenance organization's approved service area.

Sec. 5. Effective Date. The portions of this Act that amend the Maine Revised Statutes, Title 24, section 2327-A and enact Title 24-A, section 4222, subsection 4 take effect on July 1, 1993.

Sec. 6 Report. The Bureau of Insurance shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters on or before January 1, 1993, on the following issues:

1. Standard and basic health insurance plans that include health insurance mandates;

2. Guaranteed issuance and renewability of health insurance and their applicability with and without standardized plans;

3. Data collection regarding health insurance coverage and employer practices for employers of fewer than 25 employees and the self-employed;

4. Wellness programs designed for introduction at places of employment, their usage and effect, any use being made of them in rating by carriers and a definition for them for statutory enactment; and

5. Alternative models for risk sharing in the issuance of small group health plans. In developing alternative models, the Bureau of Insurance shall consult with insurers, nonprofit hospital and medical service organizations, representatives of businesses and consumer groups and other interested parties. The alternative models must include provisions allowing carriers to determine whether they will or will not participate in the risk-sharing mechanism and must be based on the principle that the carriers that participate in the risk-sharing mechanism bear the costs for the obligations of the risk-sharing mechanism.

Sec. 7. Allocation. The following funds are allocated from Other Special Revenue to carry out the purposes of this Act.

	1992-93
PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF	
Bureau of Insurance	
All Other	$70,000

Provides funds for consulting services to assist the Bureau of Insurance with a report on several health insurance issues.

FISCAL NOTE

	1992-93
APPROPRIATIONS/ALLOCATIONS	
Other Funds	$70,000
REVENUES	
General Fund	($96,000)

The community rating system proposed in this bill will result in some insurers leaving the small group health insurance market and, consequently, in some individuals becoming uninsured. This will reduce General Fund revenues from premium tax collections by approximately $192,000 annually beginning January 1, 1993. Therefore, the loss of General Fund revenue will be $96,000 in fiscal year 1992-93.

The Bureau of Insurance will require an allocation of available Other Special Revenue in the amount of $70,000 in fiscal year 1992-93 for one-time consulting services necessary to assist the bureau in preparing the report specified in section 6 of the bill.'

STATEMENT OF FACT

This amendment is the majority report of the Joint Standing Committee on Banking and Insurance and it accomplishes the following.

1. It makes the rating sections applicable to nonprofit hospital and medical service corporations and to nonprofit health care plans.

2. It amends tier rating so that rating on claims experience of groups and subgroups may occur only until January 1, 1993.

3. With respect to health plans issued to employer-based groups of fewer than 25 people and the self-employed, it enacts community rating on a gradual schedule, using a band that extends from 33% down to 0 by July 1, 1996. It forbids rating based upon health status, claims experience or duration of the policy of the group. It allows rating without limitation based upon group size, smoking status, family status and participation in wellness programs.

4. It requires guaranteed issuance and guaranteed renewal of small group health plans, with exceptions for nonpayment, fraud and going out of business.

5. It applies these provisions to health maintenance organizations but does not require the issuance or renewal of health maintenance organization coverage to groups outside the health maintenance organization's approved service area.

6. It requires a report from the Bureau of Insurance on standard and basic health plans, guaranteed issuance and renewal, data collection on employer health coverage, wellness programs and alternative models for risk sharing in the small group health market.

7. It contains fair marketing standards for small group health plans.

8. This amendment also adds a fiscal note to the bill.

Reported by the Majority of the Committee on Banking and Insurance
Reproduced and distributed under the direction of the Clerk of the House
3/2/92 (Filing No. H-1007)