115th MAINE LEGISLATURE

FIRST REGULAR SESSION-1991

Legislative Document **No. 742**

S.P. 265 Received by the Secretary, February 20, 1991

Submitted by the Department of Professional and Financial Regulation pursuant to Joint Rule 24.

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

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator GILL of Cumberland

Cosponsored by Senator GAUVREAU of Androscoggin and Representative GARLAND of Bangor.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

An Act Relating to Health Insurance.

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

PART A

Sec. A-1. 24 MRSA §2342, sub-§3, as enacted by PL 1989, c. 556, Pt. C, §1, is amended to read:

3. Information required. Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

A. The process by which the entity carries out its utilization review services, including the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State;

B. The process used by the entity for addressing beneficiary or provider complaints;

C. The types of utilization review programs offered by the entity, such as:

(1) Second opinion programs;

(2) Prehospital admission certification;

(3) Preinpatient service eligibility determination; or

(4) Concurrent hospital review to determine appropriate length of stay; and

D. The process chosen by the entity to preserve beneficiary confidentiality of medical information.

As part of its initial application, the entity shall submit copies of all materials to be used to inform beneficiaries and providers of the requirements of its utilization review plans and their rights and responsibilities under the plan.

Sec. A-2. 24-A MRSA §2771, sub-§3, as enacted by PL 1989, c. 556, Pt. C, §2, is amended to read:

3. Information required. Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

A. The process by which the entity carries out its utilization review services, including the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State;

B. The process used by the entity for addressing beneficiary or provider complaints;

C. The types of utilization review programs offered by the entity, such as:

(1) Second opinion programs;

(2) Prehospital admission certification;

(3) Preinpatient service eligibility determination; or

(4) Concurrent hospital review to determine appropriate length of stay; and

D. The process chosen by the entity to preserve beneficiary confidentiality of medical information.

As part of its initial application, the entity shall submit copies of all materials to be used to inform beneficiaries and providers of the requirements of its utilization review plans and their rights and responsibilities under the plan.

PART B

Sec. B-1. 24 MRSA §2318, as enacted by PL 1975, c. 276, §1, is repealed and the following enacted in its place:

§2318. Maternity benefits and dependent coverage

1. Definition. "Dependent children" means minor children, stepchildren and adopted children of the subscriber or member or the spouse of the subscriber or member.

2. Maternity benefits. All individual or group contracts issued by any nonprofit hospital or medical service organization operating pursuant to this chapter must provide to unmarried subscribers or members and minor dependents of the subscribers or members the same minimum maternity benefits and the same option for additional maternity benefits, at appropriate rates and under the same terms and conditions those benefits or options for benefits are provided to married subscribers or members. This requirement applies to all individual or group contracts issued or renewed after the effective date of this subsection.

3. Coverage. All individual or group contracts issued in accordance with the requirements of this section must provide unmarried subscribers with the same benefits or option of benefits for dependent children as is extended to dependent children of married subscribers, at appropriate rates and under the same terms and conditions.

4. Financial dependency. Financial dependency of dependent children on the subscriber or member or the spouse of the subscriber or member may not be required as a condition for eligibility for coverage.

Sec. B-2. 24-A MRSA §2742, as enacted by PL 1975, c. 276, §2, is repealed and the following enacted in its place:

§2742. Child coverage

1. Definition. "Dependent children" means children, stepchildren and adopted children of the policyholder or the spouse of the policyholder.

2. Coverage. All insurance policies or plans issued in accordance with the requirements of section 2741 must provide unmarried women policyholders with the coverage or option of coverage for dependent children, under the same terms and conditions and at appropriate rates as are extended to married policyholders with dependents.

3. Financial dependency. Financial dependency of dependent children on the policyholder or the spouse of the policyholder may not be required as a condition for eligibility coverage.

Sec. B-3. 24-A MRSA §2833, as amended by PL 1985, c. 652, §52, is repealed and the following enacted in its place:

§2833. Child coverage

1. Definition. "Dependent children" means children, stepchildren and adopted children of the certificate holder or the spouse of the certificate holder.

2. Coverage. All group or blanket health insurance plans issued in accordance with the requirements of section 2832 must provide unmarried women certificate holders with the option of coverage of their children from the date of birth. A certificate holder who, pursuant to the laws of this State or any other state, has been adjudicated or has acknowledged himself to be the father of an illegitimate child must be given the option of coverage for that child from the date of his adjudication or acknowledgement of paternity. This optional coverage must be the same as that provided the children of a married certificate holder with family or dependent coverage.

3. Financial dependency. Financial dependency of dependent children on the certificate holder or the spouse of the certificate holder may not be required as a condition for eligibility for coverage.

Sec. B-4. 24-A MRSA §4234 is enacted to read:

§4234. Child coverage

1. Definition. "Dependent children" means minor children, stepchildren and adopted children of the enrollee or the spouse of the enrollee.

2. Coverage. All individual or group coverage subject to this chapter must provide unmarried enrollees with the same benefits or option of benefits for dependent children as is extended to dependent children of married enrollees, at appropriate rates and under the same terms and conditions.

3. Financial dependency. Financial dependency of dependent children on the enrollee or the spouse of the enrollee may not be required as a condition for eligibility for coverage.

PART C

24-A MRSA §§5052-A, 5056 and 5057 are enacted to read:

§5052-A. Trial examination period

Nursing home care and long-term care policies must have a notice prominently printed on the first page of the policy or certificate or attached to the first page stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if for any reason, after examination of the policy or certificate, the applicant is not satisfied.

§5056. Standards for marketing

Every insurer, health care service plan or other entity marketing nursing home care or long-term care insurance coverage in this State, directly or through its producers, shall:

1. Policy comparison. Establish marketing procedures to ensure that any comparison of policies by its agents or other producers is fair and accurate;

2. Excessive insurance. Establish marketing procedures to ensure that excessive insurance is not sold or issued. The procedures must include a specific standard for persons covered by Medicaid;

3. Replacement policy. Establish marketing procedures that set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy; and

4. Compliance procedures. Establish auditable procedures for verifying compliance with the standards set out in this section.

§5057. Permitted compensation arrangements

1. Definition. For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including, but not limited to, bonuses, gifts, prizes, awards and finder's fees.

2. Compensation. An insurer or other entity may provide a commission or other compensation to an agent or other representative for the sale of a nursing home care or long-term care policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year or period.

3. Renewal. The commission or other compensation provided in subsequent or renewal years must be the same as that provided in the 2nd year or period and must be provided for a reasonable number of renewal years.

4. Replacing coverage. If an existing policy or certificate is replaced, an entity may not provide to its agents or other producers, and an agent is not entitled to receive, compensation greater than the renewal compensation payable by the replacing insurer on renewal policies or certificates, unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy.

PART D

Sec. D-1. 24-A MRSA §2627, as amended by PL 1969, c. 177, §45, is repealed.

Sec. D-2. 24-A MRSA §2627-A is enacted to read:

§2627-A. Dividends and experience refunds

The amount by which any dividend, experience refund or rate reduction exceeds the amount of premium contributed by the group policyholder for the same period must be refunded to the

employees, members or debtors in proportion to their premium contributions for that period, except that a refund smaller than $1 need not be paid.

Sec. D-3. 24-A MRSA §2812, as amended by PL 1969, c. 177, §52, is repealed.

Sec. D-4. 24-A MRSA §2812-A is enacted to read:

§2812-A. Dividends and experience refunds

The amount by which any dividend, experience refund or rate reduction exceeds the amount of premium contributed by the group policyholder for the same period must be refunded to the employees, members or debtors in proportion to their premium contributions for that period, except that a refund smaller than $1 need not be paid.

STATEMENT OF FACT

Part A requires that documents describing a utilization review plan be submitted to the Bureau of Insurance as part of the application process regardless of the source. Disclosure is central to the regulatory scheme of the bureau and must be provided in all situations.

A number of insurers have adopted eligibility standards for coverage for dependent children that require the children to be dependent on the insured for financial support. This requirement prevents a number of stepparents and parents from providing health insurance coverage for their children because the children are legally and financially dependent on another parent. Part B permits parents to provide coverage for their children or the children of their spouse without a requirement to prove financial dependency. This allows parents to cover children and encourages financial responsibility. Coordination of benefits provisions will resolve excess coverage issues in cases where children may be eligible for coverage under more than one health plan.

Part C requires a 30-day "free-look" provision in these policies consistent with the current National Association of Insurance Commissioners, or NAIC, model. First year commission on replacement sales is prohibited. This provision responds to concerns about unacceptable marketing practices by agents.

When experience refunds or dividends are paid on group credit insurance or mortgage insurance, they are generally paid to the group policyholder, such as a bank, even though the premiums were paid by the insured debtor. Current law requires other group policyholders to apply any refund in excess of the

policyholder's contribution to the premium for the sole benefit of insured employees and members. This provision does not apply to debtor groups. Part D requires all group policyholders to refund any amounts in excess of their contribution to the insureds in proportion to their contributions. An exception is made for amounts less than $1.