115th MAINE LEGISLATURE

FIRST REGULAR SESSION-1991

Legislative Document **No. 1730**

H.P. 1187 House of Representatives, April 29, 1991

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

Ed Pert

EDWIN H. PERT, Clerk

Presented by Representative CARLETON of Wells.
Cosponsored by Senator BRAWN of Knox and Representative ANDERSON of Woodland.

STATE OF MAINE

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

An Act to Provide More Affordable Health Insurance for Small Businesses.

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

24-A MRSA c. 77 is enacted to read:

CHAPTER 77

BASIC CARE MEDICAL INSURANCE

§6401. Definitions

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

1. Eligible employee. "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 or more hours. The term 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.

2. Small employer. "Small employer" means any person, firm, corporation, partnership or association actively engaged in business that, on at least 50% of its working days during the preceding calendar year quarter, employed no more than 19 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. Except as otherwise provided, the provisions of this chapter that apply to a small employer continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

§6402. Basic care benefits

Insurers may issue basic care medical insurance meeting the criteria of this chapter. For purposes of this chapter, basic care medical insurance is a policy or subscription contract that an insurer or nonprofit service plan may offer to small employers formed for purposes other than obtaining insurance coverage and that must meet the following criteria.

1. Eligible employees. For group policies or subscription contracts issued to cover employees, coverage must be available to all eligible employees.

2. Mandatory managed care provisions. The insurer or nonprofit service plan must include the following managed care provisions to control costs:

A. An exclusion for services that are not medically necessary or are not covered preventive health services; and

B. A procedure for preauthorization by the insurer or nonprofit service plan or its designees.

3. Optional managed care provisions. The insurer or nonprofit service plan may include the following managed care provisions to control costs:

A. A panel of preferred providers. Any written preferred provider agreement between a provider and an insurer or nonprofit service plan must contain a provision under which the parties agree that the insured individual or covered subscriber does not have any obligation to make payment for any medical service rendered by the provider that is determined medically unnecessary;

B. Provisions requiring a 2nd surgical opinion; and

C. A procedure for additional utilization review by the insurer or health services plan or a medical utilization review entity.

Nothing in this chapter may be construed to prohibit an insurer or nonprofit service plan from including in its policy or subscription contract additional managed care and cost control provisions that, subject to the approval of the superintendent, have the potential to control costs in a manner that does not result in inequitable treatment of insureds or subscribers.

4. Basic levels of care. The policy or subscription contract must provide basic levels of primary, preventive and hospital care for covered individuals, including, but not limited to, the following:

A. A minimum of 90 days of inpatient hospitalization coverage per policy year;

B. Prenatal and postnatal care;

C. Well-baby and well-child care that includes, but is not be limited to, 6 well-baby examinations during the first year and childhood immunizations to age 8;

D. For other covered individuals, a basic level of primary and preventive care, including, but not limited to, 2 physician office visits per calendar year;

E. Professional services including inpatient medical care, surgery and anesthesia, maternity delivery and emergency accident and medical care;

F. Outpatient facility services including emergency accident and medical care, surgery, diagnostic services and radiation and chemotherapy; and

G. A calendar year benefit of at least $2,000 for hospital outpatient laboratory, radiological and diagnostic examinations. This benefit includes coverage for screening mammograms once every 2 years for women between the ages 40 and 49 and once a year for women age 50 and over.

§6403. Exemption from certain mandates

Except as provided in this chapter, no law requiring the coverage of a health care service or benefits and no law requiring the reimbursement or utilization of a specific category of licensed health care practitioner applies to basic care medical insurance issued pursuant to this chapter.

§6404. Deductibles; coinsurance; maximum benefit

1. Deductible. The policy must contain a deductible of not less than $200 nor greater than $1000 per covered person per calendar year. The deductible does not apply to covered preventive care services.

2. Coinsurance. Coinsurance may not exceed 20% except for emergency care as provided in subsection 3. The insured or subscriber may not have out-of-pocket expenses of more than $2,500 per individual per calendar year; beyond that amount, coverage must be at 100% of the covered charge.

3. Emergency care. Coinsurance may not exceed 50% for care received in a hospital emergency room that is not emergency treatment.

A. For purposes of this section, "emergency treatment" means treatment of a case involving accidental bodily injury or the sudden and unexpected onset of a critical condition requiring medical or surgical care for which a person seeks medical attention within 24 hours of the onset.

B. The uncovered amount may not be applied to the out-of-pocket expense limit.

§6405. Renewability

All basic care medical insurance policies or subscription contracts must be renewable with respect to all eligible employees or dependents at the option of the policyholder, contract holder or employer except as provided in this section.

1. Nonpayment. The policy or contract may be canceled for nonpayment of the required premiums by the policyholder, contract holder or employer.

2. Fraud or misrepresentation. The policy or contract may be canceled for fraud or misrepresentation by the policyholder, contract holder or employer. Coverage of an individual insured may be canceled for fraud or misrepresentation by the enrollee or the enrollee's representative.

3. Withdrawal from market. An insurer may cancel a basic care medical insurance policy or subscription contract if:

A. Notice of the decision to cease doing group health insurance business in this State is provided to the superintendent and to the policyholder, contract holder or employer; and

B. The basic care medical insurance policy or contract is not canceled for 6 months after the date of the notice required by paragraph A.

Any insurer that cancels a basic care medical insurance policy or subscription contract under this subsection is prohibited from writing new group health insurance policies or contracts in this State for a period of 6 years from the date of notice to the superintendent required by paragraph A.

§6406. Disclosure

1. Statement to insured. In offering coverage under a basic care medical insurance policy or subscription contract for an eligible employee, the insurer or nonprofit service plan shall provide the eligible employee with a written disclosure statement containing at least the following:

A. An explanation of those mandated benefits and providers not covered by the policy or subscription contract;

B. An explanation of the managed care and cost control feature of the policy or subscription contract, along with all appropriate mailing addresses and telephone numbers to be used by covered persons in seeking information or authorization; and

C. An explanation of the primary and preventive care features of the policy or subscription contract.

2. Statement from policyholder. Before any insurer or nonprofit service plan issues a basic care medical policy or

subscription contract, it shall obtain from the prospective policyholder a signed written statement in which the prospective policyholder:

A. Certifies that the policyholder is eligible for coverage under the contract;

B. Acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the insurance policy or subscription contract; and

C. Acknowledges that, if misrepresentations are made regarding eligibility for coverage, the person making the misrepresentations forfeits coverage provided by the basic care medical policy or subscription contract.

3. Record keeping. A copy of the written statement required by subsection 2 must be provided to the prospective policyholder before or at the time of policy delivery, and the original of that written statement must be retained in the files of the insurer or nonprofit service plan for the period of time the contract remains in effect.

4. False statement; termination. Any material statement made by an applicant for coverage under a basic care medical insurance policy or subscription contract that falsely certifies an applicant's eligibility for coverage may be the basis for termination of coverage under the policy or subscription contract.

§6407. Forms

All basic care health policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure forms, must be submitted to the superintendent for approval in the same manner as required by section 2412 or Title 24, section 2316.

STATEMENT OF FACT

This bill permits insurers and nonprofit health plans, like Blue Cross and Blue Shield, to develop a less costly managed care health plan specifically for the small employer market.

The plan permits a number of mandated benefits to be omitted from coverage. The plan is also designed to provide coverage for preventive care services to encourage covered persons to seek treatment at appropriate times before more costly acute care needs arise.

The bill requires insurers to renew basic care policies in most cases. Additionally, the bill requires significant disclosure that the plan does not provide coverage for certain providers and types of illness and that managed care features are included in the plan.