MAINE STATE LEGISLATURE

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116th MAINE LEGISLATURE

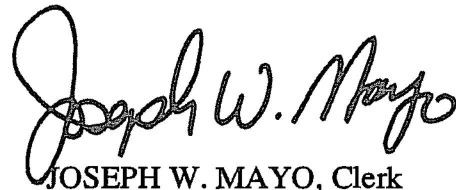
FIRST REGULAR SESSION-1993

Legislative Document **No. 504**

H.P. 391 House of Representatives, February 16, 1993

An Act to Encourage Small Businesses to Provide Health Insurance to Employees.

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



JOSEPH W. MAYO, Clerk

Presented by Representative BRUNO of Raymond.
Cosponsored by Representatives: AIKMAN of Poland, BARTH of Bethel, BENNETT of Norway, CAMERON of Rumford, CARR of Sanford, LORD of Waterboro, NORTON of Winthrop, REED of Dexter, VIGUE of Winslow, YOUNG of Limestone, ZIRNKILTON of Mount Desert, Senator: SUMMERS of Cumberland.

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

Sec. 1. 24-A MRSA c. 79 is enacted to read:

CHAPTER 79

BASIC-CARE MEDICAL INSURANCE

§6501. 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 workweek of 30 or more hours. The term includes a sole proprietor, an independent contractor or a partner of a partnership 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 99 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.

§6502. Basic-care medical insurance

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-care 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 an 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 by 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 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 40 to 49 years of age and once a year for women age 50 and over.

5. Employer choice. The policy or subscription contract may provide levels of care beyond the basic levels at the option of the employer.

§6503. 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.

§6504. Deductibles; coinsurance; maximum benefit

1. Deductible. The policy must contain a deductible of not less than $200 nor greater than $1,000 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. When out-of-pocket expenses of the insured or subscriber exceed $2,500 per individual, coverage for the remainder of that calendar year 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.

2 B. The amount not covered under this section may not be applied to the out-of-pocket expense limit under subsection 1.

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§6505. Renewability

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

12 **1. Nonpayment.** The insurer may cancel the policy or subscription contract for nonpayment of the required premiums by
14 the policyholder, contract holder or employer.

16 **2. Fraud or misrepresentation.** The insurer may cancel the policy or subscription contract for fraud or misrepresentation by
18 the policyholder, contract holder or employer. The insurer may cancel coverage of an insured individual for fraud or
20 misrepresentation by that individual or that individual's representative.

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

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

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

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

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§6506. Disclosure

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

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A. An explanation of those providers and benefits that are
50 required by law to be paid for by other policies and that are not covered by the policy or subscription contract;

B. An explanation of the managed-care and cost-control features of the policy or subscription contract, along with all appropriate mailing addresses and telephone numbers for use by insured individuals in seeking information or authorization; and

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

2. Statement from policyholder. Before issuing a basic-care medical policy or subscription contract, an insurer or nonprofit service plan 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 subscription contract remains in effect.

4. False statement; termination. A 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.

§6507. 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.

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STATEMENT OF FACT

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This bill permits insurers and nonprofit health plans, like
6 Blue Cross and Blue Shield, to develop a less costly managed-care
health plan for the small employer market, specifically employers
8 of no more than 99 employees.

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

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