116th MAINE LEGISLATURE

FIRST REGULAR SESSION-1993

Legislative Document **No. 1206**

H.P. 892 House of Representatives, April 8, 1993

An Act to Provide More Affordable Health Insurance and Community Rating for Individuals.

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

JOSEPH W. MAYO, Clerk

Presented by Representative MITCHELL of Vassalboro.
Cosponsored by Representatives: DONNELLY of Presque Isle, ERWIN of Rumford, GWADOSKY of Fairfield, JOSEPH of Waterville, LORD of Waterboro, MARSH of West Gardiner, Senator: CONLEY of Cumberland.

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

Sec. 1. 24 MRSA §2321, sub-§3, as enacted by PL 1991, c. 48, §2, is repealed.

Sec. 2. 24 MRSA §2321-A is enacted to read:

§2321-A. Rating practices in individual health insurance

Title 24-A, section 2736-C applies to nonprofit hospital corporations, nonprofit medical service corporations and nonprofit health care plans to the extent not inconsistent with this chapter.

Sec. 3. 24 MRSA §2349-A is enacted to read:

§2349-A. Continuity for group to individual transfers

1. Contracts subject to this section. This section applies to all individual contracts issued by nonprofit hospital or medical service organizations. For purposes of this section, "individual contract" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering an individual. "Individual contract" does not include the following types of insurance:

A. Accident;

B. Credit;

C. Disability;

D. Long-term care or nursing home care;

E. Medicare supplement;

F. Specified disease;

G. Dental or vision;

H. Coverage issued as a supplement to liability insurance;

I. Workers' compensation;

J. Automobile; or

K. 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. Persons provided continuity of coverage. This section provides continuity of coverage for a person who seeks coverage under an individual nonprofit hospital or medical service organization contract if:

A. That person was covered under a group contract or policy issued to an employer 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 individual contract under which the person is seeking coverage is the "succeeding contract." The group contract or policy that previously covered the person is the "prior contract or policy";

B. Coverage under the prior contract or policy terminated for any reason within 3 months before the date the person applies for enrollment in the succeeding contract; and

C. The person seeking coverage is no longer eligible for coverage under the prior contract or policy or under a replacement group contract or policy.

3. Prohibition against discontinuity. Except as provided in this section, in an individual contract subject to this section, a nonprofit hospital or medical service organization shall waive for any person described in subsection 2 any medical underwriting or preexisting condition 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.

4. 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 furnish, at the request of the issuer of the succeeding contract, a statement of the 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.

Sec. 4. 24 MRSA §2350, as enacted by PL 1989, c. 867, §1 and affected by §10, is repealed.

Sec. 5. 24-A MRSA §2736-C is enacted to read:

§2736-C. Rating standards for individual health insurance

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 or medical service organization or health maintenance organization authorized to issue individual health insurance 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 individual 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, nonprofit hospitals and medical service organizations.

B. "Community rate" means the rate to be charged for all individual health policies prior to any adjustments pursuant to subsection 2, paragraphs C and D.

C. "Individual health policy" "means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering an individual. "Individual health policy" 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; 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.

D. "Preexisting condition exclusion" has the meaning set forth in section 2848, subsection 3.

E. "Premium rate" means the rate charged to an individual for an individual health policy.

2. Rating practices. The following requirements apply to the rating practices of carriers providing individual health policies.

A. For all policies, contracts or certificates for coverage under an individual health policy executed, delivered, issued for delivery, continued or renewed in this State after the effective date of this section, a carrier shall file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent for informational purposes prior to the issuance of the policy or prior to the expiration of the effective period of the rate for an existing policy as determined in accordance with subsection 3.

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

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

D. The carrier may vary the premium rate due to age, occupation or industry and geographic area, except that the premium rates for any individual health policy may not deviate above or below the community rate filed by the carrier by more than 50%.

This subsection does not prohibit the use of premium rate structures to establish different premium rates for different family structures and for individuals under 24 years of age.

3. Duration of rates. Rates for individual health policies filed before January 1, 1994 are effective no later than January 1, 1995. Rates for individual health policies are effective for no longer than one year.

4. Guaranteed issuance and guaranteed renewal. Carriers providing individual health policies are subject to the following.

A. Except as provided in paragraph B, all carriers shall guarantee coverage to an individual and to each dependent of that individual under any individual health policy offered by the carrier in this State.

B. A carrier issuing an individual health policy may impose a preexisting condition exclusion period of up to 6 months and may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of coverage, requires ongoing medical observation or treatment.

C. A carrier shall guarantee renewal of coverage to all individual insureds except:

(1) When the policyholder or the certificate holder does not pay the required premiums;

(2) When the insured commits fraud or material misrepresentation; and

(3) When the carrier ceases providing individual health policies in compliance with subsection 5.

5. Cessation of business. Carriers that provide individual health policies after the effective date of this section and intend to cease offering individual health policies in this State are subject to the following.

A. The carrier shall provide notice of the decision to cease doing business in the individual health policy market to the bureau and to the policyholder 6 months before nonrenewal.

B. Carriers that cease to write new business in the individual health policy 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 the individual health policy 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. Loss ratios. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which rates are to be computed to provide coverage will return to policyholders at least 80% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums for that period.

7. Fair marketing standards. Carriers offering coverage under individual health policies must meet the following standards of fair marketing.

A. Each carrier shall actively market individual health policies to all individuals 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 any individual 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 any individual to seek coverage from another carrier because 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 an individual health policy to be varied because of 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. Denial by a carrier of an application for coverage from an individual must be in writing and state the reasons for the denial.

F. A violation of this section by a carrier or a representative of a carrier is an unfair trade practice under chapter 23.

8. Rule-making authority. The superintendent may adopt reasonable rules necessary to conform individual health policies and certificates to the requirements of this section, including, but not limited to:

A. Additional standards to provide for the fair marketing and broad availability of individual health policies in this State;

B. Standards for benefits, claim payments and reporting practices;

C. A uniform methodology for calculating and reporting loss ratios; and

D. Public access to policies, premiums and loss ratio information of issuers of individual health policies.

Sec. 6. 24-A MRSA §2808-B, sub-§2, ¶D, as enacted by PL 1991, c. 861, §2, is amended to read:

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 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued

or renewed in this State between July 15, 1995 and July 14, 1996, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1996 and July 14, 1997, the premium rate may not deviate above or below the community rate filed by the carrier by more than 10%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1997, the premium rate may not deviate from the community rate filed by the carrier.

~~Unless--continued--or--modified--by--law,--this--paragraph--is repealed-on-July-15,-1994.~~

Sec. 7. 24-A MRSA §2808-B, sub-§6, ¶I is enacted to read:

I. Notwithstanding any other provision of this section, a carrier may choose whether it will offer to groups having only one member coverage under the carrier's individual health policies offered to other individuals in this State in accordance with section 2736-C or coverage under a small group health plan in accordance with this section, or both, but the carrier need not offer to groups of one both small group and individual health coverage.

Sec. 6. 24-A MRSA §2849-C is enacted to read:

§2849-C. Continuity for group to individual transfers

1. Contracts subject to this section. This section applies to all individual policies issued by insurers or health maintenance organizations. For purposes of this section, "individual policy" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering an individual. "Individual policy" does not include the following types of insurance:

A. Accident;

B. Credit;

C. Disability;

D. Long-term care or nursing home care;

E. Medicare supplement;

F. Specified disease;

G. Dental or vision;

H. Coverage issued as a supplement to liability insurance;

I. Workers' compensation;

J. Automobile; or

K. 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. Persons provided continuity of coverage. This section provides continuity of coverage for a person who seeks coverage under an individual insurance or health maintenance organization policy if:

A. That person was covered under a group contract or policy issued to an employer 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, 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 individual policy under which the person is seeking coverage is the "succeeding policy." The group contract or policy that previously covered the person is the "prior contract or policy";

B. Coverage under the prior contract or policy terminated for any reason within 3 months before the date the person applies for enrollment in the succeeding policy; and

C. The person seeking coverage is no longer eligible for coverage under the prior contract or policy or under a replacement group contract or policy.

3. Prohibition against discontinuity. Except as provided in this section, in an individual policy subject to this section, an insurer or health maintenance organization shall waive for any person described in subsection 2 any medical underwriting or

preexisting condition 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 succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

4. 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 furnish, at the request of the issuer of the succeeding policy, a statement of the 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 policy. The benefit determination must be made as if coverage had not been replaced.

Sec. 7. 24-A MRSA §2850, as amended by PL 1991, c. 695, §11, is repealed.

Sec. 8. Effective date. This Act takes effect January 1, 1994.

STATEMENT OF FACT

This bill requires that insurers that offer individual health insurance use community rating in their rate-setting process. When using community rating, the insurer may not vary the premium rate due to gender, health status, claims experience or policy duration. In addition, insurers must offer coverage and guarantee renewal to all individuals and their dependents under any individual health insurance policy offered by the insurer in this State. Nonprofit medical service organizations are subject to the same requirements by operation of the Maine Revised Statutes, Title 24, section 2321-A.