MAINE STATE LEGISLATURE

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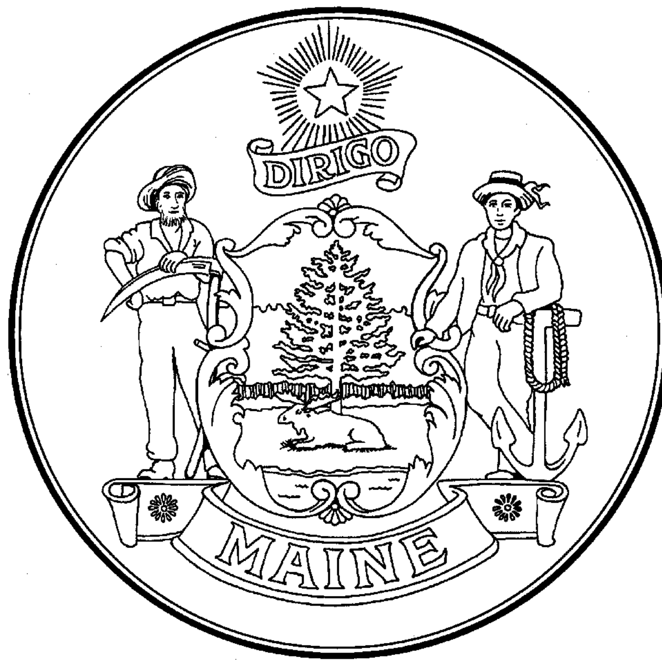

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116th MAINE LEGISLATURE

FIRST REGULAR SESSION-1993

Legislative Document **No. 1548**

S.P. 525 In Senate, June 3, 1993

An Act to Amend the Laws Regarding Health Insurance and Health Care Services.

Reported by Senator MCCORMICK of Kennebec for the Joint Standing Committee on Banking and Insurance pursuant to Joint Order S.P. 516.

JOY J. O'BRIEN
Secretary of the Senate

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

PART A

Sec. A-1. 24 MRSA §2349, sub-§§1 and 2, as enacted by PL 1989, c. 867, §1 and affected by §10, are amended to read:

1. Contracts subject to this section. This section applies to all individual and group contracts issued by nonprofit hospital or medical service organizations, except group long-term care policies as defined in Title 24-A, section 5051.

2. Persons provided continuity of coverage. Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under a an individual or group nonprofit hospital or medical service organization contract if:

A. That person was covered under an individual or group contract or policy issued by any insurer, health maintenance organization, nonprofit hospital or medical service organization, or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, the Maine High-Risk Insurance Organization, as established in Title 24-A, section 6052, 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 or group contract under which the person is seeking coverage is the "succeeding contract." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding contract. A period of ineligibility for any health plan imposed by terms of employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

Sec. A-2. 24 MRSA §2349, sub-§3, ¶A, as amended by PL 1991, c. 695. §4, is further amended to read:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment,

termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce; ~~or~~

Sec. A-3. 24 MRSA §2349, sub-§3, ¶B, as enacted by PL 1989, c. 867, §1 and affected by §10, is amended to read:

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order~~.~~; or

Sec. A-4. 24 MRSA §2349, sub-§3, ¶C is enacted to read:

C. That person was covered by the Maine High-Risk Insurance Organization on December 1, 1993 and the request for replacement coverage is made while coverage is in effect or within 30 days of the termination of coverage.

Sec. A-5. 24 MRSA §2349, sub-§4, as enacted by PL 1989, c. 867, §1 and affected by §10, is amended to read:

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

Sec. A-6. 24 MRSA §2349, sub-§7 is enacted to read:

7. Reinsurance, excess insurance or administrative services. A nonprofit hospital or medical service organization may only offer, issue or renew reinsurance or excess insurance coverage or offer administrative services to an uninsured employee benefit plan that provides payment for health services received by employees and their dependents when that plan for the payment of health services and reinsurance and excess insurance coverage meets the requirements of continuity of coverage in this chapter.

Sec. A-7. 24 MRSA §2350, sub-§2, as enacted by PL 1989, c. 867, §1 and affected by §10, is amended to read:

2. Limitation. An individual or group contract between a subscriber and a nonprofit hospital or medical service organization may not impose a preexisting condition exclusion period of more than ~~6~~ 12 months~~, except that the contract may~~

~~exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation or treatment~~. The exclusion may only relate to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage, or to a pregnancy existing on the effective date of coverage. A routine preventive screening or test yielding only negative results may not be deemed to be diagnosis, care or treatment for the purposes of this subsection.

Sec. A-8. 24-A MRSA §2849-B, sub-§1, as amended by PL 1991, c. 695, §9, is further amended to read:

1. Policies subject to this section. This section applies to all individual and group medical insurance policies except hospital indemnity, specified accident, specified disease, long-term care and Medicare supplement policies issued by insurers or health maintenance organizations.

Sec. A-9. 24-A MRSA §2849-B, sub-§2, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

2. Persons provided continuity of coverage. Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under an individual or a group insurance policy or health maintenance organization policy if:

A. That person was covered under an individual or group contract or policy issued by any nonprofit hospital or medical service organization, insurer, health maintenance organization, or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, the Maine High-Risk Insurance Organization, as established in section 6052 or 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 or group policy under which the person is seeking coverage is the "succeeding policy." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding policy. A period of ineligibility for any health plan imposed by terms of

employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

Sec. A-10. 24-A MRSA §2849-B, sub-§3, ¶A, as amended by PL 1991, c. 695, §10, is further amended to read:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract or policy because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce; ~~or~~

Sec. A-11. 24-A MRSA §2849-B, sub-§3, ¶B, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order~~.~~; or

Sec. A-12. 24-A MRSA §2849-B, sub-§3, ¶C is enacted to read:

C. That person was covered by the Maine High-Risk Insurance Organization on December 1, 1993 and the request for replacement coverage is made while coverage is in effect or within 30 days of the termination of coverage.

Sec. A-13. 24-A MRSA §2849-B, sub-§4, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

4. Prohibition against discontinuity. Except as provided in this section, in an individual or a group policy subject to this section, ~~an~~ the insurer or health maintenance organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

Sec. A-14. 24-A MRSA §2849-B, sub-§7 is enacted to read:

7. Reinsurance, excess insurance or administrative services. An insurer may only offer, issue or renew reinsurance or excess insurance coverage or offer administrative services to an uninsured employee benefit plan that provides payment for health services received by employees and their dependents when

that plan for the payment of health services and reinsurance and excess insurance coverage meets the requirements of continuity of coverage in this chapter.

Sec. A-15. 24-A MRSA §2850, sub-§2, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

2. Limitation. An individual ~~policy~~ or group contract issued by an insurer may not impose a preexisting condition exclusion waiting period of more than ~~6~~ 12 months~~, except that the policy may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation or treatment~~. The exclusion may only relate to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage, or to a pregnancy existing on the effective date of coverage. A routine preventive screening or test yielding only negative results may not be deemed to be diagnosis, care or treatment for the purposes of this subsection.

PART B

Sec. B-1. 5 MRSA §12004-G, sub-§21, as enacted by PL 1987, c. 786, §5, is repealed.

Sec. B-1. 24-A MRSA c. 71, as amended, is repealed.

Sec. B-2. Effective date and transition provisions. Section 1 of this Part takes effect on January 1, 1996, except that no new policies of insurance may be issued providing coverage by the Maine High-Risk Insurance Organization on or after December 1, 1993. Coverage under all policies issued by the Maine High-Risk Insurance Organization terminate on January 1, 1994. Any funds remaining on January 1, 1996 must be utilized to fund the Maine Health Program or for funding for another program that provides health care for the State's citizens.

Sec. B-3. Duties of the board of directors. The Board of Directors of the Maine High-Risk Insurance Organization shall perform the following duties:

1. Notify all enrollees of the organization of the termination of coverage on January 1, 1994 and of the changes in the Maine Revised Statutes, Titles 24 and 24-A that enable them to obtain coverage from insurers, self-insured employers, health maintenance organizations and nonprofit hospital and medical service organizations;

2. Notify all enrollees of the organization of the steps necessary to take to obtain coverage after termination of the organization and of the telephone number of the Bureau of Insurance for assistance with application and acceptance problems;

3. Report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters on or before March 1, 1994 and again on January 1, 1995 regarding the transition of enrollees in the Maine High-Risk Insurance Organization into coverage provided by insurers, self-insured employers, health maintenance organizations and nonprofit hospital and medical service organizations; and

4. Report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters on or before March 1, 1994 and again on January 1, 1995 regarding the reserves and financial condition of the organization.

PART C

Sec. C-1. 24-A MRSA §2808-B, sub-§2, ¶¶B, C and D, as enacted by PL 1991, c. 861, §2, are amended to read:

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

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

D. A carrier may vary the premium rate due to age, ~~gender,~~ smoking status, 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. C-2. 24-A MRSA §2808-B, sub-§3, as enacted by PL 1991, c. 861, §2, is amended to read:

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~~ 12 months or provide coverage subject to ~~an 18-month~~ a 12-month preexisting conditions exclusion. The exclusion may only relate to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage, or to a pregnancy existing on the effective date of coverage. A routine preventive screening or test yielding only negative results may not be deemed to be diagnosis, care or treatment for the purposes of this subsection.

Sec. C-3. 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.

PART D

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Sec. D-1. 24-A MRSA §2736-C is enacted to read:

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§2736-C. Individual health plans

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

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A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue individual 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 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 and nonprofit hospital and medical service organizations.

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

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C. "Individual health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. "Individual health plan" does not include the following types of insurance:

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(1) Accident;

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(2) Credit;

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(3) Disability;

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

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(5) Medicare supplement;

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(6) Specified disease;

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(7) Dental or vision;

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

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(9) Workers' compensation;

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(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.

D. "Premium rate" means the rate charged to an individual for an individual health plan.

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

A. A carrier issuing an individual 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 with the superintendent for informational purposes prior to issuance of any individual health plan.

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

C. A carrier may vary the premium rate due to family membership.

D. A carrier may vary the premium rate due to age, smoking status, 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 December 1, 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.

3. Guaranteed issuance and guaranteed renewal. Carriers providing individual health plans must meet the following requirements on issuance and renewal.

A. Coverage must be guaranteed to all individuals.

B. Renewal must be guaranteed to all individuals except:

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

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

(3) For fraud or material misrepresentation on the part of the individual or the individual's representative; and

(4) When the carrier ceases providing individual health plans in compliance with subsection 4.

C. A carrier is exempt from the guaranteed issuance requirements of paragraph A provided that the following requirements are met.

(1) The carrier does not issue or deliver any new individual health plans on or after the effective date of this section;

(2) If any individual health plans that were not issued on a guaranteed renewable basis are renewed on or after December 1, 1993, all such policies must be renewed by the carrier and renewal must be guaranteed after the first such renewal date; and

(3) The carrier complies with the rating practices requirements of subsection 2.

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

A. Notice of the decision to cease doing business in the individual health plan 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 the individual health plan market continue to be governed by this section.

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

5. Loss ratios. For all policies issued on or after the effective date of this section, 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 coverage is to be provided will return to policyholders at least 65% 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.

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

A. Each carrier must actively market individual health plan coverage to 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 individuals to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; or

(2) Encouraging or directing individuals 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 an individual 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. Denial by a carrier of an application for coverage from an individual must be in writing and must state the reason or reasons for the denial.

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

G. 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 individual 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 December 1, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

PART E

Sec. E-1. 5 MRSA §1543, first ¶, as repealed and replaced by PL 1979, c. 312, §3, is amended to read:

~~No money shall~~ Money may not be drawn from the State Treasury, except in accordance with appropriations duly authorized by law. Every disbursement from the State Treasury ~~shall~~ must be upon the authorization of the State Controller and the Treasurer of State, as evidenced by their facsimile signatures, except that the Treasurer of State may authorize interbank and intrabank transfers for purposes of pooled

investments. Disbursements ~~shall~~ must be in the form of a check or an electronic transfer of funds against a designated bank or trust company acting as a depository of the State Government.

Sec. E-2. 22 MRSA §304-A, sub-§2, as amended by PL 1989, c. 919, §4 and affected by §18, is repealed and the following enacted in its place:

2. Acquisitions of certain major medical equipment. Acquisitions of major medical equipment with a cost of $1,000,000 or more. There is a waiver for the use of major medical equipment on a temporary basis as provided in section 308, subsection 4;

Sec. E-3. 22 MRSA §304-A, sub-§2-A is enacted to read:

2-A. Acquisitions of major medical equipment with a cost in the aggregate of $1,000,000 or more. Acquisitions of major medical equipment with a cost in the aggregate of $1,000,000 or more by ambulatory surgical centers, independent cardiac catheterization centers, independent radiologic service centers and centers providing endoscopy, sigmoidoscopy, colonoscopy or other similar procedures associated with gastroenterology;

Sec. E-4. 22 MRSA §309, sub-§1, ¶D, as amended by PL 1985, c. 418, §13, is further amended to read:

D. That the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State, that the citizens of the State have the ability to underwrite the additional costs of the proposed services and that the proposed services are in accordance with standards, criteria or plans adopted and approved pursuant to the state health plan developed by the department and the findings of the Maine Health Care Finance Commission under section 396-J with respect to the ability of the citizens of the State to pay for the proposed services.

Sec. E-5. 24 MRSA §2332-E is enacted to read:

§2332-E. Standardized claim forms

On or after December 1, 1993, all nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the

current standardized claim form approved by the Federal Government.

Sec. E-6. 24 MRSA §2979 is enacted to read:

§2979. Expanded practice parameters; expanded risk management protocols

The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration may develop practice parameters and risk management protocols in the medical specialty areas not listed in section 2972. The practice parameters must define appropriate clinical indications and methods of treatment within that specialty as determined by the Board of Registration in Medicine and the Board of Osteopathic Examination and Registration. The risk management protocols must establish standards of practice designed to avoid malpractice claims and increase the defensibility of malpractice claims that are pursued. The parameters and protocols must be consistent with appropriate standards of care and levels of quality as determined by the Board of Registration in Medicine and the Board of Osteopathic Examination and Registration. The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration shall review the parameters and protocols, approve the parameters and protocols appropriate for each medical specialty area and adopt rules in accordance with the Maine Administrative Procedure Act.

All practice parameters and risk management protocols adopted pursuant to this section are subject to the provisions of the medical liability demonstration project established in chapter 21, subchapter IX.

Sec. E-7. 24 MRSA c. 21, sub-c. X is enacted to read:

SUBCHAPTER X

BILLING FOR HEALTH CARE

§2985. Billing for health care

On or after December 1, 1993, all licensed physicians who bill for health care services must use the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all licensed hospitals must use the current standardized claim form approved by the Federal Government.

Sec. E-8. 24-A MRSA §1912 is enacted to read:

§1912. Standardized claim forms

On or after December 1, 1993, all administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. E-9. 24-A MRSA §2680 is enacted to read:

§2680. Standardized claim forms

On or after December 1, 1993, administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. E-10. 24-A MRSA §2753 is enacted to read:

§2753. Standardized claim forms

On or after December 1, 1993, insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. E-11. 24-A MRSA §2823-B is enacted to read:

§2823-B. Standardized claim forms

On or after December 1, 1993, all insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all insurers providing group medical expense insurance on an expense-incurred basis

providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

Sec. E-12. 24-A MRSA §4235 is enacted to read:

§4235. Standardized claim forms

On or after December 1, 1993, all health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician must accept the current standardized claim form approved by the Federal Government. On or after December 1, 1993, all health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form approved by the Federal Government.

PART F

Sec. F-1. Report on unification of administration of all publicly funded and publicly administered health insurance programs. The Department of Human Services is directed to report to the Joint Standing Committee on Banking and Insurance on or before January 1, 1994 on options for the unification of administration of all publicly funded and publicly administered health insurance programs.

Sec. F-2. Report on single point of entry and eligibility determinations. The Department of Human Services is directed to report to the Joint Standing Committee on Banking and Insurance on or before January 1, 1994 on single point of entry and eligibility determinations utilizing the FAMIS computer system.

PART G

Sec. G-1. Effective date. This Act takes effect December 1, 1993.

Sec. G-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	1993-94	1994-95
MAINE HIGH-RISK INSURANCE ORGANIZATION		
Maine High-Risk Insurance Organization		

All Other	($3,264,000)	($4,344,000)

Provides for the deappropriation of funds due to the elimination of the Maine High-Risk Insurance Organization.

MAINE HIGH-RISK INSURANCE ORGANIZATION TOTAL	($3,264,000)	($4,344,000)

FISCAL NOTE

	1993-94	1994-95
APPROPRIATIONS/ALLOCATIONS		
General Fund	($3,264,000)	($4,344,000)

This bill eliminates the Maine High-Risk Insurance Organization effective January 1, 1996 and requires that coverage under all policies terminates on January 1, 1994. The Governor's proposed current services budget also eliminates this program, resulting in General Fund savings of $3,264,000 in fiscal year 1993-94 and $4,344,000 in fiscal year 1994-95. If the reserves are insufficient to meet the program costs, additional General Fund appropriations will be required. If the reserves are more than sufficient, any balance remaining on January 1, 1996 will be transferred to the Maine Health Program, which is also eliminated in the Governor's proposed current services budget, or another health care program, resulting in a loss of General Fund revenue. The amounts can not be determined. This estimate of fiscal impact may need to be adjusted based on final legislative actions on the current services budget.

The Bureau of Insurance will incur some minor additional costs to adopt certain rules relating to the provision of health insurance. These costs can be absorbed within the bureau's existing budgeted resources.

The changes made to certain provisions of the community rating law and the continuity law will not significantly affect General Fund revenues collected from insurance premium taxes.

The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration will incur some minor additional costs to develop expanded practice parameters and expanded risk management protocols. These costs can be absorbed within the boards' existing budgeted resources.

The Department of Human Services will incur some minor additional costs to prepare and submit the 2 required reports to the Legislature and to include nonhospital facilities using major medical equipment in the certificate of need review process. These costs can be absorbed within the Department of Human Services' existing budgeted resources.

STATEMENT OF FACT

In Part A the bill does the following.

1. It applies continuity of coverage protection to replacement coverage under individual policies and extends the prior policies receiving continuity protection to employer-affiliated and association-affiliated health plans.

2. It includes as late enrollees for continuity of coverage protection persons who were covered through the Maine High-Risk Insurance Organization.

3. It requires insurers and nonprofit hospital and medical service organizations that provide reinsurance, excess insurance and administrative services to employer-affiliated and association-affiliated health plans to require that the plans, reinsurance and excess insurance comply with the continuity law.

4. It changes the preexisting condition exclusion period to a period of 12 months and prohibits exclusions based on a routine preventive screening or test yielding only negative results.

In Part B the bill does the following.

1. It repeals the provisions on the Maine High-Risk Insurance Organization.

2. It allows the Maine High-Risk Insurance Organization to continue to provide coverage through January 1, 1994 and to pay claims through January 1, 1996. The bill requires that any funds remaining at the end of the program be paid to the Maine Health Program or other health program.

3. It requires the Board of Directors of the Maine High-Risk Insurance Organization to notify enrollees of the termination of

coverage under the program and of the availability of coverage elsewhere. It requires reports to the Joint Standing Committee on Banking and Insurance on March 1, 1994 and on January 1, 1994 regarding the transition of enrollees into other coverage and on the reserves and financial condition of the organization.

In Part C the bill does the following.

1. It forbids rating based on gender in the small group market and changes smoking status from an allowed rating factor without limitation to a rating factor within the scheduled rating bands.

2. It changes the preexisting condition exclusion period in the small group market to a waiting period of 12 months and prohibits exclusions based on a routine preventive screening or test yielding only negative results.

In Part D the bill does the following.

1. It applies the scheduled community rating from the Maine Revised Statutes, Title 24-A, section 2808-B for small groups to the individual health insurance market and prohibits rating based on gender. It allows rating based on smoking status within the scheduled rating bands. It provides for guaranteed issue and renewal of individual policies. It exempts insurers who do not write new policies from the guaranteed issue provisions for renewals of policies in force if the insurer complies with community rating. It requires minimum loss ratio standards for policies issued on or after January 1, 1994. It contains fair marketing standards.

In Part E the bill does the following.

1. It allows the payment of money by the State by electronic transfer.

2. It extends the certificate of need provisions of Title 22, chapter 103 to purchases by physicians of major medical equipment of $1,000,000 or more and to purchases by listed independent medical centers of major medical equipment with a cost in the aggregate of $1,000,000 or more. It requires consideration in the certificate of need process of the ability of the citizens of the State to underwrite the costs of equipment and the findings of the Maine Health Care Finance Commission on the ability to pay.

3. It requires insurers, physicians and hospitals to use standard forms that meet federal requirements.

4. It allows for voluntary expansion of medical specialty practice parameters and risk management protocols.

In Part F the bill does the following.

1. It requires a report from the Department of Human Services on unified administration of publicly funded and publicly administered health programs.

2. It requires a report from the Department of Human Services on single point of entry and eligibility determinations utilizing the FAMIS computer system.

In Part G the bill does the following.

1. It establishes an effective date of December 1, 1993.

2. It includes an appropriation section.