116th MAINE LEGISLATURE

SECOND REGULAR SESSION-1994

Legislative Document **No. 1980**

H.P. 1451 House of Representatives, March 15, 1994

An Act to Make Maine Law Consistent with the Federal Law Regarding the Omnibus Budget Reconciliation Act of 1993 and to Clarify Maine Laws Regarding Underwriting and Continuity.

Received by the Clerk of the House on March 11, 1994. Referred to the Committee on Banking and Insurance and 1200 ordered printed pursuant to Joint Rule 14.

Joseph W. Mayo

JOSEPH W. MAYO, Clerk

Presented by Representative CARLETON of Wells. (GOVERNOR'S BILL)

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

PART A

Sec. A-1. 24 MRSA §2318, sub-§1, as enacted by PL 1991, c. 200, Pt. B, §1, is repealed and the following enacted in its place:

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the subscriber, member or spouse of the subscriber or member.

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption.

Sec. A-2. 24 MRSA §2318, sub-§5 is enacted to read:

5. Adopted children. All individual or group contracts issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the subscriber or spouse of the subscriber under the same terms and conditions as apply to natural dependent children or stepchildren of the subscriber or spouse of the subscriber, irrespective of whether the adoption has become final.

Sec. A-3. 24-A MRSA §2742, sub-§1, as enacted by PL 1991, c. 200, Pt. B, §3, is repealed and the following enacted in its place:

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with the policyholder, member or spouse of the policyholder or member.

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption.

Sec. A-4. 24-A MRSA §2742, sub-§4 is enacted to read:

4. Adopted children. All individual policies issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the policyholder or spouse of the policyholder under the same terms and conditions as apply to natural dependent children or stepchildren of the policyholder or spouse of the policyholder, irrespective of whether the adoption has become final.

Sec. A-5. 24-A MRSA §2833, sub-§1, as enacted by PL 1991, c. 200, Pt. B, §4, is repealed and the following enacted in its place:

1. Definitions. For the purposes of the section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the certificate holder, member or spouse of the certificate holder or member.

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption.

Sec. A-6. 24-A MRSA §2833, sub-§4 is enacted to read:

4. Adopted children. All group or blanket health insurance policies and certificates issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the certificate holder or spouse of the certificate holder under the same terms and conditions as apply to natural dependent children or stepchildren of the certificate holder, irrespective of whether the adoption has become final.

Sec. A-7. 24-A MRSA §4234, sub-§1, as enacted by PL 1991, c. 200, Pt. B, §5, is repealed and the following enacted in its place:

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted

children of, or children placed for adoption with, the enrollee, member or spouse of the enrollee or member.

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption.

Sec. A-8. 24-A MRSA §4234, sub-§4 is enacted to read:

4. Adopted children. All individual or group contracts issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the enrollee or spouse of the enrollee under the same terms and conditions as apply to natural dependent children or stepchildren of the enrollee or spouse of the enrollee, irrespective of whether the adoption has become final.

PART B

Sec. B-1. 24 MRSA §2332-A, as amended by PL 1991, c. 200, Pt. B, §2, is repealed and the following enacted in its place:

§2332-A. Coordination of benefits

1. Authorization. Provisions contained in group and nongroup nonprofit hospital, medical service or health care subscriber contracts relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which the subscriber or the subscriber's dependents may be covered must conform to rules adopted by the superintendent. The rules may establish uniformity in the permissive use of coordination of benefits provisions to ensure that the subscriber receives full benefits for covered medical services, to enhance cost containment through avoidance of windfall payments and to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among the several insurers and nonprofit hospital, medical service and health care plans.

2. Medicaid. Nonprofit service organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," when considering coverage eligibility or benefit calculations for subscribers and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program for health care items or services furnished to an individual, the State is

considered to have acquired the rights of the covered subscriber or family member to payment by the nonprofit service organization for those health care items or services. Upon presentation of proof that the Medicaid program has paid for covered items or services, the nonprofit service organization shall make payment to the Medicaid program according to the coverage provided in the contract or certificate.

B. A nonprofit service organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual.

Sec. B-2. 24-A MRSA §2844, as enacted by PL 1985, c. 526, §2, is repealed and the following enacted in its place:

1. Authorization. Provisions contained in group health insurance contracts relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which a certificate holder or the certificate holder's dependents may be covered must conform to rules adopted by the superintendent. These rules may establish uniformity in the permissive use of coordination of benefits provisions in order to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among the several insurers and nonprofit hospital, medical service and health care plans.

2. Medicaid. Insurers may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," when considering coverage eligibility or benefit calculations for insureds and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the insured or family member to payment by the nonprofit service organization for those health care items or services. Upon presentation of proof that the Medicaid program has paid for covered items or services, the nonprofit service organization shall make payment to the Medicaid program according to the coverage provided in the contract or certificate.

B. An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid and covered by a subscriber contract that are

different from requirements applicable to an agent or assignee of any other covered individual.

Sec. B-3. 24-A MRSA §4234, sub-§5 is enacted to read:

5. Medicaid. Health maintenance organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," when considering coverage eligibility or benefit calculations for enrollees and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the enrollee or family member to payment by the health maintenance organization for those health care items or services. Upon presentation of proof that the Medicaid program has paid for covered items or services, the health maintenance organization shall make payment to the Medicaid program according to the coverage provided in the contract or certificate.

B. A health maintenance organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid and covered by an enrollee contract that are different from requirements applicable to an agent or assignee of any other covered individual.

PART C

Sec. C-1. 24-A MRSA §731-B, sub-§1, ¶C, as amended by PL 1993, c. 313, §17, is further amended by amending subparagraph (4) to read:

(4) In the case of a group ~~of individuals that constitutes a syndicate of~~ including incorporated and individual unincorporated ~~alien~~ underwriters, the trust must consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of at least $100,000,000, which must be held jointly for the benefit of United States ceding insurers of any member of the group. An incorporated member of the group may not be engaged in any business other than underwriting as a member of the group and is subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. The group shall make available to the superintendent an annual certification by the

group's domiciliary regulator and the independent public accountants of the solvency of each underwriter.

PART D

Sec. D-1. 24 MRSA §2347, sub-§1, as amended by PL 1991, c. 695, §2, is further amended to read:

1. Contracts subject to this section. Notwithstanding any other provision of law, this section applies to all group contracts, except group long-term care policies as defined in Title 24-A, section 5051, issued by nonprofit hospital or medical service organizations to contract holders who are obtaining coverage for a group or subgroup to replace coverage under a different contract or policy issued by any insurer, health maintenance organization or nonprofit hospital or medical service organization, or an insured employee benefit plan that provides payment for health services received by employees or their dependents. For purposes of this section, the group contract issued to replace the prior contract or policy is the "replacement contract." The group contract or policy being replaced is the "replaced contract or policy."

Sec. D-2. 24 MRSA §2349, sub-§2, as amended by PL 1993, c. 477, Pt. A, §1 and affected by Pt. F, §1, is further amended to read:

2. Persons provided continuity of coverage. Except as provided in subsection 3 and for those persons covered under group contracts that are replaced within the scope of section 2347, this section provides continuity of coverage for a person who seeks coverage under 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. D-3. 24-A MRSA §2849, sub-§1, as repealed and replaced by PL 1993, c. 349, §53, is amended to read:

1. Policies subject to this section. Notwithstanding any other provision of law, this section applies to all group medical insurance policies issued by insurers or health maintenance organizations to policyholders who are obtaining coverage for a group or subgroup to replace coverage under a different contract or policy issued by any nonprofit hospital or medical service organization, insurer or health maintenance organization, or under an uninsured employee benefit plan that provides payment for health services received by employees or their dependents. For purposes of this section, the group policy issued to replace the prior contract or policy is the "replacement policy." The group contract or policy or uninsured employee benefit plan being replaced is the "replaced contract or policy."

Sec. D-4. 24-A MRSA §2849-B, sub-§2, as amended by PL 1993, c. 477, Pt. A, §9 and affected by Pt. F, §1, is further 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. ; and

C. This section does not apply to replacements of group coverage within the scope of section 2849.

STATEMENT OF FACT

This bill does the following.

Part A contains clarification of the standards for coverage of adoptive children required by the Omnibus Budget Reconciliation Act of 1993. Under federal law, the penalty for failure to adopt is reduction in medicare funds.

Part B contains clarification that Medicaid eligibility may not be considered when calculating benefits and is also required by the Omnibus Budget Reconciliation Act of 1993.

Part C provides a reference in Maine law that reflects the decision to admit corporations as underwriters at Lloyd's of London. Maine law previously recognized only individuals as underwriters.

Part D amends the Maine Revised Statutes, Title 24, section 2347 and Title 24-A, section 2849 to provide continuity of coverage to group members whose group coverage under an employer self-funded plan is being replaced by a new group policy. This change to group-to-group transfers of coverage is consistent with Public Law 1993, chapter 477. Part D also clarifies that section 2849-B does not apply to group-to-group transfers that are covered under section 2849.

This document has not yet been reviewed to determine the need for cross-reference, stylistic and other technical amendments to conform existing law to current drafting standards.