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Legislative Document **No. 1405**

H.P. 994 House of Representatives, April 21, 1995

An Act to Amend the Laws Concerning Health Insurance.

Submitted by the Department of Professional and Financial Regulation pursuant to Joint Rule 24.

Received by the Clerk of the House on April 19, 1995. Referred to the Committee on Banking and Insurance and ordered printed pursuant to Joint Rule 14.

JOSEPH W. MAYO, Clerk

Presented by Representative MITCHELL of Vassalboro.
Cosponsored by Senator: McCORMICK of Kennebec.

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

PART A

Sec. A-1. 24 MRSA §2330, sub-§1, as amended by PL 1991, c. 822, §1 and affected by §6, is further amended to read:

1. Conversion provision required. A group hospital, medical or health care service contract issued for delivery in this State prior to January 1, 1996, by a nonprofit hospital, medical or health service organization, other than a contract that provides benefits for specific diseases or accidental injuries only, must contain a provision that if the health coverage on an employee or member ceases because of termination of employment or termination of the contract or any portion ~~thereof~~ of the contract, and the person has been continuously insured for a period of at least 3 months under the group contract or under the group contract and any prior group contract or policy providing similar benefits that it replaces, that person is entitled to have issued to that person by the nonprofit service corporation, without evidence of insurability, a nongroup health care contract or, at the option of the nonprofit service corporation, a group certificate, ~~provided~~ if that application is made and the first subscription charge paid to the nonprofit service corporation within 90 days after that termination. At the option of the employee or member, the converted contract may cover the employee or member, the employee or member and the dependents of the employee or member or the dependents of the employee or member; ~~provided that~~ if, in the latter 2 cases, the dependents had been covered for a period of at least 3 months under the group contract, unless the dependent persons were not eligible for coverage until after the beginning of the 3-month period. The nonprofit service corporation has the option to provide the required coverage upon conversion through either a group or nongroup health care contract, and may issue a separate converted contract to cover any dependent. A nonprofit service corporation may not be required to provide a conversion privilege if termination of coverage under the group contract occurred because the employee or member failed to pay any required contribution or if any discontinued group coverage is replaced by continuous and substantially similar group coverage within 31 days.

Sec. A-2. 24 MRSA §2330, sub-§1-A, as enacted by PL 1991, c. 822, §2, is amended to read:

1-A. Notification of cancellation. A nonprofit hospital, medical or health service organization must provide by first class mail notification of cancellation for nonpayment of subscription charges according to this section. The notice must

include the date of cancellation of coverage and, if applicable, the time period for exercising contract conversion rights. Notification is not required when the nonprofit hospital, medical or service organization has received written notice from the group contract holder or subgroup sponsor that replacement coverage has been obtained.

A. Notice must be mailed to the group contract holder or subgroup sponsor;

B. At the time of notification under paragraph A, notice must be mailed to the certificate holder at:

(1) The last address provided by the subgroup sponsor or the group contract holder to the nonprofit hospital, medical or health service organization; or

(2) The office of the subgroup sponsor, if any, or the group contract holder; and

C. Notice must be mailed to the Bureau of Insurance ~~and to the Bureau of Labor Standards~~.

Sec. A-3. 24 MRSA §2330, sub-§2, as enacted by PL 1981, c. 606, §1, is amended to read:

2. Other circumstances where conversion provision required. ~~The~~ If a conversion privilege ~~shall~~ is applicable pursuant to subsection 1, it must also be available:

A. Upon the death of an employee or member, to the surviving spouse with respect to the spouse and the children whose coverage terminates by reason of that death, or if there is no surviving spouse to each surviving child whose coverage so terminates. If the group contract provides for continuation of dependents' coverage upon the death of the employee or member, the conversion privilege ~~shall~~ must be made available at the end of that continuation;

B. To the spouse of a member or employee upon termination of coverage by reason of ceasing to be a qualified family member under the group policy whether by divorce or otherwise, whether or not the employee or member remains covered, with respect to the spouse and the children whose coverage terminates at the same time;

C. To a child upon termination of coverage by reason of ceasing to be a qualified family member under the group contract if a conversion privilege is not otherwise provided with respect to ~~him~~ that child in this subsection; or

D. To an employee or member whose coverage would otherwise continue under the group contract upon retirement prior to eligibility for coverage under Medicare, "United States Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Public Law 89-97, as amended, at the option of that employee or member in lieu of continued coverage under the group contract.

Sec. A-4. 24 MRSA §2330, sub-3-A is enacted to read:

3-A. Contracts issued or renewed on or after January 1, 1996. A nonprofit service corporation that offers individual health plans pursuant to Title 24-A, section 2736-C is permitted, but not required, to include a conversion privilege in group contracts issued or renewed on or after January 1, 1996. If the corporation does include a conversion privilege in these contracts, individuals exercising these rights must be offered a choice of any individual health plan offered by the corporation. A nonprofit service corporation that does not offer individual health plans pursuant to Title 24-A, section 2736-C may not include a conversion privilege in group contracts issued or renewed on or after January 1, 1996.

Sec. A-5. 24 MRSA §2330, sub-§4, ¶¶A and B, as enacted by PL 1991, c. 668, §1, are amended to read:

A. Conversion is provided through a form that is also issued to ~~individually-underwritten-standard-risks~~ members of the general public applying for an individual health plan pursuant to Title 24-A, section 2736-C;

B. The rates for that form ~~are--based--on--individually underwritten-standard-risks~~ comply with Title 24-A, section 2736-C; and

Sec. A-6. 24 MRSA §2330, sub-§§7 and 9, as enacted by PL 1981, c. 606, §1, are amended to read:

7. Notice. Notice of the conversion privilege ~~shall~~, if one is applicable, must be included in each certificate of coverage.

9. Refusal to renew. A contract issued pursuant to the conversion privilege provided by this section may provide that the nonprofit service corporation may refuse to renew the contract or coverage of any person covered ~~thereunder--for--the following-reasons-only:~~ only as permitted by Title 24-A, section 2736-C.

~~A.--Fraud-or-material-misrepresentation-in-applying-for-any benefits-under-the-converted-contract;-or~~

~~B.--Any-reason-for-which-the-nonprofit-service-corporation may-refuse-to-issue-a-converted-contract-under-subsection-3.~~

Sec. A-7. 24 MRSA §2330, sub-§10, as amended by PL 1991, c. 885, Pt. E, §21 and affected by §47, is repealed.

Sec. A-8. 24-A MRSA §2809-A, sub-§1, as amended by PL 1991, c. 822, §3 and affected by §6, is further amended to read:

1. A group policy issued prior to January 1, 1996, that provides hospital, surgical or major medical expense insurance or any combination thereof, other than a policy that provides benefits for specific diseases or accidental injuries only, must contain a provision that if the insurance on an employee or member ceases because of termination of employment or termination of the policy or any portion ~~thereof~~ of a policy, and the person has been continuously insured for a period of at least 3 months under the group policy or under the group policy and any prior group policy or contract providing similar benefits that it replaces, that person is entitled to have issued to that person by the insurer, without evidence of insurability, an individual policy or, at the insurer's option, a group certificate of health insurance, provided that application is made and the first premium paid to the insurer within 90 days after that termination. At the option of the employee or member, the converted policy may cover the employee or member, the employee or member and the employee or member's dependents or the dependents of the employee or member~~;-provided-that~~ if, in the latter 2 cases, the dependents have been covered for a period of at least 3 months under the group policy, unless the dependent persons were not eligible for coverage until after the beginning of the 3-month period. The insurer has the option to provide the required coverage upon conversion through either a group or individual policy, and may issue a separate converted policy to cover any dependent. An insurer is not required to provide a conversion privilege if termination of insurance under the group policy occurred because the employee or member failed to pay any required contribution or if any discontinued group coverage is replaced by continuous and substantially similar group coverage within 31 days.

Sec. A-9. 24-A MRSA §2809-A, sub-§1-A, as enacted by PL 1991, c. 822, §4, is amended to read:

1-A. Notification of cancellation. An insurer must provide by first class mail notification of cancellation for nonpayment of premium for hospital, surgical or major medical expense

insurance according to this section. The notice must include the date of cancellation of coverage and, if applicable, the time period for exercising policy conversion rights. Notification is not required when the insurer has received written notice from the group policyholder that replacement coverage has been obtained.

A. Notice must be mailed to the group policyholder or subgroup sponsor.

B. At the time of notification under paragraph A, notice must be mailed to the certificate holder at:

(1) The last address provided by the subgroup sponsor or the group policyholder to the insurer; or

(2) The office of the subgroup sponsor, if any, or the group policyholder.

C. Notice must be mailed to the Bureau of Insurance ~~and to the Bureau of Labor Standards~~.

Sec. A-10. 24-A MRSA §2809-A, sub-§2, as enacted by PL 1981, c. 606, §2, is amended to read:

2. ~~The~~ If a conversion privilege ~~shall~~ is applicable pursuant to subsection 1, it must also be available:

A. Upon the death of an employee or member, to the surviving spouse with respect to the spouse and the children whose coverage terminates by reason of that death, or if there is no surviving spouse to each surviving child whose coverage so terminates. If the group policy provides for continuation of dependents' coverage upon the death of the employee or member, the conversion privilege ~~shall~~ must be made available at the end of that continuation;

B. To the spouse of a member or employee upon termination of coverage by reason of ceasing to be a qualified family member under the group policy whether by divorce or otherwise, whether or not the employee or member remains insured, with respect to the spouse and the children whose coverage terminates at the same time;

C. To a child upon termination of coverage by reason of ceasing to be a qualified family member under the group policy if a conversion privilege is not otherwise provided with respect to ~~him~~ that child in this subsection; or

D. To an employee or member whose coverage would otherwise continue under the group policy upon retirement prior to eligibility for coverage under Medicare,"United States Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Public Law 89-97, as amended, at the option of that employee or member in lieu of continued coverage under the group policy.

Sec. A-11. 24-A MRSA §2809-A, sub-§3-A is enacted to read:

3. Policies issued or renewed on or after January 1, 1996. An insurer that offers individual health plans pursuant to section 2736-C is permitted, but not required, to include a conversion privilege in group policies issued or renewed on or after January 1, 1996. If the insurer does include a conversion privilege in those policies, individuals exercising these rights must be offered a choice of any individual health plan offered by the insurer. An insurer that does not offer individual health plans pursuant to section 2736-C may not include a conversion privilege in group policies issued or renewed on or after January 1, 1996.

Sec. A-12. 24-A MRSA §2809-A, sub-§4, ¶¶A and B, as enacted by PL 1991, c. 668, §2, are amended to read:

A. Conversion is provided through a form that is also issued to ~~individually underwritten standard risks~~ members of the general public applying for an individual health plan pursuant to section 2736-C;

B. The rates for that form ~~are based on individually underwritten standard risks~~ comply with section 2736-C; and

Sec. A-13. 24-A MRSA §2809-A, sub-§§7 and 9, as enacted by PL 1981, c. 668, §2, are amended to read:

7. Notice. Notice of the conversion privilege ~~shall~~, if one is applicable, must be included in each certificate of coverage.

9. Refusal to renew. A policy issued pursuant to the conversion privilege provided by this section may provide that the insurer may refuse to renew the policy or coverage of any person insured ~~thereunder for the following reasons only:~~ only as permitted by section 2736-C.

~~A. Fraud or material misrepresentation in applying for any benefits under the converted policy; or~~

~~B.--Any-reason-for-which-the-insurer-may-refuse-to-issue-a converted-policy-under-subsection-3.~~

Sec. A-14. 24-A MRSA §2809-A, §10, as amended by PL 1991, c. 885, Pt. E, §29 and affected by §47, is repealed.

PART B

Sec. B-1. 24-A MRSA §2808-A, as amended by PL 1991, c. 828, §24, is repealed.

PART C

Sec. C-1. 24-A MRSA §2740, as amended by PL 1973, c. 205, is repealed.

PART D

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

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A ~~or~~ B, C or D.

Sec. D-2. 24-A MRSA §2808-B, sub-§4, ¶A, as enacted by PL 1991, c. 861, §2, is amended to read:

A. Coverage must be guaranteed to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups. If an employee declines coverage because the employee has other coverage, any dependents of that employee who are not eligible under the employee's other coverage are eligible for coverage under the small group health plan.

Sec. D-3. 24-A MRSA §2808-B, sub-§4, ¶B, as amended by PL 1993, c. 645, Pt. A, §4, is further amended to read:

B. Renewal must be guaranteed to all eligible groups, to all eligible employees and their dependents in those groups except:

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

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

(3) With respect to coverage of eligible individuals, for fraud or material misrepresentation on the part of the individual or the individual's representative;

(4) For noncompliance with the carrier's minimum participation requirements, which may not exceed 75%;

(5) When the carrier ceases providing small group health plans in compliance with subsection 5; or

(6) When the carrier ceases offering a product and replaces it with a product that complies with the requirements of this section, including renewability, and the superintendent finds that replacement is in the best interest of the policyholders.

Sec. D-4. 24-A MRSA §2808-B, sub-§7, as enacted by PL 1991, c. 861, §2, is amended to read:

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 July 15, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary date of the policy, plan, contract ~~date~~ or certificate.

PART E

Sec. E-1. 24-A MRSA §5001, sub-§4, as amended by PL 1993, c. 154, §1, is further amended to read:

4. Medicare supplement policy. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan or health maintenance organization other than a policy issued pursuant to a contract under the federal Social Security Act, 42 United States Code, Section 1395, et seq.~~,--Section--1833~~ or Section 1876 or an issued policy under a demonstration project ~~authorized pursuant to amendments to the federal Social Security Act~~ specified in the 42 United States Code, Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Sec. E-2. 24-A MRSA §5001-A, sub-§§1 and 3, as enacted by PL 1991, c. 740, §2, are amended to read:

1. Application. Except as otherwise specifically provided in ~~sections 5004 and~~ section 5013, this chapter applies to:

A. All Medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this section; and

B. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

3. Plans not marketed as Medicare supplements. ~~The~~ Except as otherwise provided in section 5005, subsection 3-A, the provisions of this chapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held to be Medicare supplement policies or benefit plans.

Sec. E-3. 24-A MRSA §5005, sub-§3-A, as enacted by PL 1991, c. 740, §7, is amended to read:

3-A. Captions or notice requirements. The superintendent may adopt rules for captions or notice requirements determined to be in the public interest and designed to inform the prospective insureds that particular insurance coverages are not Medicare supplement coverages for all accident and sickness insurance policies sold to persons eligible for Medicare ~~by reason of age~~ other than:

A. Medicare supplement policies; or

B. Disability income policies~~;~~.

~~C. Basic, catastrophic or major medical expense policies; or~~

~~D. Single premium, nonrenewable policies.~~

PART F

Sec. F-1. 24 MRSA §2347, sub-§1, as amended by PL 1993, c. 666, Pt. D, §1, 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 to replace coverage under an uninsured employee benefit plan that provides payment for health services received by employees or their dependents if the contract holder has applied for coverage under this replacement contract within 90 days after termination of coverage under the contract or policy being replaced. 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 or the uninsured employee benefit plan, or a number of individual contracts or policies if the premiums were paid by the employer or by payroll deduction, being replaced is the "replaced contract or policy."

Sec. F-2. 24 MRSA §2349, sub-§3, as amended by PL 1993, c. 477, Pt. A, §§2 to 4 and affected by Pt. F, §1, is further amended to read:

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. A late enrollee may be excluded from coverage for not more than 12 months based on medical underwriting or preexisting conditions. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

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~~ because the individual became ineligible for reasons, other than fraud or material misrepresentation, including, but not limited to, termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce;

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~~

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~~.~~; or

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person become eligible.

Sec. F-3. 24-A MRSA § 2849, sub-§1, as amended by PL 1993, c. 666, Pt. D, §3, is further amended to read:

1. Policies subject to this section. Notwithstanding any other provision of law, this section applies to all group and blanket 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 to replace coverage under an uninsured employee benefit plan that provides payment for health services received by employees or their dependents if the policyholder has applied for coverage under the replacement policy within 90 days after termination of coverage under the contract or policy being replaced. 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 or a number of individual contracts or policies if the premiums were paid by the employer or by payroll deduction, being replaced is the "replaced contract or policy."

Sec. F-4. 24-A MRSA §2849-B, sub-§1, as amended by PL 1993, c. 477, Pt. A, §8 and affected by Pt. F, §1, is further amended to read:

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

Sec. F-5. 24-A MRSA §2849-B, sub-§3, as amended by PL 1993, c. 477, Pt. A, §§10 to 12 and affected by Pt. F, §1, is further amended to read:

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. A late enrollee may be excluded from coverage for not more than 12 months based on medical underwriting or preexisting conditions. For purposes of this

section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

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~~ because the individual became ineligible for reasons other than fraud or material misrepresentation, including, but not limited to, termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce;

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~~

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~~.~~; or

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person becomes eligible.

PART G

Sec. G-1. 24 MRSA 2325-A, sub-§5-C, ¶B, as amended by PL 1993, 586, §1, is further amended to read:

B. All policies and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1994 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide inpatient care benefits of at least 60 days per calendar year. For purposes of this paragraph, 2 days of day treatment is deemed equivalent to one day of inpatient care.

(2) The contracts must provide ~~outpatient care benefits~~ an annual benefit of at least $2,000 for ~~any~~

~~combination of~~ outpatient ~~and day treatment~~ care. The minimum level of benefits provided must be at least 50% of the usual, customary and reasonable charge.

(3) The contracts must contain a maximum lifetime benefit of at least $100,000 for the aggregate costs associated with mental illness.

Sec. G-2. 24 MRSA §2325-A, sub-§5-C, as amended by PL 1993, c. 586, §§1 and 2, is further amended by amending the last blocked paragraph to read:

This subsection is repealed July 1, ~~1995~~ 1996.

Sec. G-3. 24-A MRSA 2843, sub-§5-C, ¶B, as amended by PL 1993, c. 586, §3, is further amended to read:

B. All policies and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1994 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide inpatient care benefits of at least 60 days per calendar year. For purposes of this paragraph, 2 days of day treatment is deemed equivalent to one day of inpatient care.

(2) The contracts must provide ~~outpatient care benefits~~ an annual benefit of at least $2,000 for ~~any combination of~~ outpatient ~~and day treatment~~ care. The minimum level of benefits provided must be at least 50% of the usual, customary and reasonable charge.

(3) The contracts must contain a maximum lifetime benefit of at least $100,000 for the aggregate costs associated with mental illness.

Sec. G-4. 24-A MRSA 2843, sub-§5-C, as amended by PL 1993, c. 586, §3, is further amended by amending the last blocked paragraph to read:

This subsection is repealed July 1, ~~1995~~ 1996.

Sec. G-5. Retroactivity. This Part applies retroactively to July 1, 1995.

PART H

Sec. H-1. 24-A MRSA §2844, sub-§1, as enacted by PL 1993, c. 666, Pt. B, §2, is amended to read:

1. Authorization. Provisions contained in group and blanket 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.

PART I

Sec. I-1. 24-A MRSA §4202-A, sub-§18-A is enacted to read:

18-A. Servicing health maintenance organization. "Servicing health maintenance organization" means a health maintenance organization that does not directly market to employers or individuals, but provides health care to persons enrolled in one or more other health maintenance organizations.

PART J

Sec. J-1. 24-A MRSA §2701, sub-§2, as amended by PL 1991, c. 701, §5, is further amended to read:

2. Any group or blanket policy, except that:

A. Sections 2736, 2736-A and 2736-B ~~shall~~ apply to group Medicare supplement policies as defined in chapter 67 and group nursing home care and long-term care insurance policies as defined in chapter 68; ~~and~~

B. Section 2752 applies with respect to mandated benefits for group or blanket health policies~~.~~; and

C. Section 2736-C applies to:

(1) Association groups as defined by section 2805-A, except associations of employers; and

(2) Other groups as defined by section 2808.

Sec. J-2. 24-A MRSA §2736-C, sub-§1, ¶C, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

C. "Individual health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. It includes both individual contracts and certificates issued under group contracts specified in section 2701, subsection 2, paragraph C. "Individual health plan" 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 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.

PART K

Sec. K-1. 24-A MRSA §2736-C, sub-§6, ¶A, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

A. Each carrier must actively market individual health plan coverage, including any standardized plans defined pursuant to subsection 8, to individuals in this State.

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

A. Each carrier must actively market small group health plan coverage, including the basic and standard plans defined in subsection 8, to eligible groups in this State.

PART L

Sec. L-1. 24 MRSA §2327-A, as amended by PL 1991, c.861, §1 and affected by §4, is further amended to read:

§2327-A. Applicability

Title 24-A, sections ~~2808-A~~ 2803 and 2808-B apply to nonprofit hospital corporations, nonprofit medical service corporations and nonprofit health care plans to the extent not inconsistent with this chapter.

PART M

Sec. M-1. 24 MRSA §2302-B, as enacted by PL 1989, c. 767, §2 and PL 1993, c. 645,Pt. B, §1, is repealed and the following enacted in its place:

§2302-B. Penalty for failure to notify of hospitalization

A contract issued by a nonprofit hospital or medical services organization may not include a provision permitting the organization to impose a penalty for the failure of any person to notify the organization of a covered person's hospitalization for emergency treatment. For purposes of this section, "emergency treatment" has the same meaning as defined in Title 22, section 1829.

This section applies to contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after the effective date of this section. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Sec. M-2. 24 MRSA §2302-C is enacted to read:

§2302-C. Penalty for noncompliance with utilization review programs

A contract issued or renewed by a nonprofit service organization after April 8, 1994 may not contain a provision that permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of nonprofit

service organizations to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

Sec. M-3. 24 MRSA §2342, sub-§1, as amended by PL 1993, c. 602, §1, is further amended to read:

1. Licensure. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or an employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers, shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that Title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

Sec. M-4. 24-A MRSA §2749-B, as enacted by PL 1993, c. 645, Pt. B, §3, is amended to read:

§2749-B. Penalty for noncompliance with utilization review programs

A health insurance policy issued or renewed in this State after ~~the effective date of this section~~ April 8, 1994 may not contain a provision that ~~establishes~~ permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

Sec. M-5. 24-A MRSA §2771, sub-§1, as amended by PL 1993, c. 602, §4, is further amended to read:

1. Licensure. A person, partnership or corporation, other than an insurer, nonprofit service organization, health maintenance organization, preferred provider organization or

employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

Sec. M-6. 24-A MRSA §2772, sub-§5, as enacted by PL 1993, c. 645, Pt. B, §4, is amended to read:

5. Penalty for noncompliance with utilization review programs. A medical utilization review program may not recommend or implement a penalty of more than $500 for failure to provide notification. This subsection does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

Sec. M-7. 24-A MRSA §2847-D, as enacted by PL 1993, c. 645, Pt. B, §5, is amended to read:

§2847-D. Penalty for noncompliance with utilization review programs

A policy or certificate issued or renewed after ~~the effective date of this section~~ April 8, 1994 may not contain a provision that ~~establishes~~ permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

PART N

Sec. N-1. 24 MRSA §2319, first ¶, as enacted by PL 1975, c. 770, §101, is amended to read:

All individual and group nonprofit hospital and medical service organization contracts ~~which provide coverage for a family member of the subscriber shall, as to such family members' coverage, also~~ must provide that ~~the~~ benefits ~~applicable for children shall be applicable~~ are payable with respect to a newly born child from the moment of birth.

Sec. N-2. 24-A MRSA §2743, first ¶, as enacted by PL 1975, c. 770, §104, is amended to read:

All individual health insurance policies providing coverage on an expense incurred basis ~~which provide coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also~~ must provide that ~~the~~ health insurance benefits ~~applicable for children shall be~~ are payable with respect to a newly born child of the insured or subscriber from the moment of birth.

Sec. N-3. 24-A MRSA §2834, first ¶, as amended by PL 1993, c. 686, §12 and affected by §13, is further amended to read:

All group and blanket health insurance policies providing coverage on an expense incurred basis ~~that provide coverage for a family member of the insured or subscriber must, also~~ must provide that ~~the~~ health insurance benefits ~~applicable for children be~~ are payable for a newly born child of the insured or subscriber from the moment of birth. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. Preexisting conditions of an adopted child may not be excluded from coverage.

STATEMENT OF FACT

Part A repeals parts of the group conversion law. This law was enacted in 1983 to ensure that those losing their group coverage would have access to alternate coverage at standard rates with no new preexisting condition exclusion. Now that individual policies are guaranteed issue and subject to the continuity law, this requirement serves no purpose.

Part B repeals the Maine Revised Statutes, Title 24-A, section 2808-A since this provision is superseded by Title 24-A, section 2808-B, the small group community rating law.

Part C repeals Title 24-A, section 2740, which deals with franchise insurance. This provision is a holdover from when group coverage was not available to small groups and it conflicts with the community rate law under Title 24-A, section 2736-C.

Part D makes technical changes to small group insurance law as follows.

1. If dependent coverage is available, it is required to be available even if the employee is not covered, if the employee has other coverage and the dependents are not eligible for that coverage.

2. Title 24-A, section 2808-B, subsection 4, paragraph B, subparagraph (6) is amended to require a finding by the superintendent as in section 2736-B, subsection 3, paragraph B, subparagraph (5).

3. A cross-reference is corrected in section 2808-B, subsection 1, paragraph E, subparagraph (4). The applicability provision is clarified.

Part E, as required by federal standards, permits some duplication in the sale of insurance to persons with Medicare supplemental insurance.

Part F makes technical changes to the health insurance continuity law as follows.

1. The Maine Revised Statutes, Title 24-A, section 2849, subsection 1 and Title 24, section 2347, subsection 1 are amended to include individual policies as prior coverage if the premiums were paid by the employer or by payroll deduction.

2. The Maine Revised Statutes, Title 24-A, section 2849 and Title 24, section 2347 are clarified by specifying that a 90-day gap between plans is allowed. Current law only refers to the gap between termination of an individual's coverage under the prior plan and termination of the plan itself.

3. The law is extended to apply to Medicare supplement and blanket policies.

4. Exclusion of late enrollees is limited to 12 months. This is the same limit that applies to small groups.

5. The definition of "late enrollee" is clarified to exclude those not previously eligible and any case where prior coverage terminated involuntarily for reasons other than fraud or material misrepresentation.

Part G amends the law requiring coverage of certain mental illnesses so that day treatment is treated as a half day of inpatient treatment rather than as a form of outpatient treatment. The language in the current law was based on an

outdated version of a Bureau of Insurance rule. During the rulemaking process that amended the rule, the new language was supported by both providers and insurers.

Part H makes the coordination of benefits law applicable to blanket policies thereby making them subject to Bureau of Insurance rules which prevent situations in which an individual is covered by 2 policies, but neither will pay.

Part I exempts those health maintenance organizations, or HMOs, that do not market directly to subscribers from the requirement to issue small group and individual contracts. An HMO that only contracts with other HMOs and not directly with employers or individual subscribers is unable to comply with this requirement.

Part J makes the community rating laws applicable to associations that are not related to employment. This law currently applies to small employers, to associations of small employers and to individuals, but not to associations of individuals.

Part K clarifies the requirement that standardized plans be offered by specifying that rates for these plans must be quoted at the same time any other plans are offered.

Part L clarifies the definition of group for nonprofit hospital and medical service plans and health maintenance organizations.

Part M clarifies the restrictions on penalties for an insured's failure to provide notification under a utilization review program. This part also provides that regulation of medical utilization review performed by insurers, 3rd-party organizations or other entities related to workers' compensation claims will be regulated by the Workers' Compensation Board, not the Bureau of Insurance.

Part N extends to those covered as individuals under either group or individual health insurance the same protection for newborns as is currently afforded to those with family coverage. This protection guarantees coverage for 31 days.