117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document **No. 1475**

S.P. 537 In Senate, May 2, 1995

An Act to Promote Efficiency by Health Insurers of Maine.

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

MAY M. ROSS
Secretary of the Senate

Presented by Senator PINGREE of Knox.
Cosponsored by Senators: BUSTIN of Kennebec, LAWRENCE of York, PARADIS of Aroostook, Representatives: GATES of Rockport, SHIAH of Bowdoinham.

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

Sec. 1. 24 MRSA §2307-B is enacted to read:

§2307-B. Calculate methodology

The Superintendent of Insurance shall establish a methodology for calculating the direct service ratio to standardize the calculation by all insurers covered by this Title.

Sec. 2. 24-A MRSA §14 is enacted to read:

§14. Calculate methodology

The superintendent shall establish a methodology for calculating the direct service ratio to standardize the calculation by all insurers covered by this Title.

Sec. 3. 24-A MRSA §2301, as amended by PL 1989, c. 797, §1 and affected by §§37 and 38, is further amended by adding at the end a new paragraph to read:

For all policies or contracts issued on or after January 1, 1996, the superintendent may not allow premium rates filed by any nonprofit hospital or medical services organization and nonprofit health care plans, whether initial or revised, for a group health policy or contract unless it is anticipated that the aggregate benefits estimated to be paid under all such policies or contracts maintained in force by the nonprofit hospital or medical services organization and nonprofit health care plan for the period for which coverage is to be provided returns to policyholders or contract holders at least 90% 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.

Sec. 4. 24-A MRSA §2413, sub-§1, ¶F, as amended by PL 1991, c. 211, §2, is further amended to read:

F. As to Medicare supplement policies or contracts, as defined in chapter 67, if the policy cannot be anticipated, as estimated for the entire period for which rates are to be computed to provide coverage, on the basis of incurred claims experience and earned premiums for that period and in accordance with accepted actuarial principles and practices, to return to policyholders in the form of aggregate benefits provided under the policy at least ~~65%~~ 90% of the aggregate amount of premiums collected in the case of individual policies and at least ~~75%~~ 90% of the aggregate amount of premiums collected in the case of group policies; or

Sec. 5. 24-A MRSA §2413, sub-§1, ¶G, as enacted by PL 1991, c. 211, §3, is amended to read:

G. As to an individual health insurance policy, contract or rider, if it insures against a specific disease and does not meet the minimum loss ratio standards specified in subparagraph (2).

(1) As used in this paragraph, unless the context otherwise indicates, the following terms have the following meanings.

(a) "Conditionally renewable" means renewal may be declined by the insurer by class, geographic area or for stated reasons other than health.

(b) "Guaranteed renewable" means renewal may be declined by the insurer only for nonpayment of premium but rates may be revised on a class basis.

(c) "Noncancelable" means renewal may not be declined by the insurer and rates may not be revised.

(d) "Optionally renewable" means renewal is at the option of the insurer.

(2) The loss ratio standards for each type of renewal clause are:

(a) Optionally renewable insurance, ~~60%~~ 90%;

(b) Conditionally renewable insurance, ~~55%~~ 90%; and

(c) Guaranteed renewable and noncancelable insurance, ~~50%~~ 90%.

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

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization ~~or~~, nonprofit health care plan, preferred provider organization, physician-hospital organization, health maintenance organization or any other risk-bearing entity 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.

Sec. 7. 24-A MRSA §2736-C, sub-§5, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

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%~~ 90% 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.

Sec. 8. 24-A MRSA §2803, as amended by PL 1993, c. 171, Pt. C, §2, is further amended by adding at the end a new paragraph to read:

For all policies or contracts issued on or after January 1, 1996, the superintendent may not allow any premium rates filed by any carrier, whether initial or revised, for a group health policy or contract unless it is anticipated that the aggregate benefits estimated to be paid under all such policies or contracts maintained in force by the carrier for the period for which coverage is to be provided returns to policyholders or contract holders at least 90% 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.

Sec. 9. 24-A MRSA §5004, sub-§2, as amended by PL 1991, c. 740, §6, is further amended to read:

2. Medicare supplement policies must provide for a return to policyholders benefits that are reasonable in relation to the premium charged. The superintendent shall issue reasonable rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a

health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

For all policies or contracts issued on or after January 1, 1996, the superintendent may not allow any premium rates filed by any carrier, whether initial or revised, for a group health policy or contract unless it is anticipated that the aggregate benefits estimated to be paid under all such policies or contracts maintained in force by the carrier for the period for which coverage is to be provided returns to policyholders or contract holders at least 90% 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.

Sec. 10. Effective date. This Act takes effect January 1, 1996.

STATEMENT OF FACT

This bill promotes administrative efficiency in the payment of health care services by health insurers. This bill returns more premium dollars in direct health care services to the policyholders and limits insurer administrative inefficiencies. It extends current protections afforded individual, disease and Medicare supplemental insurance policies to all group plans. It returns 90% of premium dollars in direct health service payments to policyholders under all lines of health insurance. The bill also directs the Superintendent of Insurance to establish a methodology for calculating the direct service ratio to standardize the calculation by all insurers covered under the Maine Revised Statutes, Titles 24 and 24-A.