118th MAINE LEGISLATURE

FIRST REGULAR SESSION-1997

Legislative Document **No. 681**

S.P. 222 In Senate, February 4, 1997

An Act to Increase Access to Affordable Health Insurance for Citizens of Maine.

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

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator KIEFFER of Aroostook.
Cosponsored by Senators: AMERO of Cumberland, PARADIS of Aroostook, Representative: LANE of Enfield.

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

Sec. 1. 24-A MRSA c. 76 is enacted to read:

CHAPTER 76

BASIC CARE MEDICAL PLANS

§6351. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Basic care medical plan. "Basic care medical plan" or "plan" means a plan providing health care benefits in accordance with this chapter.

2. Basic care medical plan pool. "Basic care medical plan pool" or "pool" means a pool for distributing the risk among carriers as provided in section 6359.

3. Carrier. "Carrier" means any insurance company, health maintenance organization or nonprofit hospital and medical service organization authorized to issue individual health plans in this State. For the purposes of this chapter, 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 chapter apply as if all basic care medical plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this chapter, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

4. Eligible enrollee. "Eligible enrollee" means a person who at the time of application and determination of eligibility for a basic care medical plan is employed and unable to purchase insurance or health plan coverage, unemployed or self-employed.

5. Superintendent. "Superintendent" means Superintendent of Insurance.

§6352. Basic care medical plan benefits

Carriers may issue basic care medical plans in accordance with this chapter, and those plans must meet the following criteria.

1. Eligible enrollees. Coverage must be available to all eligible enrollees in accordance with rules adopted by the superintendent. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

2. Mandatory managed care provisions. The plan must include the following managed care provisions to control costs:

A. An exclusion for services that are not medically necessary or are not covered preventive health services; and

B. A procedure for preauthorization by the carrier or its designees.

3. Basic levels of care. The plan must provide basic levels of care for insureds, including, but not limited to, the following:

A. A minimum of 90 days of inpatient hospitalization coverage per policy year;

B. Prenatal, postnatal and new baby care;

C. Professional services including inpatient medical care, surgery and anesthesia, maternity delivery and emergency accident and medical care; and

D. Outpatient facility services including emergency accident and medical care, surgery, diagnostic services and radiation and chemotherapy.

§6353. Optional managed care provisions

1. Managed care provisions. The plan may include the following managed care provisions to control costs:

A. A panel of preferred providers;

B. Provisions requiring a 2nd surgical opinion; and

C. A procedure for additional utilization review by the carrier or the basic care medical plan or medical utilization review entity.

This chapter may not be construed to prohibit a carrier from including in its policy additional managed care and cost control provisions that, subject to the approval of the superintendent, have the potential to control costs in a manner that does not result in inequitable treatment of insureds or subscribers.

§6354. Exemption from certain mandates

Except as provided in this chapter, laws requiring the coverage of a health care service or benefits and laws requiring the reimbursement or utilization of a specific category of licensed health care practitioner do not apply to basic care medical plans issued pursuant to this chapter.

§6355. Deductibles; coinsurance; maximum benefit

1. Deductible. The plan must contain a deductible of not less than $2,000 nor greater than $5,000 per covered person per calendar year.

2. Coinsurance. The plan must include coinsurance of not less than 20% nor greater than 40%, up to a maximum of $3000 per individual per calendar year, beyond which coverage must be provided at 100%.

3. Emergency care. The plan must include coinsurance of not less than 40% nor greater than 75% for care received in a hospital emergency room that is not emergency treatment.

A. For purposes of this section, "emergency treatment" means treatment of a case involving accidental bodily injury or the sudden and unexpected onset of a critical condition requiring medical or surgical care for which a person seeks medical attention within 24 hours of the onset.

B. The uncovered amount may not be applied to the out-of-pocket expense limit.

§6356. Renewability

All plans must be renewable with respect to all insureds at the option of the insureds except as provided in this section.

1. Nonpayment. A carrier may cancel a plan for nonpayment of the required premiums by the insured.

2. Fraud or misrepresentation. A carrier may cancel a plan for fraud or misrepresentation by the insured.

3. Withdrawal from market. A carrier may cancel a plan if:

A. Notice of the decision to cease doing plan business in this State is provided to the superintendent and to all insureds; and

B. The plan is not canceled for 6 months after the date of the notice required by paragraph A.

Any carrier that cancels a plan under this subsection is prohibited from writing new plans in this State for a period of 6 years from the date of notice to the superintendent required by paragraph A.

§6357. Disclosure

1. Statement to insured. In offering coverage under a plan for an eligible enrollee, the carrier shall provide the eligible enrollee with a written disclosure statement containing at least the following:

A. An explanation of those mandated benefits and providers not covered by the plan pursuant to section 6354;

B. An explanation of the managed care and cost control features of the plan; and

C. An explanation of the primary preventive care and hospitalization features of the plan.

2. Statement from policyholder. Before any carrier issues a plan, it shall obtain from the eligible enrollee a signed written statement in which the eligible enrollee:

A. Certifies that the enrollee and all dependents are eligible for coverage under the plan;

B. Acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the plan; and

C. Acknowledges that, if misrepresentations are made regarding eligibility for coverage, the person making the misrepresentations forfeits coverage provided by the plan.

3. Record keeping. A copy of the written statement required by subsection 2 must be provided to the eligible enrollee before or at the time of plan delivery, and the original of that written statement must be retained in the files of the carrier for the period of time the plan remains in effect.

4. False statement; termination. Any material statement made by an applicant for coverage under a plan that falsely certifies an applicant's eligibility for coverage may be the basis for termination of coverage under the plan.

§6358. Forms

All plan forms, including applications, evidences of coverage, riders, amendments, endorsements and disclosure forms, must be submitted to the superintendent for approval in the same manner as required by section 2412 or Title 24, section 2316.

§6359. Basic care medical plan pool

Carriers that issue basic care medical plans may form a pool for the purpose of distributing among the members of the pool the risk of coverage of the insureds. The pool may not become operative until the superintendent has approved a plan of operation. The superintendent may approve a pool only after the superintendent has determined that the pool is in the public interest and is consistent with this chapter. The members of the pool shall guarantee, without limitation, the solvency of the pool. The guarantee constitutes a permanent financial obligation of each member on a pro rata basis.

SUMMARY

This bill authorizes basic care medical plans to provide health insurance with high deductibles and levels of coinsurance. The plans may be purchased by persons who are unemployed, self-employed or employed and unable to purchase insurance. The plans cover hospitalization, prenatal, postnatal and new baby care, surgery, emergency and outpatient care. The plans are exempt from all state mandates of health care services and reimbursement and utilization of providers. The plans are renewable except for specified situations including nonpayment of premium, fraud and withdrawal from the market. The carriers that offer basic care medical plans are authorized to form a pool to distribute the risk of providing coverage to the insureds.