118th MAINE LEGISLATURE

FIRST REGULAR SESSION-1997

Legislative Document **No. 1521**

H.P. 1084 House of Representatives, March 13, 1997

An Act to Amend the Laws Concerning Health Insurance.

Submitted by the Department of Professional and Financial Regulation pursuant to Joint Rule 204.

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

JOSEPH W. MAYO, Clerk

Presented by Representative PERRY of Bangor.
Cosponsored by Senator LaFOUNTAIN of York and
Representatives: BOLDUC of Auburn, DUNLAP of Old Town, MAYO of Bath, SAXL of Bangor.

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

PART A

Sec. A-1. 24-A MRSA §1954, sub-§2, ¶B, as enacted by PL 1995, c.673, Pt. A, §3, is amended to read:

B. Notwithstanding any other provision of this Title or Title 24 that requires coverage for outpatient benefits, the alliance ~~shall~~ may offer at least one health plan providing catastrophic coverage for inpatient hospital benefits only~~, in accordance with rules developed by the superintendent~~. The catastrophic plan must offer a range of deductibles, including a $1,000 deductible plan. This paragraph is repealed on January 1, 2000.

Sec. A-2. 24-A MRSA §1954, sub-§2, ¶C, as enacted by PL 1995, c. 673, Pt. A, §3, is repealed.

PART B

Sec. B-1. 24 MRSA §2347, sub-§3, ¶¶B and C, as enacted by PL 1989, c. 867, §1 and affected by §10, are amended to read:

B. Decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; ~~or~~

C. ~~Impose~~ 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, impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section~~.~~; or

Sec. B-2. 24 MRSA §2347, sub-§3, ¶D is enacted to read:

D. Direct or propose to the employer or the person that the person purchase an individual plan in lieu of providing coverage under the replacement policy. Procurement of an individual policy at the time of replacement of the group policy creates a rebuttable presumption of a violation of Title 24-A, section 2155-A.

Sec. B-3. 24-A MRSA §2155-A is enacted to read:

§2155-A. Dumping prohibited

The guaranteed issue requirements of section 2736-C may not be used by insurers, health maintenance organizations, agents, brokers or consultants to provide separate coverage to an employee or dependent with a health condition to improve the

claims experience of an employer-sponsored group health benefit plan.

Sec. B-4. 24-A MRSA §2849, sub-§3, ¶¶B and C, as repealed and replaced by PL 1993, c. 349, §53, are amended to read:

B. Decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; ~~or~~

C. ~~Impose~~ 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, impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section.; or

Sec. B-5. 24-A MRSA §2849, sub-§3, ¶D is enacted to read:

D. Direct or propose to the employer or the person that the person purchase an individual plan in lieu of providing coverage under the replacement policy. Procurement of an individual policy at the time of replacement of the group policy creates a rebuttable presumption of a violation of section 2155-A.

Sec. B-6. 24-A MRSA §4227, last ¶, as enacted by PL 1991, c. 709, §8, is amended to read:

An employer may satisfy the requirements of this section by offering a point-of-service option but may not satisfy the requirements of this section by contributing to the cost of an individual health plan.

PART C

Sec. C-1. 24 MRSA §2349, sub-§2, ¶A, as amended by PL 1995, C. 342, §2, is further amended to read:

A. That person was covered under an individual or group contract or policy, except for a short-term contract, 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 or the uninsured employee benefit plan that previously covered the person is the "prior contract or policy"; ~~and~~

Sec. C-2. 24 MRSA §2349, sub-§2, ¶B, as repealed and replaced by PL 1995, c. 673, Pt. B, §1, is amended to read:

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within ~~3 months~~ 90 days 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 a time period specified under this section~~.~~; and

Sec. C-3. 24 MRSA §2349, sub-§2, ¶C is enacted to read:

C. If the prior contract or policy was a Medicare supplement policy as defined in Title 24-A, chapter 67, this section applies only:

(1) If the policy was issued during the open enrollment period pursuant to Title 24-A, section 5005 or section 5010; or

(2) If the policy was issued to replace an earlier policy issued by the same or a different carrier and the insured had continuous coverage beginning in the insured's open enrollment period with no gap in coverage in excess of 90 days, then the waiver of medical underwriting and preexisting conditions exclusions required by subsection 4 apply only to the extent that benefits would have been payable under each

of the prior policies if those policies were still in force.

Sec. C-4. 24-A MRSA §2849-B, sub-§1, as repealed and replaced by PL 1995, c. 625, Pt. B, §10, is amended to read:

1. Policies subject to this section. This section applies to all individual, group and blanket medical ~~and--blanket~~ insurance policies except hospital indemnity, specified accident, specified disease, long-term care and short-term policies issued by insurers or health maintenance organizations. For purposes of this section, a short-term policy is an individual, nonrenewable policy issued for a term that does not exceed 12 months.

Sec. C-5. 24-A MRSA §2849-B, sub-§2, ¶B, as repealed and replaced by PL 1995, c. 673, Pt. B, §3, is amended to read:

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within ~~3-months~~ 90 days 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 a time period specified under this section; ~~and~~

Sec. C-6. 24-A MRSA §2849-B, sub-§2, ¶C, as enacted by PL 1993, c. 666, Pt. D, §4, is amended to read:

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

Sec. C-7. 24-A MRSA §2849-B, sub-§2, ¶D is enacted to read:

D. If the prior contract or policy was a Medicare supplement policy as defined in chapter 67, this section applies only:

(1) If the policy was issued during the open enrollment period pursuant to section 5005 or section 5010; or

(2) If the policy was issued to replace an earlier policy issued by the same or a different carrier and the insured had continuous coverage beginning in the insured's open enrollment period with no gap in coverage in excess of 90 days, then the waiver of medical underwriting and preexisting conditions exclusions required by subsection 4 apply only to the extent that benefits would have been payable under each of the prior policies if those policies were still in force.

Sec. C-8. 24-A MRSA §2850, sub-§1, as amended by PL 1993, c. 547, §4, is further amended to read:

1. Application. This section applies to individual and group medical insurance contracts subject to ~~chapter~~ chapters 33 and 35, except Medicare supplement contracts, converted contracts issued under section 2809-A and contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

PART D

Sec. D-1. 24-A MRSA §5015 is enacted to read:

§5015. Right to repurchase

A person who terminates a Medicare supplement policy while enrolling in a managed care plan that replaces standard Medicare benefits and terminates the managed care plan within 12 months after that plan took effect and returns to standard Medicare benefits may purchase a new policy identical to the prior Medicare supplement policy at any time within 30 days after returning to standard Medicare benefits. If the policy contains a preexisting condition exclusion, the exclusion may apply only to conditions that did not exist at the time the original Medicare supplement policy terminated.

PART E

Sec. E-1. 24 MRSA §2307-B, sub-§4, as enacted by PL 1995, c. 71, §1, is amended to read:

4. Exception. An insurer is not required to provide the loss information described in this section to a group ~~with fewer~~

~~than--25--members~~ that is eligible for small group coverage pursuant to Title 24-A, section 2808-B.

Sec. E-2. 24-A MRSA §2736-C, sub-§1, ¶E is enacted to read:

E. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as amended.

Sec. E-3. 24-A MRSA §2736-C, sub-§2, ¶E is enacted to read:

E. A separate community rate may be established for individuals eligible for Medicare Part A without paying a premium, however, this rate may not be applied if both the Medicare eligibility date and the issue date are prior to the effective date of this paragraph.

Sec. E-4. 24-A MRSA §2736-C, sub-§4, ¶A, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

A. Notice of the decision to cease doing business in the individual health plan market must be provided to the bureau ~~and--to~~ 3 months prior to the cessation. If existing contracts are nonrenewed, notice must be provided to the policyholder or contract holder 6 months prior to nonrenewal.

Sec. E-5. 24-A MRSA §2803-A, sub-§4, as enacted by PL 1995, c. 71, §2, is amended to read:

4. Exception. An insurer is not required to provide the loss information described in this section to a group ~~with fewer than--25--members~~ that is eligible for small group coverage pursuant to section 2808-B.

Sec. E-6. 24-A MRSA §2808-B, sub-§2, ¶D-1 is enacted to read:

D-1. Notwithstanding the requirements of paragraph D, rates with respect to employees whose work site is not in this State may be based on area adjustment factors appropriate to that location.

Sec. E-7. 24-A MRSA §2808-B, sub-§5, ¶A, as enacted by PL 1991, c. 861, §2, is amended to read:

A. Notice of the decision to cease doing business in that market must be provided to the bureau ~~and-to~~ 3 months prior to the cessation. If existing contracts are nonrenewed, notice must be provided to the policyholder or contract holder 6 months prior to nonrenewal.

Sec. E-8. 24-A MRSA §4224-A, sub-§4, as enacted by PL 1995, c. 71, §3, is amended to read:

4. Exception. An insurer is not required to provide the loss information described in this section to a ~~group with fewer than 25 members~~ a group that is eligible for small group coverage pursuant to section 2808-B.

PART F

Sec. F-1. 24-A MRSA, §4203, sub-§3, ¶S, as enacted by PL 1989, c. 842, §7, is amended to read:

S. A list of the names and addresses of all physicians and facilities with which the health maintenance organization has or will have agreements. If products are offered that pay full benefits only when providers within a subset of the contracted physicians or facilities are utilized, a list of the providers in that limited network must be included, as well as a list of the geographic areas where the products are offered.

PART G

Sec. G-1. 24-A MRSA §2412, sub-§1, as amended by PL 1989, c. 797, §35 and affected by §§37 and 38, is repealed and the following enacted in its place:

1. An insurance policy or annuity contract form may not be delivered or issued for delivery in this State unless the form has been filed with and approved by the superintendent in accordance with the following.

A. For purposes of this section, "form" includes:

(1) The basic form and any printed rider, endorsement or renewal form;

(2) An application form if a written application is required and is made a part of the policy or contract; and

(3) A certificate of coverage under a group policy or contract that is delivered or issued for delivery in this State.

B. This section does not apply to surety bonds or to specially rated inland marine risks, or to policies, riders, endorsements or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health

insurance policies and are used at the request of the individual policy holder, contract holder or certificate holder.

C. An advisory organization licensed pursuant to section 2321-A may file forms pursuant to this section on behalf of its members and subscribers. The approval of such a filing does not restrict the right of an insurer authorized to use an advisory organization form to develop and file forms on its behalf in addition to or instead of the advisory organization form.

Sec. G-2. 24-A MRSA §2412, sub-§1-A is enacted to read:

1-A. An insurer may not provide coverage to a resident of this State under a group policy or contract issued and delivered outside this State unless the following requirements of this subsection are met.

A. For "other group" insurance policies as defined in sections 2612-A and 2808, all forms must be filed with and approved by the superintendent.

B. For trustee group policies as defined in sections 2606-A and 2806 and association group policies as defined in sections 2607-A and 2805-A, certificates of coverage to be delivered or issued for delivery in this State:

(1) Must be filed with the superintendent at least 60 days before any solicitation in this State, with sufficient information concerning the nature of the group, including any trust agreements or association bylaws, to enable the superintendent to determine whether the group satisfies the statutory requirements for a trustee or association group; and

(2) May not have been disapproved.

C. For group policies other than those specified in paragraphs A and B and in section 2858, the group certificates to be delivered or issued for delivery in this State must be filed with the superintendent at the superintendent's request and may not have been disapproved.

D. The superintendent may disapprove a form filed pursuant to this subsection only if:

(1) The policy or form is not in compliance with the laws of the state in which it was issued or delivered;

(2) The policy or form is not in compliance with the laws of this State that apply when the policy is issued

outside this State, such as chapter 36 or section 2843; or

(3) The superintendent determines that the form is deceptive or misleading.

PART H

Sec. H-1. 24-A MRSA §2850-A, as enacted by PL 1995, c. 617, §4 and affected by §6, is reallocated to Title 24-A, section 2847-F.

SUMMARY

Part A removes the requirement for private purchasing alliances to offer inpatient only and outpatient only plans. Inpatient plans are permitted but not required.

Part B prohibits the practice of "dumping" by which individuals with health problems are provided individual policies in order to improve the claims experience of a group policy.

Part C makes technical amendments to the health insurance continuity law to improve consistency and clarity.

Part D allows a Medicare beneficiary who switches to a managed care plan and then switches back to repurchase a Medicare supplement policy.

Part E makes technical amendments to the small group and individual health insurance reform laws for consistency and clarity. It also creates an exception to guaranteed issue of individual policies for individuals eligible for Medicare Part A without paying a premium and allows these policies to be rated separately.

Part F clarifies filing requirements applicable to health maintenance organizations offering products using a more limited provider network rather than their full network.

Part G clarifies the requirements for filing and approval of policy forms.

Part H corrects an allocation error.