118th MAINE LEGISLATURE

FIRST SPECIAL SESSION-1997

Legislative Document **No. 1808**

H.P. 1278 House of Representatives, April 16, 1997

An Act to Make Maine Health Insurance Laws Consistent with Federal Laws.

(EMERGENCY)

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

JOSEPH W. MAYO, Clerk

Presented by Speaker MITCHELL of Vassalboro. (GOVERNOR'S BILL)
Cosponsored by Senator KIEFFER of Aroostook and
Representatives: DAVIDSON of Brunswick, MAYO of Bath, Senators: ABROMSON of Cumberland, MURRAY of Penobscot.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the United States Congress enacted and the President signed the Health Insurance Portability and Accountability Act of 1996; and

Whereas, portions of that law become effective on July 1, 1997 and preempt conflicting state laws; and

Whereas, it is in the best interests of the people of the State for the State to retain its ability to regulate its health insurance market; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

Sec. 1. 24 MRSA §2327-C is enacted to read:

§2327-C. Continuity of health insurance coverage

Title 24-A, chapter 36 applies to nonprofit hospital organizations, nonprofit medical service organizations and nonprofit health care plans that are not inconsistent with this chapter.

Sec. 2. 24 MRSA §2346, as amended by PL 1991, c. 695, §1, is repealed.

Sec. 3. 24 MRSA §2347, as amended by PL 1995, c. 332, Pt. F, §1, is repealed.

Sec. 4. 24 MRSA §2348, as enacted by PL 1989, c. 867, §§1 and 10, is repealed.

Sec. 5. 24 MRSA §2349, as amended by PL 1995, c. 673, Pt. B, §1, is repealed.

Sec. 6. 24 MRSA §2350, as amended by PL 1993, c. 477, Pt. A, §7 and affected by Pt. F, §1, is repealed.

Sec. 7. 24-A MRSA §2736-C, sub-§1, ¶¶C-1 and C-2 are enacted to read:

C-1. "Legally domiciled" means a resident of this State who has a motor vehicle operator's license from this State, is registered to vote in this State or files an income tax return for this State. A child is legally domiciled in this State if at least one of the child's parents or the child's legal guardian is legally domiciled in this State. A person with a developmental or other disability that prevents that person from obtaining a motor vehicle operator's license, registering to vote or filing an income tax return is legally domiciled in this State by living in this State.

C-2. "Resident" means a person who is legally domiciled in this State and has been for at least the last 60 days.

Sec. 8. 24-A MRSA §2736-C, sub-§3, ¶A, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

A. Coverage must be guaranteed to all ~~individuals~~ residents of this State other than those eligible without paying a premium for Medicare Part A. On or after January 1, 1998, coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. When a managed care plan, as defined by section 4301, provides coverage a carrier may:

(1) Deny coverage to individuals who neither live nor reside within the approved service area of the plan for at least 6 months of each year; and

(2) Deny coverage to individuals if the carrier has demonstrated to the superintendent's satisfaction that:

(a) The carrier does not have the capacity to deliver services adequately to additional enrollees because of its obligations to existing enrollees; and

(b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this paragraph may not enroll individuals or groups within the service area for a period of 180 days after the date of denial of coverage.

Sec. 9. 24-A MRSA §2736-C, sub-§3, ¶B, as amended by PL 1995, c. 342, §4, is repealed and the following enacted in its place:

B. Renewal is guaranteed, pursuant to section 2850-B.

Sec. 10. 24-A MRSA §2736-C, sub-§7, as amended by PL 1995, c. 342, §5, is further 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 December 1, 1993 with the exception of short-term contracts, as defined in section ~~2349, subsection 1~~ 2849-B. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

Sec. 11. 24-A MRSA §2808-B, sub-§1, ¶D, as enacted by PL 1991, c. 861, §2, is repealed and the following enacted in its place:

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that employed an average of 50 or fewer eligible employees during the preceding calendar year, more of whom are employed within this State than in any other state.

(1) If an employer was not in existence throughout the preceding calendar year, the determination must be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(2) In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(3) At the carrier's option, businesses that do not have at least 2 eligible employees on the first day of the plan year may be excluded from the definition of "eligible group." A carrier electing to exclude such businesses must inform the superintendent and may not issue a group policy to any such business. If a group was issued a policy before July 1, 1997 and had only one eligible employee on July 1, 1997, the group must be allowed to renew coverage.

Sec. 12. 24-A MRSA §2808-B, sub-§1, ¶H, as amended by PL 1995, c. 673, Pt. A, §5, is further amended to read:

H. "Subgroup" means an employer with 50 or fewer ~~than 25~~ employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract.

Sec. 13. 24-A MRSA §2808-B, sub-§2, as amended by PL 1995, c. 673, Pt. A, §6, is further amended to read:

2. Rating practices. The following requirements apply to the rating practices of carriers providing small group health plans. This subsection does not apply to policies issued before January 1, 1998 to groups that employed, on average, 25 or more eligible employees until their first renewal date on or after January 1, 1998.

A. A carrier issuing a small group health plan after the effective date of this section must file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent for informational purposes prior to issuance of any small group health plan.

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the eligible group or members of the group.

C. A carrier may vary the premium rate due to family membership, participation in wellness programs and group size.

D. A carrier may vary the premium rate due to age, smoking status, occupation or industry, and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after July 15, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%, except as provided in paragraph D-1.

D-1. With respect to eligible groups that employed, on average, 25 or more eligible employees in the preceding calendar year, a carrier may vary the premium rate due to age, smoking status, occupation or industry and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State in 1998, the premium rate may not deviate above or below the community rate filed by the carrier by more than 40%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State in 1999, the premium rate may not deviate above or below the community rate filed by the carrier by more than 30%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after January 1, 2000, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

E. The superintendent may exempt from the requirements of this subsection an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 that offers a small group health plan that complies with the premium rate requirements of this subsection and guarantees issuance and renewal to all persons and their dependents within the association or trustee group.

F. Premium rates charged to a private purchasing alliance, as defined by chapter 18-A, may be reduced in accordance with rules adopted pursuant to that chapter.

Sec. 14. 24-A MRSA §2808-B, sub-§3, as amended by PL 1993, c. 477, Pt. B, §2 and affected by Pt. F, §1, is further amended to read:

3. Coverage for late enrollees. In providing coverage to late enrollees, small group health plan carriers are allowed to exclude a late enrollee for 12 months or provide coverage subject to a 12-month preexisting conditions exclusion. The exclusion ~~may only relate to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage, or to a pregnancy existing on the effective date of~~ coverage is subject to the limitations set forth in section 2850. ~~A routine preventive screening or test yielding only negative results may not be deemed to be diagnosis, care or treatment for the purposes of this subsection.~~

Sec. 15. 24-A MRSA §2808-B, sub-§4, ¶A, as amended by PL 1995, c. 332, Pt. D, §2, is further 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. In determining compliance with minimum participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation. 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. A carrier may deny coverage under a managed care plan, as defined by section 4301:

(1) To employers who have no employees who live, reside or work within the approved service area of the plan; and

(2) To employers if the carrier has demonstrated to the superintendent's satisfaction that:

(a) The carrier does not have the capacity to deliver services adequately to additional enrollees because of its obligations to existing enrollees; and

(b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this paragraph may not enroll groups within the service area

for a period of 180 days after the date of denial of coverage.

Sec. 16. 24-A MRSA §2808-B, sub-§4, ¶B, as amended by PL 1995, c. 332, Pt. D, §3, is repealed and the following enacted in its place:

B. Renewal is guaranteed under section 2850-B.

Sec. 17. 24-A MRSA §2808-B, sub-§5, as enacted by PL 1991, c. 861, §2, is repealed.

Sec. 18. 24-A MRSA §2848, sub-§§1-A to 1-D are enacted to read:

1-A. COBRA continuation provision. "COBRA continuation provision" means any of the following:

A. Section 4980B of the Internal Revenue Code of 1986, other than Subsection (f)(1) as it relates to pediatric vaccines;

B. Part 6 of Subtitle B of Title I of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1161, other than Section 609; or

C. Title XXII of the federal Public Health Service Act, 42 United States Code, Section 201.

1-B. Creditable coverage. "Creditable coverage" means:

A. Health benefits or coverage provided under any of the following:

(1) An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, or a plan that would be an employee welfare benefit plan but for the "governmental plan" or "nonelecting church plan" exceptions, if the plan provides medical care as defined in subsection 2-A, and includes items and services paid for as medical care directly or through insurance, reimbursement or otherwise;

(2) Benefits consisting of medical care provided directly, through insurance or reimbursement and including items and services paid for as medical care under a policy, contract or certificate offered by a carrier; or

(3) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

(4) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act;

(5) The Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55;

(6) A medical care program of the federal Indian Health Care Improvement Act, 25 United States Code, Section 1601 or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under the federal Employees Health Benefits Amendments Act, 5 United States Code, Chapter 89;

(9) A public health plan as defined in federal regulations authorized by the federal Public Health Service Act, Section 2701(c)(1)(I), as amended by Public Law 104-191; or

(10) A health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code, Section 2504(e).

B. Creditable coverage does not include coverage consisting solely of one or more of the following:

(1) Coverage for accident or disability income insurance or any combination of those coverages;

(2) Liability insurance, including general liability insurance and automobile liability insurance;

(3) Coverage issued as a supplement to liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit insurance;

(7) Coverage for on-site medical clinics; or

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

C. Creditable coverage does not include the following benefits if those benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination of those benefits; and

(3) Other similar, limited benefits as specified in federal regulations issued pursuant to Public Law 104-191.

D. Creditable coverage does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, and if no coordination exists between the provision of the benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and those benefits are paid for an event without regard to whether benefits are provided for that event under a group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

E. Creditable coverage does not include the following if it is offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance under the Social Security Act, Section 1882(g)(1);

(2) Coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55; and

(3) Similar supplemental coverage under a group health plan.

For purposes of this subsection, a period of continuing creditable coverage means a period in which an individual has maintained creditable coverage through one or more plans or programs, with no break in coverage exceeding 63 days. In calculating the aggregate length of a period of continuing creditable coverage that includes one or more breaks in coverage, only the time actually covered is counted. A waiting period is not counted as a break in coverage if the individual has other creditable coverage during this period.

1-C. Federally eligible individual. "Federally eligible individual" means an individual:

A. Who has had a period of continuing creditable coverage, as defined in subsection 1-B, ending not more than 63 days before applying for an individual health plan, with an aggregate length of creditable coverage, as defined in subsection 1-B, of at least 18 months;

B. Whose most recent prior creditable coverage was under a group health plan governmental plan, church plan or health insurance coverage offered in connection with any such plan;

C. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, Medicare, or a state plan under Title XIX, Medicaid or any successor program and who does not have other health insurance coverage;

D. Whose most recent creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; and

E. Who, if offered the option of continuation of coverage under a COBRA continuation provision, as defined by subsection 1-A, or under a similar state program, elected continuation of coverage and has exhausted that coverage.

1-D. Governmental plan. "Governmental plan" has the meaning given under Section 3(32) of the federal Employee Retirement Income Security Act of 1974 or any federal governmental employee plan.

Sec. 19. 24-A MRSA §2848, sub-§2-A is enacted to read:

2-A. Medical care. Medical care includes the amounts paid for:

A. The diagnosis, care, mitigation, treatment or prevention of disease, or the amounts paid for the purpose of affecting a structure or function of the body;

B. Transportation primarily for, and essential to, medical care under paragraph A; and

C. Insurance coverage for medical care under paragraphs A and B.

Sec. 20. 24-A MRSA §2848, sub-§3, as repealed and replaced by PL 1993, c. 349, §52, is repealed.

Sec. 21. 24-A MRSA §2848-A is enacted to read:

§2848-A. Applicability to certain self-insured employers

For purposes of this chapter, an uninsured employee health plan that covers employees working in this State, including the uninsured portion of a partially insured employee health plan, is considered a group medical insurance policy and the employer maintaining the plan is considered an insurer, if the plan is subject to state regulation by virtue of the governmental plan or nonelecting church plan exception to the federal definition of "employee benefit plan" in the federal Employee Retirement Income Security Act, 29 United States Code, Section 1003(b).

Sec. 22. 24-A MRSA §2849, sub-§6 is enacted to read:

6. Rules. The superintendent may adopt rules that substitute for the requirement of subsection 3, paragraph C that prohibits application of a preexisting condition exclusion or waiting period with respect to classes or categories of benefits that are covered under the replaced contract or policy. The rules must define those classes or categories consistent with any federal regulations adopted pursuant to the federal Public Health Service Act, Title XXVII, Section 2701(c)(3)(B).

Sec. 23. 24-A MRSA §2849-B, sub-§2, ¶A, as amended by PL 1995, c. 342, §7, 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 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~~, including, but not limited to those listed in section 2848, subsection 1-B, paragraph A, subparagraphs 3 to 10. 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 or the uninsured employee benefit plan that previously covered the person is the "prior contract or policy";

Sec. 24. 24-A MRSA §2849-B, sub-§4-A is enacted to read:

4-A. Alternative method. The superintendent may adopt rules that substitute for the requirement of subsection 4 that prohibits application of a medical underwriting or preexisting condition exclusion with respect to classes or categories of benefits that are covered under the replaced contract or policy. The rules must define those classes or categories consistent with any federal regulations adopted pursuant to the federal Public Health Service Act, Title XXVII, Section 2701(c)(3)(B).

Sec. 25. 24-A MRSA §2850, sub-§1-A is enacted to read:

1-A. Definition. "Preexisting condition exclusion," with respect to coverage, means a limitation or exclusion of benefits relating to a condition based on the fact or perception that the condition was present, or that the person was at particularized risk of developing the condition, before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.

Sec. 26. 24-A MRSA §2850, sub-§2, as amended by PL 1993, c. 477, Pt. A, §15 and affected by Pt. F, §1, is repealed and the following enacted in its place:

2. Limitation. An individual or group contract issued by an insurer may not impose a preexisting condition exclusion except as provided in this subsection. A preexisting condition exclusion may not exceed 12 months. A preexisting condition exclusion may not be more restrictive than as follows.

A. In a group contract, a preexisting condition exclusion may relate only to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of coverage. An exclusion may not be imposed relating to pregnancy as a preexisting condition.

B. In an individual contract not subject to paragraph C, a preexisting condition exclusion may relate only to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage or to a pregnancy existing on the effective date of coverage.

C. An individual policy issued on or after January 1, 1998 to a federally eligible individual as defined in section 2848 may not contain a preexisting condition exclusion.

D. A routine preventive screening or test yielding only negative results may not be deemed to be diagnosis, care or treatment for the purposes of this subsection.

E. Genetic information may not be used as the basis for imposing a preexisting condition exclusion in the absence of a diagnosis of the condition relating to that information.

Sec. 27. 24-A MRSA §§2850-B to 2850-D are enacted to read:

§2850-B. Guaranteed renewal; cessation of business

1. Application. This section applies to:

A. Individual health plans subject to section 2736-C; and

B. Group medical insurance contracts subject to chapter 35 except:

(1) Medicare supplement policies subject to chapter 67; and

(2) Contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

2. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Carrier" means an insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue group health plans in this State.

B. "Individual market" means individual or group policies or contracts subject to section 2736-C.

C. "Large group market" means groups not subject to section 2736-C or 2808-B.

D. "Small group market" means groups subject to section 2808-B.

3. Renewal. Renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except:

A. When the policyholder or contract holder fails to pay premiums or contributions in accordance with the terms of the contract or the carrier has not received timely premium payments;

B. For fraud or intentional misrepresentation of material fact by the policyholder or contract holder;

C. With respect to coverage of individuals under a group policy or contract, for fraud or intentional misrepresentation of material fact on the part of the individual or the individual's representative;

D. In the large or small group market, for noncompliance with the carrier's minimum participation requirements that may not exceed 75%;

E. With respect to a managed care plan, as defined in section 4301, if there is no longer an insured who lives, resides or works in the service area;

F. When the carrier ceases offering large or small group health plans in compliance with subsection 4 and does not renew any existing policies in that market; or

G. When the carrier ceases offering a product and meets the following requirements:

(1) In the large group market:

(a) The carrier must provide notice to the policyholder and to the insureds at least 90 days before termination;

(b) The carrier must offer to each policyholder the option to purchase any other product currently being offered in the large group market; and

(c) In exercising the option to discontinue the product and in offering the option of coverage

under division (b), the carrier must act uniformly without regard to the claims experience of the policyholders or the health status of the insureds or prospective insureds;

(2) In the small group market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section 2808-B;

(b) The superintendent shall find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and to the insureds at least 90 days before replacement; or

(3) In the individual market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section 2736-C;

(b) The superintendent shall find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and, if a group policy, to the insureds at least 90 days before replacement.

4. Cessation of business. Carriers that provide health plans in the large group or small group markets after the effective date of this section that plan to cease offering coverage in one or both of those markets must comply with the following requirements.

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

B. Carriers that cease to write new small group business continue to be governed by section 2808-B with respect to business conducted after that section.

C. Carriers that cease to write new business in that market are prohibited from writing new business in that market for a period of 5 years after the date of termination of the last policy.

§2850-C. Nondiscrimination

1. Application. This section applies to group medical insurance contracts subject to chapter 35 other than contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

2. Eligibility and premium contributions. A carrier may not establish rules for eligibility of an individual to enroll, or require an individual to pay a premium or contribution that is greater than that for a similarly situated individual, based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability in relation to the individual or a dependent of the individual. Nothing in this section requires a group health plan to provide particular benefits other than those provided under the terms of the plan or restricts the amount an employer may be charged for coverage. Nothing in this section prohibits establishing limitations or restrictions on the amount, level, extent or nature of the benefits for similarly situated individuals enrolled in the plan. Nothing in this section prohibits a carrier from establishing premium discounts or refunds or modifying applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

§2850-D. Rules

Rules adopted pursuant to this chapter are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. 28. Application. The requirements of this Act apply to policies, contracts and certificates issued or renewed on or after July 1, 1997. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved.

SUMMARY

The Health Insurance Portability and Accountability Act of 1996 was enacted by Congress and signed by the President of the United States on August 21, 1996. Included in that act are health insurance reforms providing for portability of coverage, limits on preexisting condition exclusions, guaranteed renewability and guaranteed issue to small groups and certain individuals.

Although this State has had similar reforms and in many cases stronger reforms, in place for several years, many of the details differ. For this reason, many of the State's reform laws would be preempted by the federal law if not amended to conform to federal standards. This bill makes the necessary changes to avoid preemption and allow the State to continue to enforce its health insurance reform laws.

The bill eliminates duplicative language by making nonprofit hospital and medical service organizations subject to the continuity laws in the Maine Revised Statutes, Title 24-A rather than including identical language in Title 24.

The bill also amends the State's individual health insurance reform laws by clarifying residency requirements and waiving some of these requirements for federally eligible individuals. The bill also adds provisions allowing managed care plans to deny coverage to individuals not within their service area and provides a mechanism by which those plans may close enrollment if their capacity is exceeded. The bill eliminates language providing guaranteed renewal, which is now addressed in a new section applicable to both individual and group policies.

The bill also amends the State's small group health insurance reform laws. The most significant change is that this law now applies to groups with up to 50 employees, up from 24 employees in the current law. The rating restrictions for the newly covered groups take effect January 1, 1998, and are phased in over a 3-year period. Also, insurance carriers are permitted to establish a minimum group size of 2 employees. The federal law defines small groups as those with 2 to 50 employees. The bill also amends the rules for counting employees to conform to federal standards. As in the individual reform laws, provisions are added allowing managed care plans to deny coverage to individuals not within their service area and providing a mechanism by which those plans may close enrollment if capacity is exceeded. Provisions dealing with guaranteed renewal and limitations on preexisting condition exclusions are deleted because they are addressed in new sections with broader applicability.

The bill defines terms used to define "federally eligible individuals," who are entitled to certain rights detailed in other sections.

The bill also tightens the current restrictions on preexisting condition limitations to conform to the federal law. Use of genetic information is not allowed as a basis for an exclusion. In group contracts, only conditions for which medical advice, diagnosis, care or treatment was recommended or received in the past 6 months may be excluded and no exclusion may be imposed relating to pregnancy as a preexisting condition. No exclusion at all is permitted for federally eligible individuals.

The bill makes the continuity laws applicable to certain self-insured groups that are not otherwise exempt from state law.

The bill requires guaranteed renewal of all medical policies with certain exceptions that are based on the federal laws. Unlike the current laws, which apply to individuals and small groups, this guaranteed renewal provision applies to large groups as well.

The bill prohibits group insurance carriers from discriminating against individuals within a group with respect to eligibility standards or premium contributions based on the individual's medical condition or claims experience. Similar requirements already apply to individuals and small groups, but this bill applies to large groups as well.

The requirements of the bill apply to policies, contracts and certificates issued or renewed on or after July 1, 1997. This is the effective date for the group health insurance reforms of the federal laws.