L.D. 2050

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BANKING AND INSURANCE

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
118TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 1459, L.D. 2050, Bill, "An Act to Amend the Laws Concerning Life and Health Insurance"

Amend the bill in Part B by striking out all of section B-3 and inserting in its place the following:

'**Sec. B-3. 24-A MRSA §2809-A, sub-§1-B** is enacted to read:

1-B. Notification of availability of individual coverage. An insurer must provide forms to group policyholders for the purpose of informing terminating group members of their right to purchase any individual health plan available in this State. An adequate supply of forms must be provided to each group policyholder when the policy is issued and at least annually thereafter. The superintendent may prescribe the content of the form by routine technical rule pursuant to Title 5, chapter 375, subchapter II-A. The form must include at least the following:

A. A statement that all state residents not eligible for Medicare have a right to purchase any individual health plan available in this State;

B. A statement that in order to avoid a gap in coverage, the individual should apply for individual coverage prior to termination of group coverage;

C. A statement that if more than 90 days pass between the time the group coverage ends and the time individual coverage begins, the individual coverage may exclude preexisting conditions for one year; and

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D. A statement that information concerning individual coverage is available from the Bureau of Insurance. The bureau's toll-free telephone number must also be provided.'

Further amend the bill in Part C by striking out all of section C-3 and inserting in its place the following:

'**Sec. C-3. 24-A MRSA §2834,** as amended by PL 1995, c. 332, Pt. N, §3, is further amended to read:

§2834. Newborn children coverage

All group and blanket health insurance policies providing coverage on an expense incurred basis must provide that health insurance benefits 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.

The coverage for newly born children ~~shall~~ must consist of coverage of injury or sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond ~~such~~ that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 2834-A must be paid regardless of whether coverage under this section is elected.

The requirements of this section ~~shall~~ apply to all policies delivered or issued for delivery in this State more than 120 days after the effective date of this Act.'

Further amend the bill by striking out all of Part E and inserting in its place the following:

'**PART E**

Sec. E-1. 24 MRSA §2332-H is enacted to read:

§2332-H. Assignment of benefits

All contracts providing benefits for medical care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the contract.

Sec. E-2. 24-A MRSA §2755 is enacted to read:

§2755. Assignment of benefits

All policies providing benefits for medical care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy.

Sec. E-3. 24-A MRSA §2827-A is enacted to read:

§2827-A. Assignment of benefits

All policies and certificates providing benefits for medical care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy or certificate.

Sec. E-4. 24-A MRSA §4207-A, sub-§5-A is enacted to read:

5-A. Assignment of benefits. All point-of-service contracts and certificates must contain a provision permitting the insured to assign any benefits provided for medical care on an expense-incurred basis to the provider of the care. An assignment of benefits under this subsection does not affect or limit the payment of benefits otherwise payable under the contract or certificate.'

Further amend the bill by striking out all of Parts G and F and inserting in their place the following:

'PART F

Sec. F-1. 24 MRSA §2332-I is enacted to read:

§2332-I. Effective date of cancellation

Contracts that do not provide for any refund of premium when a subscriber requests cancellation prior to the end of the period for which premiums have been paid must state that no refund is payable and that the cancellation will take effect at the end of

the period for which premiums have been paid unless the subscriber requests an earlier cancellation date. If a subscriber requests cancellation of a contract before the end of the period for which premiums have been paid, then the nonprofit hospital or medical service organization must inform the subscriber in writing that no refund is payable and give the subscriber an opportunity to amend the cancellation request to take effect at the end of the period for which premiums have been paid.

Sec. F-2. 24-A MRSA §2453 is enacted to read:

§2453. Effective date of cancellation

Life and health insurance policies that do not provide for any refund of premium when a policyholder requests cancellation prior to the end of the period for which premiums have been paid must state that no refund is payable and that the cancellation will take effect at the end of the period for which premiums have been paid unless the policyholder requests an earlier cancellation date. If a policyholder requests cancellation of a contract before the end of the period for which premiums have been paid, then the insurer must inform the policyholder in writing that no refund is payable and give the policyholder an opportunity to amend the cancellation request to take effect at the end of the period for which premiums have been paid.

PART G

Sec. G-1. 24 MRSA §2332-A, sub-§1-A is enacted to read:

1-A. Coordination with Medicare. Coordination of benefits is governed by the following provisions.

A. The contract may not coordinate benefits with Medicare Part A unless:

(1) The insured is enrolled in Medicare Part A;

(2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or

(4) The insured is eligible for Medicare Part A without paying a premium and the contract states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the

insured's right to premium-free Medicare Part A coverage.

B. The contract may not coordinate benefits with Medicare Part B unless:

(1) The insured is enrolled in Medicare Part B;

(2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or

(4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the contract was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the contract will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B.

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B.

Sec. G-2. 24-A MRSA §2844, sub-§1-A is enacted to read:

1-A. Coordination with Medicare. Coordination of benefits is governed by the following provisions.

A. The contract may not coordinate benefits with Medicare Part A unless:

(1) The insured is enrolled in Medicare Part A;

(2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or

(4) The insured is eligible for Medicare Part A without paying a premium and the certificate states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage.

B. The contract may not coordinate benefits with Medicare Part B unless:

(1) The insured is enrolled in Medicare Part B;

(2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or

(4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the certificate was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the contract will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B.

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B.

PART H

Sec. H-1. 24-A MRSA §2849-A, sub-§4, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

4. Liability after discontinuance. After discontinuance of a policy, the insurer or health maintenance organization remains liable only to the extent of its accrued liabilities and extensions of benefits. ~~The liability of the insurer or health maintenance organization is the same whether the group policyholder or other entity secures replacement coverage from any insurer, nonprofit hospital or medical service organization or health maintenance organization, self insures or foregoes the provision of coverage.~~

Sec. H-2. 24-A MRSA §2849-A, sub-§4-A is enacted to read:

4-A. Coordination of benefits. If replacement coverage is secured by the group policyholder from any insurer, nonprofit hospital or medical service organization or health maintenance organization and a totally disabled person is covered under such replacement coverage, the replacement coverage must pay as primary coverage and the replaced coverage must pay as secondary coverage for the covered expenses directly relating to the condition causing total disability during the extension of benefits required under this section.'

Further amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

Further amend the bill by inserting at the end before the summary the following:

'**FISCAL NOTE**

This bill may increase the number of civil suits and civil violations filed in the court system. The additional workload and administrative costs associated with the minimal number of new cases filed can be absorbed within the budgeted resources of the Judicial Department. The collection of additional filing fees and fines may also increase General Fund revenue by minor amounts.

The Bureau of Insurance within the Department of Professional and Financial Regulation will incur some minor additional costs to administer new filings and to amend certain rules. These costs can be absorbed within the bureau's existing budgeted resources.'

SUMMARY

This amendment does the following.

1. It rewrites awkward language in Part B.

2. It makes the language regarding requirements for newborn coverage consistent with other provisions.

3. It clarifies that the amount payable upon assignment of benefits under a health insurance policy is the amount that would otherwise be payable under the policy or contract.

4. It requires that insurers include a statement in the contract regarding whether or not a refund of premium is available when a policyholder requests termination of a policy prior to the end of the period for which premiums have been paid.

5. It clarifies the coordination of Medicare benefits provisions.

6. It requires that if a totally disabled person obtains replacement coverage the replacement plan is primary coverage during the extension of benefits period.

The amendment also adds a fiscal note to the bill.