118th MAINE LEGISLATURE

SECOND REGULAR SESSION-1998

Legislative Document **No. 2050**

H.P. 1459 House of Representatives, January 15, 1998

An Act to Amend the Laws Concerning Life and 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 SAXL of Bangor.
Cosponsored by Representative DAVIDSON of Brunswick.

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

PART A

Sec. A-1. 24-A MRSA §4301, sub-§1, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

1. Carrier. "Carrier" means an insurance company licensed in accordance with this Title, a health maintenance organization licensed pursuant to chapter 56, a preferred provider organization licensed pursuant to chapter 32 ~~or~~, a nonprofit hospital or medical service organization licensed pursuant to Title 24 or a multiple-employer welfare arrangement licensed pursuant to chapter 81. An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

PART B

Sec. B-1. 24 MRSA §2327-A, as amended by PL 1997, c. 445, §1 and affected by §32, is further amended to read:

§2327-A. Applicability

Title 24-A, sections 2803, 2808-B, 2809-A and 2834-B apply to nonprofit hospital corporations, nonprofit medical service corporations and nonprofit health care plans to the extent not inconsistent with this chapter.

Sec. B-2. 24 MRSA §2330, as amended by PL 1997, c. 393, Pt. A, §25, is repealed.

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 conditions covered under the group policy will not be excluded as preexisting conditions under the individual policy unless there is a gap in coverage greater than 90 days; and

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.

PART C

Sec. C-1. 24 MRSA §2319, as amended by PL 1995, c. 332, Pt. N, §1, is further amended to read:

§2319. Newborn children coverage

All individual and group nonprofit hospital and medical service organization contracts must provide that benefits are payable with respect to a newly born child from the moment of birth.

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

If payment of a specific subscription fee is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required fees must be furnished to the nonprofit hospital or medical service organization 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 2318-A must be paid regardless of whether coverage under this section is elected.

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

Sec. C-2. 24-A MRSA §2743, as amended by PL 1995, c. 332, Pt. N, §2, is further amended to read:

§2743. Newborn children coverage

All individual health insurance policies providing coverage on an ~~expense-incurred~~ expense-incurred basis must provide that health insurance benefits are payable with respect to a newly born child of the insured or subscriber from the moment of birth.

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 2743-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.

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 consist~~ consists 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.

Sec. C-4. 24-A MRSA §4234-C is enacted to read:

§4234-C. Newborn children coverage

All individual and group health maintenance organization contracts must provide that benefits are payable with respect to a newly born child from the moment of birth.

The coverage for newly born children must consist of coverage of injury, sickness or other benefits provided by the contract, 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 contract may require that notification of birth of a newly born child and payment of the required fees must be furnished to the nonprofit hospital or medical service organization within 31 days after the date of birth in order to have the coverage continue beyond that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 4234-B must be paid regardless of whether coverage under this section is elected.

The requirements of this section apply to all contracts delivered or issued for delivery in this State on or after the effective date of this Act.

PART D

Sec. D-1. 24-A MRSA §5051, sub-§1, ¶E, as enacted by PL 1989, c. 556, Pt. B, §1, is amended to read:

E. A policy or contract offered primarily to provide basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection, ~~accident--only~~ accident-only coverage, specified disease or specified accident coverage, home health care coverage or limited benefit health coverage.

Sec. D-2. 24-A MRSA §5051, sub-§3-A is enacted to read:

3-A. Home health care policy. "Home health care policy" means a group or individual policy of health insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan that is advertised, marketed or designed primarily to provide benefits on either an expense-incurred or indemnity basis for confinements or costs associated with home health care services. For purposes of this definition, a policy is deemed to provide primarily home health care benefits if 50% or more of benefits payable or anticipated to be payable under the policy are related to home health care services. The term does not include:

A. A policy or contract defined as Medicare supplement insurance pursuant to chapter 67;

B. A policy or contract issued to one or more employers or labor organizations or to the trustees of a fund established by one or more employers or labor organizations, or combination of both, or for members or former members, or combination of both, of the labor organizations;

C. A policy or contract issued to any professional, trade or occupational association for its members, former members or retired members, or combination of members, if the association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least 2 years prior to the date of its initial offering of the policy or plan to its members; or

D. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance, when that group or individual policy or contract includes provisions that are inconsistent with the requirements of this chapter.

Sec. D-3. 24-A MRSA §5052, as enacted by PL 1985, c. 648, §12, is amended to read:

§5052. Specific standards

1. Standards for long-term care, home health care and nursing home care policies. The superintendent may ~~promulgate~~ adopt rules to establish specific standards for policy provisions of long-term care, home health care and nursing home care policies. The standards ~~shall~~ must be in addition to and in accordance with applicable laws of this State, including chapters 33 and 35, and may include, but are not limited to:

A. Terms of renewability;

B. Initial and subsequent conditions of eligibility;

C. Nonduplication of coverage;

D. Probationary periods;

E. Benefit limitations, exceptions and reductions;

F. Elimination periods;

G. Requirements for replacement;

H. Recurrent confinements; and

I. Definition of terms.

2. Prohibited policy provision. The superintendent may ~~promulgate~~ adopt rules that specify prohibited provisions not otherwise specifically authorized by law ~~which~~ that, in the opinion of the superintendent, are unjust, unfair, inequitable or unfairly discriminatory to any person insured or proposed for coverage under a long-term care, home health care or nursing home care policy.

Sec. D-4. 24-A MRSA §5052-A, as enacted by PL 1991, c. 200, Pt. C, §1, is amended to read:

§5052-A. Trial examination period

Nursing home care, home health care and long-term care policies must have a notice prominently printed on the first page of the policy or certificate or attached to the first page stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if for any reason, after examination of the policy or certificate, the applicant is not satisfied.

Sec. D-5. 24-A MRSA §5053, as amended by PL 1991, c. 200, Pt. C, §2, is further amended to read:

§5053. Rulemaking, disclosure standards, compensation

The superintendent may ~~promulgate~~ adopt reasonable rules to provide for the full and fair disclosure of information in connection with the sale of long-term care, home health care and nursing home care policies, including, but not limited to, an outline of coverage requirements and requirements relating to the replacement sale of the policies and compensation or commission to an agent or representative for the sale of a nursing home care, home health care or long-term care policy or certificate.

The superintendent may ~~promulgate~~ adopt reasonable rules setting or limiting the rate of compensation or commission to an agent or other representative for the sale of a nursing home care, home health care or long-term care policy or certificate and regarding replacement sale of a nursing home care, home health care or long-term care policy or certificate.

Sec. D-6. 24-A MRSA §5054, sub-§1, as enacted by PL 1989, c. 556, Pt. B, §4, is amended to read:

1. Filing of form. Any insurer, nonprofit hospital or medical service organization, or nonprofit health care plan may, at the time it files a policy or contract for approval for issuance or delivery in the State, or at any time thereafter, request that the superintendent certify the policy or contract as a long-term care policy within the meaning of section 5051.

Within 60 days of receipt of a request for certification, the superintendent shall:

A. Certify in writing that the policy or contract complies with this section;

B. Deny the request in writing, stating the reasons for denial; or

C. Notify the insurer or nonprofit hospital or medical service organization or nonprofit health care plan, in writing, that an insufficient basis exists for determining whether a certification should be made, indicating in what respects the request was insufficient.

Sec. D-7. 24-A MRSA §5056, first ¶, as enacted by PL 1991, c. 200, Pt. C, §3, is amended to read:

Every insurer, health care service plan or other entity marketing nursing home care, home health care or long-term care insurance coverage in this State, directly or through its producers, shall:

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.

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.

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.

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

5-A. 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.

PART F

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

§2332-I. Effective date of cancellation

If a subscriber requests cancellation of a contract before the expiration of the period for which premiums have been paid and the contract does not provide for any refund of premium, then the insurer must notify the subscriber in writing 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 subsequently requests an earlier cancellation date.

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

§2453. Effective date of cancellation

If a policyholder requests cancellation of a policy of life or health insurance before the expiration of the period for which premiums have been paid and the policy does not provide for any refund of premium, then the insurer must notify the policyholder in writing 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 subsequently requests an earlier cancellation date.

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; or

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

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 at the later of the time of application or the time of Medicare eligibility that the insured is responsible for enrolling in Medicare Parts A and B and the policy will not pay benefits that would be payable under Medicare.

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; or

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

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 at the later of the time of application or the time of Medicare eligibility that the insured is responsible for enrolling in Medicare Parts A and B and that the policy will not pay benefits that would be payable under Medicare.

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.

SUMMARY

Part A clarifies the applicability to multiple-employer welfare arrangements of the consumer protections provided in the Maine Revised Statutes, Title 24-A, chapter 56-A.

Part B requires a notice to terminating employees of their right to purchase an individual medical policy.

Part C clarifies requirements for coverage of newborn children and extends this requirement to health maintenance organizations.

Part D clarifies the law with respect to home health care insurance policies.

Part E requires assignment of benefits if requested by the insured.

Policyholders sometimes request termination of a life or health insurance policy prior to the end of the period for which premiums have been paid, not realizing that there will be no refund premium. Part F requires disclosure in these circumstances and requires coverage for the full period for which premium has been paid unless the policyholder requests otherwise.

Part G prohibits coordination with Medicare coverage for which the insured is eligible but not enrolled except under specified conditions.