L.D. 1703

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MAJORITY

BANKING AND INSURANCE

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
120TH LEGISLATURE
FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 1256, L.D. 1703, Bill, "An Act to Ensure Access to Health Insurance"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

'**Sec. 1. 24 MRSA §2319-A** is enacted to read:

§2319-A. Mandated offer of domestic partner benefits

1. Definition. As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of a subscriber or member who:

A. Is a mentally competent adult as is the subscriber or member;

B. Has been legally domiciled with the subscriber or member for at least 12 months;

C. Is not legally married to or legally separated from another individual;

D. Is the sole partner of the subscriber or member and expects to remain so; and

E. Is jointly responsible with the subscriber or member for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

COMMITTEE AMENDMENT

2. Mandated offer of domestic partner benefits. All individual or group contracts issued by any nonprofit hospital or medical service organization operating pursuant to this chapter must make available to an individual or group policyholder the option for additional benefits for the domestic partner of a subscriber or member, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married subscribers or members covered under an individual or group policy.

3. Financial dependency. Financial dependency of a domestic partner on the subscriber or member may not be required as a condition for eligibility for coverage.

4. Evidence of domestic partnership. As a condition of eligibility for coverage, a nonprofit hospital and medical service organization or a group policyholder may require a subscriber or member and the subscriber's or member's domestic partner to sign an affidavit attesting that the subscriber or member and the subscriber's or member's domestic partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

5. Preexisting conditions. A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of a subscriber or member.

6. Termination of domestic partner benefits. A nonprofit hospital and medical service organization may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of a subscriber or member upon notification by the subscriber or member that the domestic partner relationship has terminated. A subscriber or member may not enroll another individual as a domestic partner under an individual or group contract until 12 months after the termination of coverage for a prior domestic partner.

7. Construction. This section does not prohibit a nonprofit hospital and medical service organization from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

Sec. 2. 24-A MRSA §2741-A is enacted to read:

§2741-A. Mandated offer of domestic partner benefits

1. Definition. As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of a policyholder who:

A. Is a mentally competent adult as is the policyholder;

B. Has been legally domiciled with the policyholder for at least 12 months;

C. Is not legally married to or legally separated from another individual;

D. Is the sole partner of the policyholder and expects to remain so; and

E. Is jointly responsible with the policyholder for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

2. Mandated offer of domestic partner benefits. All individual health insurance policies or contracts issued by any insurer operating pursuant to this chapter must make available to policyholders the option for additional benefits for the domestic partner of a policyholder, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married policyholders.

3. Financial dependency. Financial dependency of a domestic partner on the policyholder may not be required as a condition for eligibility for coverage.

4. Evidence of domestic partnership. As a condition of eligibility for coverage, an insurer may require a policyholder and the policyholder's domestic partner to sign an affidavit attesting that the policyholder and the policyholder's domestic partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

5. Preexisting conditions. A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of a policyholder.

6. Termination of domestic partner benefits. An insurer may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of a policyholder upon

notification by the policyholder that the domestic partner relationship has terminated. A policyholder may not enroll another individual as a domestic partner under an individual contract until 12 months after the termination of coverage for a prior domestic partner.

7. Construction. This section does not prohibit an insurer from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

8. Exemption. This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care and other limited benefit health insurance policies.

Sec. 3. 24-A MRSA §2832-A is enacted to read:

§2832-A. Mandated offer of domestic partner benefits

1. Definition. As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of a certificate holder who:

A. Is a mentally competent adult as is the certificate holder;

B. Has been legally domiciled with the certificate holder for at least 12 months;

C. Is not legally married to or legally separated from another individual;

D. Is the sole partner of the certificate holder and expects to remain so; and

E. Is jointly responsible with the certificate holder for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

2. Mandated offer of domestic partner benefits. All group or blanket health insurance policies or contracts issued by any insurer operating pursuant to this chapter must make available to group policyholders the option for additional benefits for the domestic partner of a certificate holder, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married certificate holders covered under a group policy.

3. Financial dependency. Financial dependency of a domestic partner on the certificate holder may not be required as a condition for eligibility for coverage.

4. Evidence of domestic partnership. As a condition of eligibility for coverage, an insurer or group policyholder may require a certificate holder and the certificate holder's domestic partner to sign an affidavit attesting that the certificate holder and the certificate holder's domestic partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

5. Preexisting conditions. A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of a certificate holder.

6. Termination of domestic partner benefits. An insurer may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of a certificate holder upon notification by the certificate holder that the domestic partner relationship has terminated. A certificate holder may not enroll another individual as a domestic partner under a group contract until 12 months after the termination of coverage for a prior domestic partner.

7. Construction. This section does not prohibit an insurer from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

8. Exemption. This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care and other limited benefit health insurance policies.

Sec. 4. 24-A MRSA §4249 is enacted to read:

§4249. Mandated offer of domestic partner benefits

1. Definition. As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of an enrollee or member who:

A. Is a mentally competent adult as is the enrollee or member;

B. Has been legally domiciled with the enrollee or member for at least 12 months;

C. Is not legally married to or legally separated from another individual;

D. Is the sole partner of the enrollee or member and expects to remain so; and

E. Is jointly responsible with the enrollee or member for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

2. Mandated offer of domestic partner benefits. All individual or group policies or contracts issued by any health maintenance organization operating pursuant to this chapter must make available to an individual or group policyholder the option for additional benefits for the domestic partner of an enrollee or member, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married enrollees or members covered under a health maintenance organization individual or group contract.

3. Financial dependency. Financial dependency of a domestic partner on the enrollee or member may not be required as a condition for eligibility for coverage.

4. Evidence of domestic partnership. As a condition of eligibility for coverage, a health maintenance organization or group policyholder may require an enrollee or member and the enrollee's or member's domestic partner to sign an affidavit attesting that the enrollee or member and enrollee's or member's domestic partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

5. Preexisting conditions. A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of an enrollee or member.

6. Termination of domestic partner benefits. A health maintenance organization may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of an enrollee or member upon notification by the enrollee or member that the domestic partner relationship has terminated. An enrollee or member may not enroll another

individual as a domestic partner under an individual or group contract until 12 months after the termination of coverage for a prior domestic partner.

7. Construction. This section does not prohibit a health maintenance organization from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

Sec. 5. Application. The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2002. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.'

SUMMARY

This amendment is the majority report of the committee and replaces the bill. It requires health carriers to offer policies providing coverage for domestic partners of health plan members under the same terms and conditions as coverage for spouses of health plan members. It clarifies that the offer of domestic partner benefits is made to the group policyholder, not to each member covered under a group policy.

The amendment clarifies the definition of domestic partner to require that the domestic partners be legally domiciled with one another for at least 12 months, that the domestic partners not be legally married to or legally separated from another individual, that the domestic partners be mentally competent and that the domestic partners are each other's sole domestic partner and intend to remain so. The amendment clarifies that carriers may require domestic partners to sign an affidavit attesting that the definition of a domestic partner is met. The amendment clarifies that, after terminating a domestic partnership, a health plan member may not enroll another domestic partner for at least 12 months.

The amendment also clarifies that carriers may provide domestic partner benefits to policyholders that do not comply with the requirements of the bill. The provisions apply to all policies and contracts issued or renewed on or after January 1, 2002.