

# MAINE STATE LEGISLATURE

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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.

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

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

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

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

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

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

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

43 §2741-A. Mandated offer of domestic partner benefits  
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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.

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

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

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

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

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

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

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

40 **§4249. Mandated offer of domestic partner benefits**

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

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

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

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

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

8 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.

10 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.

14 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.

16 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.

20 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.

22 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.