120th MAINE LEGISLATURE

FIRST REGULAR SESSION-2001

Legislative Document **No. 1742**

H.P. 1282 House of Representatives, March 22, 2001

An Act to Clarify and Update the Laws Related to Health Insurance Contracts.

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.

Millicent M. MacFarland

MILLICENT M. MacFARLAND, Clerk

Presented by Representative SULLIVAN of Biddeford.
Cosponsored by Senator ABROMSON of Cumberland and
Representatives: DUDLEY of Portland, GLYNN of South Portland, MARRACHE of Waterville, MAYO of Bath, O'NEIL of Saco, Senator: LaFOUNTAIN of York.

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

PART A

Sec. A-1. 24 MRSA §2318-A, as enacted by PL 1995, c. 615, §1, is amended to read:

§2318-A. Maternity and routine newborn care

A nonprofit hospital or medical service organization that issues individual and group contracts providing maternity benefits, including benefits for childbirth, ~~must~~ shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section.

Sec. A-2. 24-A MRSA §2743-A, as enacted by PL 1995, c. 615, §2, is amended to read:

§2743-A. Maternity and routine newborn care

An insurer that issues individual contracts providing maternity benefits, including benefits for childbirth, ~~must~~ shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the

newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section.

Sec. A-3. 24-A MRSA §2834-A, as enacted by PL 1995, c. 615, §3, is amended to read:

§2834-A. Maternity and routine newborn care

An insurer that issues group contracts providing maternity benefits, including benefits for childbirth, ~~must~~ shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section.

Sec. A-4. 24-A MRSA §4234-B, as enacted by PL 1995, c. 615, §4, is amended to read:

§4234-B. Maternity and routine newborn care

Individual and group contracts issued by a health maintenance organization that provide maternity benefits, including benefits for childbirth, ~~must~~ shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section.

PART B

Sec. B-1. 24-A MRSA §2736-C, sub-§4, ¶A, as amended by PL 1997, c. 370, Pt. E, §4, is further amended to read:

A. Notice of the decision to cease doing business in the individual health plan market must be provided to the bureau 3 months prior to the cessation unless a shorter notice period is approved by the superintendent. If existing contracts are nonrenewed, notice must be provided to the policyholder or contract holder 6 months prior to nonrenewal.

Sec. B-2. 24-A MRSA §2736-C, sub-§4, ¶C, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

C. Carriers that cease to write new business in the individual health plan market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent unless the superintendent waives this requirement for good cause shown.

Sec. B-3. 24-A MRSA §2850-B, sub-§4, ¶¶A and C, as enacted by PL 1997, c. 445, §30 and affected by §32, are amended to read:

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

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 unless the superintendent waives this requirement for good cause shown.

PART C

Sec. C-1. 24-A MRSA §2849-C is enacted to read:

§2849-C. Certifications of coverage

1. Application. This section applies to:

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

B. Group and blanket health 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. Requirement for certification of period of creditable coverage. The requirement for a certification of the period of creditable coverage is as follows.

A. A carrier, as defined in section 4301-A, subsection 3, must provide the certification described in paragraph B with respect to health plans subject to this section:

(1) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(2) In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) On the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in subparagraph (1) or (2), whichever is later. The certification under subparagraph (1) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

B. The certification described in this paragraph is a written certification of:

(1) The period of federally creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision; and

(2) The waiting period, if any, imposed with respect to the individual for any coverage under the plan.

3. Alternative evidence of prior coverage. A carrier may not deny continuity rights as required by section 2849-B solely because the individual does not provide a certification described in subsection 2. The carrier must accept alternative evidence of prior coverage provided by the individual. If the individual

asserts the existence of prior coverage but is unable to provide evidence, the carrier must make reasonable efforts to verify the existence of the prior coverage. The carrier may deny continuity rights if the individual refuses to cooperate in the carrier's efforts to verify prior coverage, such as if the individual refuses to provide needed authorization for the release of information to the carrier when requested by the carrier.

4. Notice. A carrier may not impose a preexisting condition exclusion before notifying the individual of the individual's continuity rights and giving the individual an opportunity to provide a certification as described in subsection 2 or alternative evidence of prior coverage as described in subsection 3.

5. Rules. The superintendent may issue rules specifying the contents of certifications or other requirements consistent with this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

PART D

Sec. D-1. 24-A MRSA §2808-B, sub-§4, ¶A, as amended by PL 1999, c. 256, Pt. E, §2, is further amended to read:

A. ~~Coverage~~ Any small group health plan offered to any eligible group or subgroup must be ~~guaranteed~~ offered 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 within all or a designated part of its service area 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 subparagraph may not enroll individuals residing within the area subject to denial of coverage, or groups or subgroups within ~~the service~~ that area for a period of 180 days after the date of the first denial of coverage.

Sec. D-2. 24-A MRSA §2848, sub-§1-C, ¶E, as enacted by PL 1997, c. 445, §20 and affected by §32, is amended to read:

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. For purposes of this paragraph, an individual is considered to have exhausted COBRA continuation coverage when the individual no longer resides, lives or works in a service area of a managed care plan and there is no other COBRA continuation coverage available to the individual.

Sec. D-3. 24-A MRSA §2850, sub-§2, as amended by PL 1999, c. 256, Pt. L, §9, is further amended to read:

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, including the waiting period, if any. For purposes of this subsection, "waiting period" includes any period between the time an individual files a substantially complete application for an individual health plan and the time the coverage takes affect. 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 date of enrollment. An exclusion may not be imposed relating to pregnancy as a preexisting condition.

B. In an individual contract not subject to paragraph C, or in a blanket policy, 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 date of application 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 considered 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. For the purposes of this paragraph, "genetic information" has the same meaning as set forth in the Code of Federal Regulations.

PART E

Sec. E-1. 24-A MRSA §2701, sub-§2, ¶C, as enacted by PL 1995, c. 332, Pt. J, §1, is amended to read:

C. ~~Section~~ Sections 2736, 2736-A, 2736-B and 2736-C ~~applies~~ apply to:

(1) Association groups as defined by section 2805-A, except associations of employers; and

(2) Other groups as defined by section 2808, except employee leasing companies registered pursuant to Title 32, chapter 125.

Sec. E-2. 24-A MRSA §2736-C, sub-§3, ¶A, as amended by PL 1997, c. 445, §9 and affected by §32, is further amended to read:

A. Coverage must be guaranteed to all 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. Except for federally eligible individuals, coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months. 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 within all or a designated part of its service area 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 residing within the area subject to denial of coverage or groups or subgroups within ~~the service~~ that area for a period of 180 days after the date of the first denial of coverage.

Sec. E-3. 24-A MRSA §2808-B, sub-§1, ¶D, as repealed and replaced by PL 1997, c. 445, §12 and affected by §32, is amended to read:

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) A group is not an eligible group if there is any one other state where there are more eligible employees than are employed within this State and the group had coverage in that state or is eligible for guaranteed issuance of coverage in that state.

Sec. E-4. 24-A MRSA §2808-B, sub-§2, ¶E, as repealed and replaced by PL 1999, c. 256, Pt. E, §1, is amended to read:

E. The superintendent may ~~exempt from the requirements of this subsection~~ authorize a carrier to establish a separate community rate for an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 ~~that offers~~ a, as long as association group membership or eligibility for participation in the trustee group is not conditional on health status, claims experience or other risk selection criteria and all small group health ~~plan~~ plans offered by the carrier through that association or trustee group:

(1) ~~Complies~~ Are otherwise in compliance with the premium rate requirements of this subsection; and

(2) ~~Guarantees issuance and renewal to all persons and their dependents within~~ Are offered on a guaranteed issue basis to all eligible employers that are members of the association or are eligible to participate in the trustee group except that a professional association may require that a minimum percentage of the eligible professionals employed by a subgroup be members of the association in order for the subgroup to be eligible for issuance or renewal of coverage through the association. The minimum percentage must not exceed 90%. For purposes of this subparagraph, "professional association" means an association that:

(a) Serves a single profession that requires a significant amount of education, training or experience or a license or certificate from a state authority to practice that profession;

(b) Has been actively in existence for 5 years;

(c) Has a constitution and bylaws or other analogous governing documents;

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

(e) Is not owned or controlled by a carrier or affiliated with a carrier;

~~(f) Does not make membership in the association conditional on health status or claims experience;~~

(g) Has a least 1,000 members if it is a national association; 200 members if it is a state or local association;

(h) All members and dependents of members are eligible for coverage regardless of health status or claims experience; and

(i) Is governed by a board of directors and sponsors annual meetings of its members.

Producers may only market association memberships, accept applications for membership or sign up members in the professional association where the individuals are actively engaged in or directly related to the profession represented by the professional association.

Sec. E-5. 24-A MRSA §2848, sub-§1-B, as amended by PL 1999, c. 256, Pt. L, §2, is further amended by amending the last blocked paragraph to read:

For purposes of this subsection, a "period of continuing federally creditable coverage" means a period in which an individual has maintained federally 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 federally 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 federally creditable coverage during this period. For purposes of this subsection and subsection 1-C, "group health plan" has the same meaning as specified in the federal Public Health Service Act, Title XXVII, Section 2791(a).

Sec. E-6. 24-A MRSA §2849, sub-§4. as repealed and replaced by PL 1993, c. 349, §53, is repealed.

Sec. E-7. 24-A MRSA §2849-B. sub-§2, ¶A, as amended by PL 1999, c. 36, §2, is further amended to read:

A. That person was covered under an individual or group contract or policy 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, 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 or governmental program that previously covered the person is the "prior contract or policy"; and

Sec. E-8. 24-A MRSA §2849-B, sub-§3, as amended by PL 1999, c. 256, Pt. L, §7, is further amended to read:

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee except as provided in this subsection. A late enrollee may be excluded from coverage for a waiting period of not more than 12 months based on medical underwriting or preexisting conditions. If a shorter waiting period or no waiting period is imposed, coverage for the late enrollee may exclude preexisting conditions for the lesser of 18 months, reduced by any federally creditable coverage, or 12 months. The exclusion is subject to the limitations set forth in section ~~1850~~ 2850. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract or policy or terminated coverage under the succeeding contract because that individual was covered under a prior contract or policy and:

(1) Coverage under that contract or policy ceased because the individual became ineligible for reasons other than fraud or material misrepresentation, including, but not limited to, termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce; or

(2) Employer contributions toward that coverage were terminated;

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and

the request for coverage is made within 30 days after issuance of the court order;

C-1. That person was covered by the Cub Care program under Title 22, section 3174-R, and the request for replacement coverage is made while coverage is in effect or within 30 days from the termination of coverage; or

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person becomes eligible.

Sec. E-9. 24-A MRSA §2850, sub-§1-A, as enacted by PL 1997, c. 445, §28 and affected by §32, is repealed and the following enacted in its place:

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

A. "Date of enrollment" means the effective date of coverage or, if earlier, the first day of the waiting period for such coverage.

B. "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. E-10. 24-A MRSA §2850-B, sub-§3, as enacted by PL 1997, c. 445, §30 and affected by §32, is amended by amending the first paragraph to read:

3. Renewal. ~~Renewal~~ Coverage may not be cancelled, and renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except:

Sec. E-11. 24-A MRSA §2850-B, sub-§4, ¶B, as enacted by PL 1997, c. 445, §30 and affected by §32, is amended to read:

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~~ small group contracts in force and their renewal or replacement contracts.

PART F

Sec. F-1. 24-A MRSA §5001, sub-§4-B is enacted to read:

4-B. Open enrollment period. "Open enrollment period" means the 6-month period beginning when an individual of any age first enrolls for benefits under Medicare Part B and the 6-month period beginning on the 65th birthday of an individual who has enrolled for benefits under Medicare Part B before turning 65 years of age.

Sec. F-2. 24-A MRSA §5004, sub-§2, as amended by PL 1991, c. 740, §6, is further amended to read:

2. Medicare supplement policies must ~~provide for a~~ return to policyholders benefits that are reasonable in relation to the premium charged. The superintendent shall issue reasonable rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

Sec. F-3. 24-A MRSA §5005, sub-§3-B, ¶D, as enacted by PL 1991, c. 740, §7, is repealed.

Sec. F-4. 24-A MRSA §5011, sub-§1, ¶B, as enacted by PL 1991, c. 740, §13, is amended to read:

B. In revising rates for ~~a~~ standardized ~~plan~~ plans, an issuer shall pool all experience for ~~that plan~~ standardized plans under individual policies. Experience may be pooled separately for each standardized plan or experience for similar benefits in different standardized plans may be pooled, including, but not limited to, basing the component of the rate for skilled nursing coinsurance on the pooled experience of all standardized plans that include that benefit. Group plans may be rated separately. A group with credible experience may be rated differently than other groups.

Sec. F-5. 24-A MRSA §5011, sub-§1, ¶¶C and D are enacted to read:

C. An issuer that offers both group and individual plans may not use stricter medical underwriting standards for any group plan than it uses for individual plans.

D. An issuer may not use stricter medical underwriting standards than any affiliated issuer uses for its individual plans.

PART G

Sec. G-1. 24 MRSA §2317-B, sub-§10, as amended by PL 1999, c. 790, Pt. A, §27, is further amended to read:

10. Title 24-A, section 2747. Arbitration of disputed claims, Title 24-A, section ~~2749~~ 2747;

Sec. G-2. 24 MRSA §2317-B, sub-§16-A is enacted to read:

16-A. Title 24-A, section 2845. Cardiac rehabilitation coverage; Title 24-A, section 2845;

Sec. G-3. 24-A MRSA §4222-B, sub-§14, as enacted by PL 1999, c. 256, Pt. F, §1, is amended to read:

14. The requirement of filing a report of experience of claims payment for alcoholism and drug dependency treatment in the format prescribed by section 2842, subsection 9; for chiropractic services in the format prescribed by section 2748, subsection 3 and section 2840-A, subsection 3; and for breast cancer screening services in the format prescribed by section 2745-A, subsection 4 and section 2837-A, subsection 4 applies to health maintenance organizations.

PART H

Sec. H-1. 24-A MRSA §2412, sub-§1-A, as enacted by PL 1997, c. 370, Pt. G, §2, is amended to read:

1-A. An insurer may not provide coverage to a resident of this State under a group or blanket policy or contract issued and delivered outside this State unless the following requirements of this subsection are met.

A. For "other group" insurance policies as defined in sections 2612-A and 2808, all forms must be filed with and approved by the superintendent.

B. For trustee group policies as defined in sections 2606-A and 2806 and association group policies as defined in sections 2607-A and 2805-A, certificates of coverage to be delivered or issued for delivery in this State:

(1) Must be filed with the superintendent at least 60 days before any solicitation in this State, with sufficient information concerning the nature of the group, including any trust agreements or association bylaws, to enable the superintendent to determine whether the group satisfies the statutory requirements for a trustee or association group; and

(2) May not have been disapproved.

C. For group or blanket policies other than those specified in paragraphs A and B and in section 2858, the group certificates to be delivered or issued for delivery in this State must be filed with the superintendent at the superintendent's request and may not have been disapproved.

D. The superintendent may disapprove a form filed pursuant to this subsection only if:

(1) The policy or form is not in compliance with the laws of the state in which it was issued or delivered;

(2) The policy or form is not in compliance with the laws of this State that apply when the policy is issued outside this State, such as chapter 36 or section 2843; or

(3) The superintendent determines that the form is deceptive or misleading.

SUMMARY

This bill does the following.

Part A clarifies the requirement for coverage of newborns under maternity benefits by specifying that newborns are not subject to a separate deductible.

Part B gives the Superintendent of Insurance authority to waive the requirement that an insurer that exits the individual, small group or large group health insurance market in the State can not reenter for 5 years. It also gives the superintendent authority to waive the requirement that an insurer give a 3-month notice before ceasing to issue individual, small group or large group health insurance in the State.

Part C requires insurers to provide a certificate of creditable coverage to terminating insureds consistent with federal law.

Part D conforms various definitions and other provisions to federal regulations adopted pursuant to the Health Insurance Accessibility and Accountability Act of 1996.

Part E clarifies several definitions and other provisions in the individual health insurance reform laws, the small group health insurance reform laws and the continuity of coverage laws.

Part F amends the laws pertaining to Medicare supplement policies. It allows rates for benefit components of one plan to be based on the average cost of that benefit component across all standardized plans. It restricts the ability of insurers to segregate insureds by health status through the use of association groups.

Part G corrects errors from a previous law.

Part H makes out-of-state blanket policies providing coverage in the State subject to the same filing requirements as out-of-state group policies.