L.D. 1745

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BANKING AND INSURANCE

Reported by:

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STATE OF MAINE
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COMMITTEE AMENDMENT "B" to S.P. 573, L.D. 1745, Bill, "An Act to Address Issues in the Maine Health Insurance Market"

Amend the bill in Part A by striking out all of sections 1 and 2.

Further amend the bill in Part A by striking out all of sections 4 and 5 and inserting in their place the following:

'**Sec. A-4. 24-A MRSA §2736-C, sub-§1, ¶B-1** is enacted to read:

B-1. "Adjusted rate" means a carrier's rate for a given benefit plan, family status, age and geographic area before any variation based on smoking status.

Sec. A-5. 24-A MRSA §2736-C, sub-§2, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

B. A carrier may not vary the premium rate due to the gender, health status, occupation or industry, claims experience or policy duration of the individual.'

Further amend the bill in Part A by striking out all of section 7 and inserting in its place the following:

'**Sec. A-7. 24-A MRSA §2736-C, sub-§2, ¶D-1** is enacted to read:

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D-1. On or after January 1, 2002, a carrier may vary rates due to smoking status only as permitted by this paragraph.

(1) A carrier shall establish a standard rating class. If the carrier does not vary rates based on smoking status, standard rates must be equal to the adjusted rates. If the carrier does vary rates based on smoking status, standards rates must be a fixed percentage above the adjusted rates and must comply with subparagraph (3).

(2) A carrier may offer a discount to an individual who does not smoke.

(3) The discounting methodology must be chosen so as to make the projected average rate for a given benefit package and family structure equal to the community rate, calculating the average on the basis of the carrier's anticipated distribution of rating adjustments for smoking status, age and geographic area.

(4) The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts. Rules adopted pursuant to this subparagraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.'

Further amend the bill in Part A by striking out all of section 8.

Further amend the bill in Part A by striking out all of section 10 and inserting in its place the following:

'**Sec. A-10. 24-A MRSA §2808-B, sub-§1, ¶B-1** is enacted to read:

B-1. "Adjusted rate" means a carrier's rate for a given benefit plan, group size, family status, age, industry and geographic area before any variation based on smoking status.

Sec. A-11. 24-A MRSA §2808-B, sub-§2, ¶C, as amended by PL 1993, c. 477, Pt. B, §1 and affected by Pt. F, §1, is further amended to read:

C. A carrier may vary the premium rate due to family membership, smoking status, participation in wellness programs and group size.'

Further amend the bill in Part A by inserting after section 12 the following:

'**Sec. A-13. 24-A MRSA §2808-B, sub-§2, ¶D-3** is enacted to read:

D-3. On or after January 1, 2002, a carrier may vary rates due to smoking status or participation in wellness programs only as permitted by this paragraph.

(1) A carrier shall establish a standard rating class. If the carrier does not vary rates based on smoking status or participation in wellness programs, standard rates must be equal to the adjusted rates. If the carrier does vary rates based on smoking status or participation in wellness programs, standard rates must be a fixed percentage above the adjusted rates and must comply with subparagraph (3).

(2) A carrier may offer one or more discounts to an individual who does not smoke or who participates in a wellness program.

(3) The discounting methodology must be chosen so as to make the projected average rate for a given benefit package and family structure equal to the community rate, calculating the average on the basis of the carrier's anticipated distribution of rating adjustments for smoking status, participation in wellness programs, age, industry and geographic area.

(4) The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts. Rules adopted pursuant to this subparagraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.'

Further amend the bill in Part B by striking out all of sections 1 to 5 and inserting in their place the following:

'**Sec. B-1. 24-A MRSA §2803-A, sub-§§2 and 3,** as enacted by PL 1995, c. 71, §2, are amended to read:

2. Disclosure of basic loss information. Upon written request, every insurer shall provide loss information concerning a group policy or contract to its policyholder ~~at least 60 days prior to renewal of the policy or contract and again 6 months from the date the policy becomes effective~~ within 21 business days of the date of the request.

3. Transmittal of request. ~~If a policyholder requests loss information from an~~ An insurance ~~agent~~ producer or other authorized representative, ~~the representative or agent~~ who receives a request for loss information in accordance with this section shall transmit the request for loss information to the insurer within 4 ~~working~~ business days.

Sec. B-2. 24-A MRSA §2803-A, sub-§4, as amended by PL 1997, c. 370, Pt. E, §5, is further amended to read:

4. Exception. An insurer is not required to provide the loss information described in this section ~~to~~ for a group that is eligible for small group coverage pursuant to section 2808-B.

Sec. B-3. 24-A MRSA §4222-B, sub-§§17 to 19 are enacted to read:

17. Section 2803-A, relating to disclosure of loss information, applies to health maintenance organizations.

18. The requirement of section 2809-A, subsection 11 to continue group coverage under certain circumstances applies to health maintenance organizations.

19. Section 12-A, relating to penalties, applies to health maintenance organizations.'

Further amend the bill in Part B by striking out all of section 9 and inserting in its place the following:

'**Sec. B-9. 24-A MRSA §5002-B, sub-§2-A** is enacted to read:

2-A. Low-cost drugs for the elderly or disabled program. An issuer that offers standardized plans that include prescription drug benefits shall permit an insured who has a plan from the same issuer without prescription drug benefits to purchase a plan with prescription drug benefits under the following circumstances:

A. The insured was covered under the low-cost drugs for the elderly or disabled program established by Title 22, section 254;

B. The insured applies for a plan with prescription drug coverage within 90 days after losing eligibility for the low-cost drugs for the elderly or disabled program established by Title 22, section 254; and

C. The insured either:

(1) Had a Medicare supplement plan with prescription drug benefits from the same issuer prior to enrolling in the low-cost drugs for the elderly or disabled program established by Title 22, section 254; or

(2) Is entitled to continuity of coverage pursuant to subsection 1 and has had prescription drug benefits, through either a Medicare supplement plan or the low-cost drugs for the elderly or disabled program established by Title 22, section 254, since the insured's open enrollment period with no gap in prescription drug coverage in excess of 90 days.

The purchase of a plan with prescription drug benefits by an insured pursuant to this subsection does not affect eligibility for coverage under the low-cost drugs for the elderly or disabled program established by Title 22, section 254 if the insured is not covered by a Medicare supplement plan with prescription drug benefits at the time of reapplying for coverage under the low-cost drugs for the elderly or disabled program established by Title 22, section 254.'

Further amend the bill in Part C in section 1 in that part designated "**§2691.**" in subsection 3 by striking out all of paragraphs D and E and inserting in their place the following:

'D. Long-term care insurance policies subject to chapter 68;

E. Group disability income protection coverage; or

F. Insurance policies supplemental to the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55 (2000).'

Further amend the bill in Part C in section 1 in that part designated "**§2694.**" by striking out all of subsection 7 and inserting in its place the following:

'**7. Individual disability income protection coverage.** Individual disability income protection coverage;'

Further amend the bill in Part C in section 1 in that part designated "**§2697.**" in the first paragraph in the 3rd line (page 18, line 46 in L.D.) by striking out the following: "routine technical" and inserting in its place the following: 'major substantive'

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

The Bureau of Insurance within the Department of Professional and Financial Regulation will incur some minor additional costs to adopt rules to implement the provisions of this bill. These costs can be absorbed within the bureau's existing budgeted resources.'

SUMMARY

This amendment is the minority report of the committee. It differs from the majority report only in Part A because it retains the provisions relating to community rating with the exception of the medical underwriting and healthy lifestyle provisions in the bill. The changes proposed in the amendment to Parts B and C of the bill are identical to those contained in the majority report.

In Part A, this amendment does the following.

1. It removes the provisions relating to private purchasing alliances because those changes are included in other legislation.

2. It removes the provisions proposing to allow medical underwriting on the basis of health status and healthy lifestyle in the individual health insurance market, but retains the provisions allowing rating on the basis of smoking status in the community rating laws applicable to individual and small group health insurance.

3. It retains the provisions increasing the downward adjustments in the community rating bands in the individual and small group health insurance market on the basis of age and geographic area.

4. It removes the provisions authorizing the Superintendent of Insurance to authorize pilot projects for innovative products and multistate products in the individual and small group health insurance markets.

5. It retains the provision eliminating the requirement for carriers to offer standardized plans in the small group market.

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In Part B, the amendment does the following.

1. It removes the provisions relating to notices of rate increases to policyholders because similar provisions are included in other legislation.

2. It requires insurers to provide loss information in aggregate form to group policyholders upon written request within 21 business days of the request. Under current law, insurers are required to provide the information upon request 60 days prior to renewal of the policy and again 6 months from the date the policy becomes effective.

3. It removes the provisions that would have permitted the disclosure of confidential loss information relating to the medical diagnosis, treatment or health status of group members, including potentially identifying information.

4. It retains the provision making the continuity and penalties provisions of the Maine Insurance Code applicable to health maintenance organizations.

5. It retains the provision relating to standards applicable to health insurance policies that limit payment of claims for covered services based on a determination of "usual, customary and reasonable " charges.

6. It retains the provision requiring utilization review entities to advise whether or not the service reviewed for medical necessity is a covered service under the health policy or contract at issue.

7. It retains the provision permitting those who lose eligibility for the low-cost drugs for the elderly and disabled program to purchase a Medicare supplement policy with prescription drug benefits. The amendment also clarifies that Medicare supplement coverage with prescription drug benefits may not affect eligibility for coverage under the low-cost drugs for the elderly and disabled program if the individual no longer has Medicare supplement coverage with prescription drug benefits at the time of reapplication for the program.

In Part C, the amendment clarifies that the new chapter of the Maine Insurance Code does not apply to group disability income protection coverage. The amendment also makes the rules adopted by the Superintendent of Insurance major substantive and subject to legislative review before final adoption.

The amendment also adds a fiscal note to the bill.