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S.P. 573 In Senate, March 27, 2001

An Act to Address Issues in the Maine Health Insurance Market.

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.

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator ABROMSON of Cumberland.
Cosponsored by Senators: GOLDTHWAIT of Hancock, LaFOUNTAIN of York, MARTIN of Aroostook, Representatives: BRUNO of Raymond, O'NEIL of Saco.

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

PART A

Sec. A-1. 24-A MRSA §1951, sub-§2, as amended by PL 1997, c. 616, §1, is further amended to read:

2. Private purchasing alliance. "Private purchasing alliance" or "alliance" means a corporation licensed pursuant to this section established under Title 13-A or Title 13-B to provide health insurance to its members through ~~multiple unaffiliated~~ one or more participating carriers.

Sec. A-2. 24-A MRSA §1954, sub-§2, as amended by PL 1997, c. 370, Pt. A, §§1 and 2, is repealed.

Sec. A-3. 24-A MRSA §2736-C, sub-§1, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is repealed and the following enacted in its place:

B. "Community rate" means a carrier's average rate for a given benefit package for a given family status such as individual, couple or family. The average must be based on the anticipated mix of business during the rating period.

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 health status, smoking status or healthy lifestyle.

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.

Sec. A-6. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 1995, c. 177, §1, is further amended to read:

D. A carrier may vary the premium rate due to age~~,--smoking status,--occupation--or--industry,~~ and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State ~~after~~ between July 15, 1995 and December 31, 2001, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State in calendar year 2002, the adjusted rate may not be less than 70% nor greater than 120% of the community rate filed by the carrier.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2003, the adjusted rate may not be less than 60% nor greater than 120% of the community rate filed by the carrier.

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

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

(1) A carrier shall establish a standard rating class. Standard rates may be equal to the adjusted rates or may be a fixed percentage above or below the adjusted rates, but must comply with subparagraph (4).

(2) A carrier may establish one or more substandard rating classes.

(a) An individual applying for coverage on or after January 1, 2002 may be assigned to a

substandard rating class based on health status or health history.

(b) A substandard rate may not exceed 150% of the standard rate for the same age, geographic area, benefit plan and family status.

(c) A carrier may reduce the multiple of the standard rate that an individual is charged on any renewal date based on improved health status, but may never increase the multiple.

(3) A carrier may offer one or more discounts to an individual who does not smoke or who has a healthy lifestyle.

(a) Criteria used to define a healthy lifestyle must be based upon factors within an individual's control. These criteria may not be based on health history or health status. These criteria must be filed with and approved by the superintendent.

(b) Discounts must apply equally to eligible individuals in the standard and substandard rating classes.

(4) The multiples used for standard and substandard rates and 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 health status, lifestyle, age and geography.

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

Sec. A-8. 24-A MRSA §§2759 and 2760 are enacted to read:

§2759. Pilot projects for innovative products

1. Pilot projects permitted. An insurer may apply to the superintendent for approval of a pilot project under which it will offer an individual health insurance product with an innovative design. Notwithstanding any other provision of this

Title, a policy form offered under the pilot project may be exempted from statutory or regulatory requirements to the extent that the superintendent considers appropriate. This subsection is repealed October 1, 2005.

2. Reports to superintendent. An insurer that has an approved pilot project under this section must report to the superintendent annually on or before October 1st. The report must include data on the number and types of policies sold, demographic data on the population covered and a comparison of this data to the insurer's conventional products. The superintendent may specify additional information to be included in the report. This subsection is repealed October 1, 2005.

3. Reports to Legislature. The superintendent shall report to the joint standing committee of the Legislature having jurisdiction over health insurance matters annually on or before January 1st. Each report must summarize reports received from insurers with approved pilot projects and must include the superintendent's assessment of the success of the projects. This subsection is repealed October 1, 2005.

4. Policy issued under pilot project. A policy issued under a pilot project authorized under this section and in force on October 1, 2005 must, on the first renewal date on or after October 1, 2005, be amended to comply with all applicable provisions of this Title or be terminated and replaced with another product offered by the carrier. If the policy was an individual health plan as defined by section 2736-C or a small group health plan as defined by section 2808-B, it may only be terminated if the superintendent finds that the carrier offers another product sufficiently similar to the policy being terminated.

§2760. Pilot projects for multistate products

1. Pilot projects permitted. An insurer may apply to the superintendent for approval of a pilot project under which it will offer one or more individual health insurance products simultaneously in this State and in one or more other states. Notwithstanding any other provision of this Title, a policy form offered under the pilot project and approved by the other participating states where that product is offered may be exempted from statutory or regulatory requirements to the extent that the superintendent considers appropriate. This subsection is repealed October 1, 2005.

2. Report to Legislature. The superintendent shall report to the joint standing committee of the Legislature having jurisdiction over health insurance matters on or before January

1, 2004. Each report must describe the experience under an approved pilot project and must include the superintendent's assessment of the success of the project. This subsection is repealed October 1, 2005.

3. Policy issued under pilot project. A policy issued under a pilot project authorized under this section and in force on October 1, 2005 must, on the first renewal date on or after October 1, 2005, be amended to comply with all applicable provisions of this Title or be terminated and replaced with another product offered by the carrier. If the policy was an individual health plan as defined by section 2736-C or a small group health plan as defined by section 2808-B, it may only be terminated if the superintendent finds that the carrier offers another product sufficiently similar to the policy being terminated.

Sec. A-9. 24-A MRSA §2808-B, sub-§1, ¶B, as enacted by PL 1991, c. 861, §2, is repealed and the following enacted in its place:

B. "Community rate" means a carrier's average rate for a given benefit package for a given family status such as individual, couple or family. The average must be based on the anticipated mix of business during the rating period.

Sec. A-10. 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, healthy lifestyle, participation in wellness programs and group size.

(1) Criteria used to define a healthy lifestyle must be based upon factors within an individual's control. These criteria may not be based on health history or health status. These criteria must be filed with and approved by the superintendent. If within 60 days of filing, the superintendent does not approve or disapprove the filing and does not request additional information, the filing is deemed approved. If the superintendent requests additional information and within 60 days after the information is provided does not approve or disapprove the filing and does not request additional information, the filing is deemed approved.

(2) The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts for

healthy lifestyles and participation in wellness programs. Rules adopted pursuant to this subparagraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. A-11. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 1997, c. 445, §14 and affected by §32, is further amended to read:

D. A carrier may vary the premium rate due to age, ~~smoking status,~~ occupation or industry, and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State ~~after~~ between July 15, 1995 and December 31, 2001, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%, ~~except as provided in paragraph D-1~~.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State in calendar year 2002, the premium rate may not be less than 70% nor greater than 120% of the community rate filed by the carrier.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2003, the premium rate may not be less than 60% nor greater than 120% of the community rate filed by the carrier.

Sec. A-12. 24-A MRSA §2808-B, sub-§2, ¶D-1, as enacted by PL 1997, c. 445, §14 and affected by §32, is repealed.

Sec. A-13. 24-A MRSA §2808-B, sub-§6, ¶A, as amended by PL 1995, c. 332, Pt. K, §2, is further amended to read:

A. Each carrier must actively market small group health plan coverage~~, including the basic and standard plans defined in subsection 8~~, to eligible groups in this State.

Sec. A-14. 24-A MRSA §2808-B, sub-§8, as amended by PL 1993, c. 588, §2, is repealed.

Sec. A-15. 24-A MRSA §§2847-J and 2847-K are enacted to read:

§2847-J. Pilot projects for innovative products

1. Pilot projects permitted. An insurer may apply to the superintendent for approval of a pilot project under which it will offer a group health insurance product with an innovative design. Notwithstanding any other provision of this Title, a policy form offered under the pilot project may be exempted from statutory or regulatory requirements to the extent that the superintendent considers appropriate. This subsection is repealed October 1, 2005.

2. Reports to superintendent. An insurer that has an approved pilot project under this section must report to the superintendent annually on or before October 1st. Each report must include data on the number and types of policies sold, demographic data on the population covered and a comparison of this data to the insurer's conventional products. The superintendent may specify additional information to be included in the report. This subsection is repealed October 1, 2005.

3. Reports to Legislature. The superintendent shall report to the joint standing committee of the Legislature having jurisdiction over health insurance matters annually on or before January 1st. Each report must summarize reports received from insurers with approved pilot projects and must include the superintendent's assessment of the success of the projects. This subsection is repealed October 1, 2005.

4. Policy issued under pilot project. A policy issued under a pilot project authorized under this section and in force on October 1, 2005 must, on the first renewal date on or after October 1, 2005, be amended to comply with all applicable provisions of this Title or be terminated and replaced with another product offered by the carrier. If the policy was an individual health plan as defined by section 2736-C or a small group health plan as defined by section 2808-B, it may only be terminated if the superintendent finds that the carrier offers

another product sufficiently similar to the policy being terminated.

§2847-K. Pilot projects for multistate products

1. Pilot projects permitted. An insurer may apply to the superintendent for approval of a pilot project under which it will offer one or more group health insurance products simultaneously in this State and in one or more other states. Notwithstanding any other provision of this Title, a policy form offered under the pilot project and approved by the other participating states where that product is offered may be exempted from statutory or regulatory requirements to the extent that the superintendent considers appropriate. This subsection is repealed October 1, 2005.

2. Report to Legislature. The superintendent shall report to the joint standing committee of the Legislature having jurisdiction over health insurance matters on or before January 1, 2003. That report must describe the experience under the approved pilot project and must include the superintendent's assessment of the success of the project. This subsection is repealed October 1, 2005.

3. Policy issued under pilot project. A policy issued under a pilot project authorized under this section and in force on October 1, 2005 must, on the first renewal date on or after October 1, 2005, be amended to comply with all applicable provisions of this Title or be terminated and replaced with another product offered by the carrier. If the policy was an individual health plan as defined by section 2736-C or a small group health plan as defined by section 2808-B, it may only be terminated if the superintendent finds that the carrier offers another product sufficiently similar to the policy being terminated.

Sec. A-16. 24-A MRSA §4204, sub-§2-A, ¶J, as amended by PL 1995, c. 332, Pt. I, §1, is repealed.

Sec. A-17. 24-A MRSA §6603, sub-§1, ¶H, as amended by PL 1999, c. 256, Pt. R, §1, is further amended to read:

H. May issue only health care benefit plans that comply with the requirements of section 2808-B with regard to rating practices, coverage for late enrollees and guaranteed renewal ~~and offer the standard and basic plans as adopted by the Bureau of Insurance in Rule Chapter 750. The superintendent may waive the requirement to offer standard and basic plans for an arrangement that provides benefits only to members of an association meeting the requirements~~

~~of section 2805-A~~. An arrangement may not provide health care benefits that do not meet or exceed the requirements for ~~the basic plan~~ mandated benefits applicable to comparable insured plans.

Sec. A-18. Effective date. Those sections of this Part that repeal and replace the Maine Revised Statutes, Title 24-A, section 2736-C, subsection 1, paragraph B and section 2808-B, subsection 1, paragraph B take effect January 1, 2002.

PART B

Sec. B-1. 24 MRSA §2317-B, sub-§7-A is enacted to read:

7-A. Title 24-A, sections 2735-A and 2839-A. Notice of rate increase, Title 24-A, sections 2735-A and 2839-A;

Sec. B-2. 24-A MRSA §2735-A is enacted to read:

§2735-A. Notice of rate increase

1. Existing business. An insurer must provide written notice by one of the methods provided in this subsection to all affected policyholders at least 30 days before the effective date of any increase in premium rates. If the increase is pending approval at the time of notice, the notice must show the proposed rate and state that it is subject to regulatory approval. An increase may not be implemented until 30 days after the notice is provided, or the effective date under section 2736, whichever is later.

A. The notice must be provided by first class mail.

B. The notice must be provided to the producer at least 40 days before the effective date and the producer must provide the notice to the policyholder by first class mail or hand delivery at least 30 days before the effective date.

2. New business. When an insurer quotes a rate for new business, it must disclose any rate increase that the insurer anticipates implementing within the following 90 days. If the quote is in writing, the disclosure must also be in writing. If the increase is pending approval at the time of notice, the disclosure must include the proposed rate and state that it is subject to regulatory approval. If disclosure required by this subsection is not provided, an increase may not be implemented until at least 90 days after the date the quote is provided, or the effective date under section 2736, whichever is later.

Sec. B-3. 24-A MRSA §2803-A, as amended by PL 1997, c. 370, Pt. E, §5, is further amended to read:

§2803-A. Loss information

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

A. "Insurance policy" means the insurance policy relating to the loss information requested pursuant to this section.

B. "~~Loss~~ Basic loss information" means the aggregate claims experience of the group insurance policy or contract. "~~Loss~~ Basic loss information" includes the amount of premium received, the amount of claims paid and the loss ratio. "~~Loss~~ Basic loss information" does not include any information or data pertaining to the medical diagnosis, treatment or health status that identifies an individual covered under the group contract or policy.

B-1. "Confidential loss information" means information or data pertaining to the medical diagnosis, treatment or health status of group members, including information that may potentially identify an individual covered under the group contract or policy.

C. "Loss ratio" means the ratio between the amount of premium received and the amount of claims paid by the insurer under the group insurance contract or policy.

2. Disclosure of basic loss information. Upon written request, every insurer shall provide basic 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 10 business days of the date of the request.

2-A. Disclosure of confidential loss information. Upon written request by a policyholder, an insurer shall provide an insurance producer or another insurer with confidential loss information for purposes of securing insurance coverage with another carrier. This information must be provided within 10 working days of the date of the request. Confidential loss information may not be disclosed to a policyholder, employer or any other individual not directly involved in securing insurance coverage.

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 basic or confidential loss information in accordance with this section shall transmit the request ~~for loss information~~ to the insurer within 4 working days.

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

Sec. B-4. 24-A MRSA §2839-A is enacted to read:

§2839-A. Notice of rate increase

1. Existing business. An insurer must provide written notice by one of the methods provided in this subsection to all affected policyholders or others who are directly billed for group coverage at least 30 days before the effective date of any increase in premium rates. An increase may not be implemented until 30 days after the notice is provided.

A. The notice must be provided by first class mail.

B. The notice must be provided to the producer at least 40 days before the effective date and the producer must provide the notice to the policyholder by first class mail or hand delivery at least 30 days before the effective date.

2. New business. When an insurer quotes a rate for new business, it must disclose any rate increase that the insurer anticipates implementing within the following 90 days. If the quote is in writing, the disclosure must also be in writing. If such disclosure is not provided, an increase may not be implemented until at least 90 days after the date the quote is provided.

Sec. B-5. 24-A MRSA §4222-B, sub-§§15 to 19 are enacted to read:

15. Sections 2735-A and 2839-A, relating to notice of rate increases, apply to health maintenance organizations.

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

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

18. Sections 2759, 2760, 2847-J and 2847-K relating to pilot projects apply to health maintenance organizations.

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

Sec. B-6. 24-A MRSA §4224-A, as amended by PL 1997, c. 370, Pt. E, §7, is repealed.

Sec. B-7. 24-A MRSA §4303, sub-§8 is enacted to read:

8. Maximum allowable charges. All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.

A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:

(1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and

(2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service.

B. The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service.

Sec. B-8. 24-A MRSA §4304, sub-§6 is enacted to read:

6. Notice. A notice issued by a carrier or its contracted utilization review entity in response to a request by or on behalf of an insured or enrollee for authorization of medical services that advises that the requested service has been determined to be medically necessary must also advise whether the service is covered under the policy or contract under which the insured or enrollee is covered. Nothing in this subsection

requires a carrier to provide coverage for services performed when the insured or enrollee is no longer covered by the health plan.

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 must 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.

PART C

Sec. C-1. 24-A MRSA c. 32-A is enacted to read:

CHAPTER 32-A

TYPES OF HEALTH INSURANCE

§2691. Scope

1. Health insurance policies. This chapter applies to individual health insurance policies subject to chapter 33 and to

group health insurance policies and certificates subject to chapter 35.

2. Dental plans and vision care plans. This chapter applies to dental plans and vision care plans only as specified.

3. Policies not subject to this chapter. This chapter does not apply to:

A. 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;

B. Policies issued to employees or members as additions to franchise plans in existence on the effective date of this chapter;

C. Medicare supplement policies subject to chapter 67;

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

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

§2692. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Certificate. "Certificate" means a statement of the coverage and provisions of a policy of group health insurance that has been delivered or issued for delivery in this State. "Certificate" includes riders, endorsements and enrollment forms, if attached.

2. Dental plan. "Dental plan" means insurance written to provide coverage for dental treatment.

3. Direct response advertising. "Direct response advertising" means a solicitation through a sponsoring or endorsing entity or individually through mail, telephone, the internet or other mass communication media.

4. Form. "Form" means a policy, contract, rider, endorsement or application as provided in section 2412.

5. Policy. "Policy" means an entire contract between the insurer and the insured, including riders, endorsements and the application, if attached.

6. Vision care plan. "Vision care plan" means insurance written to provide coverage for eye care.

§2693. Standards for policy provisions

1. Rules regarding manner, content and required disclosure. The superintendent may adopt rules to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of individual and group health insurance. The superintendent may adopt additional rules to establish specific standards for the sale of dental plans and vision care plans.

2. Rules regarding prohibited policies or provisions. The superintendent may adopt rules that specify prohibited policies or policy provisions not otherwise specifically authorized by statute that, in the opinion of the superintendent, are unjust, unfair or unfairly discriminatory to the policyholder or a person insured under the policy or to a beneficiary of the policy.

§2694. Minimum standards for benefits

The superintendent shall adopt rules to establish minimum standards for benefits under individual and group health insurance. These rules must clarify the meaning of limited benefits health insurance as referred to in chapters 33, 35 and 56-A. The rules must also set minimum standards for benefits for each of the following categories of coverage:

1. Basic hospital expense coverage. Basic hospital expense coverage;

2. Basic medical-surgical expense coverage. Basic medical-surgical expense coverage;

3. Basic hospital and medical-surgical expense coverage. Basic hospital and medical-surgical expense coverage;

4. Hospital confinement indemnity coverage. Hospital confinement indemnity coverage;

5. Individual major medical expense coverage. Individual major medical expense coverage;

6. Individual basic medical expense coverage. Individual basic medical expense coverage;

7. Disability income protection coverage. Disability income protection coverage;

8. Accident only coverage. Accident only coverage;

9. Specified disease coverage. Specified disease coverage; and

10. Specified accident coverage. Specified accident coverage.

This section does not preclude the issuance of a policy or contract that combines 2 or more of the categories of coverage in subsections 1 to 10.

§2695. Disclosure requirements

1. Outline of coverage. Except as provided in subsections 7 and 8, an insurer shall deliver an outline of coverage to an applicant or enrollee in connection with the sale of individual health insurance, group health insurance, dental plans and vision care plans delivered or issued for delivery in this State.

2. Sale through producer. If the sale of a policy described in subsection 1 occurs through a producer, the outline of coverage must be delivered to the applicant at the time of application or to the certificate holder at the time of enrollment.

3. Sale through direct-response advertising. If the sale of a policy described in subsection 1 occurs through direct-response advertising, the outline of coverage must be delivered no later than in conjunction with the issuance of the policy or delivery of the certificate.

4. Outline of coverage not delivered at time of application or enrollment. If the outline of coverage required in subsections 1 and 8 and in any rules adopted by the superintendent pursuant to this chapter is not delivered at the time of application or enrollment, the advertising materials delivered to the applicant or enrollee must contain all the information required in subsection 8 and in any rules adopted by the superintendent pursuant to this chapter.

5. Outline of coverage delivered at time of application or enrollment. If the outline of coverage is delivered to the applicant or enrollee at the time of application or enrollment,

the insurer must collect an acknowledgment of receipt or certificate of delivery of the outline of coverage and the insurer must maintain evidence of the delivery.

6. Coverage issued on basis other than as applied for. If coverage is issued on a basis other than as applied for, an outline of coverage properly describing the coverage or contract actually issued must be delivered with the policy or certificate to the applicant or enrollee.

7. Outline of coverage not required. An outline of coverage for group health insurance, a group dental plan or a group vision care plan is not required to be delivered to certificate holders if the certificate contains a brief description of:

A. Benefits;

B. Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits;

C. Renewability provisions; and

D. Notice requirements as provided in rules adopted pursuant to this chapter.

8. Superintendent shall prescribe format and content of outline of coverage. The superintendent shall prescribe the format and content of the outline of coverage required by subsection 1. As used in this subsection, "format" means style, arrangement and overall appearance, including items such as the size, color and prominence of type and the arrangement of text and captions. The rules may exempt certain group policies from the requirement to deliver an outline of coverage to an applicant or enrollee. The outline of coverage must include:

A. A statement identifying the applicable category or categories of coverage as prescribed in section 2694;

B. A description of the principal benefits and coverage provided;

C. A statement of exceptions, reductions and limitations;

D. A statement of renewal provisions, including any reservation by the insurer of a right to change premiums; and

E. A statement that the outline is a summary of the policy or certificate issued or applied for and that the policy or

certificate should be consulted to determine governing policy provisions.

9. Notice must be delivered to all applicants eligible for Medicare. An insurer shall deliver the notice required under rules applicable to Medicare supplement insurance to all applicants eligible for Medicare.

§2696. Preexisting conditions

1. Exclusion based on preexisting condition limited after 12 months. Notwithstanding the provisions of section 2706, subsection 2, division (b), if an insurer elects to use a simplified application or enrollment form, with or without a question as to the prospective insured's health at the time of application or enrollment but without any questions concerning the prospective insured's health history or medical treatment history, the policy must cover any loss occurring after the policy has been in force for 12 months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except for such specific exclusions, the policy or certificate may not include wording that would permit a defense based upon preexisting conditions, other than rescission for affirmative misrepresentations, after it has been in force for 12 months.

2. Exclusion based on preexisting condition limited after 6 months. Notwithstanding the provisions of subsection 1 and section 2706, subsection 2, division (b), an insurer that issues a specified disease policy or certificate, regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form may not deny a claim for any covered loss that begins after the policy or certificate has been in force for at least 6 months, unless that loss results from a preexisting condition that was diagnosed by a physician before the date of application for coverage or that first manifested itself within the six months immediately preceding the application date. Except for rescission for misrepresentation, defenses based upon preexisting conditions are not permitted.

§2697. Rulemaking

The superintendent may adopt rules to carry out the purposes of this chapter. Rules adopted pursuant to this chapter are routine technical rules as defined by Title 5, chapter 375, subchapter II-A.

SUMMARY

Part A amends several provisions of the individual and small group health insurance reform laws in the following ways.

1. It eliminates the requirement that private purchasing alliances offer health coverage through more than one carrier.

2. It increases the permitted downward adjustments in individual insurance rates based on age and geographic area from 20% to 40% over a 2-year period. It increases the permitted downward adjustments in small group insurance rates based on age, geographic area and occupation or industry from 20% to 40% over a 2-year period. Upward variations for both individual and small group rates would remain limited to 20%.

3. It removes entirely the current restrictions on differentiating individual and small group health insurance rates based on smoking status and permits discounts for nonsmokers and those with healthy lifestyles.

4. It permits rates for individual health insurance to vary based on health status, within limits. For policies issued after January 1, 2002, higher rates may be used for those in poor health at time of issue, but renewal rates may not be increased based on subsequent deterioration of health. The highest rate charged for a given age and geographic area is limited to 150% of the standard rate for that age and geographic area.

5. It authorizes the Superintendent of Insurance to approve pilot projects under which insurers may offer innovative products that are exempted from certain provisions of the insurance code including access requirements and mandated benefits. It also authorizes approval of pilot projects under which insurers may be exempted from certain provisions of the insurance code in order to offer the same product in multiple states.

6. It eliminates the requirement for carriers to offer standardized plans in the small group market.

Part B includes the following consumer protection provisions.

1. It requires health insurers to provide a minimum 30-day notice of rate increases to policyholders. It also requires disclosure of anticipated rate increases when quoting rates for new business.

2. It requires more complete disclosure of loss information in order to facilitate shopping by employers for alternate

coverage while protecting confidential information from improper disclosure.

3. It makes health maintenance organizations subject to the same continuation of coverage requirements currently applicable to group indemnity coverage. It also clarifies that the general penalty provisions of the insurance code apply to health maintenance organizations.

4. It establishes standards applicable to health policies and contracts that limit payment of claims for covered services based on a determination of "usual, customary and reasonable charges," UCR or similar methodology. The bill requires disclosure to insureds that they may be subject to balance billing, requires carriers to give insureds the opportunity to request the carrier's UCR rate for a given procedure to permit the insured to shop around for services, requires carriers to disclose their methodology and specific data relied upon in calculating UCR for a given claim and limits carriers' ability to apply UCR when credible data is not available.

5. It requires utilization review notices to advise whether or not the service reviewed for medical necessity is covered under the health contract or policy at issue. Utilization review notices frequently advise only whether or not a requested service is medically necessary, causing consumer confusion when a service authorized as medically necessary is subsequently denied as not being covered.

6. It permits those who lose eligibility for the low-cost drugs for the elderly or disabled program to purchase a Medicare supplement policy with prescription drug benefits.

Part C creates a new chapter of the Maine Insurance Code based on a National Association of Insurance Commissioners model law to standardize and simplify the terms and coverages of individual health insurance policies and group health insurance policies and certificates. It is also intended to facilitate public understanding and comparison and to eliminate provisions contained in health insurance policies that may be misleading or unreasonably confusing in connection either with the purchase of these coverages or with the settlement of claims. It further provides for full disclosure in the sale of health coverages and gives the Superintendent of Insurance authority to adopt rules to carry out the purposes of the chapter.