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H.P. 1100 House of Representatives, April 1, 2003

An Act To Clarify and Update the Laws Related to Health Insurance

Submitted by the Department of Professional and Financial Regulation pursuant to Joint Rule 204.

Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative CANAVAN of Waterville.
Cosponsored by Senator MAYO of Sagadahoc and
Representative: 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 §2850-B, sub-§3, ¶¶G and H, as enacted by PL 1997, c. 445, §30 and affected by §32, are amended to read:

G. When the carrier ceases offering a product and meets the following requirements:

(1) In the large group market:

(a) The carrier must provide notice to the policyholder and to the insureds at least 90 days before termination;

(b) The carrier must offer to each policyholder the option to purchase any other product currently being offered in the large group market; and

(c) In exercising the option to discontinue the product and in offering the option of coverage under division (b), the carrier must act uniformly without regard to the claims experience of the policyholders or the health status of the insureds or prospective insureds;

(2) In the small group market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section 2808-B;

(b) The superintendent shall find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and to the insureds at least 90 days before replacement; or

(3) In the individual market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section 2736-C;

(b) The superintendent shall find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and, if a group policy, to the insureds at least 90 days before replacement; ~~or~~

H. In renewing a large group policy in accordance with this section, a carrier may modify the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications are applied uniformly to all policyholders of the same product. ~~This paragraph does not apply to individual or small group policies.~~; or

Sec. A-2. 24-A MRSA §2850-B, sub-§3, ¶I is enacted to read:

I. In renewing an individual or small group policy in accordance with this section, a carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product. Modifications not meeting the requirements in this paragraph are considered a discontinuance of the product pursuant to paragraph G.

(1) A modification pursuant to this paragraph must be approved by the superintendent. The superintendent shall approve the modification if it meets the requirements of this section.

(2) A change in a requirement for eligibility is not a minor modification pursuant to this paragraph if the change results in the exclusion of a class or category of enrollees currently covered.

(3) Benefit modifications required by law are deemed minor modifications for purposes of this paragraph.

(4) Benefit modifications other than modifications required by law are minor modifications only if they meet the requirements of this subparagraph. For purposes of this subparagraph, changes in conditions or requirements specified in the policy, such as preauthorization requirements, are considered benefit modifications.

(a) The total of any increases in benefits may not increase the actuarial value of the total benefit package by more than 5%.

(b) The total of any decreases in benefits may not decrease the actuarial value of the total benefit package by more than 5%.

(c) For purposes of the calculations in divisions (a) and (b), increases and decreases must be considered separately and may not offset one another.

(5) A carrier must give 60 days' notice of any modification pursuant to this paragraph to all affected policyholders and certificate holders.

PART B

Sec. B-1. 24 MRSA §2317-B, sub-§15-A is enacted to read:

15-A. Title 24-A, section 2809-A. Conversion on termination of policy or eligibility, Title 24-A, section 2809-A;

Sec. B-2. 24-A MRSA §2809-A, sub-§1-A, as repealed and replaced by PL 1995, c. 625, Pt. A, §25, is amended to read:

1-A. Notification of cancellation. An insurer ~~must provide by first class mail at least 10 days' prior notification of cancellation for nonpayment of premium~~ may not cancel or refuse to renew any policy for hospital, surgical, dental or major medical expense insurance until the insurer has provided by first class mail at least 10 days' prior notification according to this section. The notice must include the date of cancellation of coverage and, if applicable, the time period for exercising policy conversion rights. The notice also must include an explanation of any applicable grace period. Notification is not required when the insurer has received written notice from the group policyholder that replacement coverage has been obtained.

A. Notice must be mailed to the group policyholder or subgroup sponsor.

B. At the time of notification under paragraph A, notice must be mailed to the certificate holder at: the last address provided to the insurer by the group policyholder, the subgroup sponsor or the certificate holder.

~~(1) The last address provided by the subgroup sponsor or the group policyholder to the insurer; or~~

~~(2) The office of the subgroup sponsor, if any, or the group policyholder.~~

~~C. Notice must be mailed to the bureau.~~

Sec. B-3. 24-A MRSA §4209, sub-§6, as enacted by PL 1995, c. 189, §3 and affected by §4, is amended to read:

6. Notification of cancellation. A health maintenance organization ~~must provide~~ may not cancel or refuse to renew any contract until it has provided by first class mail at least 10 days' prior notification ~~of cancellation for nonpayment of enrollment charges~~ according to this section. The notice must include the date of cancellation of coverage and the time period for exercising contract conversion rights. The notice also must include an explanation of the applicable grace period. Notification is not required when the insurer has received written notice from the group contract holder that replacement coverage has been obtained.

A. Notice must be mailed to the group contract holder or subgroup sponsor.

B. At the time of notification under paragraph A, notice must be mailed to the individual enrollee at: the last address provided to the health maintenance organization by the group contract holder, the subgroup sponsor or the enrollee.

~~(1) The last address provided by the group contract holder to the health maintenance organization; or~~

~~(2) The office of the subgroup sponsor, if any, or the group contract holder.~~

~~C. Notice must be mailed to the Bureau of Insurance and to the Bureau of Labor Standards.~~

PART C

Sec. C-1. 24-A MRSA §1901, sub-§1, as amended by PL 1999, c. 609, §2, is further amended by amending the first paragraph to read:

1. "Administrator" means any person who, on behalf of a plan sponsor, health care service plan, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of this State in connection with any type of life, annuity, health ~~or~~, workers' compensation or employee benefit

excess insurance benefit provided in or as an alternative to insurance as defined by sections 702 to 704, former Title 39 or Title 39-A, other than any of the following:

PART D

Sec. D-1. 24-A MRSA §2803-A, sub-§2, as amended by PL 2001, c. 410, Pt. B, §1, is further 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 or former policyholder within 21 business days of the date of the request.

PART E

Sec. E-1. 24 MRSA §2327, as amended by PL 1985, c. 648, §2, is further amended to read:

§2327. Group rates

~~No~~ A group health care contract may not be issued by a nonprofit hospital or medical service organization in this State until a copy of the group ~~manual~~ rates to be used in calculating the ~~rates~~ premium for these contracts has been filed for informational purposes with the superintendent. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care contracts and for certain group contracts included within the definition of "individual health plan" in Title 24-A, section 2736-C, subsection 1, paragraph C must be filed in accordance with section 2321.

Sec. E-2. 24-A MRSA §2839, as amended by PL 1985, c. 648, §11, is further amended to read:

§2839. Rates filed

~~No~~ A policy of group health insurance may not be delivered in this State until a copy of the group ~~manual~~ rates to be used in calculating the premium for these policies has been filed for informational purposes with the superintendent. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care

or long-term care insurance contracts and for certain association groups and other groups specified in section 2701, subsection 2, paragraph C must be filed in accordance with section 2736. Rates for small group health insurance subject to section 2808-B are subject to the additional filing requirements specified in that section.

PART F

Sec. F-1. 24 MRSA §2321, sub-§1, as amended by PL 1997, c. 344, §6, is further amended to read:

1. Filing of rate information. Every nonprofit hospital and medical service organization shall file with the superintendent, ~~except as to group subscriber and membership contracts other than group Medicare supplement contracts as defined in Title 24-A, chapter 67 and group nursing home or long-term care contracts as defined in Title 24-A, chapter 68,~~ every rate, rating formula and every modification of any of the foregoing that it proposes to use in connection with individual health insurance contracts, group Medicare supplement contracts as defined in Title 24-A, chapter 67, group nursing home or long-term care contracts as defined in Title 24-A, chapter 68 or 68-A, and certain group contracts included within the definition of "individual health plan" in Title 24-A, section 2736-C, subsection 1, paragraph C. Every filing under this subsection must state the effective date of the filing. Every filing under this subsection must be made not less than 60 days in advance of the stated effective date unless the 60-day requirement is waived by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection 4, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests. ~~In the case of nursing home and long term contracts, rates filed are effective for no more than 3 years, except that rates for contracts with guaranteed level premiums are effective for the duration of the contract.~~

Sec. F-2. 24-A MRSA §2736, sub-§1, as amended by PL 1997, c. 344, §8, is further amended to read:

1. Filing of rate information. Every insurer shall file with the superintendent, ~~except as to group policy rates other than those for group Medicare supplement policies as defined in chapter 67, and group nursing home care and long-term care insurance as defined in chapter 68,~~ every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies

specified in section 2701. Every such filing must state the effective date of the filing. Every such filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection 3, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests. ~~In the case of nursing home care and long-term care insurance policies, rates filed are effective for no more than 3 years, except that rates for contracts with guaranteed level premiums are effective for the duration of the contract.~~

PART G

Sec. G-1. 24 MRSA §2317-B, sub-§20, as enacted by PL 1999, c. 256, Pt. M, §10, is amended to read:

20. Title 24-A, chapters 68 and 68-A. Long-term care insurance, nursing home care insurance and home health care insurance, Title 24-A, ~~chapter~~ chapters 68 and 68-A.

Sec. G-2. 24-A MRSA §2691, sub-§3, ¶D, as enacted by PL 2001, c. 410, Pt. C, §1, is amended to read:

D. Long-term care insurance policies subject to ~~chapter~~ chapters 68 and 68-A;

Sec. G-3. 24-A MRSA §2701, sub-§2, ¶A, as amended by PL 1995, c. 332, Pt. J, §1, is further amended to read:

A. Sections 2736, 2736-A and 2736-B apply to group Medicare supplement policies as defined in chapter 67 ~~and~~ , group nursing home care and long-term care insurance policies as defined in chapter 68 or 68-A;

PART H

Sec. H-1. 24-A MRSA §1951, sub-§2, as corrected by RR 2001, c. 2, Pt. B, §42 and affected by §58, is amended to read:

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

Sec. H-2. 24-A MRSA §1952, as enacted by PL 1995, c. 673, Pt. A, §3, is amended to read:

§1952. Licensure

A ~~person--or--entity~~ private purchasing alliance may not market, sell, offer or arrange for a package of one or more health benefit plans underwritten by ~~2~~ one or more carriers without first being licensed by the superintendent. The superintendent shall specify by rule standards and procedures for the issuance and renewal of licenses for private purchasing alliances. A rule may require an application fee of not more than $400 and an annual license fee of not more than $100. A license may not be issued until the rulemaking required by this chapter has been undertaken and all required rules are in effect.

Sec. H-3. 24-A MRSA §2736-C, sub-§5, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

5. Loss ratios. For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums.

Sec. H-4. 24-A MRSA §2747, sub-§1, as enacted by PL 1981, c. 205, §2, is amended to read:

1. Any insurer denying medical expense reimbursement benefits on any of the grounds specified in subsection 2 for a claim filed pursuant to a policy issued under this chapter, other than a policy that is subject to section 4312, shall provide the policy or certificate holder with an opportunity to have the denial reviewed by the insurer and to arbitrate the denial if not satisfied after review. The right to review and arbitrate ~~shall~~ must be prominently set forth in any written notice sent to the policy or certificate holder denying the claim. The arbitration ~~shall--be~~ is nonbinding and ~~shall~~ must be carried out in accordance with procedures established by the insurer.

Sec. H-5. 24-A MRSA §2808-B, sub-§1, ¶D, as amended by PL 2001, c. 258, Pt. E, §3 and c. 400, §1 and affected by §2, is repealed and the following enacted in its place:

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.

(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.

(4) An employer qualifies as an eligible group for 2-person coverage if the employer provides a carrier with the following information demonstrating that the employer's business and employees meet the minimum qualifications for group coverage in paragraph C:

(a) A copy of the most recent quarterly combined filing for income tax withholding and unemployment contributions, Form 941/C1-ME;

(b) For an employee claimed to be an employee eligible for group coverage whose name is not listed on Form 941/C1-ME, a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding;

(c) If an employer is exempt from filing Form 941/C1-ME for group coverage, documentation of that exemption and a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a

payroll company showing wages paid to that employee for the most recent quarter with tax withholding; or

(d) If the name of the business owner or employee does not appear on Form 941/C1-ME, a copy of one of the following:

(i) Federal income tax Form Schedule C or Schedule F;

(ii) Federal income tax Form 1120S, Schedule K-1;

(iii) Federal income tax Form 1065, Schedule K-1;

(iv) A workers' compensation insurance audit or evidence of a waiver of benefits under Title 39-A;

(v) A description of operations in a commercial general liability insurance policy or equivalent insurance policy providing coverage for the business; or

(vi) A signature card from a financial institution or credit union authorizing the employee to sign checks on a business checking or share draft account that is at least 6 months old; a notarized affidavit from the employer describing the duties of the employee and the average number of hours worked by the employee and attesting that the employer is not defrauding the carrier and is aware of the consequences of committing fraud or making a material misrepresentation to the carrier, including a loss of coverage and benefits; and, if the group coverage is purchased through a producer, a notarized affidavit from the producer affirming the producer's belief that the employer qualifies as an eligible group for coverage.

In determining if a new business or a business that adds an owner or a new employee to payroll during the course of a year qualifies as an eligible group for 2-person coverage under this subparagraph, the employer must submit an affidavit stating that all employees meet the criteria in this subparagraph and that the

documentation and forms required under this subparagraph will be provided to the carrier when payroll records become available, when ownership distribution forms become available or the first renewal date of the coverage, whichever date is earlier. A false affidavit or misrepresentation on an affidavit submitted by an employer may result in the loss of group coverage and repayment of claims paid. This subparagraph may not be construed to prohibit a carrier from recognizing an employer as an eligible group if the employer has not produced the documentation required in this subparagraph.

This subparagraph applies only to an employer applying for group health insurance coverage as a 2-person group on or after October 1, 2001.

Sec. H-6. 24-A MRSA §4331, sub-§4, as enacted by PL 1999, c. 609, §20, is amended to read:

4. Downstream risk arrangement. "Downstream risk arrangement" means ~~any compensation~~ an arrangement ~~between~~ that transfers insurance risk from a carrier ~~and~~ to a downstream entity ~~that may directly or indirectly have the effect of reducing or limiting services furnished to enrollees of the carrier~~.

Sec. H-7. 24-A MRSA §5011, sub-§2, as enacted by PL 1991, c. 740, §13, is amended to read:

2. Discounts. Issuers that do not vary rates for a standardized plan based on age, gender, health status, claims experience, policy duration, industry or occupation, and that do not refuse issue of that plan to any individual or group based on health status, may provide discounts on that plan to individuals who purchase coverage during their initial period of ~~eligibility for~~ enrollment in Medicare Part A ~~by reason of age~~ B at or after 65 years of age, subject to approval by the superintendent. The superintendent may adopt rules governing the appropriate use of discounts.

SUMMARY

Part A facilitates the updating of small group and individual health insurance policies by permitting limited minor changes at renewal with 60 days' notice to policyholders and insureds.

Part B strengthens and clarifies the law requiring notice of termination of a group health plan. It expands the requirement to apply to terminations other than for nonpayment of premium and to apply to dental insurance. It also requires the notice to be sent to each insured's last known home address and repeals the requirement to send copies of termination notices to the Department of Professional and Financial Regulation, Bureau of Insurance and to the Department of Labor, Bureau of Labor Standards.

Part C expands the scope of the law governing 3rd-party administrators to include entities that administer employee benefit excess insurance.

Part D clarifies that the requirement for health carriers to provide experience data to large groups applies with respect to former policyholders as well as current policyholders.

Part E clarifies the rate information that must be filed with the Bureau of Insurance with respect to group health insurance.

Part F repeals the provision making long-term care insurance rates effective for only 3 years and clarifies the rate filing requirements for individual health insurance to specify that they apply to association group coverage that falls within the definition of individual health plan.

Part G corrects several references to the long-term care insurance laws.

Part H makes several housekeeping corrections. It clarifies the definition of "private purchasing alliance" by removing a reference to licensure. It removes reference to "2 or more carriers" in the purchasing alliance law, consistent with recent amendments that permit purchasing alliances to use a single carrier. It clarifies that a provision of the individual health plan law applies to certificates as well as policies. It exempts policies from the statute concerning arbitration if they are subject to the newer statute concerning external review. It corrects a reference to a tax form. It clarifies the definition of "downstream risk arrangement." Lastly, it corrects a reference in the provision concerning discounts on Medicare supplement insurance.