L.D. 1205

Date: 5/28/9 (Filing No. H-446)

Majority

INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

124TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 830, L.D. 1205, Bill, "An Act To Establish a Health Care Bill of Rights"

Amend the bill in Part A in section 4 in subsection 13 in the last paragraph in the second line (page 2, line 18 in L.D.) by inserting after the following: "carriers" the following: ', taking into consideration any national standards for explanation of benefits forms'

Amend the bill in Part A by inserting after section 4 the following:

'**Sec. A-5. 24-A MRSA §4303, sub-§14** is enacted to read:

14. Policy terms. The superintendent may by rule define standard policy terms that must be used in all policies issued by carriers offering health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-6. Appropriations and allocations. The following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Insurance - Bureau of 0092

Initiative: Allocates funds for the one-time costs of required rule-making proceedings.

OTHER SPECIAL REVENUE FUNDS	2009-10	2010-11
All Other	$2,100	$0
OTHER SPECIAL REVENUE FUNDS TOTAL	$2,100	$0

Amend the bill in Part B in section 5 in paragraph E by inserting at the end a new blocked paragraph to read:

'If a carrier has a provider profiling program that includes out-of-network providers, a carrier must meet the requirements of this paragraph with regard to an out-of-network provider as well as for a provider in a carrier's network.'

Amend the bill by striking out all of Parts C, D, E, F and G and inserting the following:

'PART C

Sec. C-1. 24-A MRSA §2736, sub-§1, as amended by PL 2009, c. 14, §4, is further amended to read:

1. Filing of rate information. Every insurer shall file with the superintendent 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. If the filing applies to individual health plans as defined in section 2736-C, the insurer shall simultaneously file a copy with the Attorney General. 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. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

2. Filing; information. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records ~~within the meaning of~~ notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to section 2736-A.

Sec. C-3. 24-A MRSA §2736-A, first ¶, as amended by PL 2007, c. 629, Pt. M, §3, is further amended to read:

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate, unfairly discriminatory or not in compliance with ~~former~~ section 6913 or that the filing violates any of the provisions of

chapter 23, the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual health plan as defined in section 2736-C, the superintendent shall cause a hearing to be held at the request of the Attorney General. In any hearing conducted under this section, the insurer has the burden of proving rates are not excessive, inadequate or unfairly discriminatory and in compliance with section 6913.

PART D

Sec. D-1. 24-A MRSA §2808-B, sub-§2-A, ¶B, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records ~~except as provided by~~ notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to subsection 2-B, ~~paragraphs~~ paragraph B or F.

Sec. D-2. 24-A MRSA §2808-B, sub-§2-B, ¶A, as amended by PL 2007, c. 629, Pt. M, §7, is further amended to read:

A. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least ~~75%~~ 78% 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. For the purposes of this calculation, any payments paid pursuant to ~~former~~ section 6913 must be treated as incurred claims.

Sec. D-3. 24-A MRSA §2808-B, sub-§2-C, ¶C, as amended by PL 2007, c. 629, Pt. M, §10, is further amended to read:

C. If incurred claims were less than ~~78%~~ 80% of aggregate earned premiums over a continuous 36-month period, the carrier shall refund a percentage of the premium to the current in-force policyholder. For the purposes of calculating this loss-ratio percentage, any payments paid pursuant to ~~former~~ section 6913 must be treated as incurred claims. The excess premium is the amount of premium above that amount necessary to achieve ~~a 78%~~ an 80% loss ratio for all of the carrier's small group policies during the same 36-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums.

(1) For determination of loss-ratio percentages in 2005, actual aggregate incurred claims expenses include expenses incurred in 2005 and projected expenses for 2006 and 2007. For determination of loss-ratio percentages in 2006, actual incurred claims expenses include expenses in 2005 and 2006 and projected expenses for 2007.

(2) The superintendent may waive the requirement for refunds during the first 3 years after the effective date of this subsection.

Sec. D-4. 24-A MRSA §2808-B, sub-§6, ¶A, as amended by PL 2001, c. 410, Pt. A, §6, is further amended to read:

A. Each carrier must actively market small group health plan coverage, including any standardized plans required to be offered pursuant to subsection 8-A, to eligible groups in this State.

Sec. D-5. 24-A MRSA §2808-B, sub-§8-A is enacted to read:

8-A. Authority of the superintendent. The superintendent may by rule define one or more standardized small group health plans that must be offered by all carriers offering small group health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. D-6. Superintendent of Insurance report. The Superintendent of Insurance shall review possible ways to improve the availability and affordability of the State's individual health insurance market, including, but not limited to, increases in the minimum loss-ratio standards applicable to that market and consideration of an insurer's loss experience in all lines of insurance marketed by a carrier in this State when reviewing health insurance rate filings. The superintendent shall report the results of the review, including any recommendations for legislation, to the Joint Standing Committee on Insurance and Financial Services no later than February 1, 2010. The joint standing committee may report out a bill based on the report to the Second Regular Session of the 124th Legislature.

PART E

Sec. E-1. 24-A MRSA §221, sub-§5 is enacted to read:

5. Examination of health carriers. The superintendent shall examine the market conduct of each domestic health carrier, as defined in section 4301-A, subsection 3, and each foreign health carrier with at least 1,000 covered lives in this State, offering a health plan as defined in section 4301-A, subsection 7, no less frequently than once every 5 years. An examination under this subsection may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination. In lieu of an examination conducted by the superintendent, the superintendent may participate in a multistate examination, or, in the case of a foreign company, approve an examination by the company's domiciliary regulator upon a finding that the examination and report adequately address relevant aspects of the company's market conduct within this State.

Sec. E-2. Transition. The Superintendent of Insurance shall begin conducting the market conduct examinations required by the Maine Revised Statutes, Title 24-A, section 221, subsection 5 during calendar year 2010, and all health carriers subject to the examination requirement must be examined at least once before January 1, 2015.

PART F

Sec. F-1. 24-A MRSA §4303, sub-§7-A is enacted to read:

7-A. Continuity of prescriptions. If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee's coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee's prescribing provider. Policies must include a notice of the right to request a review with the enrollee's provider, and the replacing carrier must honor the prior carrier's authorization if the enrollee's provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy.'

SUMMARY

This amendment does the following.

1. It amends Part A to require the Superintendent of Insurance, when making rules, to take into consideration national standards and to give the superintendent authority to define standard policy terms by rulemaking. It provides a one-time allocation to cover the costs of rulemaking.

2. It amends Part B to establish standards for provider profiling programs used by carriers for out-of-network providers.

3. It removes Part C, which requires carriers and health maintenance organizations to include certain information about product offerings in the annual report supplement to the Department of Professional and Financial Regulation, Bureau of Insurance.

4. Part C in this amendment permits the Attorney General to request a rate hearing regarding proposed rate increases for individual health plans. It removes the provisions in the bill that extended the notice period for carriers to notify policyholders of proposed rate increases.

5. Part D in this amendment requires a benefits-incurred-to-premiums-earned loss ratio of 78% for one year or 80% over a 3-year average in the small group insurance market. Part D authorizes the Superintendent of Insurance to adopt rules requiring small group health carriers to offer standardized small group health plans. Part D also authorizes the superintendent to study the impact of increases in the loss ratio in the individual market and the consideration of losses in all health insurance markets as part of rate filings.

6. Part E in this amendment requires the Superintendent of Insurance to undertake market conduct examinations of health insurance companies no less frequently than once every 5 years, beginning in 2010. Part E requires all health insurance carriers to be examined at least once by 2015.

7. Part F in this amendment requires a carrier replacing a previous carrier to honor any prior authorizations for prescription drugs for an enrollee undergoing a course of treatment until the replacement carrier conducts a review of that prior authorization with the enrollee's prescribing provider.

FISCAL NOTE REQUIRED

(See attached)

Approved: 05/24/09 mac

124th MAINE LEGISLATURE

LD 1205 **LR 1504(02)**

An Act To Establish a Health Care Bill of Rights

Fiscal Note for Bill as Amended by Committee Amendment "A"
Committee: Insurance and Financial Services
Fiscal Note Required: Yes

Fiscal Note

	2009-10	2010-11	Projections 2011-12	Projections 2012-13
Appropriations/Allocations				
Other Special Revenue Funds	$2,100	$0	$0	$0

Fiscal Detail and Notes

Allocates $2,100 in Fiscal Year 2009-10 to the Bureau of Insurance in the Department of Professional and Financial Regulation for the one-time costs of required rulemaking proceedings. Additional costs to other state agencies and programs are expected to be minor and can be absorbed utilizing existing budgeted resources.