124th MAINE LEGISLATURE

FIRST REGULAR SESSION-2009

Legislative Document **No. 1205**

H.P. 830 House of Representatives, March 26, 2009

An Act To Establish a Health Care Bill of Rights

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

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative TREAT of Hallowell.
Cosponsored by Senator BOWMAN of York and
Representatives: ADAMS of Portland, BEAUDOIN of Biddeford, GOODE of Bangor, Speaker PINGREE of North Haven, PRIEST of Brunswick, RUSSELL of Portland, TRINWARD of Waterville, Senator: MARRACHÉ of Kennebec.

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

PART A

Sec. A-1. 24-A MRSA §2809-A, sub-§1-A, ¶B-2 is enacted to read:

B-2. All notices of cancellation sent to certificate holders pursuant to paragraph B-1 must include a telephone number that certificate holders can call to determine if the policy has been cancelled for nonpayment of premium or if the policy has been reinstated because the premium has been paid. If a notice of cancellation has been mailed to certificate holders pursuant to paragraph B-1 and the policy is not thereafter cancelled because the premium has been paid or the policy is reinstated, the insurer shall mail notice of noncancellation or reinstatement to certificate holders by first class mail as expeditiously as possible, but in no event more than 10 days after the premium for continued coverage or reinstatement has been received by the insurer. Notice pursuant to this paragraph must be provided in the same manner as notice provided pursuant to paragraph B-1.

Sec. A-2. 24-A MRSA §4302, sub-§1, ¶A, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not ~~limited~~ to the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type; ~~and~~

(4) Health care services that are or may be provided only by referral; and

(5) Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics;

Sec. A-3. 24-A MRSA §4303, sub-§12 is enacted to read:

12. Publication of policies by carriers. A carrier must publish at least 5 individual health plans with the highest level of enrollment and at least 5 small group health plans with the highest level of enrollment on the carrier's publicly accessible website in a manner that will allow consumers to review the coverage offered under each policy. The policies posted on the website must be updated when changes are made to the policies by the carrier. The appearance of the policy on the website must duplicate the appearance of a paper copy of the policy. The bureau shall provide a link from its website to each carrier's website. A carrier must review annually which policies to post and make any necessary changes on its website. A carrier must post the required policies on its website within 90 days after the effective date of this subsection.

Sec. A-4. 24-A MRSA §4303, sub-§13 is enacted to read:

13. Explanation of benefits. A carrier offering an individual expense-incurred health plan to residents of this State or an expense-incurred group health plan to an employer in this State shall provide individual policyholders and group certificate holders with clear written explanations of benefit documents in response to the filing of any claim providing for coverage of hospital or medical expenses. The explanation of benefits must include all of the following information:

A. The date of service;

B. The provider of the service;

C. An identification of the service for which the claim is made;

D. Any amount the insured is obligated to pay under the policy for copayment or coinsurance;

E. A telephone number and address where the insured may obtain clarification of the explanation of benefits;

F. A notice of appeal rights;

G. A notice of the right to file a complaint with the bureau; and

H. Such other information as the superintendent may require by rule.

The superintendent shall establish by rule the minimum information and standards for explanation of benefits forms used by carriers. At a minimum, the rules must require the information required by this subsection and may require any additional information helpful to consumers in understanding how a carrier administers its policies. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. This subsection applies to any explanation of benefits form issued on or after January 1, 2010.

PART B

Sec. B-1. 24-A MRSA §4301-A, sub-§16-A is enacted to read:

16-A. Provider profiling program. "Provider profiling program" means a program that uses provider data in order to rate or rank provider quality or efficiency of care by the use of a grade, star, tier, rating or any other form of designation.

Sec. B-2. 24-A MRSA §4302, sub-§1, ¶J, as enacted by PL 1999, c. 742, §5, is amended to read:

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter; ~~and~~

Sec. B-3. 24-A MRSA §4302, sub-§1, ¶K, as enacted by PL 1999, c. 742, §5, is amended to read:

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the

federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended~~.~~; and

Sec. B-4. 24-A MRSA §4302, sub-§1, ¶L is enacted to read:

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating.

Sec. B-5. 24-A MRSA §4303, sub-§2, ¶E is enacted to read:

E. A carrier with a provider profiling program shall:

(1) Disclose to providers the methodologies, criteria, data and analysis used to evaluate provider quality, performance and cost-efficiency ratings;

(2) Create and share with providers their provider profile at least 60 days prior to using or publicly disclosing the results of the provider profiling program;

(3) Afford providers the opportunity to correct errors, submit additional information for consideration and seek review of data and performance ratings; and

(4) Afford providers due process appeal rights to challenge the profiling determination described in this subsection and by Bureau of Insurance Rule Chapter 850, Health Plan Accountability.

PART C

Sec. C-1. 24-A MRSA §423-D, sub-§1, as enacted by PL 2003, c. 469, Pt. E, §2, is amended to read:

1. Annual report supplement required. Each health insurer and health maintenance organization shall file an annual report supplement on or before March 1st of each year, or within any reasonable extension of time that the superintendent for good cause may have granted on or before March 1st. The superintendent shall adopt rules regarding specifications for the annual report supplement. The annual report supplements must provide the public with general, understandable and comparable product offerings and financial information relative to the in-state operations and results of authorized insurers and health maintenance organizations. Such information must include, but is not limited to, medical claims expense, administrative expense and underwriting gain for each line segment of the market in this State in which the insurer participates. Information regarding product offerings must include products described in section 2736-C, subsection 6, paragraph A; section 2808-B, subsection 6, paragraph A; and section 4303, subsection 12. The annual report supplements must contain sufficient detail for the public to understand the components of cost incurred by authorized health insurers

and health maintenance organizations as well as the annual cost trends of these carriers. Information regarding product offerings must contain sufficient detail for the public to understand and compare product offerings of each insurer or health maintenance organization by price, services that are covered, services that are not covered or services that are excluded and out-of-pocket costs. The superintendent shall develop standardized definitions of each reported measure. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

PART D

Sec. D-1. 24-A MRSA §2735-A, sub-§1, as enacted by PL 2001, c. 432, §4, is amended to read:

1. Notice of rate filing or rate increase on existing policies. An insurer offering individual health plans as defined in section 2736-C must provide written notice by first class mail of a rate filing to all affected policyholders at least ~~60~~ 90 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks or modification of any formula or classification of risks. The notice must also inform policyholders of their right to request a hearing pursuant to section 229 or a special rate hearing pursuant to section 2736, subsection 4 or Title 24, section 2321, subsection 5. The notice must show the proposed rate and state that the rate is subject to regulatory approval. The superintendent may not take final action on a rate filing until ~~40~~ 70 days after the date notice is mailed by an insurer. An increase in premium rates may not be implemented until ~~60~~ 90 days after the notice is provided or until the effective date under section 2736, whichever is later.

Sec. D-2. 24-A MRSA §2736, sub-§1, as amended by PL 2003, c. 428, Pt. F, §2, 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, or 90 days in the case of a filing that applies to individual health plans as defined in section 2736-C, in advance of the stated effective date, unless the 60-day or 90-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.

Sec. D-3. 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. For any rate filing, the superintendent shall consider revenues and expenses from all line segments of the filing insurer. A filing and all supporting information, 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 within the meaning of Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to section 2736-A.

Sec. D-4. 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 burden of proving rates are reasonable, adequate, not unfairly discriminatory and in compliance with section 6913 remains with the insurer.

Sec. D-5. 24-A MRSA §2839-A, as amended by PL 2005, c. 121, Pt. F, §1 and c. 400, Pt. A, §2, is further amended to read:

§2839-A. Notice of rate increase

1. Notice of rate increase on existing policies. An insurer offering group health insurance, except for small group health plans as defined in section 2808-B and accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, must provide written notice by first class mail of a rate increase to all affected policyholders or others who are directly billed for group coverage at least 60 days before the effective date of any increase in premium rates. An increase in premium rates may not be implemented until 60 days after the notice is provided. ~~For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.~~

2. Notice of rate increase on new business. When an insurer offering group health insurance, except for small group health plans as defined in section 2808-B and accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, 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. ~~For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.~~

4. Notice of rate increase on existing small group health plans. An insurer offering small group health plans as defined in section 2808-B shall provide written notice by first class mail of a rate increase to all affected policyholders or others who are directly billed for group coverage at least 90 days before the effective date of any increase in premium rates. The notice must also inform policyholders of their right to request a hearing pursuant to section 229. The notice must state that the Attorney General is authorized to represent small employers in rate proceedings and must include information about how to contact the Office of the Attorney General. The notice must show the proposed rate and state that the rate is subject to regulatory approval. The superintendent may not take final action on a rate filing until 70 days after the date notice is mailed by an insurer. An increase in premium rates may not be implemented until 90 days after the notice is provided or until the effective date under section 2808-B, subsection 2-A, whichever is later.

5. Notice of rate increase on new small group business. When an insurer offering small group health plans as defined in section 2808-B quotes a rate for new business, the insurer must disclose any rate increase that the insurer anticipates implementing within the following 120 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 the increase is subject to regulatory approval. If such disclosure is not provided, an increase may not be implemented until at least 120 days after the date the quote is provided or until the effective date under section 2808-B, subsection 2-A, whichever is later.

Sec. D-6. 24-A MRSA §4224-B is enacted to read:

§4224-B. Loss information

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

A. "Contract" means the health maintenance organization contract relating to the loss information requested pursuant to this section.

B. "Loss information" means the aggregate claims experience of the group insurance policy health maintenance organization contract. "Loss information" includes the amount of premium received, the amount of claims paid and the loss ratio. "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.

C. "Loss ratio" means the ratio between the amount of premium received and the amount of claims paid by the insurer under the health maintenance organization contract.

2. Disclosure of basic loss information. Upon written request, every health maintenance organization shall provide loss information concerning a group contract to its contract holder or former contract holder within 21 business days of the date of the request. This subsection does not apply to a former contract holder whose coverage terminated more than 18 months prior to the date of a request.

3. Transmittal of request. An insurance producer or another authorized representative of a health maintenance organization who receives a request for loss information in accordance with this section shall transmit the request for loss information to the health maintenance organization within 4 business days.

PART E

Sec. E-1. 24-A MRSA §2736-C, sub-§5, as amended by PL 2007, c. 629, Pt. M, §5, is further 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%~~ 85% 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. If incurred claims were less than 85% of aggregate earned premiums over a continuous 12-month period, the carrier shall refund a percentage of the premium to the current in-force policyholder. The excess premium is the amount of premium above that amount necessary to achieve an 85% loss ratio for all of the carrier's individual policies during the same 12-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. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large. The superintendent may adopt rules setting forth appropriate methodologies regarding refunds pursuant to this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. E-2. 24-A MRSA §2803-A, sub-§4, as amended by PL 2001, c. 410, Pt. B, §2, is repealed.

Sec. E-3. 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 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 and become part of the official record of any hearing held pursuant to subsection 2-B, paragraphs B or F.

Sec. E-4. 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%~~ 85% 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. E-5. 24-A MRSA §2808-B, sub-§2-B, ¶B, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

B. If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. For any rate filing, notwithstanding subsection 2-C, the superintendent shall consider revenues and expenses from all line segments of the filing insurer. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

Sec. E-6. 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%~~ 88% 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 88% 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. E-7. 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. E-8. 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.

PART F

Sec. F-1. Market conduct exams. The Superintendent of Insurance shall undertake market conduct exams of health insurance companies no less frequently than once every 3 years, beginning in 2010.

PART G

Sec. G-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.

SUMMARY

This bill does the following.

1. Part A requires carriers to provide notice to policyholders when a policy has been reinstated and the premium paid following a cancellation notice for nonpayment of premium. It requires carriers to provide notice to plan enrollees regarding any exclusions or limits of coverage for childhood immunizations. Part A also requires carriers to post at least 5 individual and 5 small group health plans on its publicly accessible website for comparison purposes and sets minimum standards for explanation of benefits documents used by carriers.

2. Part B establishes standards for provider profiling programs used by carriers.

3. Part C 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 D extends the notice period for carriers to notify policyholders of proposed rate increases. It also permits the Attorney General to request a rate hearing regarding proposed rate increases for individual health plans.

5. Part E increases the minimum loss ratio for individual and small group health plans to 85%. Part E also requires health maintenance organizations to disclose loss information upon request from contract holders in the same manner as insurance companies. Part E also authorizes the Superintendent of Insurance to adopt rules requiring small group health carriers to offer standardized small group health plans.

6. Part F requires the Superintendent of Insurance to undertake market conduct exams of health insurance companies no less frequently than once every 3 years, beginning in 2010.

7. Part G 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.