129th MAINE LEGISLATURE

FIRST REGULAR SESSION-2019

Legislative Document	**No. 1**
S.P. 10	In Senate, January 2, 2019

An Act To Protect Health Care Coverage for Maine Families

(EMERGENCY)

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

DAREK M. GRANT
Secretary of the Senate

Presented by President JACKSON of Aroostook.
Cosponsored by Speaker GIDEON of Freeport.

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, Maine residents need access to comprehensive, quality health insurance coverage; and

Whereas, recent court decisions may endanger important consumer protections related to health insurance coverage in the federal Patient Protection and Affordable Care Act, including preexisting condition exclusions, essential health benefits and annual and lifetime limits on the dollar value of benefits; and

Whereas, the purpose of this legislation is to ensure that those consumer protections are codified in state law; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2011, c. 364, §4, is further amended to read:

D. A carrier may vary the premium rate due to age and tobacco use in accordance with the limitations set out in this paragraph.

(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 between July 15, 1995 and June 30, 2012, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2013, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2015, the maximum rate differential due to age filed by the carrier as determined by ratio is ~~5~~ 3 to 1 ~~to the extent permitted by the federal Affordable Care Act~~. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2012, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1.

Sec. A-2. 24-A MRSA §2736-C, sub-§11, as enacted by PL 2013, c. 271, §1, is amended to read:

11. Open enrollment; rules. Notwithstanding subsection 3, on or after January 1, 2014, a carrier may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods ~~consistent with requirements of the federal Affordable Care Act~~ to the extent not inconsistent with applicable federal law. The superintendent may adopt rules establishing minimum open enrollment dates and minimum criteria for special enrollment periods for all individual health plans offered in this State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-3. 24-A MRSA §2742-B, as amended by PL 2007, c. 514, §§1 to 5, is further amended to read:

§2742-B. Mandatory offer to extend coverage for dependent children up to 26 years of age

1. Dependent child; definition. As used in this section, "dependent child" means the child of a person covered under an individual health insurance policy when that child:

A. Is unmarried;

B. Has no dependent of the child's own; and

C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education.

2. Offer of coverage. Notwithstanding section 2703, subsection 3, an individual health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child ~~is 25~~ attains 26 years of age. An insurer may require, as a condition of eligibility for coverage in accordance

with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

Sec. A-4. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 2011, c. 638, §2, is further amended to read:

D. A carrier may vary the premium rate due to age, group size and tobacco use 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 between July 15, 1995 and September 30, 2011, 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 between October 1, 2011 and September 30, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2012 and December 31, 2013, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 3 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is ~~5~~ 3 to 1 ~~to the extent permitted by the federal Affordable Care Act~~. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(9) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1.

Sec. A-5. 24-A MRSA §2833-B, as amended by PL 2007, c. 514, §§6 to 10, is further amended to read:

§2833-B. Mandatory offer to extend coverage for dependent children up to 26 years of age

1. Dependent child; definition. As used in this section, "dependent child" means the child of a person covered under a group health insurance policy when that child:

A. Is unmarried;

B. Has no dependent of the child's own; and

C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education.

2. Offer of coverage. Notwithstanding section 2822, a group health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child ~~is 25~~ attains 26 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

Sec. A-6. 24-A MRSA §2849-B, sub-§8, as amended by PL 2011, c. 90, Pt. G, §2, is repealed.

Sec. A-7. 24-A MRSA §2850, sub-§2, as amended by PL 2011, c. 364, §18, is further amended to read:

2. Limitation. An individual, group or blanket contract issued by an insurer may not impose a preexisting condition exclusion ~~except as provided in this subsection. A preexisting condition exclusion may not exceed 12 months from the date of enrollment, including the waiting period, if any. For purposes of this subsection, "waiting period" includes any period between the time a substantially complete application for an individual or small group health plan is filed and the time the coverage takes effect. A preexisting condition exclusion may not be more restrictive than as follows~~. This subsection does not limit a carrier's ability to restrict enrollment in an individual contract to open enrollment and special enrollment periods in accordance with section 2736-C, subsection 11.

~~A. In a group contract, a preexisting condition exclusion may relate only to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period ending on the earlier of the date of enrollment in the contract and the date of enrollment in a prior contract covering the same group if there has not been a gap in coverage of greater than 90 days between contracts. An exclusion may not be imposed relating to pregnancy as a preexisting condition.~~

~~B. In an individual contract not subject to paragraph C, or in a blanket policy, a preexisting condition exclusion may relate only to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the date of application or to a pregnancy existing on the effective date of coverage.~~

~~C. An individual policy issued on or after January 1, 1998 to a federally eligible individual as defined in section 2848 may not contain a preexisting condition exclusion.~~

~~D. A routine preventive screening or test yielding only negative results may not be considered to be diagnosis, care or treatment for the purposes of this subsection.~~

~~E. Genetic information may not be used as the basis for imposing a preexisting condition exclusion in the absence of a diagnosis of the condition relating to that information. For the purposes of this paragraph, "genetic information" has the same meaning as set forth in the Code of Federal Regulations.~~

~~F. Except for individual health plans in effect on March 23, 2010 that have grandfathered status under the federal Affordable Care Act, a carrier as defined in section 4301-A, subsection 3 offering a health plan as defined in section 4301-A, subsection 7 may not apply a preexisting condition exclusion to any enrollee under 19 years of age. A preexisting condition exclusion may not be imposed on any enrollee after January 1, 2014 to the extent prohibited by the federal Affordable Care Act.~~

Sec. A-8. 24-A MRSA §4233-B, as amended by PL 2007, c. 514, §§11 to 15, is further amended to read:

§4233-B. Mandatory offer to extend coverage for dependent children up to 26 years of age

1. Dependent child; definition. As used in this section, "dependent child" means the child of a person covered under an individual or group health maintenance organization contract when that child:

A. Is unmarried;

B. Has no dependent of the child's own; and

C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education.

2. Offer of coverage. An individual or group health maintenance organization contract that offers coverage for a dependent child ~~shall~~ must offer such coverage, at the option of the contract holder, until the dependent child ~~is 25~~ attains 26 years of age. An

insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

Sec. A-9. 24-A MRSA §4318, as amended by PL 2011, c. 364, §33, is repealed.

Sec. A-10. 24-A MRSA §4320, as enacted by PL 2011, c. 364, §34, is amended to read:

§4320. No lifetime or annual limits on health plans

~~Notwithstanding the requirements of section 4318, a~~ A carrier offering ~~a~~ an individual or group health plan ~~subject to the federal Affordable Care Act~~ may not:

1. Establish lifetime limits. Establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or

2. Establish annual limits. Establish annual limits on the dollar value of essential benefits~~, except that, prior to January 1, 2014, health plans may include restricted annual limits on essential benefits consistent with the requirements of the federal Affordable Care Act and may establish annual limits consistent with waivers granted by the Secretary of the United States Department of Health and Human Services~~ as determined by the superintendent to the extent not inconsistent with applicable federal law.

PART B

Sec. B-1. 24-A MRSA §4320-D, as enacted by PL 2011, c. 364, §34, is amended to read:

§4320-D. Comprehensive health coverage

Notwithstanding any other requirements of this Title, a carrier offering a health plan ~~subject to the requirements of the federal Affordable Care Act~~ in this State shall, at a minimum, provide coverage that incorporates an essential health benefits ~~and cost-sharing limitations~~ package consistent with the requirements of ~~the federal Affordable Care Act~~ this section.

1. Essential health benefits package; definition. As used in this section, "essential health benefits package" means, with respect to any health plan, coverage that:

A. Provides for the essential health benefits defined by the superintendent under subsection 2;

B. Limits cost sharing for coverage in accordance with subsection 4; and

C. Provides for levels of coverage in accordance with subsection 5.

2. Substantially similar to federal Affordable Care Act; required categories. The superintendent shall ensure that the scope of the essential health benefits required under this section is substantially similar to that of the essential health benefits required

for a health plan subject to the federal Affordable Care Act as of January 1, 2019. The superintendent shall define the essential health benefits required for a health plan, except that such benefits must include at least the following general categories and the items and services covered within the categories:

A. Ambulatory patient services;

B. Emergency services;

C. Hospitalization;

D. Maternity and newborn care;

E. Mental health and substance use disorder services, including behavioral health treatment;

F. Prescription drugs;

G. Rehabilitative and habilitative services and devices;

H. Laboratory services;

I. Preventive and wellness services and chronic disease management; and

J. Pediatric services, including oral and vision care.

3. Required elements for consideration. In defining essential health benefits under this section, the superintendent shall:

A. Ensure that such essential health benefits reflect an appropriate balance among the categories described in subsection 2, so that benefits are not unduly weighted toward any category;

B. Ensure that coverage decisions, determination of reimbursement rates, establishment of incentive programs and designation of benefits are done in ways that do not discriminate against individuals because of their age, disability or expected length of life;

C. Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities and other groups;

D. Ensure that health benefits established as essential are not subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency or quality of life;

E. Provide that a qualified health plan may not be treated as providing coverage for the essential health benefits package described in subsection 1 unless the plan provides that:

(1) Coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency

department services received from providers who do have such a contractual relationship with the plan; and

(2) If emergency department services are provided out of network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, is the same requirement that would apply if such services were provided in network;

F. Provide that if a plan is offered through an exchange, another health plan offered through that exchange may not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under subsection 2, paragraph J;

G. Periodically review the essential health benefits package under subsection 1 and provide a report to the Legislature and the public that contains:

(1) An assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(2) An assessment of whether the essential health benefits package needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(3) Information on how the essential health benefits package will be modified to address any gaps in access or changes in the evidence base; and

(4) An assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations; and

H. Periodically update the essential health benefits package under subsection 1 to address any gaps in access to coverage or changes in the evidence base the superintendent identifies in the review conducted under paragraph G.

4. Cost-sharing limitations. The superintendent shall establish annual limitations on cost sharing and deductibles that are substantially similar to the limitations for health plans subject to the federal Affordable Care Act as of January 1, 2019. The superintendent may increase the annual limitation as needed to reflect any premium adjustment percentage. For purposes of this subsection, "premium adjustment percentage" means the percentage, if any, by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year as estimated by the superintendent no later than October 1st of such preceding calendar year exceeds such average per capita premium for 2019.

5. Levels of coverage. The superintendent shall define levels of coverage that are substantially similar to the levels of coverage required for health plans subject to the federal Affordable Care Act as of January 1, 2019.

6. Report. Within 30 days of defining essential health benefits as required under this section or within 30 days after adopting any changes to the definition of essential health benefits, the superintendent shall submit a report summarizing the definition of essential health benefits to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters.

7. Rule of construction. This section may not be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this section.

8. Rules. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

SUMMARY

The purpose of this bill is to ensure that consumer protections related to health insurance coverage included in the federal Patient Protection and Affordable Care Act are codified in state law.

In Part A, the bill does the following.

1. It makes clear that individual and group health plans may not impose any preexisting condition exclusion on an enrollee. The bill does permit a carrier to restrict enrollment in individual health plans to open enrollment and special enrollment periods established in rule.

2. It clarifies that carriers offering individual or group health plans may not establish lifetime or annual limits on the dollar value of benefits. The bill specifies that the provision prohibiting annual limits on the dollar value of benefits applies to the dollar value of essential health benefits as determined by the Superintendent of Insurance.

3. It allows children, until they attain 26 years of age, to remain on their parents' health insurance policy.

4. It changes the maximum rate differential due to age that may be filed by the carrier to the rate differential that is permitted under the federal Patient Protection and Affordable Care Act.

In Part B, the bill requires that, at a minimum, health plans cover essential health benefits that are substantially similar to those benefits required for health plans subject to the federal Patient Protection and Affordable Care Act as of January 1, 2019. The bill directs the Superintendent of Insurance to define essential health benefits in rule and designates those rules as major substantive and subject to legislative review and approval.