LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWELFTH LEGISLATURE

SECOND REGULAR SESSION
January 8, 1986 to April 16, 1986

SECOND SPECIAL SESSION
May 28, 1986 to May 30, 1986

AND AT THE

THIRD SPECIAL SESSION
October 17, 1986

PUBLISHED BY THE DIRECTOR OF REVISOR OF STATUTES IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED, TITLE 3, SECTION 163-A, SUBSECTION 4.

J.S. McCarthy Co., Inc.
Augusta, Maine

PUBLIC LAWS

OF THE

STATE OF MAINE

AS PASSED AT THE

SECOND REGULAR SESSION

of the

ONE HUNDRED AND TWELFTH LEGISLATURE

1985

CHAPTER 648

H.P. 1582 - L.D. 2226

AN ACT to Insure Fair Practices in the Sale of Health Insurance Policies to Elderly Consumers.

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

Sec. 1. 24 MRSA §2321, sub-§1, as amended by PL 1979, c. 558, §1, 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 which it proposes to use. Every such filing shall state the effective date thereof. Every such filing shall be made not less than 60 days in advance of the stated effective date unless such 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 nursing home and long-term contracts, rates filed prior to August 1, 1986, shall be effective until no later than August 1, 1989. Rates filed on or after August 1, 1986, for these types of contracts shall be effective for no more than 3 years, except that rates for contracts with guaranteed level premiums shall be effective for the duration of the contract.

Sec. 2. 24 MRSA §2327, as enacted by PL 1979, c. 558, §5, is amended to read:

§2327. Group rates

No group health care contract ~~shall~~ may 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 for these contracts ~~have~~ has been filed for informational purposes with the superintendent. Notwithstanding this section, rates for group Medicare supplement, nursing

home care or long-term care contracts must be filed in accordance with section 2321.

Sec. 3. 24 MRSA §2328-A is enacted to read:

§2328-A. Nursing home and long-term care contracts; compliance with Title 24-A, chapter 68

Every nonprofit hospital, medical service organization or nonprofit health care plan which issues group or individual health care contracts which are designed primarily to provide nursing home or long-term care benefits to residents of this State shall be subject to the requirements of Title 24-A, chapter 68 and any rule promulgated by the superintendent under those sections. Any such requirements shall be in addition to any requirements of this Title.

Sec. 4. 24-A MRSA §2151, as enacted by PL 1969, c. 132, §1, is amended to read:

§2151. Purpose

The purpose of ~~sections 2151 to 2167~~ this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, Public Law 15, 79th Congress, by defining or providing for the determination of all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices, by defining or providing for the determination of all such practices in other states by residents of this State which constitute unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined.

Sec. 5. 24-A MRSA §2151-B is enacted to read:

§2151-B. Rules

Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may promulgate rules defining, limiting or prescribing acts and practices which are deemed to be in violation of this chapter.

Sec. 6. 24-A MRSA §2165, sub-§1, as amended by PL 1973, c. 585, §12, is further amended to read:

1. If, after a hearing thereon of which notice of such hearing and of the charges against him were

given such person, the superintendent finds that any person in this State has engaged or is engaging in any act or practice defined in or prohibited under this chapter or rules promulgated under this chapter, or that a resident of this State has so engaged or is so engaging in another state, the superintendent shall order such person to desist from such acts or practices.

Sec. 7. 24-A MRSA §2165, sub-§5, as enacted by PL 1969, c. 132, §1, is amended to read:

5. Violation of any such desist order shall be deemed to be and shall be punishable as a violation of this Title. The Superior Court shall assess a civil penalty, payable to the Bureau of Insurance to be applied toward the administration of this Title, against any person who violates a cease and desist order issued by the superintendent or an injunction issued by a court pursuant to this chapter. The amount of the civil penalty shall not exceed $10,000 for each violation.

Sec. 8. 24-A MRSA §2166, sub-§1, as amended by PL 1973, c. 585, §12, is further amended to read:

1. If the superintendent believes that any person engaged in the insurance business is engaging in this State, or that any resident of this State engaged in the insurance business is engaging in another state, in any method of competition or in any act or practice not defined in this chapter or in rules promulgated under this chapter, in the conduct of such business, which is unfair or deceptive and that a proceeding by him in respect thereto would be in the public interest, he shall, after a hearing of which notice of the hearing and of the charges against him are given such person, make a written report of his findings of fact relative to such charges and serve a copy thereof upon such person and any intervenor at the hearing.

Sec. 9. 24-A MRSA §2701, sub-§2, as enacted by PL 1969, c. 132, §1, is amended to read:

2. Any group or blanket policy, except that sections 2736, 2736-A and 2736-B shall apply to group Medicare supplement policies as defined in chapter 67 and group nursing home and long-term care insurance policies as defined in chapter 68;

Sec. 10. 24-A MRSA §2736, sub-§1, as amended by PL 1979, c. 558, §6, is repealed and the following enacted in its place:

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 which it proposes to use. Every such filing must state the effective date of the filing. Every such filing shall 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 nursing home care and long-term care insurance policies, rates filed prior to August 1, 1986, shall be effective until no later than August 1, 1989. Rates filed on or after August 1, 1986, for these types of policies shall be effective for no more than 3 years, except that rates for contracts with guaranteed level premiums shall be effective for the duration of the contract.

Sec. 11. 24-A MRSA §2839, as reallocated by PL 1979, c. 663, §149, is amended to read:

§2839. Rates filed

No policy of group ~~accident and sickness~~ health insurance ~~shall~~ may be delivered in this State until a copy of the group manual rates to be used in calculating the premium for these policies ~~have~~ has been filed for informational purposes with the superintendent. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care insurance contracts must be filed in accordance with section 2736.

Sec. 12. 24-A MRSA c. 68 is enacted to read:

CHAPTER 68

NURSING HOME CARE AND LONG-TERM CARE

INSURANCE POLICIES

§5051. Definitions

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

1. Long-term care policy. "Long-term care policy" means a group or individual policy of health insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan which is advertised, marketed or designed primarily to provide coverage or services for chronic or terminally ill care in either institutional or community based settings. That term does not include:

A. A policy or contract defined as Medicare supplement insurance pursuant to chapter 67;

B. A policy or contract issued to one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or combination of both, or for members or former members, or combination of both, of the labor organizations;

C. A policy or contract issued to any professional, trade or occupational association for its members, former members or retired members or combination of all members, if the association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least 2 years prior to the date of its initial offering of the policy or plan to its members; and

D. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when that group or individual policy or contract includes provisions which are inconsistent with the requirements of this chapter.

2. Nursing home. "Nursing home" means any facility located in this State which is licensed by the Department of Human Services as a skilled nursing facility or intermediate care facility and any equivalent facility located in another state or country and licensed according to the laws of that jurisdiction.

3. Nursing home care policy. "Nursing home care policy" means a group or individual policy of health

insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan which is advertised, marketed or designed primarily to provide benefits on either an expense-incurred or indemnity basis for confinements or costs associated with confinements of a covered person in a nursing home. For purposes of this definition, a policy is deemed to primarily provide nursing home benefits if 50% or more of benefits payable or anticipated to be payable under the policy are related to nursing home confinements. The term does not include:

A. A policy or contract defined as Medicare supplement insurance pursuant to chapter 67;

B. A policy or contract issued to one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or combination of both, or for members or former members, or combination of both, of the labor organizations;

C. A policy or contract issued to any professional, trade or occupational association for its members, former members or retired members, or combination of members if, the association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least 2 years prior to the date of its initial offering of the policy or plan to its members; or

D. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance, when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this chapter.

§5052. Specific standards

1. Standards for long-term and nursing home care policies. The superintendent may promulgate rules to establish specific standards for policy provisions of

long-term and nursing home care policies. The standards shall be in addition to and in accordance with applicable laws of this State, including chapters 33 and 35, and may include, but are not limited to:

A. Terms of renewability;

B. Initial and subsequent conditions of eligibility;

C. Nonduplication of coverage;

D. Probationary periods;

E. Benefit limitations, exceptions and reductions;

F. Elimination periods;

G. Requirements for replacement;

H. Recurrent confinements; and

I. Definition of terms.

2. Prohibited policy provision. The superintendent may promulgate rules that specify prohibited provisions not otherwise specifically authorized by law which, in the opinion of the superintendent, are unjust, unfair, inequitable or unfairly discriminatory to any person insured or proposed for coverage under a long-term nursing home care policy.

§5053. Disclosure standards

The superintendent may promulgate reasonable rules to provide for the full and fair disclosure of information in connection with the sale of long-term and nursing home care policies, including, but not limited to, outline of coverage requirements and requirements relating to the replacement sale of the policies.

Effective July 16, 1986.

CHAPTER 649

H.P. 1221 - L.D. 1729

AN ACT to Clarify the Sand Dunes Law.