LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND FIFTEENTH LEGISLATURE

SECOND SPECIAL SESSION
December 12, 1991 to January 7, 1992

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

J.S. McCarthy Company
Augusta, Maine
1992

PUBLIC LAWS

OF THE

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AS PASSED AT THE

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1991

5. Immunity of facilities and establishments. Notwithstanding any other provision of law, a hospital or other health care facility licensed by the Department of Human Services, or an eating establishment licensed under Title 22, chapter 562 that, in good faith and in accordance with guidelines established by the recipient organization, donates food that is apparently fit for human consumption at the time it is donated to a bona fide charitable or nonprofit organization for free distribution is immune from civil liability arising from injury, illness or death due to the condition or content of the food, unless the injury, illness or death is a direct result of intentional misconduct of the donor. Nothing in this subsection prevents a licensed hospital, health care facility or eating establishment from receiving the immunity provided in subsection 2 if the donor qualifies for immunity under the terms of that subsection.

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

Effective March 26, 1992.

CHAPTER 740

S.P. 840 - L.D. 2144

An Act to Amend the Law Pursuant to the Medicare Supplement Insurance Minimum Standards Model Act and to Provide Consumer Information for Purchasers of Insurance

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

Whereas, federal law requires the states to adopt the National Association of Insurance Commissioners' Medicare supplemental insurance minimum standards model act and rule prior to July 30, 1992; and

Whereas, immediate action is necessary to ensure that Maine can meet that deadline or prevent federal preemption of its Medicare supplemental insurance regulatory program; 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:

Sec. 1. 24-A MRSA §5001, as enacted by PL 1981, c. 234, §4, is amended to read:

§5001. Definitions

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

1. Applicant. "Applicant" means:

A. In the case of an individual Medicare supplement policy ~~or subscriber contract~~, the person who seeks to contract for insurance benefits; and

B. In the case of a group Medicare supplement policy ~~or subscriber contract~~, the proposed certificate holder.

2. Certificate. "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy~~, which policy has been delivered or issued for delivery in this State~~.

2-A. Certificate form. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

2-B. Issuer. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

3. Medicare. "Medicare" means the "~~United States~~ Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965~~, Public Law 89-97~~, as amended.

4. Medicare supplement policy. "Medicare supplement policy" means a group or individual policy of ~~health~~ accident and sickness insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan or health maintenance organization other than a policy issued pursuant to a contract under the federal Social Security Act, Section 1876 or Section 1833 or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, which is advertised, marketed or designed primarily as a supplement to reimbursements ~~made~~ under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare ~~by reason of age. Such term does not include:~~

~~A. 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 thereof, or for members or former members, or combination thereof, of the labor organizations;~~

~~B. A policy or contract issued to any professional, trade or occupational association for its members~~

~~or former or retired members, or combination thereof, if such 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 such policy or plan to its members; or b! 1981, c. 234, § 4 (new). ¶b~~

~~C. 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.~~

4-A. Policy form. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

5. Superintendent. "Superintendent" means the Superintendent of Insurance.

Sec. 2. 24-A MRSA §5001-A is enacted to read:

§5001-A. Applicability and scope

1. Application. Except as otherwise specifically provided in sections 5004 and 5013, this chapter applies to:

A. All Medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this section; and

B. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

2. Employers or labor organizations. This chapter does not apply to a policy of 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 thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

3. Plans not marketed as Medicare supplements. The provisions of this chapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held to be Medicare supplement policies or benefit plans.

Sec. 3. 24-A MRSA §5002, as amended by PL 1991, c. 48, §3, is repealed.

Sec. 4. 24-A MRSA §5002-A is enacted to read:

§5002-A. Standards for policy provisions and authority to adopt rules

1. Duplicate benefits. A Medicare supplement policy or certificate in force in the State may not contain benefits that duplicate benefits provided by Medicare.

2. Standardization. The superintendent may adopt rules specifying the minimum Medicare supplement contract benefits required in the State and the optional benefits available for sale in the State. All other benefits or options are prohibited in a Medicare supplement contract subject to this chapter.

3. Preexisting conditions. Notwithstanding any other provision of law of this State, a Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because the medical condition involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

4. Specific standards. The superintendent shall adopt rules to establish specific standards for policy provisions of Medicare supplement policies and certificates. These standards must be in addition to and in accordance with applicable laws of this State. No requirement of the insurance laws relating to minimum required policy benefits, other than the minimum standards contained in this chapter, applies to Medicare supplement policies and certificates. The standards may cover, 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, which may not be more restrictive than those of Medicare for any type of care covered under the policy;

F. Elimination periods;

G. Requirements for replacement;

H. Recurrent conditions; and

I. Definitions of terms.

5. Minimum standards for benefits, claims, marketing, compensation and reporting. The superintendent shall adopt reasonable rules to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices for Medicare supplement policies and certificates.

6. Other policies not prohibited. Nothing in this section may be construed to prohibit the sale of insurance policies or contracts to persons eligible for Medicare by reason of age because those policies or contracts fail to meet the requirements of this chapter. Such policies may not be advertised, marketed or designed as Medicare supplement policies.

7. Method of identification. The superintendent shall prescribe the method of identification of Medicare supplement policies. The superintendent shall prescribe a method of identification of health insurance policies other than Medicare supplement policies or contracts that are advertised, marketed or designed for persons eligible for Medicare by reason of age. That method may include, but is not limited to, a requirement that such policies clearly indicate they are limited benefit health coverage policies and clearly specify that they do not meet the minimum standards for Medicare supplement policies.

8. Conformance of policies to federal law. The superintendent may adopt from time to time such reasonable rules as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and rules adopted pursuant to federal law, including but not limited to:

A. Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

B. Establishing a uniform methodology for calculating and reporting loss ratios;

C. Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance;

D. Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

E. Establishing a policy for holding public hearings prior to approval of premium increases; and

F. Establishing standards for Medicare select policies and certificates.

9. Prohibited policy provisions. The superintendent may adopt reasonable rules that prohibit policy provisions not specifically authorized by statute that in the opinion of the superintendent are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

Sec. 5. 24-A MRSA §5003, as amended by PL 1989, c. 852, §1, is repealed.

Sec. 6. 24-A MRSA §5004, as amended by PL 1989, c. 852, §§2 and 3, is further amended to read:

§5004. Loss ratio standards

1. Any Medicare supplement policy or contract is subject to the minimum loss ratio standards of section 2413, subsection 1, paragraph F, as well as any other laws of this State as apply to rate filings with respect to health insurance and nonprofit hospital and medical service organizations and nonprofit health care plan contracts.

2. ~~If a Medicare supplement certificate is to be provided to a resident of this State under a master policy issued for delivery outside this State, the group certificate shall be filed with the superintendent at least 60 days prior to any solicitation in this State, along with sufficient information concerning the nature of the group, to permit the superintendent to make the determinations required by section 2412.~~ Medicare supplement policies must provide for a return to policyholders benefits that are reasonable in relation to the premium charged. The superintendent shall issue reasonable rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

Sec. 7. 24-A MRSA §5005, as enacted by PL 1981, c. 234, §4, is amended to read:

§5005. Disclosure standards

1. Delivery of outline of coverage. In order to provide for full and fair disclosure in the sale of Medicare supplement policies ~~and contracts~~, no ~~such~~ Medicare supplement policy or ~~contract~~ certificate may be delivered ~~or issued for delivery~~ in this State, unless ~~the~~ an outline of coverage ~~described in subsection 2~~ is delivered to the applicant at the time application is made.

2. Format; content or outline. The superintendent shall prescribe ~~a uniform~~ the format and content of the outline of coverage required by subsection 1. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and the arrangement of

text and captions. The outline of coverage ~~shall~~ must include:

A. A description of the principal benefits and coverage provided in the policy;

~~B. A statement of the exceptions, reductions and limitations contained in the policy;~~

C. A statement of the renewal provisions, including any reservation by the ~~insurer~~ issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

D. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

3. Standard form; contents of informational brochure. The superintendent may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare ~~by reason of age~~, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the superintendent may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with the delivery of the outline of coverage. With respect to direct response insurance policies, the superintendent may require by rule that the prescribed brochure ~~must~~ be provided upon request to any prospective insureds eligible for Medicare ~~by reason of age upon request~~, but in no event later than the time of policy delivery.

3-A. Captions or notice requirements. The superintendent may adopt rules for captions or notice requirements determined to be in the public interest and designed to inform the prospective insureds that particular insurance coverages are not Medicare supplement coverages for all accident and sickness insurance policies sold to persons eligible for Medicare by reason of age other than:

A. Medicare supplement policies;

B. Disability income policies;

C. Basic, catastrophic or major medical expense policies; or

D. Single premium, nonrenewable policies.

3-B. Application forms; health statements. Additional disclosure is required in applications or enrollment forms employed on or after January 1, 1993.

A. An issuer including health status questions in an application or enrollment form employed during an applicant's open enrollment period shall disclose that coverage in any plan offered by the issuer is guaranteed to be issued and will be provided without regard to health status.

B. An issuer including health status questions in an application or enrollment form shall disclose to applicants enrolling after their open enrollment period, including applicants replacing coverage, that enrollment in standard Medicare Supplement Plan A is guaranteed to be issued during the annual guaranteed issue period and will be provided without regard to health status.

C. Enrollment or application forms employed to effect the replacement of coverage provided by section 5010 must disclose that:

(1) For all persons, coverage in the standardized Medicare supplement plans that do not contain an outpatient prescription drug benefit is guaranteed to be issued and will be provided without regard to health status and without preexisting conditions exclusions, waiting periods, elimination periods or probationary periods for similar benefits to the extent time was spent under prior coverage; and

(2) For persons with existing prescription drug coverage, coverage in the standardized Medicare supplement plans that do not contain an outpatient prescription drug benefit greater than that provided by the plan that is in force is guaranteed to be issued and will be provided without regard to health status and without preexisting conditions exclusions, waiting periods, elimination periods or probationary periods for similar benefits to the extent time was spent under prior coverage.

D. For purposes of this section, an open enrollment period is the 6-month period beginning with the first month in which an individual who is 65 years of age or older first enrolled for benefits under Medicare Part B.

4. Rules. The superintendent may ~~promulgate~~ adopt reasonable rules to govern the full and fair disclosure of information in connection with the replacement of ~~Medicare supplement~~ accident and sickness policies ~~and~~, subscriber contracts or certificates by persons eligible for Medicare.

Sec. 8. 24-A MRSA §5006, as enacted by PL 1981, c. 234, §4, is repealed.

Sec. 9. 24-A MRSA §5006-A is enacted to read:

§5006-A. Filing requirements for advertising

Every issuer of Medicare supplement insurance policies or certificates in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State, whether through written, radio or television medium, to the superintendent for review or approval by the superintendent at least 30 days prior to the date the advertisement will be used in this State.

Sec. 10. 24-A MRSA §5007, as amended by PL 1989, c. 27, §5, is further amended to read:

§5007. Notice of free examination

Medicare supplement policies ~~or~~ and certificates ~~shall~~ must have a notice prominently printed on the first page of the policy or certificate or attached ~~thereto~~ to the policy or certificate, stating in substance that the applicant ~~shall have~~ has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section must be paid directly to the applicant by the issuer in a timely manner.

Sec. 11. 24-A MRSA §5008, as enacted by PL 1989, c. 27, §6, is repealed.

Sec. 12. 24-A MRSA §5009, as enacted by PL 1989, c. 27, §6, is repealed.

Sec. 13. 24-A MRSA §§5010, 5011, 5012 and 5013 are enacted to read:

§5010. Replacement of policies issued prior to January 1, 1992

1. Applicability. This section applies to individual policies and group certificates and policies issued in Maine or covering Maine residents.

2. Insured's right to replace coverage. Insureds under Medicare supplement policies issued prior to January 1, 1992 must be permitted at any time to replace their coverage with any of the standardized plans offered by the same issuer, subject to the following conditions.

A. The issuer may decline to issue a particular standardized plan to an existing insured if:

(1) The standardized plan includes coverage of prescription drugs greater than that in the plan being replaced; and

(2) The insured does not otherwise qualify for the standardized plan.

B. If the standardized plan is rated on the basis of age at issue, the issuer shall use the insured's age at the time of issue of the prior policy.

C. The issuer shall provide at each policy anniversary, and at the time of any rate increase, a notice describing the standardized plans which are available and the rates for those plans.

3. Mandatory replacement. Prior to October 1, 1992, all issuers shall submit to the superintendent a copy of each Medicare supplement policy form for which policies issued prior to January 1, 1992 are in force in Maine and a list of standardized plans offered on the effective date of this section. The issuer shall designate the standardized plan, if any, that has substantially similar benefits to the policy issued prior to January 1, 1992. For any of the policies that the superintendent determines are substantially similar to one of the offered standardized plans, the issuer shall replace the policy with the similar standardized plan or, at the option of the insured, one of the other standardized plans selected by the insured pursuant to subsection 1, on or before the first policy anniversary after June 30, 1993.

§5011. Rating restrictions

1. Community rating. This subsection applies to any policy delivered or issued for delivery on or after January 1, 1993. It also applies, as of the first policy or certificate anniversary on or after January 1, 1993, to policies or certificates delivered or issued for delivery in 1992.

A. Rates for policies subject to this subsection may not vary based on age, gender, health status, claims experience, policy duration, industry or occupation.

B. In revising rates for a standardized plan, an issuer shall pool all experience for that plan under individual policies. Group plans may be rated separately. A group with credible experience may be rated differently than other groups.

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 Medicare Part A by reason of age, subject to approval by the superintendent. The superintendent may adopt rules governing the appropriate use of discounts.

§5012. Annnal guaranteed issue period

During a guaranteed issue period of at least one month each calendar year, as established by the issuer,

every issuer shall offer standardized Medicare Supplement Plan A, as defined by rule, to all applicants on a basis that does not deny coverage to any individual or group based on health status, claims experience, receipt of health care, or medical condition.

§5013. Notice regarding policies that are not Medicare supplement policies

Any individual accident and sickness insurance policy or group insurance certificate, including the contract of a nonprofit hospital and medical service or health care plan issued for delivery in this State to persons eligible for Medicare by reason of age must notify insureds that the policy or certificate is not a Medicare supplement policy or certificate. The notice must be either printed on or attached to the first page of the outline of coverage delivered to insureds, or if no outline of coverage is delivered, to the first page of the policy or certificate. The notice must be in no less than 12-point type and must contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. If you have a Medicare supplement policy or major medical policy, this coverage may be more than you need. For information call the Bureau of Insurance at (toll-free phone number)."

This section does not apply to a Medicare supplement policy; a policy issued pursuant to a contract under the Federal Social Security Act, 42 United States Code, Section 1833 or 1876; a disability income policy; a single premium nonrenewable policy; or a policy identified in section 5001-A, subsection 2.

Sec. 14. Severability. If the United States Secretary of Health and Human Services concludes that the effect of inclusion of the provisions in section 7 of this Act enacting the Maine Revised Statutes, Title 24-A, section 5005, subsection 4; in section 12 of this Act enacting Title 24-A, section 5010, subsection 3 and Title 24-A, section 5011 and Title 24-A, section 5012 in the State of Maine Medicare Supplement regulatory program prevents certification under the federal Social Security Act, 42 United States Code, Section 1395ss (b)(1), the provisions of those sections are null and void.

Sec. 15. Allocation. The following funds are allocated from Other Special Revenue to carry out the purposes of this Act.

	1992-93
PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF	
Bureau of Insurance	
Positions	(0.5)
Personal Services	$12,960
All Other	250
Capital Expenditures	3,000

Provides funds for the salary, fringe benefits and operating expenses of a part-time Market Conduct Examiner position and for one-time computer costs.

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION TOTAL	$16,210

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

Effective March 26, 1992.

CHAPTER 741

S.P. 834 - L.D. 2138

An Act to Update and Revise the Exemptions under the Maine Bankruptcy Code

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

Sec. 1. 14 MRSA §4422, sub-§1, ¶A, as enacted by PL 1989, c. 286, §1, is amended to read:

A. Except as provided in paragraph B, the debtor's aggregate interest, not to exceed ~~$7,500~~ $12,500 in value, in real or personal property that the debtor or a dependent of the debtor uses as a residence, in a cooperative that owns property that the debtor or a dependent of the debtor uses as a residence, or in a burial plot for the debtor or a dependent of the debtor, provided that if minor dependents of the debtor have their principal place of residence with the debtor, the debtor's aggregate interest may not exceed $25,000 and provided further that if the debtor's interest is held jointly with any other person or persons, the exemption ~~shall~~ may not exceed in value the lesser of ~~$7,500~~ $12,500 or the product of the debtor's fractional share times ~~$15,000~~ $25,000.

Sec. 2. 14 MRSA §4422, sub-§§2, 4 and 5, as enacted by PL 1981, c. 431, §2, are amended to read:

2. Motor vehicle. The debtor's interest, not to exceed ~~$1,200~~ $2,500 in value, in one motor vehicle.

4. Jewelry. The debtor's aggregate interest, not to exceed ~~$500~~ $750 in value, in jewelry held primarily for the personal, family or household use of the debtor or a