LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND SEVENTEENTH LEGISLATURE

FIRST REGULAR SESSION

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IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED,
TITLE 3, SECTION 163-A, SUBSECTION 4

J.S. McCarthy Company
Augusta, Maine
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4-A. Food establishment. "Food establishment" means a factory, plant, warehouse or store in which food and food products are manufactured, processed, packed, held for introduction into commerce or sold. The following establishments are not considered food establishments required to be licensed under section 2167:

A. Eating establishments, as defined in section 2491, subsection 7;

B. Fish and shellfish processing establishments inspected under Title 12, section 4682, 6101, 6102 or 6856;

C. Storage facilities for native produce;

D. Establishments, such as farm stands primarily selling fresh produce, not including dairy and meat products;

E. Establishments engaged in the washing, cleaning or sorting of whole produce, provided the produce remains in essentially the same condition as when harvested. The whole produce may be packaged for sale, provided that packaging is not by a vacuum packaging process or a modified atmosphere packaging process; and

F. Establishments that are engaged in the drying of single herbs that are generally recognized as safe under 21 Code of Federal Regulations, Sections 182 to 189. The single herbs may be packaged for sale, provided that packaging is not by a vacuum packaging process or a modified atmosphere packaging process.

Sec. 2. 36 MRSA §4312-B, sub-§4, as repealed and replaced by PL 1985, c. 737, Pt. A, §100, is amended to read:

4. Organization. Members of the commission shall elect annually by majority vote one member of the commission ~~who shall~~ to serve as ~~chairman~~ chair. The ~~chairman~~ commission may appoint by majority vote an executive director ~~or~~ and such personnel as ~~he deems~~ the commission considers necessary to administer policies and programs established by the commission. The executive director and other staff serve at the pleasure of the commission. The salaries paid to the executive director and other staff of the commission must be fixed by the commission, subject to the approval of the Governor. ~~These officers or personnel shall~~ The executive director and other staff are not ~~be~~ subject to the ~~Personnel Laws~~ personnel laws of the State.

See title page for effective date.

CHAPTER 332

H.P. 994 - L.D. 1405

An Act to Amend the Laws Concerning Health Insurance

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

PART A

Sec. A-1. 24 MRSA §2330, sub-§1, as amended by PL 1991, c. 822, §1 and affected by §6, is further amended to read:

1. Conversion provision required. A group hospital, medical or health care service contract issued for delivery in this State prior to January 1, 1996, by a nonprofit hospital, medical or health service organization, other than a contract that provides benefits for specific diseases or accidental injuries only, must contain a provision that if the health coverage on an employee or member ceases because of termination of employment or termination of the contract or any portion ~~thereof~~ of the contract, and the person has been continuously insured for a period of at least 3 months under the group contract or under the group contract and any prior group contract or policy providing similar benefits that it replaces, that person is entitled to have issued to that person by the nonprofit service corporation, without evidence of insurability, a nongroup health care contract or, at the option of the nonprofit service corporation, a group certificate, ~~provided~~ if ~~that~~ application is made and the first subscription charge paid to the nonprofit service corporation within 90 days after that termination. At the option of the employee or member, the converted contract may cover the employee or member, the employee or member and the dependents of the employee or member or the dependents of the employee or member; ~~provided that~~ if, in the latter 2 cases, the dependents had been covered for a period of at least 3 months under the group contract, unless the dependent persons were not eligible for coverage until after the beginning of the 3-month period. The nonprofit service corporation has the option to provide the required coverage upon conversion through either a group or nongroup health care contract, and may issue a separate converted contract to cover any dependent. A nonprofit service corporation may not be required to provide a conversion privilege if termination of coverage under the group contract occurred because the employee or member failed to pay any required contribution or if any discontinued group coverage is replaced by continuous and substantially similar group coverage within 31 days.

Sec. A-2. 24 MRSA §2330, sub-§1-A, as amended by PL 1995, c. 189, §1, is further amended to read:

1-A. Notification of cancellation. A nonprofit hospital or medical service organization or nonprofit health care plan must provide by first class mail at least 10 days' prior notification of cancellation for nonpayment of subscription charges according to this section. The notice must include the date of cancellation of coverage and, if applicable, the time period for exercising contract conversion rights. Notification is not required when the nonprofit hospital or medical service organization or nonprofit health care plan has received written notice from the group contract holder or subgroup sponsor that replacement coverage has been obtained.

A. Notice must be mailed to the group contract holder or subgroup sponsor;

B. At the time of notification under paragraph A, notice must be mailed to the certificate holder at:

(1) The last address provided by the subgroup sponsor or the group contract holder to the nonprofit hospital or medical service organization or nonprofit health care plan; or

(2) The office of the subgroup sponsor, if any, or the group contract holder; and

C. Notice must be mailed to the Bureau of Insurance ~~and to the Bureau of Labor Standards~~.

Sec. A-3. 24 MRSA §2330, sub-§2, as enacted by PL 1981, c. 606, §1, is amended to read:

2. Other circumstances where conversion provision required. ~~The~~ If a conversion privilege ~~shall~~ is applicable pursuant to subsection 1, it must also be available:

A. Upon the death of an employee or member, to the surviving spouse with respect to the spouse and the children whose coverage terminates by reason of that death, or if there is no surviving spouse to each surviving child whose coverage so terminates. If the group contract provides for continuation of dependents' coverage upon the death of the employee or member, the conversion privilege ~~shall~~ must be made available at the end of that continuation;

B. To the spouse of a member or employee upon termination of coverage by reason of ceasing to be a qualified family member under the group policy whether by divorce or otherwise, whether or not the employee or member remains covered, with respect to the spouse and the children whose coverage terminates at the same time;

C. To a child upon termination of coverage by reason of ceasing to be a qualified family member under the group contract if a conversion privilege is not otherwise provided with respect to ~~him~~ that child in this subsection; or

D. To an employee or member whose coverage would otherwise continue under the group contract upon retirement prior to eligibility for coverage under Medicare, "United States Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Public Law 89-97, as amended, at the option of that employee or member in lieu of continued coverage under the group contract.

Sec. A-4. 24 MRSA §2330, sub-3-A is enacted to read:

3-A. Contracts issued or renewed on or after January 1, 1996. A nonprofit service corporation that offers individual health plans pursuant to Title 24-A, section 2736-C is permitted, but not required, to include a conversion privilege in group contracts issued or renewed on or after January 1, 1996. If the corporation does include a conversion privilege in these contracts, individuals exercising these rights must be offered a choice of any individual health plan offered by the corporation. A nonprofit service corporation that does not offer individual health plans pursuant to Title 24-A, section 2736-C may not include a conversion privilege in group contracts issued or renewed on or after January 1, 1996.

Sec. A-5. 24 MRSA §2330, sub-§4, ¶¶A and B, as enacted by PL 1991, c. 668, §1, are amended to read:

A. Conversion is provided through a form that is also issued to ~~individually underwritten standard risks~~ members of the general public applying for an individual health plan pursuant to Title 24-A, section 2736-C;

B. The rates for that form ~~are based on individually underwritten standard risks~~ comply with Title 24-A, section 2736-C; and

Sec. A-6. 24 MRSA §2330, sub-§§7 and 9, as enacted by PL 1981, c. 606, §1, are amended to read:

7. Notice. Notice of the conversion privilege ~~shall~~, if one is applicable, must be included in each certificate of coverage.

9. Refusal to renew. A contract issued pursuant to the conversion privilege provided by this section

may provide that the nonprofit service corporation may refuse to renew the contract or coverage of any person covered ~~thereunder for the following reasons only:~~ only as permitted by Title 24-A, section 2736-C.

~~A. Fraud or material misrepresentation in applying for any benefits under the converted contract; or~~

~~B. Any reason for which the nonprofit service corporation may refuse to issue a converted contract under subsection 3.~~

Sec. A-7. 24 MRSA §2330, sub-§10, as amended by PL 1991, c. 885, Pt. E, §21 and affected by §47, is repealed.

Sec. A-8. 24-A MRSA §2809-A, sub-§1, as amended by PL 1991, c. 822, §3 and affected by §6, is further amended to read:

1. A group policy issued prior to January 1, 1996, that provides hospital, surgical or major medical expense insurance or any combination thereof, other than a policy that provides benefits for specific diseases or accidental injuries only, must contain a provision that if the insurance on an employee or member ceases because of termination of employment or termination of the policy or any portion ~~thereof~~ of a policy, and the person has been continuously insured for a period of at least 3 months under the group policy or under the group policy and any prior group policy or contract providing similar benefits that it replaces, that person is entitled to have issued to that person by the insurer, without evidence of insurability, an individual policy or, at the insurer's option, a group certificate of health insurance, provided that application is made and the first premium paid to the insurer within 90 days after that termination. At the option of the employee or member, the converted policy may cover the employee or member, the employee or member and the employee or member's dependents or the dependents of the employee or member~~; provided that~~ if, in the latter 2 cases, the dependents have been covered for a period of at least 3 months under the group policy, unless the dependent persons were not eligible for coverage until after the beginning of the 3-month period. The insurer has the option to provide the required coverage upon conversion through either a group or individual policy, and may issue a separate converted policy to cover any dependent. An insurer is not required to provide a conversion privilege if termination of insurance under the group policy occurred because the employee or member failed to pay any required contribution or if any discontinued group coverage is replaced by continuous and substantially similar group coverage within 31 days.

Sec. A-9. 24-A MRSA §2809-A, sub-§1-A, as enacted by PL 1991, c. 822, §4, is amended to read:

1-A. Notification of cancellation. An insurer must provide by first class mail notification of cancellation for nonpayment of premium for hospital, surgical or major medical expense insurance according to this section. The notice must include the date of cancellation of coverage and, if applicable, the time period for exercising policy conversion rights. Notification is not required when the insurer has received written notice from the group policyholder that replacement coverage has been obtained.

A. Notice must be mailed to the group policyholder or subgroup sponsor.

B. At the time of notification under paragraph A, notice must be mailed to the certificate holder at:

(1) The last address provided by the subgroup sponsor or the group policyholder to the insurer; or

(2) The office of the subgroup sponsor, if any, or the group policyholder.

C. Notice must be mailed to the Bureau of Insurance ~~and to the Bureau of Labor Standards~~.

Sec. A-10. 24-A MRSA §2809-A, sub-§2, as enacted by PL 1981, c. 606, §2, is amended to read:

2. ~~The~~ If a conversion privilege ~~shall~~ is applicable pursuant to subsection 1, it must also be available:

A. Upon the death of an employee or member, to the surviving spouse with respect to the spouse and the children whose coverage terminates by reason of that death, or if there is no surviving spouse to each surviving child whose coverage so terminates. If the group policy provides for continuation of dependents' coverage upon the death of the employee or member, the conversion privilege ~~shall~~ must be made available at the end of that continuation;

B. To the spouse of a member or employee upon termination of coverage by reason of ceasing to be a qualified family member under the group policy whether by divorce or otherwise, whether or not the employee or member remains insured, with respect to the spouse and the children whose coverage terminates at the same time;

C. To a child upon termination of coverage by reason of ceasing to be a qualified family member under the group policy if a conversion privilege is not otherwise provided with respect to ~~him~~ that child in this subsection; or

D. To an employee or member whose coverage would otherwise continue under the group policy

upon retirement prior to eligibility for coverage under Medicare,"United States Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Public Law 89-97, as amended, at the option of that employee or member in lieu of continued coverage under the group policy.

Sec. A-11. 24-A MRSA §2809-A, sub-§3-A is enacted to read:

3. Policies issued or renewed on or after January 1, 1996. An insurer that offers individual health plans pursuant to section 2736-C is permitted, but not required, to include a conversion privilege in group policies issued or renewed on or after January 1, 1996. If the insurer does include a conversion privilege in those policies, individuals exercising these rights must be offered a choice of any individual health plan offered by the insurer. An insurer that does not offer individual health plans pursuant to section 2736-C may not include a conversion privilege in group policies issued or renewed on or after January 1, 1996.

Sec. A-12. 24-A MRSA §2809-A, sub-§4, ¶¶A and B, as enacted by PL 1991, c. 668, §2, are amended to read:

A. Conversion is provided through a form that is also issued to ~~individually underwritten standard risks~~ members of the general public applying for an individual health plan pursuant to section 2736-C;

B. The rates for that form ~~are based on individually underwritten standard risks~~ comply with section 2736-C; and

Sec. A-13. 24-A MRSA §2809-A, sub-§§7 and 9, as enacted by PL 1981, c. 606, §2, are amended to read:

7. Notice. Notice of the conversion privilege ~~shall~~, if one is applicable, must be included in each certificate of coverage.

9. Refusal to renew. A policy issued pursuant to the conversion privilege provided by this section may provide that the insurer may refuse to renew the policy or coverage of any person insured ~~thereunder for the following reasons only:~~ only as permitted by section 2736-C.

~~A. Fraud or material misrepresentation in applying for any benefits under the converted policy; or~~

~~B. Any reason for which the insurer may refuse to issue a converted policy under subsection 3.~~

Sec. A-14. 24-A MRSA §2809-A, sub-§10, as amended by PL 1991, c. 885, Pt. E, §29 and affected by §47, is repealed.

PART B

Sec. B-1. 24-A MRSA §2808-A, as amended by PL 1991, c. 828, §24, is repealed.

PART C

Sec. C-1. 24-A MRSA §2740, as amended by PL 1973, c. 205, is repealed.

PART D

Sec. D-1. 24-A MRSA 2808-B, sub-§1, ¶E, as enacted by PL 1991, c. 861, §2, is amended to read:

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A ~~or~~ B, C or D.

Sec. D-2. 24-A MRSA §2808-B, sub-§4, ¶A, as enacted by PL 1991, c. 861, §2, is amended to read:

A. Coverage must be guaranteed to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups. If an employee declines coverage because the employee has other coverage, any dependents of that employee who are not eligible under the employee's other coverage are eligible for coverage under the small group health plan.

Sec. D-3. 24-A MRSA §2808-B, sub-§4, ¶B, as amended by PL 1993, c. 645, Pt. A, §4, is further amended to read:

B. Renewal must be guaranteed to all eligible groups, to all eligible employees and their dependents in those groups except:

(1) For nonpayment of the required premiums by the policyholder, contract holder or employer;

(2) For fraud or material misrepresentation by the policyholder, contract holder or employer or;

(3) With respect to coverage of eligible individuals, for fraud or material misrepresentation on the part of the individual or the individual's representative;

(4) For noncompliance with the carrier's minimum participation requirements, which may not exceed 75%;

(5) When the carrier ceases providing small group health plans in compliance with subsection 5; or

(6) When the carrier ceases offering a product and replaces it with a product that complies with the requirements of this section, including renewability, and the superintendent finds that replacement is in the best interest of the policyholders.

Sec. D-4. 24-A MRSA §2808-B, sub-§7, as enacted by PL 1991, c. 861, §2, is amended to read:

7. Applicability. This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary date of the policy, plan, contract ~~date~~ or certificate.

PART E

Sec. E-1. 24-A MRSA §5001, sub-§4, as amended by PL 1993, c. 154, §1, is further amended to read:

4. Medicare supplement policy. "Medicare supplement policy" means a group or individual policy of 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, 42 United States Code, Section 1395, et seq.~~, Section 1833~~ or Section 1876 or an issued policy under a demonstration project ~~authorized pursuant to amendments to the federal Social Security Act~~ specified in the 42 United States Code, Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Sec. E-2. 24-A MRSA §5001-A, sub-§§1 and 3, as enacted by PL 1991, c. 740, §2, are amended to read:

1. Application. Except as otherwise specifically provided in ~~sections 5004 and~~ section 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.

3. Plans not marketed as Medicare supplements. ~~The~~ Except as otherwise provided in section 5005, subsection 3-A, 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. E-3. 24-A MRSA §5005, sub-§3-A, as enacted by PL 1991, c. 740, §7, is amended to read:

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; or

B. Disability income policies~~;~~.

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

~~D. Single premium, nonrenewable policies.~~

PART F

Sec. F-1. 24 MRSA §2347, sub-§1, as amended by PL 1993, c. 666, Pt. D, §1, is further amended to read:

1. Contracts subject to this section. Notwithstanding any other provision of law, this section applies to all group contracts, except group long-term care policies as defined in Title 24-A, section 5051, issued by nonprofit hospital or medical service organizations to contract holders who are obtaining coverage for a group or subgroup to replace coverage under a different contract or policy issued by any insurer, health maintenance organization or nonprofit hospital or medical service organization, or to replace coverage under an uninsured employee benefit plan that provides payment for health services received by employees or their dependents if the contract holder has applied for coverage under this replacement contract within 90 days after termination of coverage under the contract or policy being replaced. For purposes of this section, the group contract issued to

replace the prior contract or policy is the "replacement contract." The group contract or policy or the uninsured employee benefit plan, or a number of individual contracts or policies if the premiums were paid by the employer or by payroll deduction, being replaced is the "replaced contract or policy."

Sec. F-2. 24 MRSA §2349, sub-§3, as amended by PL 1995, c. 77, §1, is further amended to read:

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. A late enrollee may be excluded from coverage for not more than 12 months based on medical underwriting or preexisting conditions. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract, or terminated coverage under the succeeding contract, because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased ~~due to~~ because the individual became ineligible for reasons other than fraud or material misrepresentation, including, but not limited to, termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce;

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order; ~~or~~

C. That person was covered by the Maine High-Risk Insurance Organization on December 1, 1993 and the request for replacement coverage is made while coverage is in effect or within 30 days of the termination of coverage~~.~~; or

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person becomes eligible.

Sec. F-3. 24-A MRSA §2849, sub-§1, as amended by PL 1993, c. 666, Pt. D, §3, is further amended to read:

1. Policies subject to this section. Notwithstanding any other provision of law, this section applies to all group and blanket medical insurance policies issued by insurers or health maintenance organizations to policyholders who are obtaining coverage for a group or subgroup to replace coverage under a different contract or policy issued by any nonprofit hospital or medical service organization, insurer or health maintenance organization, or to replace coverage under an uninsured employee benefit plan that provides payment for health services received by employees or their dependents if the policyholder has applied for coverage under the replacement policy within 90 days after termination of coverage under the contract or policy being replaced. For purposes of this section, the group policy issued to replace the prior contract or policy is the "replacement policy." The group contract or policy or uninsured employee benefit plan or a number of individual contracts or policies if the premiums were paid by the employer or by payroll deduction, being replaced is the "replaced contract or policy."

Sec. F-4. 24-A MRSA §2849-B, sub-§1, as amended by PL 1993, c. 477, Pt. A, §8 and affected by Pt. F, §1, is further amended to read:

1. Policies subject to this section. This section applies to all individual ~~and~~, group medical and blanket insurance policies except hospital indemnity, specified accident, specified disease~~,~~ and long-term care ~~and Medicare supplement~~ policies issued by insurers or health maintenance organizations.

Sec. F-5. 24-A MRSA §2849-B, sub-§3, as amended by PL 1995, c. 77, §2, is further amended to read:

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. A late enrollee may be excluded from coverage for not more than 12 months based on medical underwriting or preexisting conditions. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract or policy, or terminated coverage under the succeeding contract, because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased ~~due to~~ because the individual became ineligible for reasons other than fraud or material misrepresentation, including, but not limited to, termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce;

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order; ~~or~~

C. That person was covered by the Maine High-Risk Insurance Organization on December 1, 1993 and the request for replacement coverage is made while coverage is in effect or within 30 days of the termination of coverage~~.~~; or

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person becomes eligible.

PART G

Sec. G-1. 24 MRSA 2325-A, sub-§5-C, ¶B, as amended by PL 1993, c. 586, §1, is further amended to read:

B. All policies and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1994 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide inpatient care benefits of at least 60 days per calendar year. For purposes of this paragraph, 2 days of day treatment is deemed equivalent to one day of inpatient care.

(2) The contracts must provide ~~outpatient care benefits~~ an annual benefit of at least $2,000 for ~~any combination of~~ outpatient ~~and day treatment~~ care. The minimum level of benefits provided must be at least 50% of the usual, customary and reasonable charge.

(3) The contracts must contain a maximum lifetime benefit of at least $100,000 for the aggregate costs associated with mental illness.

Sec. G-2. 24-A MRSA 2843, sub-§5-C, ¶B, as amended by PL 1993, c. 586, §3, is further amended to read:

B. All policies and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1994 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide inpatient care benefits of at least 60 days per calendar year. For purposes of this paragraph, 2 days of day treatment is deemed equivalent to one day of inpatient care.

(2) The contracts must provide ~~outpatient care benefits~~ an annual benefit of at least $2,000 for ~~any combination of~~ outpatient ~~and day treatment~~ care. The minimum level of benefits provided must be at least 50% of the usual, customary and reasonable charge.

(3) The contracts must contain a maximum lifetime benefit of at least $100,000 for the aggregate costs associated with mental illness.

PART H

Sec. H-1. 24-A MRSA §2844, sub-§1, as enacted by PL 1993, c. 666, Pt. B, §2, is amended to read:

1. Authorization. Provisions contained in group and blanket health insurance contracts relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which a certificate holder or the certificate holder's dependents may be covered must conform to rules adopted by the superintendent. These rules may establish uniformity in the permissive use of coordination of benefits provisions in order to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among the several insurers and nonprofit hospital, medical service and health care plans.

PART I

Sec. I-1. 24-A MRSA §4204, sub-§2-A, ¶J, as enacted by PL 1993, c. 702, Pt. B, §1, is amended to read:

J. ~~The~~ A health maintenance organization that offers coverage to groups in this State shall offer to groups of all sizes health benefit plans that meet the requirements for standardized health plans specified in Bureau of Insurance Rule Chapter 750.

Sec. I-2. 24-A MRSA §4204, sub-§2-A, ¶N, as enacted by PL 1993, c. 702, Pt. B, §1, is amended to read:

N. Beginning July 1, 1995, ~~the~~ a health maintenance organization that offers coverage to groups

in the State shall offer coverage for purchase by individuals.

PART J

Sec. J-1. 24-A MRSA §2701, sub-§2, as amended by PL 1991, c. 701, §5, is further amended to read:

2. Any group or blanket policy, except that:

A. Sections 2736, 2736-A and 2736-B ~~shall~~ apply to group Medicare supplement policies as defined in chapter 67 and group nursing home care and long-term care insurance policies as defined in chapter 68; ~~and~~

B. Section 2752 applies with respect to mandated benefits for group or blanket health policies~~.~~; and

C. Section 2736-C applies to:

(1) Association groups as defined by section 2805-A, except associations of employers; and

(2) Other groups as defined by section 2808.

Sec. J-2. 24-A MRSA §2736-C, sub-§1, ¶C, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

C. "Individual health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. It includes both individual contracts and certificates issued under group contracts specified in section 2701, subsection 2, paragraph C. "Individual health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment; or

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance.

PART K

Sec. K-1. 24-A MRSA §2736-C, sub-§6, ¶A, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

A. Each carrier must actively market individual health plan coverage, including any standardized plans defined pursuant to subsection 8, to individuals in this State.

Sec. K-2. 24-A MRSA §2808-B, sub-§6, ¶A, as enacted by PL 1991, c. 861, §2, is amended to read:

A. Each carrier must actively market small group health plan coverage, including the basic and standard plans defined in subsection 8, to eligible groups in this State.

PART L

Sec. L-1. 24 MRSA §2327-A, as amended by PL 1991, c. 861, §1 and affected by §4, is further amended to read:

§2327-A. Applicability

Title 24-A, sections ~~2808-A~~ 2803 and 2808-B apply to nonprofit hospital corporations, nonprofit medical service corporations and nonprofit health care plans to the extent not inconsistent with this chapter.

Sec. L-2. 24-A MRSA §4222, sub-§4, as enacted by PL 1991, c. 861, §3 and affected by §4, is amended to read:

4. ~~Section~~ Sections 2803 and 2808-B ~~applies~~ apply to health maintenance organizations except that a health maintenance organization is not required to offer coverage or accept applications from an eligible group located outside the health maintenance organization's approved service area.

PART M

Sec. M-1. 24 MRSA §2302-B, as enacted by PL 1989, c. 767, §2 and PL 1993, c. 645, Pt. B, §1, is repealed and the following enacted in its place:

§2302-B. Penalty for failure to notify of hospitalization

A contract issued by a nonprofit hospital or medical services organization may not include a

provision permitting the organization to impose a penalty for the failure of any person to notify the organization of a covered person's hospitalization for emergency treatment. For purposes of this section, "emergency treatment" has the same meaning as defined in Title 22, section 1829.

This section applies to contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after the effective date of this section. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Sec. M-2. 24 MRSA §2302-C is enacted to read:

§2302-C. Penalty for noncompliance with utilization review programs

A contract issued or renewed by a nonprofit service organization after April 8, 1994 may not contain a provision that permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of nonprofit service organizations to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

Sec. M-3. 24 MRSA §2342, sub-§1, as amended by PL 1993, c. 602, §1, is further amended to read:

1. Licensure. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or an employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers, shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that Title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

Sec. M-4. 24-A MRSA §2749-B, as enacted by PL 1993, c. 645, Pt. B, §3, is amended to read:

§2749-B. Penalty for noncompliance with utilization review programs

A health insurance policy issued or renewed in this State after ~~the effective date of this section~~ April 8, 1994 may not contain a provision that ~~establishes~~ permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

Sec. M-5. 24-A MRSA §2771, sub-§1, as amended by PL 1993, c. 602, §4, is further amended to read:

1. Licensure. A person, partnership or corporation, other than an insurer, nonprofit service organization, health maintenance organization, preferred provider organization or employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

Sec. M-6. 24-A MRSA §2771, sub-§3, ¶A, as amended by PL 1993, c. 171, Pt. B, §1, is further amended to read:

A. The process by which the entity carries out its utilization review services. The information provided to the bureau must include the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State ~~and all medical utilization review criteria employed in the review process by these individuals. Updated medical utilization review criteria must be filed with an application for renewal of a license~~. The infor-

mation provided to the bureau also must include copies of any licensure agreements the utilization review entity has in effect with any entity that sells or furnishes the utilization review entity with medical utilization review criteria and the expiration date of any such agreements. If the utilization review entity develops its own medical utilization review criteria, the utilization review entity shall include copies of any policies and procedures or both for the use of the criteria;

Sec. M-7. 24-A MRSA §2772, sub-§3-A is enacted to read:

3-A. Medical utilization review criteria. The licensee must have written medical utilization review criteria to be employed in the review process. The criteria must be available for review as a part of any review conducted pursuant to section 2774, subsection 1 and a copy of the criteria must be provided to the bureau upon request.

Sec. M-8. 24-A MRSA §2772, sub-§5, as enacted by PL 1993, c. 645, Pt. B, §4, is amended to read:

5. Penalty for noncompliance with utilization review programs. A medical utilization review program may not recommend or implement a penalty of more than $500 for failure to provide notification. This subsection does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

Sec. M-9. 24-A MRSA §2847-D, as enacted by PL 1993, c. 645, Pt. B, §5, is amended to read:

§2847-D. Penalty for noncompliance with utilization review programs

A policy or certificate issued or renewed after ~~the effective date of this section~~ April 8, 1994 may not contain a provision that ~~establishes~~ permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

PART N

Sec. N-1. 24 MRSA §2319, first ¶, as enacted by PL 1975, c. 770, §101, is amended to read:

All individual and group nonprofit hospital and medical service organization contracts ~~which provide coverage for a family member of the subscriber shall, as to such family members' coverage, also~~ must provide that ~~the~~ benefits ~~applicable for children shall be applicable~~ are payable with respect to a newly born child from the moment of birth.

Sec. N-2. 24-A MRSA §2743, first ¶, as enacted by PL 1975, c. 770, §104, is amended to read:

All individual health insurance policies providing coverage on an expense incurred basis ~~which provide coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also~~ must provide that ~~the~~ health insurance benefits ~~applicable for children shall be~~ are payable with respect to a newly born child of the insured or subscriber from the moment of birth.

Sec. N-3. 24-A MRSA §2834, first ¶, as amended by PL 1993, c. 686, §12 and affected by §13, is further amended to read:

All group and blanket health insurance policies providing coverage on an expense incurred basis ~~that provide coverage for a family member of the insured or subscriber must, also~~ must provide that ~~the~~ health insurance benefits ~~applicable for children be~~ are payable for a newly born child of the insured or subscriber from the moment of birth. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. Preexisting conditions of an adopted child may not be excluded from coverage.

PART O

Sec. O-1. 24-A MRSA §4203, sub-§1, as amended by PL 1993, c. 702, Pt. A, §11, is further amended to read:

1. Subject to the Maine Certificate of Need Act of 1978, a person may apply to the superintendent for and obtain a certificate of authority to establish, maintain, own, merge with, organize or operate a health maintenance organization in compliance with this chapter. A person may not establish, maintain, own, merge with, organize or operate a health maintenance organization in this State either directly as a division or a line of business or indirectly through a subsidiary or affiliate, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with, a health maintenance organization without obtaining a certificate of authority under this chapter. ~~A foreign corporation may qualify under this chapter, subject to its registration to do business in this State as a foreign corporation.~~

Sec. O-2. 24-A MRSA §4204, sub-§2-A, ¶I, as enacted by PL 1989, c. 842, §10, is amended to read:

I. If any agreement, as set forth in paragraph D, subparagraph ~~(3)~~ (2), division (c), is made by the health maintenance organization, the entity executing the agreement with the health maintenance organization must demonstrate to the superintendent's satisfaction that the entity has sufficient unencumbered surplus funds to cover the assured payments under the agreement, otherwise the superintendent shall disallow the agreement. In considering approval of such an agreement, the superintendent shall consider the entity's record of earnings for the most recent 3 years, the risk characteristics of its investments and whether its investments and other assets are reasonably liquid and available to make payments for health services.

Sec. O-3. 24-A MRSA §4207, sub-§2, as enacted by PL 1975, c. 503, is amended to read:

2. No evidence of coverage, or amendment thereto, ~~shall~~ or underlying contract may be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, ~~or~~ amendment thereto and any underlying contract, has been filed with and approved by the superintendent.

Sec. O-4. 24-A MRSA §4210, sub-§1, as enacted by PL 1975, c. 503, is amended to read:

1. After a health maintenance organization has been in operation 24 months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. ~~A~~ To the extent not inconsistent with the requirements of chapter 36 and sections 2736-C and 2808-B as qualified by section 4222-B, subsection 3, a health maintenance organization may apply to the superintendent for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees~~,~~ or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The superintendent shall approve or deny ~~such~~ the application within 10 days of the receipt ~~thereof~~ of that application from the health maintenance organization.

Sec. O-5. 24-A MRSA §4210-A, as enacted by PL 1989, c. 867, §§9 and 10, is repealed.

Sec. O-6. 24-A MRSA §4212, sub-§2, as enacted by PL 1975, c. 503, is repealed and the following enacted in its place:

2. An enrollee may not be cancelled nor denied renewal except for the following:

A. Fraud or material misrepresentation;

B. Failure to pay the charge for coverage;

C. When the provisions of the State's community rating law are applicable, as provided by section 2736-C, subsection 3, paragraph B and section 2808-B, subsection 4, paragraph B; or

D. Other reasons promulgated by the superintendent.

Sec. O-7. 24-A MRSA §4222, sub-§4, as enacted by PL 1991, c. 861, §3 and affected by §4, is repealed.

Sec. O-8. 24-A MRSA §4222-B is enacted to read:

§4222-B. Applicability

1. Every health maintenance organization licensed under this chapter is considered an insurer for purposes of those provisions of the insurance laws that do not expressly reference health maintenance organizations, but are applicable to health maintenance organizations under this chapter.

2. The requirements of chapter 36, continuity of health insurance coverage law, apply to health maintenance organizations.

3. The requirements of sections 2736-C and 2808-B, community rating law, apply to health maintenance organizations, except that a health maintenance organization is not required to offer coverage or accept applications from an eligible group or individual located outside the health maintenance organization's approved service area.

4. The requirements of chapter 23 and any rules adopted pursuant to it, to the extent not inconsistent with this chapter and the reasonable implications of this chapter, apply to health maintenance organizations.

5. The requirements of section 222, subsections 2 to 9 and subsections 13 to 18 apply to domestic health maintenance organizations.

6. The requirements of chapter 57, subchapters I and II apply to domestic health maintenance organizations.

7. The requirements of sections 421 and 422 apply to health maintenance organizations.

8. The requirements of chapter 32, the Preferred Provider Arrangement Act of 1986, apply to health maintenance organizations only with respect to activities that are not otherwise authorized by chapter 56.

Sec. O-9. 24-A MRSA §4230, as enacted by PL 1989, c. 345, §2, is repealed.

Sec. O-10. 24-A MRSA §4231, sub-§3, as enacted by PL 1989, c. 842, §18, is repealed.

Sec. O-11. 24-A MRSA §4233, sub-§1, as enacted by PL 1993, c. 313, §36, is repealed.

PART P

Sec. P-1. 24-A MRSA §2671, sub-§1, as enacted by PL 1985, c. 704, §4, is amended to read:

1. "Administrator" means any person, partnership or corporation, other than an insurer, health maintenance organization or nonprofit health service organization, that arranges, contracts with or administers contracts with a provider ~~whereby~~ in which beneficiaries are provided an incentive to use the services of that provider.

PART Q

Sec. Q-1. Bureau of Insurance report required. The Bureau of Insurance shall report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters on or before January 1, 1996 on the alternatives for clarifying the guaranteed issuance requirement for small group health plans under the Maine Revised Statutes, Title 24-A, section 2808-B. The committee may then report out legislation based on the bureau's report.

See title page for effective date.

CHAPTER 333

S.P. 383 - L.D. 1060

An Act to Correct Errors and Inconsistencies with Regard to the Restructuring of Maine Government to Conform with the Provisions of the Texas Compact

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

Whereas, this legislation corrects inadvertent errors and inconsistencies in legislation previously enacted to streamline the regulatory functions of the State and alter the regulation of radioactive waste in the State; and

Whereas, the changes would be beneficial to the State if made immediately; 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. 22 MRSA §679-B, sub-§2, as enacted by PL 1993, c. 664, §10, is amended to read:

2. Service fee; ceiling. Except for waste that is exempt in accordance with subsection 4, the department shall assess annually by September 1st each low-level radioactive waste generator a service fee on all low-level radioactive waste generated in this State that is shipped to a low-level radioactive waste disposal facility, stored awaiting disposal at such a facility or stored for any other purpose. The service fee must be based 50% on the volume and 50% on the radioactivity of the waste disposed in a disposal facility in the previous calendar year or placed in storage in the previous calendar year if the State did not have access to a disposal facility for that year, but each generator must be assessed a minimum of $100 annually. Each generator must pay this service fee within 30 days, except that any generator may choose to make quarterly payments instead. Any radioactive waste for which a service fee was assessed and collected under this section can not be reassessed for the purposes of this section. The radiation control program within the Division of Health Engineering shall adopt rules in accordance with the Maine Administrative Procedure Act concerning the calculation of the fee and the exemptions to the fee, consistent with this section. The revenue from this service fee each year must amount to ~~$260,000~~ $135,000 and must be credited to the fund established in subsection 1 and used to carry out the purposes of this section and of Title 38, section 1453-A. If the Advisory Commission on Radioactive Waste, as established in Title 38, section 1453-A is dissolved, the service fee ceiling must be lowered by the amount of the budget of that commission.

Sec. 2. 22 MRSA §679-B, sub-§5, as enacted by PL 1993, c. 664, §10, is amended to read:

5. Allocation from fund. Money in the Radioactive Waste Fund established by this section must be allocated from time to time by the Legislature for the following purposes: to the Radioactive Waste Advisory Commission Fund as established in Title 38, section 1454-A to fund the activities of the Advisory Commission on Radioactive Waste as described in Title 38, section 1453-A for advisory and public information activities; and to the department for administrative and regulatory activities as described in