LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND EIGHTEENTH LEGISLATURE

SECOND REGULAR SESSION
January 7, 1998 to March 31, 1998

SECOND SPECIAL SESSION
April 1, 1998 to April 9, 1998

THE GENERAL EFFECTIVE DATE FOR
SECOND REGULAR SESSION
NON-EMERGENCY LAWS IS
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NON-EMERGENCY LAWS IS
JULY 9, 1998

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
1997

3-A. Medium borrow pits unlicensed on October 1, 1993. Notwithstanding subsection 3, the following provisions apply to a medium borrow pit that on October 1, 1993 was not licensed under article 6 and on which gravel had been extracted to a level less than 5 feet above, at or below the seasonal high water table.

The medium borrow pit owner or operator may not further excavate in areas where gravel had been extracted to a level less than 5 feet above, at or below the seasonal high water table unless a variance is granted by the department.

A. The department may not require the medium borrow pit owner or operator to elevate the medium borrow pit floor to 5 feet or more above the seasonal high water table as a condition of operation.

C. The medium borrow pit owner or operator may reclaim as a pond that area of the medium borrow pit ~~less than 5 feet above~~ on which gravel had been extracted to a level at or below the seasonal high water table.

Sec. 7. PL 1995, c. 704, Pt. A, §23, sub-§3, as amended by PL 1997, c. 502, §12, is further amended to read:

3. A municipality with delegated authority pursuant to the Maine Revised Statutes, Title 38, section 489-A prior to the effective date of this Act continues to have delegated authority following the effective date of this Act ~~and is presumed to have capacity pursuant to Title 38, section 488, subsection 19 as of the effective date of this Act~~.

Sec. 8. PL 1995, c. 704, Pt. C, §2 is amended to read:

Sec. C-2. Effective date. This Act takes effect July 1, 1997, except section 1 of this Part takes effect 90 days after adjournment of the Second Regular Session of the 117th Legislature. The following provisions take effect September 19, 1997: Part A, section 10 that amends the Maine Revised Statutes, Title 38, section 484, subsection 4; Part A, section 11 that enacts Title 38, section 484, subsection 4-A; and that portion of Part B, section 2 that enacts Title 38, section 420-D.

Sec. 9. Retroactivity. That section of this Act that amends Public Law 1995, chapter 704, Part C, section 2 applies retroactively to July 1, 1997.

See title page for effective date, unless otherwise indicated.

CHAPTER 604

H.P. 1459 - L.D. 2050

An Act to Amend the Laws Concerning Life and Health Insurance

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

PART A

Sec. A-1. 24-A MRSA §4301, sub-§1, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

1. Carrier. "Carrier" means an insurance company licensed in accordance with this Title, a health maintenance organization licensed pursuant to chapter 56, a preferred provider organization licensed pursuant to chapter 32 ~~or,~~ a nonprofit hospital or medical service organization licensed pursuant to Title 24 or a multiple-employer welfare arrangement licensed pursuant to chapter 81. An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

PART B

Sec. B-1. 24 MRSA §2327-A, as amended by PL 1997, c. 445, §1 and affected by §32, is further amended to read:

§2327-A. Applicability

Title 24-A, sections 2803, 2808-B, 2809-A and 2834-B apply to nonprofit hospital corporations, nonprofit medical service corporations and nonprofit health care plans to the extent not inconsistent with this chapter.

Sec. B-2. 24 MRSA §2330, as amended by PL 1997, c. 393, Pt. A, §25, is repealed.

Sec. B-3. 24-A MRSA §2809-A, sub-§1-B is enacted to read:

1-B. Notification of availability of individual coverage. An insurer must provide forms to group policyholders for the purpose of informing terminating group members of their right to purchase any individual health plan available in this State. An adequate supply of forms must be provided to each group policyholder when the policy is issued and at least annually thereafter. The superintendent may prescribe the content of the form by routine technical rule pursuant to Title 5, chapter 375, subchapter II-A. The form must include at least the following:

A. A statement that all state residents not eligible for Medicare have a right to purchase any individual health plan available in this State;

B. A statement that in order to avoid a gap in coverage, the individual should apply for individual coverage prior to termination of group coverage;

C. A statement that if more than 90 days pass between the time the group coverage ends and the time individual coverage begins, the individual coverage may exclude preexisting conditions for one year; and

D. A statement that information concerning individual coverage is available from the Bureau of Insurance. The bureau's toll-free telephone number must also be provided.

PART C

Sec. C-1. 24 MRSA §2319, as amended by PL 1995, c. 332, Pt. N, §1, is further amended to read:

§2319. Newborn children coverage

All individual and group nonprofit hospital and medical service organization contracts must provide that benefits are payable with respect to a newly born child from the moment of birth.

The coverage for newly born children ~~shall~~ must consist of coverage of injury ~~or~~, sickness or other benefits provided by the contract, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific subscription fee is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required fees must be furnished to the nonprofit hospital or medical service organization within 31 days after the date of birth in order to have the coverage continue beyond ~~such~~ that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 2318-A must be paid regardless of whether coverage under this section is elected.

The requirements of this section ~~shall~~ apply to all subscriber contracts delivered or issued for delivery in this State more than 120 days after the effective date of this Act.

Sec. C-2. 24-A MRSA §2743, as amended by PL 1995, c. 332, Pt. N, §2, is further amended to read:

§2743. Newborn children coverage

All individual health insurance policies providing coverage on an ~~expense incurred~~ expense-incurred basis must provide that health insurance benefits are payable with respect to a newly born child of the insured or subscriber from the moment of birth.

The coverage for newly born children ~~shall~~ must consist of coverage of injury ~~or~~, sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond ~~such~~ that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 2743-A must be paid regardless of whether coverage under this section is elected.

The requirements of this section ~~shall~~ apply to all policies delivered or issued for delivery in this State more than 120 days after the effective date of this Act.

Sec. C-3. 24-A MRSA §2834, as amended by PL 1995, c. 332, Pt. N, §3, is further amended to read:

§2834. Newborn children coverage

All group and blanket health insurance policies providing coverage on an expense incurred basis must provide that health insurance benefits 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.

The coverage for newly born children ~~shall~~ must consist of coverage of injury or sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond ~~such~~ that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 2834-A

must be paid regardless of whether coverage under this section is elected.

The requirements of this section ~~shall~~ apply to all policies delivered or issued for delivery in this State more than 120 days after the effective date of this Act.

Sec. C-4. 24-A MRSA §4234-C is enacted to read:

§4234-C. Newborn children coverage

All individual and group health maintenance organization contracts must provide that benefits are payable with respect to a newly born child from the moment of birth.

The coverage for newly born children must consist of coverage of injury, sickness or other benefits provided by the contract, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required fees must be furnished to the nonprofit hospital or medical service organization within 31 days after the date of birth in order to have the coverage continue beyond that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 4234-B must be paid regardless of whether coverage under this section is elected.

The requirements of this section apply to all contracts delivered or issued for delivery in this State on or after the effective date of this Act.

PART D

Sec. D-1. 24-A MRSA §5051, sub-§1, ¶E, as enacted by PL 1989, c. 556, Pt. B, §1, is amended to read:

E. A policy or contract offered primarily to provide basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection, ~~accident only~~ accident-only coverage, specified disease or specified accident coverage, home health care coverage or limited benefit health coverage.

Sec. D-2. 24-A MRSA §5051, sub-§3-A is enacted to read:

3-A. Home health care policy. "Home health 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 that is advertised, marketed or designed primarily to provide benefits on either an expense-incurred or indemnity basis for confinements or costs associated with home health care services. For purposes of this definition, a policy is deemed to provide primarily home health care benefits if 50% or more of benefits payable or anticipated to be payable under the policy are related to home health care services. 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 to 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 that group or individual policy or contract includes provisions that are inconsistent with the requirements of this chapter.

Sec. D-3. 24-A MRSA §5052, as enacted by PL 1985, c. 648, §12, is amended to read:

§5052. Specific standards

1. Standards for long-term care, home health care and nursing home care policies. The superintendent may ~~promulgate~~ adopt rules to establish specific standards for policy provisions of long-term care, home health care and nursing home care policies. The standards ~~shall~~ must 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~~ adopt rules that specify prohibited provisions not otherwise specifically authorized by law ~~which~~ that, 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 care, home health care or nursing home care policy.

Sec. D-4. 24-A MRSA §5052-A, as enacted by PL 1991, c. 200, Pt. C, §1, is amended to read:

§5052-A. Trial examination period

Nursing home care, home health care and long-term care policies must have a notice prominently printed on the first page of the policy or certificate or attached to the first page stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if for any reason, after examination of the policy or certificate, the applicant is not satisfied.

Sec. D-5. 24-A MRSA §5053, as amended by PL 1991, c. 200, Pt. C, §2, is further amended to read:

§5053. Rulemaking, disclosure standards, compensation

The superintendent may ~~promulgate~~ adopt reasonable rules to provide for the full and fair disclosure of information in connection with the sale of long-term care, home health care and nursing home care policies, including, but not limited to, an outline of coverage requirements and requirements relating to the replacement sale of the policies and compensation or commission to an agent or representative for the sale of a nursing home care, home health care or long-term care policy or certificate.

The superintendent may ~~promulgate~~ adopt reasonable rules setting or limiting the rate of compensation or commission to an agent or other representative for the sale of a nursing home care, home health care or long-term care policy or certificate and regarding replacement sale of a nursing home care, home health care or long-term care policy or certificate.

Sec. D-6. 24-A MRSA §5054, sub-§1, as enacted by PL 1989, c. 556, Pt. B, §4, is amended to read:

1. Filing of form. Any insurer, nonprofit hospital or medical service organization, or nonprofit health care plan may, at the time it files a policy or contract for approval for issuance or delivery in the State, or at any time thereafter, request that the superintendent certify the policy or contract as a long-term care policy within the meaning of section 5051.

Within 60 days of receipt of a request for certification, the superintendent shall:

A. Certify in writing that the policy or contract complies with this section;

B. Deny the request in writing, stating the reasons for denial; or

C. Notify the insurer or nonprofit hospital or medical service organization or nonprofit health care plan, in writing, that an insufficient basis exists for determining whether a certification should be made, indicating in what respects the request was insufficient.

Sec. D-7. 24-A MRSA §5056, first ¶, as enacted by PL 1991, c. 200, Pt. C, §3, is amended to read:

Every insurer, health care service plan or other entity marketing nursing home care, home health care or long-term care insurance coverage in this State, directly or through its producers, shall:

PART E

Sec. E-1. 24 MRSA §2332-H is enacted to read:

§2332-H. Assignment of benefits

All contracts providing benefits for medical care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the contract.

Sec. E-2. 24-A MRSA §2755 is enacted to read:

§2755. Assignment of benefits

All policies providing benefits for medical care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy.

Sec. E-3. 24-A MRSA §2827-A is enacted to read:

§2827-A. Assignment of benefits

All policies and certificates providing benefits for medical care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy or certificate.

Sec. E-4. 24-A MRSA §4207-A, sub-§5-A is enacted to read:

5-A. Assignment of benefits. All point-of-service contracts and certificates must contain a provision permitting the insured to assign any benefits provided for medical care on an expense-incurred basis to the provider of the care. An assignment of benefits under this subsection does not affect or limit the payment of benefits otherwise payable under the contract or certificate.

PART F

Sec. F-1. 24 MRSA §2332-I is enacted to read:

§2332-I. Effective date of cancellation

Contracts that do not provide for any refund of premium when a subscriber requests cancellation prior to the end of the period for which premiums have been paid must state that no refund is payable and that the cancellation will take effect at the end of the period for which premiums have been paid unless the subscriber requests an earlier cancellation date. If a subscriber requests cancellation of a contract before the end of the period for which premiums have been paid, then the nonprofit hospital or medical service organization must inform the subscriber in writing that no refund is payable and give the subscriber an opportunity to amend the cancellation request to take effect at the end of the period for which premiums have been paid.

Sec. F-2. 24-A MRSA §2453 is enacted to read:

§2453. Effective date of cancellation

Life and health insurance policies that do not provide for any refund of premium when a policyholder requests cancellation prior to the end of the period for which premiums have been paid must state that no refund is payable and that the cancellation will take effect at the end of the period for which premiums have been paid unless the policyholder requests an earlier cancellation date. If a policyholder requests cancellation of a contract before the end of the period for which premiums have been paid, then the insurer must inform the policyholder in writing that no refund is payable and give the policyholder an opportunity to amend the cancellation request to take effect at the end of the period for which premiums have been paid.

PART G

Sec. G-1. 24 MRSA §2332-A, sub-§1-A is enacted to read:

1-A. Coordination with Medicare. Coordination of benefits is governed by the following provisions.

A. The contract may not coordinate benefits with Medicare Part A unless:

(1) The insured is enrolled in Medicare Part A;

(2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or

(4) The insured is eligible for Medicare Part A without paying a premium and the contract states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage.

B. The contract may not coordinate benefits with Medicare Part B unless:

(1) The insured is enrolled in Medicare Part B;

(2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or

(4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the contract was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the contract will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B.

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B.

Sec. G-2. 24-A MRSA §2844, sub-§1-A is enacted to read:

1-A. Coordination with Medicare. Coordination of benefits is governed by the following provisions.

A. The contract may not coordinate benefits with Medicare Part A unless:

(1) The insured is enrolled in Medicare Part A;

(2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or

(4) The insured is eligible for Medicare Part A without paying a premium and the certificate states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage.

B. The contract may not coordinate benefits with Medicare Part B unless:

(1) The insured is enrolled in Medicare Part B;

(2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or

(4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the certificate was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the contract will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B.

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B.

PART H

Sec. H-1. 24-A MRSA §2849-A, sub-§4, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

4. Liability after discontinuance. After discontinuance of a policy, the insurer or health maintenance organization remains liable only to the extent of its accrued liabilities and extensions of benefits. ~~The liability of the insurer or health maintenance organization is the same whether the group policyholder or other entity secures replacement coverage from any insurer, nonprofit hospital or medical service organization or health maintenance organization, self insures or foregoes the provision of coverage.~~

Sec. H-2. 24-A MRSA §2849-A, sub-§4-A is enacted to read:

4-A. Coordination of benefits. If replacement coverage is secured by the group policyholder from any insurer, nonprofit hospital or medical service organization or health maintenance organization and a totally disabled person is covered under such replacement coverage, the replacement coverage must pay as primary coverage and the replaced coverage must pay as secondary coverage for the covered expenses directly relating to the condition causing total disability during the extension of benefits required under this section.

See title page for effective date.

CHAPTER 605

S.P. 335 - L.D. 1113

An Act to Require the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services to Report the Facts of an Unnatural Death of a Patient under the Care of the Department to the Legislature