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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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

consultation with the Superintendent of Insurance, to be met by the contracting entity in the areas of financial solvency, quality assurance, utilization review, network sufficiency, access to services, network performance, complaint and grievance procedures and records maintenance;

B. Prior to contracting with any health care servicing entity, must have in place a memorandum of understanding with the Superintendent of Insurance for the provision of technical assistance, which must provide for the sharing of information between the department and the superintendent and the analysis of that information by the superintendent as it relates to the fiscal integrity of the contracting entity;

C. May require periodic reporting by the health care servicing entity as to activities and operations of the entity, including the entity's activities undertaken pursuant to commercial contracts with licensed insurers and health maintenance organizations;

D. May share with the Superintendent of Insurance all documents filed by the health care servicing entity, including documents subject to confidential treatment if the information is treated with the same degree of confidentiality as is required of the department; and

E. May make all necessary rules for the administration of contracts with health care servicing entities. All rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

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

Effective April 2, 1998.

CHAPTER 677

S.P. 384 - L.D. 1243

An Act to Protect the Privacy of Genetic Information

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

Sec. 1. 5 MRSA c. 503 is enacted to read:

CHAPTER 503

USE OF GENETIC INFORMATION FOR EMPLOYMENT PURPOSES

§19301. Definitions

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

1. Genetic characteristic. "Genetic characteristic" means any inherited gene or chromosome, or alteration of a gene or chromosome, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome or to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome.

2. Genetic information. "Genetic information" means the information concerning genes, gene products or inherited characteristics that may be obtained from an individual or family member.

3. Genetic test. "Genetic test" means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids such as deoxyribonucleic acid, or DNA, ribonucleic acid, or RNA, or mitochondrial DNA, and tests of chromosomes or proteins in order to identify a predisposing genetic characteristic.

§19302. Employment discrimination on the basis of genetic information or genetic testing

1. Discrimination prohibited. An employer may not fail or refuse to hire, discharge or otherwise discriminate against an employee or applicant for employment with respect to the compensation, terms or conditions of employment on the basis of genetic information concerning that individual or because of the individual's refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual received a genetic test or genetic counseling, except when based on a bona fide occupational qualification.

2. Enforcement; remedies. The Maine Human Rights Commission shall enforce this section. Violations of this section are subject to the remedies available under chapter 337, subchapters VI and VII.

Sec. 2. 24-A MRSA §2159-C is enacted to read:

§2159-C. Discrimination on the basis of genetic information or testing

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Genetic characteristic" means any inherited gene or chromosome, or alteration of a gene or chromosome, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome or to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome.

B. "Genetic information" means the information concerning genes, gene products or inherited characteristics that may be obtained from an individual or family member.

C. "Genetic test" means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids, such as deoxyribonucleic acid, or DNA, ribonucleic acid, or RNA, or mitochondrial DNA, and tests of chromosomes or proteins in order to identify a predisposing genetic characteristic.

2. Discrimination in health, hospital and dental insurance. An insurer, nonprofit hospital and medical service organization or health maintenance organization that issues individual or group hospital, health or dental insurance may not discriminate against an individual or eligible dependent on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual or eligible dependent received a genetic test or genetic counseling in the issuance, withholding, extension or renewal of any hospital confinement or other health insurance, as defined by the superintendent, by rule, or in the fixing of the rates, terms or conditions for insurance, or in the issuance or acceptance of any application for insurance. This subsection does not apply to accidental injury, specified disease, hospital indemnity, disability, long-term care and other limited benefit health insurance policies and contracts.

3. Discrimination in life, disability and long-term care insurance. An insurer may not make or permit any unfair discrimination against an individual in the application of genetic information or the results of a genetic test in the issuance, withholding, extension or renewal of an insurance policy for life, credit life, disability, long-term care, accidental injury, specified disease, hospital indemnity or credit accident insurance or an annuity. For the purposes of this subsection, "unfair discrimination" includes, but is not limited to, the application of the results of a genetic test in a manner that is not reasonably related to anticipated claims experience.

A. If the superintendent has reason to believe that unfair discrimination has occurred and that a proceeding by the superintendent is in the interest of the public, the superintendent, in accordance with chapter 3, shall serve upon the insurer a statement of the charges. Upon a determination that the practice or act of the insurer is in conflict with this subsection, the superintendent shall issue an order requiring the insurer to cease and desist from engaging in the practice or act and may order payment of a penalty consistent with the provisions of section 12-A.

B. If, in the issuance, withholding, extension or renewal of an insurance policy covered by this subsection, an insurer uses the results of a genetic test in compliance with this subsection, the insurer shall notify the individual who is the subject of the genetic test that such a test is required and shall obtain the individual's authorization in accordance with the requirements of chapter 24. If a genetic test is required, the insurer shall ensure that the individual states in writing whether the individual wishes to be informed of the test results and, if authorized by the individual, shall provide a copy of the test results, along with a written interpretation of the results by a qualified professional, to the individual or to a physician or other health care practitioner designated by the individual.

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

CHAPTER 24

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

§2201. Short title

This chapter may be known and cited as the "Insurance Information and Privacy Protection Act."

§2202. Purpose

The purpose of this chapter is to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions; to maintain a balance between insurance carriers' need for information and the public's need for fair information practices that respect privacy; to establish a regulatory mechanism to enable insurance consumers to ascertain what information is being collected about them and to verify its accuracy; to limit the distribution of information collected in connection with insurance transactions; and to enable consumers to obtain the reasons for adverse underwriting decisions.

§2203. Scope

1. Scope. This chapter applies to all persons and other entities required to be licensed by the superin-

tendent under this Title, or Title 24, and to all insurance support organizations, as defined in section 2204, that collect, maintain or distribute information on residents of this State or arising out of insurance transactions in this State. With respect to particular insurance transactions, this chapter applies if the transaction arises out of a policy, contract or certificate delivered, issued for delivery or renewed in this State or arises out of an application for such coverage. With respect to information practices, this chapter applies if information is collected or maintained in connection with an insurance transaction subject to this chapter or if personal information about residents of this State is collected or maintained in such a manner as to be accessible by the name of the insurance consumer referred to.

2. Residents. For purposes of this chapter, a person is considered a resident of this State if the person's last known mailing address, as shown in the records of the regulated insurance entity or insurance support organization, is in this State.

3. Exception. This chapter does not apply to insurance transactions arising out of workers' compensation, medical malpractice, fidelity, suretyship, boiler and machinery, property or casualty insurance or information collected from public records for the purpose of title insurance.

§2204. Definitions

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

1. Adverse underwriting decision. "Adverse underwriting decision" means any of the following actions with respect to consumer insurance transactions involving insurance coverage that is individually underwritten:

A. A declination, cancellation or nonrenewal of insurance coverage, in whole or part;

B. Failure of a producer or agency to apply for insurance coverage with a specific insurance institution that the producer or agency represents and that is requested by an applicant;

C. An offer to insure at higher than standard rates; or

D. Any other increase in any charge for, any reduction in or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for.

2. Affiliate; affiliated. "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

3. Applicant. "Applicant" means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

4. Confidential investigative information. "Confidential investigative information" means any information that:

A. Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual;

B. Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving an individual; and

C. Has not been disclosed to 3rd parties in violation of section 2215.

5. Consumer insurance transaction. "Consumer insurance transaction" means an insurance transaction involving insurance primarily for personal, family or household needs rather than business or professional needs.

6. Consumer report. "Consumer report" has the same meaning as in Title 10, section 1312, subsection 3.

7. Consumer reporting agency. "Consumer reporting agency" has the same meaning as in Title 10, section 1312, subsection 4.

8. Control; controlled by; under common control with. "Control," including the terms "controlled by" and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services or otherwise, unless the power is the result of an official position with or a corporate office held by the person.

9. Health care. "Health care" means preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that affects an individual's physical, mental or behavioral condition, including individual cells or their components or genetic information, or affects the structure or function of the human body or any part of the human body. "Health care" includes prescribing, dispensing, furnishing or providing to a patient drugs, biologicals, medical devices, health care equipment

and supplies or hospice services and the banking of blood, sperm, organs or any other tissue.

10. Health care facility. "Health care facility" means a facility, institution or entity licensed pursuant to Title 22 that offers health care to persons in this State, including a home health care entity and a hospice program, or a pharmacy licensed pursuant to Title 32. For the purposes of this chapter, "health care facility" does not include a state mental health institute, the Elizabeth Levinson Center, the Aroostook Residential Center or Freeport Towne Square.

11. Health care information. "Health care information" means information that:

A. Relates to an individual's physical, mental or behavioral condition, personal or family medical history or health care; and

B. Is obtained from a health care provider, from the individual or from the individual's spouse, parent or legal guardian.

12. Health care practitioner. "Health care practitioner" means a person licensed in this State to provide or otherwise lawfully providing health care, and includes a partnership or corporation made up of health care practitioners, or an officer, employee, agent or contractor of a health care practitioner acting in the course and scope of employment, agency or contract related to or supportive of the provision of health care to an individual.

13. Health care provider. "Health care provider" means a health care practitioner or health care facility.

14. Institutional source. "Institutional source" means any person or governmental entity that provides information about an individual to a regulated insurance entity or insurance support organization other than:

A. A producer or producer agency;

B. The individual who is the subject of the information; or

C. An individual acting in a personal capacity rather than in a business or professional capacity.

15. Insurance carrier; carrier. "Insurance carrier" or "carrier" means:

A. Any person or entity required to be licensed by the superintendent to assume risk, including without limitation an insurer, nonprofit hospital, medical or health care service organization, health maintenance organization or multiple-employer welfare arrangement;

B. A self-funded plan subject to state regulation as described in section 2848-A;

C. A preferred provider arrangement administrator as defined in section 2671; or

D. A 3rd-party administrator, as described in section 1901, that provides administrative services for an entity that is not a carrier.

"Carrier" does not include other nonrisk-bearing regulated insurance entities, such as producers or agencies.

16. Insurance consumer; consumer. "Insurance consumer" or "consumer" means any individual who resides or obtains insurance in this State and:

A. Is a past, present or proposed principal insured or certificate holder;

B. Is a past, present or proposed policyowner;

C. Is a past or present applicant;

D. Is a past or present claimant; or

E. Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate subject to this chapter.

17. Insurance support organization. "Insurance support organization" means any person, other than a regulated insurance entity, health care provider or governmental agency, who regularly engages, in whole or in part, in the practice of assembling or collecting information for the primary purpose of providing the information to carriers, producers or agencies for insurance transactions, including:

A. Furnishing consumer reports or investigative consumer reports for use in connection with insurance transactions; or

B. Collecting personal information from regulated insurance entities or other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

18. Insurance transaction. "Insurance transaction" means any transaction that entails:

A. The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

B. The servicing of an insurance application, policy, contract or certificate.

19. Investigative consumer report. "Investigative consumer report" has the same meaning as in Title 10, section 1312, subsection 7.

20. Personal information. "Personal information" means any information that identifies an individual gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics. "Personal information" includes but is not limited to an individual's name and address and health care information.

21. Policyholder. "Policyholder" means any person who:

A. Is a present policyowner; or

B. In the case of group insurance that is individually underwritten, is a present group certificate holder.

22. Pretext interview. "Pretext interview" means an interview wherein a person, in an attempt to obtain information, performs one or more of the following acts:

A. Pretends to be someone the person is not;

B. Pretends to represent a person that person is not in fact representing;

C. Misrepresents the true purpose of the interview; or

D. Refuses to provide that person's identity upon request.

23. Regulated insurance entity. "Regulated insurance entity" means any person or entity required to be licensed by the superintendent under this Title or Title 24, including without limitation a carrier, producer, producer agency or administrator.

24. Residual market. "Residual market" means any special-purpose insurer, association, organization or other entity that provides insurance coverage to persons who are unable to obtain it in the voluntary market.

§2205. Pretext interviews

A regulated insurance entity or insurance support organization may not use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction unless that entity or organization does not have a generally or statutorily recognized privileged relationship with the insurance consumer about whom the information is related, the interview is conducted for the purpose of investigating a claim and there is a reasonable basis, supported by specific information available for review by the superintendent, for suspecting criminal activity, fraud, material misrepresentation or material nondisclosure.

§2206. Notice of insurance information practices

The following requirements apply to notices provided by regulated insurance entities.

1. Written notice. A regulated insurance entity shall provide a written notice of information practices to the applicant, policyholder or claimant in connection with all consumer insurance transactions in accordance with the following.

A. In the case of an application for insurance, the notice must be provided no later than:

(1) The time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records;

(2) The time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records; or

(3) The time of initial notification to the consumer when the insurance transaction is not initiated by the consumer and the consumer was selected based on specific criteria derived from personal information obtained from any source.

B. In the case of a policy renewal, the notice must be provided no later than the policy renewal date, unless:

(1) Personal information is collected only from the policyholder or from public records; or

(2) A notice meeting the requirements of this section has been given within the previous 24 months.

C. In the case of a policy reinstatement or change in insurance benefits, the notice must be provided no later than the time the request for reinstatement or change in benefits is received by the carrier, unless personal information is collected only from the policyholder or from public records.

2. Required provisions. The notice must state:

A. Whether personal information may be collected from persons other than the insurance consumer or consumers proposed for coverage;

B. The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information;

C. The types of disclosures that may be made without prior authorization under section 2215 and the circumstances under which any such disclosures may be made without prior authorization, except that only those circumstances need be described that occur with such frequency as to indicate a general business practice;

D. A description of the rights established under sections 2210 and 2211 and the manner in which those rights may be exercised;

E. That information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons; and

F. A description of the types of persons who may have access to the insurance consumer's personal information.

3. Abbreviated notice. In lieu of the notice prescribed in subsection 2, the regulated insurance entity may provide an abbreviated notice informing the applicant or policyholder that:

A. Personal information may be collected from persons other than the insurance consumer or consumers proposed for coverage;

B. Information described in paragraph A as well as other personal information subsequently collected by the regulated insurance entity may in certain circumstances be disclosed to 3rd parties without authorization pursuant to section 2215;

C. A right of access and correction exists with respect to all personal information collected; and

D. The notice prescribed in subsection 2 will be furnished to the applicant or policyholder upon request.

4. Satisfaction by other carrier, producer or administrator. The notice requirements imposed by this section upon a regulated insurance entity may be satisfied by a carrier, producer or administrator authorized to act on the entity's behalf.

5. Standard notice forms. All carriers shall develop and use standard notice forms, but are not required to use the same form as other carriers.

§2207. Marketing and research surveys

A regulated insurance entity that asks questions in connection with an insurance transaction shall clearly identify any questions that are designed to obtain information solely for marketing or research purposes and shall inform consumers that answering the questions is voluntary.

§2208. Content of disclosure authorization forms

Notwithstanding any other provision of law, a regulated insurance entity or insurance support organization may not use a disclosure authorization form unless the form or statement:

1. Signed. Is signed by the insurance consumer except that:

A. A consumer's spouse, family member or other authorized individual may sign the disclosure authorization form if:

(1) The individual is acting under a valid written power of attorney or acting pursuant to the Uniform Health-care Decisions Act; or

(2) The individual is the consumer's parent or legal guardian, in which case the authorization is valid only insofar as that parent or legal guardian has the exclusive authority to consent for the health care services received by a minor for which the authorization for payment is sought and only as to those disclosures when the holder of the information can reasonably infer that the parent's or legal guardian's interest in disclosure is not adverse to the consumer's; or

B. A consumer may authorize disclosure in electronic or telephonic form if a unique identifier of the insurance consumer is provided and the insurance consumer authenticates the electronic or telephonic authorization;

2. Plain language. Is written in plain language;

3. Dated. Is dated;

4. Persons authorized to disclose. Specifies the types of persons authorized to disclose information about the consumer;

5. Nature of information. Specifies the nature of the information authorized to be disclosed;

6. Name of regulated insurance entity. Names the regulated insurance entity and identifies by generic reference representatives of the carrier to whom the consumer is authorizing information to be disclosed;

7. Purpose. Specifies the purposes for which the information is collected;

8. Time period of authorization. Specifies the period of time the authorization remains valid. The period of time may be no longer than:

A. In the case of life, disability or long-term care insurance:

(1) Thirty months from the date the authorization is signed if the authorization is signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for change in policy benefits; or

(2) The duration of the claim if the authorization is signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy; or

B. In the case of health or medical insurance, the term of coverage of the policy and any renewals of that policy;

9. Right to copy. Advises the consumer or a person authorized to act on behalf of the consumer that the consumer or the consumer's authorized representative is entitled to receive a copy of the authorization form;

10. Revocation. Advises the consumer how to revoke the authorization and that the revocation may be a basis for denying insurance benefits; and

11. Failure to sign. Advises the consumer that failure to sign an authorization form may impair the ability of a regulated insurance entity to evaluate or process an application or claim and may be a basis for denying an application or claims for benefits.

§2209. Investigative consumer reports

1. Required notice. A regulated insurance entity or insurance support organization may not prepare or request an investigative consumer report about an insurance consumer in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement or a change in insurance benefits unless the regulated insurance entity complies with Title 10, section 1314 and informs the consumer in writing that the consumer may request to be interviewed in connection with the preparation of the investigative consumer report.

2. Personal interview. If an investigative consumer report is to be prepared by the regulated insurance entity, the regulated insurance entity shall institute reasonable procedures to conduct a personal interview when requested by a consumer.

3. Insurance support organization. If an investigative consumer report is to be prepared by an insurance support organization, the regulated insurance entity requesting the report shall inform the insurance support organization whether a personal interview has been requested by the consumer. The insurance support organization shall institute reasonable procedures to conduct such interviews.

§2210. Access to recorded personal information

1. Recorded personal information. If any insurance consumer, after proper identification, submits a written request to a regulated insurance entity or insurance support organization for access to recorded personal information about the consumer that is reasonably described by the consumer and reasonably locatable and retrievable by the regulated insurance entity or insurance support organization, the regulated insurance entity or insurance support organization shall, within 30 days after the date the request is received:

A. Inform the consumer of the nature and substance of the recorded personal information in writing or by telephone or other oral communication;

B. Permit the consumer to see and copy, in person, the recorded personal information or to obtain a copy of the recorded personal information by mail, whichever method the consumer prefers, unless the recorded personal information is in coded form, in which case an accurate translation in plain language must be provided in writing;

C. Disclose to the consumer the identity, if recorded, of those persons to whom the regulated insurance entity or insurance support organization has disclosed the information described or similar personal information about the consumer during the 2 years preceding the request and, if the identity is not recorded, the names of those carriers, producers, agencies, insurance support organizations or other persons to whom any such information is normally disclosed; and

D. Provide the consumer with a summary of the procedures by which the consumer may request correction, amendment or deletion of recorded personal information.

2. Resident considered consumer. For purposes of this section and section 2211, as applied to insurance support organizations, any resident of this State is considered an insurance consumer.

3. Institutional source. Any personal information provided pursuant to subsection 1 must identify

the source of the information if it is an institutional source.

4. Election relating to health care information. In lieu of disclosure directly to the consumer, the carrier or producer may elect to disclose health care information, together with the identity of the health care provider who provided the information, to a person designated by the consumer who is licensed to provide health care with respect to the condition to which the information relates. The regulated insurance entity or insurance support organization shall notify the consumer at the time of the disclosure that it has provided the information to the health care practitioner.

5. Fee. Except for personal information provided under section 2212, a regulated insurance entity or insurance support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to consumers.

6. Satisfaction by other carrier, producer or administrator. The obligations imposed by this section upon a regulated insurance entity may be satisfied by another carrier, producer or administrator authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under subsection 1, a regulated insurance entity or insurance support organization may make arrangements with an insurance support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

7. Confidential investigative information. Confidential investigative information and personal information in which a 3rd person has a nondisclosure right pursuant to section 2215 are not subject to the provisions of this section.

8. Applicability. This section does not apply to a consumer reporting agency except to the extent that this section imposes more stringent requirements on a consumer reporting agency than other state or federal law.

§2211. Correction, amendment or deletion of recorded personal information

1. Action by regulated insurance entity. Within 30 days after receiving a written request from an insurance consumer to correct, amend or delete any recorded personal information within its possession about the consumer, a regulated insurance entity or insurance support organization shall:

A. In the case of recorded personal information contained within a consumer report, provide the consumer with the name and address of the consumer reporting agency that furnished the report and notify the consumer of the rights under Title 10, section 1317 governing the correction of inaccurate personal information contained in a consumer report; or

B. In the case of other recorded personal information, either:

(1) Correct, amend or delete the portion of the recorded personal information in dispute; or

(2) Notify the consumer of its refusal to make the requested correction, amendment or deletion; the reasons for the refusal; and the consumer's right to file a statement as provided in subsection 3.

2. Notice to others. If the regulated insurance entity or insurance support organization corrects, amends or deletes recorded personal information in accordance with subsection 1, paragraph B, the regulated insurance entity or insurance support organization shall notify the consumer in writing and furnish the correction, amendment or fact of deletion to:

A. Any person specifically designated by the consumer who may have, within the preceding 2 years, received that recorded personal information;

B. Any insurance support organization whose primary source of personal information is insurance carriers, if the insurance support organization has systematically received recorded personal information from the carrier within the preceding 7 years. However, the correction, amendment or fact of deletion need not be furnished if the insurance support organization no longer maintains recorded personal information about the consumer; and

C. Any insurance support organization that furnished the personal information that has been corrected, amended or deleted.

3. Consumer statement. When a consumer disagrees with a regulated insurance entity's or insurance support organization's refusal to correct, amend or delete recorded personal information, or when the regulated insurance entity or insurance support organization has not made all relevant recorded personal information available for verification by the consumer, the consumer must be permitted to file with the regulated insurance entity or insurance support organization:

A. A concise statement setting forth what the consumer thinks is the correct, relevant or fair information; and

B. A concise statement of the reasons why the consumer disagrees with the regulated insurance entity's or insurance support organization's refusal to correct, amend or delete recorded personal information.

4. Filing of statement. In the event a consumer files a statement as described in subsection 3, the regulated insurance entity or insurance support organization shall:

A. File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the consumer's statement and have access to it;

B. In any subsequent disclosure by the regulated insurance entity or insurance support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the consumer's statement along with the recorded personal information being disclosed; and

C. Furnish the statement to the persons and in the manner specified in subsection 2.

5. Applicability. This section does not apply to a consumer reporting agency except to the extent that this section imposes more stringent requirements on a consumer reporting agency than other state or federal law.

§2212. Reasons for adverse underwriting decisions

1. Notice to consumer. In the event of an adverse underwriting decision, the carrier or producer responsible for the decision shall:

A. Comply with Title 10, section 1320, subsection 1-B if the decision is based in whole or in part on any information contained in a consumer report;

B. Either provide the consumer with the specific reason or reasons for the adverse underwriting decision in writing or advise the consumer that upon written request the consumer may receive the specific reason or reasons in writing; and

C. Provide the consumer with a summary of the rights established under subsection 2 and sections 2210 and 2211.

2. Request for explanation. If a consumer makes a written request for explanation of an adverse underwriting decision within 90 days after receiving written notice of the decision, the carrier or producer shall furnish to the consumer within 21 days after receiving the request:

A. The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to subsection 1, paragraph A or B;

B. The specific items of personal information that support those reasons, except that:

(1) The carrier or producer is not required to furnish confidential investigative information if it has a reasonable suspicion, based upon specific information available for review by the superintendent, that the consumer has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure; and

(2) In lieu of disclosure directly to the consumer, the carrier or producer may elect to disclose health care information to a person designated by the consumer who is licensed to provide health care with respect to the condition to which the information relates; and

C. The names and addresses of the institutional sources that supplied the specific items of information pursuant to paragraph B, except that the carrier may elect to disclose the identity of any health care provider to the consumer's designated health care practitioner.

3. Satisfaction by other carrier, producer or administrator. The obligations imposed by this section upon a carrier or producer may be satisfied by another carrier, producer or administrator authorized to act on its behalf.

§2213. Information concerning previous adverse underwriting decisions

Unless an inquiry of a regulated insurance entity or insurance support organization also requests the reasons for the underwriting decision or placement, a regulated insurance entity or insurance support organization may not seek information in connection with an insurance transaction concerning:

1. Previous adverse decision. Any previous adverse underwriting decision experienced by an insurance consumer; or

2. Residual market, surplus lines or substandard risk carrier. Any previous insurance coverage obtained by a consumer through a residual market, a surplus lines insurer or a carrier that specializes in substandard risks.

§2214. Previous adverse underwriting decisions

A carrier, producer or producer agency may not base an adverse underwriting decision in whole or in part:

1. Previous adverse underwriting decisions. On the fact of a previous adverse underwriting decision or on the fact that a consumer previously obtained insurance coverage through a residual market, a surplus lines insurer or a carrier that specializes in substandard risks. However, a carrier or producer may base an adverse underwriting decision on further information obtained from a carrier, producer or producer agency responsible for a previous adverse underwriting decision; or

2. Information from insurance support organizations. On personal information received from an insurance support organization whose primary source of information is insurance carriers. However, a carrier or producer may base an adverse underwriting decision on further personal information obtained as a result of information received from the insurance support organization, including primary source information confirming the information received from the insurance support organization.

§2215. Disclosure limitations and conditions

1. Disclosure of personal information. A regulated insurance entity or insurance support organization may not disclose any personal information about a consumer collected or received in connection with an insurance transaction unless the disclosure is made with due consideration for the safety and reputation of all persons who may be affected by the disclosure, is limited to the minimum amount of personal information necessary to accomplish a lawful purpose and is disclosed:

A. With the written authorization of the individual, only:

(1) If that authorization is submitted directly by the consumer, a person purporting to represent the consumer, another regulated insurance entity or insurance support organization and the authorization meets the requirements of section 2208; or

(2) If the authorization is submitted by a person other than a regulated insurance entity or insurance support organization and the authorization describes with reasonable particularity the nature of the information to be disclosed and the purpose of the disclosure and is:

(a) Dated;

(b) Signed by the consumer, except that another authorized individual may provide authorization or the consumer may authorize disclosure in electronic or telephonic form in accordance with section 2208, subsection 1; and

(c) Obtained one year or less before the date a disclosure is sought pursuant to this subsection;

B. To a person other than a regulated insurance entity or insurance support organization, only if that disclosure is reasonably necessary:

(1) To enable that person to perform a business, professional or insurance function for the disclosing regulated insurance entity or insurance support organization and that person agrees not to disclose the information further without the consumer's written authorization unless the further disclosure:

(a) Would otherwise be permitted by this section if made by a regulated insurance entity or insurance support organization; or

(b) Is reasonably necessary for that person to perform its function for the disclosing regulated insurance entity or insurance support organization; or

(2) To enable that person to provide information to the disclosing regulated insurance entity or insurance support organization for the purpose of:

(a) Determining a consumer's eligibility for an insurance benefit or payment; or

(b) Detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction;

C. To a regulated insurance entity, insurance support organization or self-insurer, only if the information disclosed is limited to that which is reasonably necessary:

(1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions; or

(2) For either the disclosing or the receiving regulated insurance entity or insurance support organization to perform its function in connection with an insurance transaction involving the consumer;

D. To a health care provider for the purpose of:

(1) Verifying insurance coverage or benefits;

(2) Informing a consumer of a medical problem of which the consumer may not be aware; or

(3) Conducting an operations or services audit to verify the consumers of the regulated insurance entity or insurance support organization treated by the health care provider;

E. To an insurance regulatory authority;

F. To a law enforcement or other governmental authority to protect the interests of the regulated insurance entity or insurance support organization in preventing or prosecuting the perpetration of fraud upon that entity or organization;

G. In response to a facially valid administrative or judicial order, including a search warrant or subpoena, or otherwise required by law;

H. For the purpose of conducting actuarial or research studies, except that:

(1) No insurance consumer may be identified in any actuarial or research report;

(2) Materials allowing the consumer to be identified must be returned or destroyed as soon as they are no longer needed; and

(3) The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by a regulated insurance entity or insurance support organization;

I. To a party or representative of a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the regulated insurance entity or insurance support organization, only if:

(1) Before the consummation of the sale, transfer, merger or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger or consolidation; and

(2) The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by a regulated insurance entity or insurance support organization;

J. To a person whose only use of the information will be in connection with the marketing of a product or service, only if:

(1) No health care information, confidential investigative information or information relating to a consumer's character, personal habits, mode of living or general reputation is disclosed and no classification derived from any such information is disclosed;

(2) The consumer has been given an opportunity to indicate that the consumer does not want personal information disclosed for marketing purposes and has given no indication that the consumer does not want the information disclosed; and

(3) The person receiving the information agrees not to use it except in connection with the marketing of a product or service;

K. By a consumer reporting agency to a person other than a regulated insurance entity;

L. To a group policyholder for the purpose of reporting claims experience or conducting an audit of the regulated insurance entity's operations or services, only if the information disclosed is aggregate information and reasonably necessary for the group policyholder to conduct the review or audit;

M. To a professional peer review organization for the purpose of reviewing the service or conduct of a health care provider;

N. To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction;

O. To a lienholder, mortgagee, assignee, lessor or other person shown on the records of a carrier or producer as having a legal or beneficial interest in a policy of insurance, only if:

(1) No health care information is disclosed unless the disclosure would otherwise be permitted by this section; and

(2) The information disclosed is limited to that which is reasonably necessary to permit that person to protect its interests in the policy; or

P. To an affiliate whose only use of the information will be in connection with an audit of the regulated insurance entity or the marketing of a product or service of the affiliate, if the information disclosed for marketing purposes does not include health care information and if the

affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons.

§2216. Insurance support organizations

1. Examination and investigation. The superintendent may examine and investigate into the affairs of every insurance support organization acting on behalf of a regulated insurance entity that either transacts business in this State or transacts business outside this State that has an effect on a resident of this State in order to determine whether the insurance support organization has been or is engaged in any conduct in violation of this chapter.

2. Service of process. An insurance support organization transacting business outside this State that has an effect on a resident of this State is deemed to have appointed the superintendent to accept service of process on its behalf. Service is complete when the superintendent sends a copy of the process by registered mail to the insurance support organization at its last known principal place of business. The return receipt is sufficient proof that notice was properly mailed by the superintendent.

§2217. Individual remedies

1. Appeal to superintendent. Any insurance consumer aggrieved by a regulated insurance entity's or insurance support organization's response or failure to respond to a request made pursuant to sections 2210, 2211 and 2212 may appeal to the superintendent, who may convene an adjudicatory hearing to determine whether there has been a violation of this chapter and may order the regulated insurance entity or insurance support organization to take such measures as are necessary to comply with this chapter.

2. Superior Court action. An insurance consumer who is injured by a disclosure of information relating to the consumer in violation of section 2215 may bring an action in the Superior Court against the regulated insurance entity or insurance support organization within 2 years after the disclosure is or should have been discovered. The consumer may recover damages, together with costs and disbursements, reasonable attorney's fees and interest on damages at the rate of 1 1/2% per month.

3. No private right of action. Except as specifically provided in this section, this chapter provides no express or implied private right of action.

§2218. Immunity

No cause of action in the nature of defamation, invasion of privacy or negligence arises against any person for disclosing personal information in accordance with this chapter, nor does such a cause of action arise against any person for furnishing personal information to a regulated insurance entity or insurance support organization. This section provides no immunity for disclosing or furnishing false information with malice or willful intent to injure any person.

§2219. Criminal penalties

A person who knowingly obtains personal information under false pretenses from a regulated insurance entity or insurance support organization is guilty of obtaining personal insurance information under false pretenses. Obtaining personal insurance information under false pretenses is a Class D crime.

§2220. Rulemaking

The superintendent may adopt rules to carry out the purposes of this chapter. Rules adopted pursuant to this chapter are major substantive rules as defined by Title 5, chapter 375, subchapter II-A.

Sec. 4. 24-A MRSA §4222-B, sub-§12 is enacted to read:

12. The requirements of chapter 24 and any rules adopted pursuant to that chapter apply to health maintenance organizations.

Sec. 5. Application. The requirements of the Maine Revised Statutes, Title 24-A, chapter 24 apply to all consumer insurance transactions that take place on or after January 1, 1999.

See title page for effective date.

CHAPTER 678

S.P. 635 - L.D. 1852

An Act to Reorganize and Clarify the Laws Relating to the Establishment, Powers and Duties of the Bureau of Parks and Lands

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

Sec. 1. 5 MRSA §12004-I, sub-§24-E, as enacted by PL 1995, c. 666, §1, is amended to read:

24-E. Environment: Natural Resources	Submerged Lands Advisory Board	Not Authorized	12 MRSA ~~§558-C~~ §1864

Sec. 2. 12 MRSA §542, sub-§6, as enacted by PL 1977, c. 360, §6, is amended to read:

6. Royalties, fees and rents. The survey ~~shall receive~~ receives all royalties, fees and rents accruing to the State under this chapter, which ~~shall~~ must be