LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND NINETEENTH LEGISLATURE

FIRST REGULAR SESSION
December 2, 1998 to June 19, 1999

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

J.S. McCarthy Company
Augusta, Maine
1999

show that a person held a license is prima facie evidence that the person did not hold the license on the date specified in the certificate. A certificate stating that the records show that a shellfish conservation ordinance or portions of an ordinance were in effect on a particular date is prima facie evidence that the ordinance was in effect on the date specified in the certificate. The certified copy is admissible in evidence on the testimony of a municipal shellfish conservation warden that the warden received the certificate after requesting it from the municipality. Further foundation is not necessary for the admission of the certificate.

Sec. 8. Retroactivity. This Act is retroactive to January 1, 1999.

See title page for effective date.

CHAPTER 256

S.P. 765 - L.D. 2157

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 amended by PL 1997, c. 604, Pt. A, §1, is further 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, a fraternal benefit society, as defined by section 4101, or a nonprofit hospital or medical service organization or health plan 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-A MRSA §2834-B, sub-§3, as enacted by PL 1997, c. 445, §19 and affected by §32, is amended to read:

3. Requirement. If a policy makes coverage available with respect to dependents of certificate holders, the policy must provide for a dependent special enrollment period when a person becomes a dependent of an eligible individual through marriage, birth or adoption or placement for adoption or if a court order is issued changing custody of a child. During this period, the ~~new~~ dependent may be enrolled under the plan as a dependent of the eligible individual and, in the case of the birth or adoption of a child, the spouse of the eligible individual may be enrolled as a dependent if otherwise eligible for coverage. If the eligible individual is not already enrolled, the individual may enroll during this period.

Sec. B-2. 24-A MRSA §2834-B, sub-§4, ¶B, as enacted by PL 1997, c. 445, §19 and affected by §32, is amended to read:

B. The date of the marriage, birth or adoption or placement for adoption or the date of the court order.

Sec. B-3. 24-A MRSA §2834-B, sub-§5, ¶¶B and C, as enacted by PL 1997, c. 445, §19 and affected by §32, are amended to read:

B. In the case of a dependent's birth, as of the date of the birth; ~~or~~

C. In the case of a dependent's adoption or placement for adoption, as of the date of the adoption or placement for adoption~~.~~; or

Sec. B-4. 24-A MRSA §2834-B, sub-§5, ¶D is enacted to read:

D. In the case of a court order changing custody of a child, as of the date of the order.

PART C

Sec. C-1. 24-A MRSA §2736-C, sub-§1, ¶C-1, as enacted by PL 1997, c. 445, §8 and affected by §32, is amended to read:

C-1. "Legally domiciled" means a ~~resident of~~ person who lives in this State and who satisfies 3 of the following 4 criteria: has a motor vehicle operator's license from this State, is registered to vote in this State, has a permanent dwelling place in this State or files an income tax return for this State that declares the person is a Maine resident. A person may establish that that person is "legally domiciled" in this State by providing evidence of other relevant criteria associated with residency. A child is legally domiciled in this State if at least one of the child's parents or the child's legal guardian is legally domiciled in this State. A person with a developmental or other disability that prevents that person from obtaining a motor vehicle operator's license, registering to vote or filing an income tax return

is legally domiciled in this State by living in this State.

PART D

Sec. D-1. 24-A MRSA §2736-C, sub-§3, ¶D is enacted to read:

D. Notwithstanding paragraph A, carriers offering supplemental coverage for the Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are not required to issue this coverage if the applicant for insurance does not have CHAMPUS coverage.

Sec. D-2. 24-A MRSA §2736-C, sub-§8, as enacted by PL 1993, c. 645, Pt. B, §2, is amended to read:

8. Authority of the superintendent. The superintendent may by rule define one or more standardized individual health plans that must be offered by all carriers offering individual health plans in the State, other than carriers offering only CHAMPUS supplemental coverage.

PART E

Sec. E-1. 24-A MRSA §2808-B, sub-§2, ¶E, as enacted by PL 1991, c. 861, §2, is repealed and the following enacted in its place:

E. The superintendent may exempt from the requirements of this subsection an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 that offers a small group health plan that:

(1) Complies with the premium rate requirements of this subsection; and

(2) Guarantees issuance and renewal to all persons and their dependents within the association or trustee group except that a professional association may require that a minimum percentage of the eligible professionals employed by a subgroup be members of the association in order for the subgroup to be eligible for issuance or renewal of coverage through the association. The minimum percentage must not exceed 90%. For purposes of this subparagraph, "professional association" means an association that:

(a) Serves a single profession that requires a significant amount of education, training or experience or a license or certificate from a state authority to practice that profession;

(b) Has been actively in existence for 5 years;

(c) Has a constitution and bylaws or other analogous governing documents;

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

(e) Is not owned or controlled by a carrier or affiliated with a carrier;

(f) Does not make membership in the association conditional on health status or claims experience;

(g) Has a least 1,000 members if it is a national association; 200 members if it is a state or local association;

(h) All members and dependents of members are eligible for coverage regardless of health status or claims experience; and

(i) Is governed by a board of directors and sponsors annual meetings of its members.

Producers may only market association memberships, accept applications for membership or sign up members in the professional association where the individuals are actively engaged in or directly related to the profession represented by the professional association.

Sec. E-2. 24-A MRSA §2808-B, sub-§4, ¶A, as amended by PL 1997, c. 445, §16 and affected by §32, is further 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. In determining compliance with minimum participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation. 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. A carrier may deny coverage under a managed care plan, as defined by section 4301:

(1) To employers who have no employees who live, reside or work within the approved service area of the plan; and

(2) To employers if the carrier has demonstrated to the superintendent's satisfaction that:

(a) The carrier does not have the capacity to deliver services adequately to additional enrollees because of its obligations to existing enrollees; and

(b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this ~~paragraph~~ subparagraph may not enroll groups within the service area for a period of 180 days after the date of denial of coverage.

PART F

Sec. F-1. 24-A MRSA §4222-B, sub-§§13 and 14 are enacted to read:

13. The requirements of sections 2436 and 2436-A apply to health maintenance organizations.

14. The requirement of filing a report of experience of claims payment for alcoholism and drug dependency treatment in the format prescribed by section 2842, subsection 9; for chiropractic services in the format prescribed by section 2748, subsection 3 and section 2840-A, subsection 3; and for breast cancer screening services in the format prescribed by section 2745-A, subsection 4 and section 2837-A, subsection 4.

PART G

Sec. G-1. 24-A MRSA §2804, sub-§3, as amended by PL 1989, c. 867, §2 and affected by §10, is further amended to read:

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. G-2. 24-A MRSA §2805, sub-§3, as amended by PL 1989, c. 867, §3 and affected by §10, is further amended to read:

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. G-3. 24-A MRSA §2805-A, sub-§4, as amended by PL 1989, c. 867, §4 and affected by §10, is further amended to read:

4. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. G-4. 24-A MRSA §2806, sub-§3, as amended by PL 1989, c. 867, §5 and affected by §10, is further amended to read:

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. G-5. 24-A MRSA §2807-A, sub-§3, as amended by PL 1989, c. 867, §6 and affected by §10, is further amended to read:

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. G-6. 24-A MRSA §2808, sub-§4, as amended by PL 1989, c. 867, §7 and affected by §10, is further amended to read:

4. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

PART H

Sec. H-1. 24-A MRSA §2851, as repealed and replaced by PL 1981, c. 175, §3, is repealed and the following enacted in its place:

§2851. Scope of provisions

All life insurance and all health insurance in connection with loans or other credit transactions are subject to this chapter, except:

1. Long-term loan. Insurance in connection with a loan or other credit transaction of more than 15 years' duration;

2. Isolated transactions. Insurance issued in an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor; or

3. Real estate loan. Insurance in connection with real estate loans when the charge, if any, to the debtor is periodic and not financed.

PART I

Sec. I-1. 24-A MRSA §2436, as repealed and replaced by PL 1987, c. 344, is amended to read:

§2436. Interest on overdue payments

1. A claim for payment of benefits under a policy or certificate of insurance ~~against loss~~ delivered or issued for delivery ~~within~~ in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy~~, and a~~. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim ~~which~~ that is neither disputed nor paid within 30 days is overdue, ~~provided that if~~. If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim ~~shall~~ is not ~~be~~ overdue until 30 days following receipt by the insurer of the additional required information; except that the time period applicable to a standard fire policy and to that portion of a policy providing a combination of coverages, as described in section 3003, insuring against the peril of fire ~~shall~~ must be 60 days, as provided in section 3002.

2. An insurer may dispute a claim by furnishing to the insured or beneficiary, or ~~his~~ a representative of the insured or beneficiary, a written statement that the claim is disputed with a statement of the grounds upon which it is disputed. The statement must be based upon a reasonable investigation of the claim and must include sufficient detail to permit the insured or beneficiary to understand and respond to the insurer's position. For purposes of this subsection, a claim for payments under a policy or certificate providing health care coverage is disputed if the insurer has denied the claim or has requested further information that is consistent with Bureau of Insurance Rule Chapter 850.

3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim ~~shall bear~~ bears interest at the rate of 1 1/2% per month after the due date.

4. A reasonable ~~attorneys~~ attorney's fee for advising and representing a claimant on an overdue claim or action for an overdue claim ~~shall~~ must be paid by the insurer if overdue benefits are recovered in an action against the insurer or if overdue benefits are paid after receipt of notice of the attorney's representation.

5. Nothing in this section prohibits or limits any claim or action for a claim ~~which~~ that the claimant has against the insurer.

PART J

Sec. J-1. 24-A MRSA §2525, sub-§1, ¶B, as enacted by PL 1969, c. 132, §1, is amended to read:

B. A provision ~~which~~ that excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein in the event of death under any one or more of the following circumstances:

(1) Death as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces, or of any act or hazard of such war or action, or of service in the military, naval or air forces or in civilian forces auxiliary thereto, or from any cause while a member of such military, naval or air forces of any country at war, declared or undeclared, or of any country engaged in such military action;

(2) Death as a result of aviation or any air travel or flight;

(3) Death as a result of a specified hazardous occupation or occupations or avocation;

(4) Death while the insured is a resident outside continental United States and Canada; ~~or~~

(5) Death within 2 years from the date of issue of the policy as a result of suicide, while sane or insane~~.~~ or

(6) Death within 2 years from the date of issue of an increase in policy face amount, as a result of suicide, while sane or insane.

Sec. J-2. 24-A MRSA §2525, sub-§2, as amended by PL 1979, c. 541, Pt. A, §164, is further amended to read:

2. A policy ~~which~~ that contains any exclusion or restriction pursuant to subsection 1, paragraph B, subparagraphs (1) to (5) ~~shall~~ must also provide that, in the event of death under the circumstances to which any such exclusion or restriction is applicable, the insurer will pay an amount not less than the reserve attributable thereto determined according to the commissioners reserve valuation method upon the

basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits~~,~~ or, if the policy provides for no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy, with adjustment for indebtedness or dividend credit.

Sec. J-3. 24-A MRSA §2525, sub-§2-A is enacted to read:

2-A. A policy that contains any exclusion or restriction pursuant to subsection 1, paragraph B, subparagraph (6) must also provide that, in the event of death under the circumstances to which an exclusion or restriction regarding the increase in policy face amount is applicable, the insurer will pay, with respect to the increase in policy face amount, a return of premiums paid.

PART K

Sec. K-1. 24-A MRSA §2721-B, as enacted by PL 1975, c. 121, is repealed.

PART L

Sec. L-1. 24-A MRSA §2808-B, sub-§3, as amended by PL 1997, c. 445, §15 and affected by §32, is further amended to read:

3. Coverage for late enrollees. In providing coverage to late enrollees, small group health plan carriers are allowed to exclude or limit coverage for a late enrollee ~~for 12 months or provide coverage subject to a 12-month preexisting conditions exclusion. The exclusion is~~ subject to the limitations set forth in section ~~2850~~ 2849-B, subsection 3.

Sec. L-2. 24-A MRSA §2848, sub-§1-B, as amended by PL 1997, c. 777, Pt. B, §4, is further amended to read:

1-B. Federally creditable coverage. "~~Creditable~~ Federally creditable coverage" ~~means:~~ is defined as follows.

A. ~~Health~~ "Federally creditable coverage" means health benefits or coverage provided under any of the following:

(1) An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, or a plan that would be an employee welfare benefit plan but for the "governmental plan" or "nonelecting church plan" exceptions, if the plan provides medical care as defined in subsection 2-A, and includes items and services paid for as medical care directly or through insurance, reimbursement or otherwise;

(2) Benefits consisting of medical care provided directly, through insurance or reimbursement and including items and services paid for as medical care under a policy, contract or certificate offered by a carrier;

(3) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

(4) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act or a state children's health insurance program under Title XXI of the Social Security Act;

(5) The Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55;

(6) A medical care program of the federal Indian Health Care Improvement Act, 25 United States Code, Section 1601 or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under the federal Employees Health Benefits Amendments Act, 5 United States Code, Chapter 89;

(9) A public health plan as defined in federal regulations authorized by the federal Public Health Service Act, Section 2701(c)(1)(I), as amended by Public Law 104-191; or

(10) A health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code, Section 2504(e).

B. ~~Creditable~~ "Federally creditable coverage" does not include coverage consisting solely of one or more of the following:

(1) Coverage for accident or disability income insurance or any combination of those coverages;

(2) Liability insurance, including general liability insurance and automobile liability insurance;

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

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit insurance;

(7) Coverage for on-site medical clinics; or

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

C. ~~Creditable~~ "Federally creditable coverage" does not include the following benefits if those benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination of those benefits; and

(3) Other similar, limited benefits as specified in federal regulations issued pursuant to Public Law 104-191.

D. ~~Creditable~~ "Federally creditable coverage" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, and if no coordination exists between the provision of the benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and those benefits are paid for an event without regard to whether benefits are provided for that event under a group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

E. ~~Creditable~~ "Federally creditable coverage" does not include the following if it is offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance under the Social Security Act, Section 1882(g)(1);

(2) Coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55; and

(3) Similar supplemental coverage under a group health plan.

For purposes of this subsection, a "period of continuing federally creditable coverage" means a period in which an individual has maintained federally creditable coverage through one or more plans or programs, with no break in coverage exceeding 63 days. In calculating the aggregate length of a period of continuing federally creditable coverage that includes one or more breaks in coverage, only the time actually covered is counted. A waiting period is not counted as a break in coverage if the individual has other federally creditable coverage during this period.

Sec. L-3. 24-A MRSA §2848, sub-§1-C, as amended by PL 1997, c. 683, Pt. A, §13, is further amended to read:

1-C. Federally eligible individual. "Federally eligible individual" means an individual:

A. Who has had a period of continuing federally creditable coverage, as defined in subsection 1-B, ending not more than 63 days before applying for an individual health plan, with an aggregate length of federally creditable coverage, as defined in subsection 1-B, of at least 18 months;

B. Whose most recent prior federally creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan;

C. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, Medicare, or a state plan under Title XIX, Medicaid or any successor program and who does not have other health insurance coverage;

D. Whose most recent federally creditable coverage was not terminated based on nonpayment of premiums, fraud or intentional misrepresentation of material fact; and

E. Who, if offered the option of continuation of coverage under a COBRA continuation provision, as defined by subsection 1-A, or under a similar state program, elected continuation of coverage and has exhausted that coverage.

Sec. L-4. 24-A MRSA §2848, sub-§5, as repealed and replaced by PL 1993, c. 349, §52, is amended to read:

5. Waiting period. "Waiting period" means a period of time after the ~~effective~~ date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of any or all medical conditions.

Sec. L-5. 24-A MRSA §2849-A, sub-§1, as amended by PL 1991, c. 695, §8, is further amended to read:

1. Policies subject to this section. This section applies to group and blanket policies that provide hospital or medical expense coverage or specific indemnity during hospital confinement. This section does not apply to group policies providing coverage only for dental expense or to group long-term care policies as defined in section 5051 or group short-term and long-term disability policies.

Sec. L-6. 24-A MRSA §2849-A, sub-§2, as enacted by PL 1989, c. 867, §8 and affected by §10, is amended to read:

2. Requirement. Every group policy subject to this section must provide a reasonable extension of benefits for a person who is totally disabled on the date the group policy is discontinued, or on the date coverage for a subgroup in the policy is discontinued. A premium may not be charged during the period of extension. For a policy providing hospital or medical expense coverage, an extension of benefits provision is reasonable if it provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance. For a policy providing ~~benefits for loss of time from work or~~ specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that ~~disability or~~ confinement.

Sec. L-7. 24-A MRSA §2849-B, sub-§3, as amended by PL 1997, c. 777, Pt. B, §§5 and 6, 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 except as provided in this subsection. A late enrollee may be excluded from coverage for a waiting period of not more than 12 months based on medical underwriting or preexisting conditions. If a shorter waiting period or no waiting period is imposed, coverage for the late enrollee may exclude preexisting conditions for the lesser of 18 months, reduced by any federally creditable coverage, or 12 months. The exclusion is subject to the limitations set forth in section 1850. 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:

(1) Coverage under that contract or policy ceased 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; or

(2) Employer contributions toward that coverage were terminated;

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;

C-1. That person was covered by the Cub Care program under Title 22, section 3174-R, and the request for replacement coverage is made while coverage is in effect or within 30 days from 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. L-8. 24-A MRSA §2850, sub-§1, as amended by PL 1997, c. 370, Pt. C, §5, is further amended to read:

1. Application. This section applies to individual ~~and~~, group and blanket medical insurance contracts subject to chapters 33 and 35, except Medicare supplement contracts, converted contracts issued under section 2809-A and contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

Sec. L-9. 24-A MRSA §2850, sub-§2, as repealed and replaced by PL 1997, c. 445, §29 and affected by §32, is amended to read:

2. Limitation. An individual or group contract issued by an insurer may not impose a preexisting condition exclusion except as provided in this subsection. A preexisting condition exclusion may not exceed 12 months, including the waiting period, if any. A preexisting condition exclusion may not be more restrictive than as follows.

A. In a group contract, a preexisting condition exclusion may relate only to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the ~~effective~~ date of ~~coverage~~ enrollment. An exclusion may not be imposed relating to pregnancy as a preexisting condition.

B. In an individual contract not subject to paragraph C, or in a blanket policy, a preexisting condition exclusion may relate only to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the ~~effective~~ date of ~~coverage~~ application or to a pregnancy existing on the effective date of coverage.

C. An individual policy issued on or after January 1, 1998 to a federally eligible individual as defined in section 2848 may not contain a preexisting condition exclusion.

D. A routine preventive screening or test yielding only negative results may not be ~~deemed~~ considered to be diagnosis, care or treatment for the purposes of this subsection.

E. Genetic information may not be used as the basis for imposing a preexisting condition exclusion in the absence of a diagnosis of the condition relating to that information. For the purposes of this paragraph, "genetic information" has the same meaning as set forth in the Code of Federal Regulations.

Sec. L-10. 24-A MRSA §2850-B, sub-§1, ¶B, as enacted by PL 1997, c. 445, §30 and affected by §32, is amended to read:

B. Group and blanket medical insurance contracts subject to chapter 35 except:

(1) Medicare supplement policies subject to chapter 67; and

(2) Contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

PART M

Sec. M-1. 24 MRSA §2301, sub-§3-A, ¶B, as enacted by PL 1993, c. 702, Pt. A, §1, is amended to read:

B. Issue and maintain in force employee benefit excess insurance as defined in Title 24-A, section 707, subsection 1, paragraph C-1 with respect to health insurance and underlying risks that the corporation is authorized to cover under this chapter~~. The provisions of Title 24-A, section 707, subsection 3 apply to the employee benefit excess insurance issued by a hospital or medical service corporation~~;

Sec. M-2. 24 MRSA §2303, sub-§2, as amended by PL 1987, c. 80, §1, is repealed.

Sec. M-3. 24 MRSA §2303, sub-§4, as enacted by PL 1979, c. 415, §2, is repealed.

Sec. M-4. 24 MRSA §2303, sub-§5, as enacted by PL 1995, c. 561, §1, is repealed.

Sec. M-5. 24 MRSA §2303-A, as enacted by PL 1975, c. 345, §1, is repealed.

Sec. M-6. 24 MRSA §2303-C, as amended by PL 1993, c. 669, §1, is repealed.

Sec. M-7. 24 MRSA §2307-B, as amended by PL 1997, c. 370, Pt. E, §1, is repealed.

Sec. M-8. 24 MRSA §2316, as amended by PL 1997, c. 369, §1, is further amended to read:

§2316. Certificates or contracts; approval by superintendent

A nonprofit hospital and medical service organization may not issue or deliver in this State any certificate or other evidence of any contract unless and until the form used, together with the form of application and all riders or endorsements for use in connection with the certificate or other evidence of a contract, have been filed with and approved by the superintendent as conforming to reasonable rules and regulations from time to time made by the superintendent and as consistent with any other provisions of law. The superintendent shall, within a reasonable time after the filing of any such form, notify the organization filing the form either of the approval or of the disapproval of the form. The superintendent may approve any form that in the superintendent's opinion contains provisions on any one or more of the several requirements made by the superintendent that are more favorable to the subscribers than the one or ones required. The superintendent is authorized to make, alter and supersede reasonable regulations prescribing the required, optional and prohibited provisions in any contracts, and such regulations must conform, as far as practicable, to Title 24-A, chapters 33 and 35. If the superintendent determines those chapters to be inapplicable, either in part or in their entirety, the superintendent may prescribe the portions or summary of the contract to be printed on the certificate issued to the subscriber. ~~A contract may not be delivered or issued for delivery~~

~~in this State unless it meets the requirements of Title 24-A, sections 2438 to 2445, section 2729-A and section 2747.~~ Any filing made in accordance with this section is deemed approved unless disapproved within 60 days from the date of the filing.

Sec. M-9. 24 MRSA §2317-A, as amended by PL 1997, c. 592, §5, is repealed.

Sec. M-10. 24 MRSA §2317-B is enacted to read:

§2317-B. Applicability of provisions

The following provisions of Title 24-A are applicable to each nonprofit hospital or medical service organization or health care plan licensed under this Title.

1. Title 24-A, section 707, subsection 3. Employee benefit excess insurance, Title 24-A, section 707, subsection 3;

2. Title 24-A, section 2436. Interest on overdue payments;

3. Title 24-A, section 2437. The practice of dentistry, Title 24-A, section 2437;

4. Title 24-A, sections 2438 to 2445. Policy language simplification;

5. Title 24-A, section 2450. Diethylstilbestrol, commonly referred to as DES, Title 24-A, section 2450;

6. Title 24-A, sections 2713-A and 2823-A. Minor children, Title 24-A, sections 2713-A and 2823-A;

7. Title 24-A, section 2729-A. Renewability;

8. Title 24-A, section 2736-C. Individual health plans, Title 24-A, section 2736-C;

9. Title 24-A, sections 2744 and 2835. Mental health services, Title 24-A, sections 2744 and 2835;

10. Title 24-A, section 2749. Arbitration of disputed claims;

11. Title 24-A, sections 2748 and 2840-A. Coverage for chiropractic services, Title 24-A, sections 2748 and 2840-A;

12. Title 24-A, section 2752. Any legislative measure that proposes a mandated health benefit applicable to nonprofit hospital or medical services organizations, to the extent the requirements apply to proposals applicable to insurers governed by Title 24-A, section 2752;

13. Title 24-A, section 2803. Categories of group health insurance, Title 24-A, section 2803;

14. Title 24-A, section 2803-A. Provision of loss information, Title 24-A, section 2803-A;

15. Title 24-A, section 2808-B. Small group health plans, Title 24-A, section 2808-B;

16. Title 24-A, section 2834-B. Dependent special enrollment, Title 24-A, section 2834-B;

17. Title 24-A, chapter 32. Preferred provider arrangements;

18. Title 24-A, chapter 36. Continuity of health insurance coverage, Title 24-A, chapter 36;

19. Title 24-A, chapter 67. Medicare supplement insurance policies, Title 24-A, chapter 67; and

20. Title 24-A, chapter 68. Long-term care insurance, nursing home care insurance and home health care insurance, Title 24-A, chapter 68.

Sec. M-11. 24 MRSA §2327-A, as amended by PL 1997, c. 604, Pt. B, §1, is repealed.

Sec. M-12. 24 MRSA §2327-B, as enacted by PL 1993, c. 547, §1, is repealed.

Sec. M-13. 24 MRSA §2327-C, as enacted by PL 1997, c. 445, §2 and affected by §32, is repealed.

Sec. M-14. 24 MRSA §2328, as reallocated by PL 1981, c. 698, §107, is repealed.

Sec. M-15. 24 MRSA §2328-A, as enacted by PL 1985, c. 648, §3, is repealed.

Sec. M-16. 24 MRSA §2332-C, as amended by PL 1991, c. 701, §4, is repealed.

Sec. M-17. 24 MRSA c. 19, sub-c. II, as amended, is repealed.

PART N

Sec. N-1. 24-A MRSA §2723-A is enacted to read:

§2723-A. Coordination of benefits

1. Authorization. There may be a provision for coordination of benefits payable under the policy and under other plans of insurance or health care coverage, in conformance with rules adopted by the superintendent to 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 or medical service organization plans and nonprofit health care organization plans. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

2. Coordination with Medicare. Coordination of benefits with Medicare is governed by the following provisions.

A. The policy 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 policy 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 policy 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 B without paying a premium and the insurer provided prominent notification to the insured both when the policy was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the policy 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 O

Sec. O-1. 24 MRSA §2325-A, sub-§3, ¶E, as amended by PL 1995, c. 560, Pt. K, §82 and affected by §83, is further amended to read:

E. "Provider" means those individuals included in Title ~~24, section 2303, subsection 2~~ 24-A, section 2744, subsection 1, and a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Mental Health, Mental Retardation and Substance Abuse Services. All agency or institutional providers named in this paragraph shall ~~assure~~ ensure that services are supervised by a psychiatrist or licensed psychologist.

Sec. O-2. 24 MRSA §2336, sub-§3, as enacted by PL 1989, c. 588, Pt. A, §44, is amended to read:

3. Length of contract; contracting process. Contracts for preferred provider arrangements ~~shall~~ may not exceed a term of 3 years. A preferred provider arrangement for all subscribers of a nonprofit services organization must be awarded on the basis of an open bidding process after invitation to all providers of that service in the State. Each preferred provider arrangement affecting all subscribers must be bid and contracted for as separate services. ~~Each service on the list set forth in section 2339 shall constitute a separate service.~~

Sec. O-3. 24-A MRSA §4234-A, sub-§3, ¶E, as amended by PL 1995, c. 560, Pt. K, §82 and affected by §83, is further amended to read:

E. "Provider" means an individual included in ~~Title 24, section 2303, subsection 2~~ section 2744, subsection 1, a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Mental Health, Mental Retardation and Substance Abuse Services. All agency or institutional providers named in this paragraph shall ensure that services are supervised by a psychiatrist or licensed psychologist.

PART P

Sec. P-1. 24-A MRSA §2808-B, sub-§1, ¶C, as amended by PL 1993, c. 588, §1, is further amended to read:

C. "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not

include employees who work on a temporary or substitute basis. An employer may elect to treat as eligible employees part-time employees who work a normal work week of 10 hours or more as long as at least one employee works a normal work week of 30 hours or more. An employer may elect to treat as eligible employees employees who retire from the employer's employment.

PART Q

Sec. Q-1. 24-A MRSA §4202-A, sub-§12-A is enacted to read:

12-A. NCQA accreditation survey report. "NCQA accreditation survey report" means the unpublished, detailed survey report to a health maintenance organization by the National Committee for Quality Assurance upon completion of NCQA's accreditation survey of the health maintenance organization.

Sec. Q-2. 24-A MRSA §4245 is enacted to read:

§4245. NCQA accreditation survey report

1. Access and confidentiality. The superintendent or the Commissioner of Human Services may require a health maintenance organization to submit its NCQA accreditation survey report. An NCQA accreditation survey report obtained by or submitted to the superintendent or the Commissioner of Human Services is confidential, is not subject to subpoena and may not be made public by the superintendent or the Commissioner of Human Services except as otherwise provided in this section.

2. Use in examination. In conducting an examination of a health maintenance organization pursuant to section 4215, the superintendent or the Commissioner of Human Services has the discretion to adopt relevant findings in the NCQA accreditation survey report in whole or in part as the examiner's conclusions, if the examiner determines that the NCQA survey, by itself or in combination with the examiner's own findings, sufficiently demonstrates that the health maintenance organization has satisfied the pertinent requirements of this chapter. If the NCQA accreditation survey report indicates that the health maintenance organization may not be in compliance with one or more requirements of this chapter, the examiner may investigate and make independent findings.

3. Examination report. The information from the NCQA accreditation survey report that sufficiently demonstrates that the health maintenance organization has satisfied the pertinent requirements of this section as adopted by the superintendent or the Commissioner of Human Services pursuant to subsection 2 may be incorporated into an examination report, which is a public record except for any information relating to an individual applicant or enrollee.

4. Use of information for regulatory purposes. The confidentiality of the NCQA accreditation survey report does not prohibit its use by the superintendent or the Commissioner of Human Services for regulatory or law enforcement purposes subject to the restrictions of section 216, subsection 5 and section 226, subsection 7.

PART R

Sec. R-1. 24-A MRSA §6603, sub-§1, ¶H, as enacted by PL 1993, c. 688, §1, is amended to read:

H. May issue only health care benefit plans that comply with the requirements of section 2808-B with regard to rating practices, coverage for late enrollees and guaranteed renewal and ~~must provide health care benefits that meet the requirements for~~ offer the standard and basic plans as adopted by the Bureau of Insurance in Rule Chapter 750. The superintendent may waive the requirement to offer standard and basic plans for an arrangement that provides benefits only to members of an association meeting the requirements of section 2805-A. An arrangement may not provide health care benefits that do not meet or exceed the requirements for the basic plan.

See title page for effective date.

CHAPTER 257

S.P. 398 - L.D. 1189

An Act to Ensure Adequate Funding of Certain Public Safety Programs of Occupational or Professional Licensure Boards

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

Sec. 1. 32 MRSA §3652, first and 2nd ¶¶, as amended by PL 1993, c. 600, Pt. A, §245, are further amended to read:

An applicant for an examination for a license to practice podiatry shall pay, at the time of filing an application, to the board a license application fee of not more than $200, a license fee of not more than $600, plus actual cost of examination administration as set by the board. If the application is denied and examination refused, 1/2 of the application fee and all of the license fee must be returned to the applicant. An applicant who fails to pass an examination is entitled to a reexamination within 6 months upon the