LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTIETH LEGISLATURE

FIRST REGULAR SESSION
December 6, 2000 to June 22, 2001

THE GENERAL EFFECTIVE DATE FOR
FIRST REGULAR SESSION
NON-EMERGENCY LAWS IS
SEPTEMBER 21, 2001

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
2001

regardless of when that creditable service was earned, except that for a member qualifying under subsection 2, paragraph B:

(1) If the member had 10 years of service on July 1, 1993, the benefit must be reduced as provided in section 17852, subsection 3, paragraphs A and B for each year the member's age precedes 55 years of age; or

(2) If the member had fewer than 10 years of creditable service on July 1, 1993, the benefit must be reduced by 6% for each year that the member's age precedes 55 years of age.

Sec. 6. 5 MRSA §17851-A, sub-§5, as amended by PL 1999, c. 493, §9, is further amended to read:

5. Contributions. Notwithstanding any other provision of subchapter III, after June 30, 1998~~,~~ for employees identified in subsection 1, paragraphs A to H, ~~and~~ after December 31, 1999~~,~~ for employees identified in subsection 1, paragraphs I to K and after December 31, 2001 for employees identified in subsection 1, paragraph L, a member in the capacities specified in subsection 1 must contribute to the retirement system or have pick-up contributions made at the rate of 8.65% of earnable compensation until the member has completed 25 years of creditable service as provided in this section and at the rate of 7.65% thereafter.

Sec. 7. 38 MRSA §551, sub-§5, ¶H, as amended by PL 1991, c. 698, §11, is further amended to read:

H. Sums, up to $50,000 each year, that have been allocated by the Legislature on a contingency basis in accordance with section 555 for payment of costs for damage assessment for specific spills and site-specific studies of the environmental impacts of a particular discharge prohibited by section 543 that may have adverse economic effects and occur subsequent to such an allocation, when those studies are determined necessary by the commissioner; ~~and~~

Sec. 8. 38 MRSA §551, sub-§5, ¶I, as enacted by PL 1989, c. 868, §8, is amended to read:

I. Payment of costs for the collection of overdue reimbursements~~.~~; and

Sec. 9. 38 MRSA §551, sub-§5, ¶J is enacted to read:

J. Payment of 0.25¢ per barrel of the 3¢ per barrel received pursuant to subsection 4 to fund the purposes of Title 5, section 17851-A, subsection 1, paragraph L.

Sec. 10. Allocation. The following funds are allocated from the Federal Expenditures Fund to carry out the purposes of this Act.

	2001-02	2002-03
ENVIRONMENTAL PROTECTION, DEPARTMENT OF		
Remediation and Waste Management		
Personal Services	$1,821	$1,844
Provides an allocation for the 1.65% increase to the normal retirement rate for certain oil and hazardous materials emergency response workers due to a plan change.		

Sec. 11. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Act.

	2001-02	2002-03
ENVIRONMENTAL PROTECTION, DEPARTMENT OF		
Remediation and Waste Management		
Personal Services	$497,901	$14,870
Provides an allocation in the first year for the unfunded liability and in both years for the 1.65% increase to the normal retirement rate for certain oil and hazardous materials emergency response workers due to a plan change.		

See title page for effective date.

CHAPTER 410

S.P. 573 - L.D. 1745

An Act to Address Issues in the Maine Health Insurance Market

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

PART A

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

C. A carrier may vary the premium rate due to smoking status and family membership. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts based on smoking status. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. A-2. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 1995, c. 177, §1, is further amended to read:

D. A carrier may vary the premium rate due to age, ~~smoking status,~~ occupation or industry~~,~~ and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after July 15, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

Sec. A-3. 24-A MRSA §2808-B, sub-§2, ¶C, as amended by PL 1993, c. 477, Pt. B, §1 and affected by Pt. F, §1, is further amended to read:

C. A carrier may vary the premium rate due to family membership, smoking status, participation in wellness programs and group size. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts pursuant to this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. A-4. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 1997, c. 445, §14 and affected by §32, is further amended to read:

D. A carrier may vary the premium rate due to age, ~~smoking status,~~ occupation or industry~~,~~ and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after July 15, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%, except as provided in paragraph D-1.

Sec. A-5. 24-A MRSA §2808-B, sub-§2, ¶D-1, as enacted by PL 1997, c. 445, §14 and affected by §32, is amended to read:

D-1. With respect to eligible groups that employed, on average, 25 to 50 eligible employees in the preceding calendar year, a carrier may vary the premium rate due to age, ~~smoking status,~~ occupation or industry and geographic area only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State in 1998, the premium rate may not deviate above or below the community rate filed by the carrier by more than 40%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State in 1999, the premium rate may not deviate above or below the community rate filed by the carrier by more than 30%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for de-

livery, continued or renewed in this State after January 1, 2000, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

Sec. A-6. 24-A MRSA §2808-B, sub-§6, ¶A, as amended by PL 1995, c. 332, Pt. K, §2, is further amended to read:

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

Sec. A-7. 24-A MRSA §2808-B, sub-§8, as amended by PL 1993, c. 588, §2, is repealed.

Sec. A-8. 24-A MRSA §4204, sub-§2-A, ¶J, as amended by PL 1995, c. 332, Pt. I, §1, is repealed.

Sec. A-9. 24-A MRSA §6603, sub-§1, ¶H, as amended by PL 1999, c. 256, Pt. R, §1, is further 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 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~~ mandated benefits applicable to comparable insured plans.

Sec. A-10. Application. Those sections of this Part that amend the Maine Revised Statutes, Title 24-A, section 2736-C, subsection 2, paragraphs C and D and section 2808-B, subsection 2, paragraphs C, D and D-1 apply to all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2002.

PART B

Sec. B-1. 24-A MRSA §2803-A, sub-§§2 and 3, as enacted by PL 1995, c. 71, §2, are amended to read:

2. Disclosure of basic loss information. Upon written request, every insurer shall provide loss information concerning a group policy or contract to its policyholder ~~at least 60 days prior to renewal of the policy or contract and again 6 months from the date the policy becomes effective~~ within 21 business days of the date of the request.

3. Transmittal of request. ~~If a policyholder requests loss information from an~~ An insurance ~~agent~~ producer or other authorized representative~~, the representative or agent~~ who receives a request for loss information in accordance with this section shall transmit the request for loss information to the insurer within 4 ~~working~~ business days.

Sec. B-2. 24-A MRSA §2803-A, sub-§4, as amended by PL 1997, c. 370, Pt. E, §5, is further amended to read:

4. Exception. An insurer is not required to provide the loss information described in this section ~~to~~ for a group that is eligible for small group coverage pursuant to section 2808-B.

Sec. B-3. 24-A MRSA §4222-B, sub-§§17 to 19 are enacted to read:

17. Section 2803-A, relating to disclosure of loss information, applies to health maintenance organizations.

18. The requirement of section 2809-A, subsection 11 to continue group coverage under certain circumstances applies to health maintenance organizations.

19. Section 12-A, relating to penalties, applies to health maintenance organizations.

Sec. B-4. 24-A MRSA §4224-A, as amended by PL 1997, c. 370, Pt. E, §7, is repealed.

Sec. B-5. 24-A MRSA §4303, sub-§8 is enacted to read:

8. Maximum allowable charges. All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.

A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:

(1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and

(2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allow-

able charge permitted by the carrier for a specified service.

B. The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service.

Sec. B-6. 24-A MRSA §4304, sub-§6 is enacted to read:

6. Notice. A notice issued by a carrier or its contracted utilization review entity in response to a request by or on behalf of an insured or enrollee for authorization of medical services that advises that the requested service has been determined to be medically necessary must also advise whether the service is covered under the policy or contract under which the insured or enrollee is covered. Nothing in this subsection requires a carrier to provide coverage for services performed when the insured or enrollee is no longer covered by the health plan.

Sec. B-7. 24-A MRSA §5002-B, sub-§2-A is enacted to read:

2-A. Low-cost drugs for the elderly or disabled program. An issuer that offers standardized plans that include prescription drug benefits shall permit an insured who has a plan from the same issuer without prescription drug benefits to purchase a plan with prescription drug benefits under the following circumstances:

A. The insured was covered under the low-cost drugs for the elderly or disabled program established by Title 22, section 254;

B. The insured applies for a plan with prescription drug coverage within 90 days after losing eligibility for the low-cost drugs for the elderly or disabled program established by Title 22, section 254; and

C. The insured either:

(1) Had a Medicare supplement plan with prescription drug benefits from the same issuer prior to enrolling in the low-cost drugs for the elderly or disabled program established by Title 22, section 254; or

(2) Is entitled to continuity of coverage pursuant to subsection 1 and has had prescription drug benefits, through either a Medicare supplement plan or the low-cost drugs for the elderly or disabled program established by Title 22, section 254, since the insured's open enrollment period with no gap in prescription drug coverage in excess of 90 days.

The purchase of a plan with prescription drug benefits by an insured pursuant to this subsection does not affect eligibility for coverage under the low-cost drugs for the elderly or disabled program established by Title 22, section 254 if the insured is not covered by a Medicare supplement plan with prescription drug benefits at the time of reapplying for coverage under the low-cost drugs for the elderly or disabled program established by Title 22, section 254.

PART C

Sec. C-1. 24-A MRSA c. 32-A is enacted to read:

CHAPTER 32-A

TYPES OF HEALTH INSURANCE

§2691. Scope

1. Health insurance policies. This chapter applies to individual health insurance policies subject to chapter 33 and to group health insurance policies and certificates subject to chapter 35.

2. Dental plans and vision care plans. This chapter applies to dental plans and vision care plans only as specified.

3. Policies not subject to this chapter. This chapter does not apply to:

A. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when that group or individual policy or contract includes provisions that are inconsistent with the requirements of this chapter;

B. Policies issued to employees or members as additions to franchise plans in existence on the effective date of this chapter;

C. Medicare supplement policies subject to chapter 67;

D. Long-term care insurance policies subject to chapter 68;

E. Group disability income protection coverage; or

F. Insurance policies supplemental to the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55 (2000).

§2692. Definitions

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

1. Certificate. "Certificate" means a statement of the coverage and provisions of a policy of group health insurance that has been delivered or issued for delivery in this State. "Certificate" includes riders, endorsements and enrollment forms, if attached.

2. Dental plan. "Dental plan" means insurance written to provide coverage for dental treatment.

3. Direct response advertising. "Direct response advertising" means a solicitation through a sponsoring or endorsing entity or individually through mail, telephone, the Internet or other mass communication media.

4. Form. "Form" means a policy, contract, rider, endorsement or application as provided in section 2412.

5. Policy. "Policy" means an entire contract between the insurer and the insured, including riders, endorsements and the application, if attached.

6. Vision care plan. "Vision care plan" means insurance written to provide coverage for eye care.

§2693. Standards for policy provisions

1. Rules regarding manner, content and required disclosure. The superintendent may adopt rules to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of individual and group health insurance. The superintendent may adopt additional rules to establish specific standards for the sale of dental plans and vision care plans.

2. Rules regarding prohibited policies or provisions. The superintendent may adopt rules that specify prohibited policies or policy provisions not otherwise specifically authorized by statute that, in the opinion of the superintendent, are unjust, unfair or unfairly discriminatory to the policyholder or a person insured under the policy or to a beneficiary of the policy.

§2694. Minimum standards for benefits

The superintendent shall adopt rules to establish minimum standards for benefits under individual and group health insurance. These rules must clarify the meaning of limited benefits health insurance as referred to in chapters 33, 35 and 56-A. The rules must also set minimum standards for benefits for each of the following categories of coverage:

1. Basic hospital expense coverage. Basic hospital expense coverage;

2. Basic medical-surgical expense coverage. Basic medical-surgical expense coverage;

3. Basic hospital and medical-surgical expense coverage. Basic hospital and medical-surgical expense coverage;

4. Hospital confinement indemnity coverage. Hospital confinement indemnity coverage;

5. Individual major medical expense coverage. Individual major medical expense coverage;

6. Individual basic medical expense coverage. Individual basic medical expense coverage;

7. Individual disability income protection coverage. Individual disability income protection coverage;

8. Accident only coverage. Accident only coverage;

9. Specified disease coverage. Specified disease coverage; and

10. Specified accident coverage. Specified accident coverage.

This section does not preclude the issuance of a policy or contract that combines 2 or more of the categories of coverage in subsections 1 to 10.

§2695. Disclosure requirements

1. Outline of coverage. Except as provided in subsections 7 and 8, an insurer shall deliver an outline of coverage to an applicant or enrollee in connection with the sale of individual health insurance, group health insurance, dental plans and vision care plans delivered or issued for delivery in this State.

2. Sale through producer. If the sale of a policy described in subsection 1 occurs through a producer, the outline of coverage must be delivered to the applicant at the time of application or to the certificate holder at the time of enrollment.

3. Sale through direct-response advertising. If the sale of a policy described in subsection 1 occurs through direct-response advertising, the outline of

coverage must be delivered no later than in conjunction with the issuance of the policy or delivery of the certificate.

4. Outline of coverage not delivered at time of application or enrollment. If the outline of coverage required in subsections 1 and 8 and in any rules adopted by the superintendent pursuant to this chapter is not delivered at the time of application or enrollment, the advertising materials delivered to the applicant or enrollee must contain all the information required in subsection 8 and in any rules adopted by the superintendent pursuant to this chapter.

5. Outline of coverage delivered at time of application or enrollment. If the outline of coverage is delivered to the applicant or enrollee at the time of application or enrollment, the insurer must collect an acknowledgment of receipt or certificate of delivery of the outline of coverage and the insurer must maintain evidence of the delivery.

6. Coverage issued on basis other than as applied for. If coverage is issued on a basis other than as applied for, an outline of coverage properly describing the coverage or contract actually issued must be delivered with the policy or certificate to the applicant or enrollee.

7. Outline of coverage not required. An outline of coverage for group health insurance, a group dental plan or a group vision care plan is not required to be delivered to certificate holders if the certificate contains a brief description of:

A. Benefits;

B. Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits;

C. Renewability provisions; and

D. Notice requirements as provided in rules adopted pursuant to this chapter.

8. Superintendent shall prescribe format and content of outline of coverage. The superintendent shall prescribe the format and content of the outline of coverage required by subsection 1. As used in this subsection, "format" means style, arrangement and overall appearance, including items such as the size, color and prominence of type and the arrangement of text and captions. The rules may exempt certain group policies from the requirement to deliver an outline of coverage to an applicant or enrollee. The outline of coverage must include:

A. A statement identifying the applicable category or categories of coverage as prescribed in section 2694;

B. A description of the principal benefits and coverage provided;

C. A statement of exceptions, reductions and limitations;

D. A statement of renewal provisions, including any reservation by the insurer of a right to change premiums; and

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

9. Notice must be delivered to all applicants eligible for Medicare. An insurer shall deliver the notice required under rules applicable to Medicare supplement insurance to all applicants eligible for Medicare.

§2696. Preexisting conditions

1. Exclusion based on preexisting condition limited after 12 months. Notwithstanding the provisions of section 2706, subsection 2, division (b), if an insurer elects to use a simplified application or enrollment form, with or without a question as to the prospective insured's health at the time of application or enrollment but without any questions concerning the prospective insured's health history or medical treatment history, the policy must cover any loss occurring after the policy has been in force for 12 months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except for such specific exclusions, the policy or certificate may not include wording that would permit a defense based upon preexisting conditions, other than rescission for affirmative misrepresentations, after it has been in force for 12 months.

2. Exclusion based on preexisting condition limited after 6 months. Notwithstanding the provisions of subsection 1 and section 2706, subsection 2, division (b), an insurer that issues a specified disease policy or certificate, regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form may not deny a claim for any covered loss that begins after the policy or certificate has been in force for at least 6 months, unless that loss results from a preexisting condition that was diagnosed by a physician before the date of application for coverage or that first manifested itself within the 6 months immediately preceding the application date. Except for rescission for misrepresentation, defenses based upon preexisting conditions are not permitted.

§2697. 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.

See title page for effective date.

CHAPTER 411

H.P. 594 - L.D. 749

An Act to Prohibit Cyberstalking

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

Sec. 1. 17-A MRSA §210-A, sub-§2, ¶A, as enacted by PL 1995, c. 668, §3, is amended to read:

A. "Course of conduct" means repeatedly maintaining a visual or physical proximity to a person or repeatedly conveying oral or written threats, threats implied by conduct or a combination of threats and conduct directed at or toward a person. For purposes of this section, "conveying oral or written threats" includes, but is not limited to, communicating or causing a communication to be initiated by mail or by mechanical or electronic means. For purposes of this section, "course of conduct" also includes, but is not limited to, gaining unauthorized access to personal, medical, financial or other identifying information, including access by computer network, mail, telephone or written communication. "Course of conduct" does not include activity protected by the Constitution of Maine, the United States Constitution or by state or federal statute.

See title page for effective date.

CHAPTER 412

H.P. 121 - L.D. 125

An Act to Specify That Possession of Sexually Explicit Materials by Way of the Internet is Criminal

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

Sec. 1. 17 MRSA §2923, sub-§2, as amended by PL 1999, c. 444, §4, is further amended to read:

2. Presumption. For the purposes of this section, possession of 10 or more copies of the same book, magazine, newspaper, print, negative, slide, motion picture, computer data file, videotape or other mechanically, electronically or chemically reproduced visual image or material gives rise to a presumption that the person possesses those items with intent to disseminate.

Sec. 2. 17 MRSA §2924, sub-§2, as corrected by RR 1993, c. 2, §8, is amended to read:

2. Offense. A person is guilty of possession of sexually explicit material if that person intentionally or knowingly transports, exhibits, purchases or possesses any book, magazine, print, negative, slide, motion picture, computer data file, videotape or other mechanically, electronically or chemically reproduced visual image or material that the person knows or should know depicts another person engaging in sexually explicit conduct, and:

A. The other person has not in fact attained the age of 14 years; or

B. The person knows or has reason to know that the other person has not attained the age of 14 years.

See title page for effective date.

CHAPTER 413

H.P. 867 - L.D. 1147

An Act Creating the New Crime of Aggravated Attempted Murder

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

Sec. 1. 17-A MRSA §152, sub-§4, as amended by PL 1995, c. 422, §1, is repealed and the following enacted in its place:

4. Criminal attempt is an offense classified as one grade less serious than the classification of the offense attempted, except that an attempt to commit a Class E crime is a Class E crime and an attempt to commit murder is a Class A crime.

Sec. 2. 17-A MRSA §152-A is enacted to read:

§152-A. Aggravated attempted murder

1. A person is guilty of aggravated attempted murder if that person commits attempted murder and, at the time of that person's actions, one or more of the following aggravating circumstances is in fact present:

A. The person's intent to kill was accompanied by premeditation-in-fact;