LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTY-SECOND LEGISLATURE

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December 1, 2004 to March 30, 2005

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

Penmor Lithographers
Lewiston, Maine
2005

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

(1) "Knowingly" means having actual knowledge of or acting with deliberate ignorance or reckless disregard for the prohibition involved.

(2) "Person" has the meaning given that term by Section 7701(a)(1) of the Internal Revenue Code of 1986.

(3) "Trade or business" includes the employer's workforce.

(4) "Violates or attempts to violate" includes, but is not limited to, intent to evade, misrepresentation or willful nondisclosure.

E. The commissioner shall adopt rules to identify the transfer or acquisition of a business for purposes of this subsection. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

F. This subsection must be interpreted and applied in such a manner as to meet the minimum requirements contained in any guidance or regulations issued by the United States Department of Labor.

See title page for effective date.

CHAPTER 121

S.P. 517 - L.D. 1499

An Act To Amend the Laws Related to Health Insurance and Confidentiality of Property and Casualty Filings

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

PART A

Sec. A-1. 24-A MRSA §6603, sub-§1, ¶F-1 is enacted to read:

F-1. Must comply with the requirements of section 2809-A, subsection 11, concerning continued coverage in the event of an employee's being temporarily laid off or losing employment because of an injury or disease that the employee claims to be compensable under workers' compensation;

PART B

Sec. B-1. 24-A MRSA §2701, sub-§2, ¶C, as amended by PL 2001, c. 258, Pt. E, §1, is further amended to read:

C. Sections 2736, 2736-A, 2736-B and 2736-C apply to:

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

(1-A) Credit union groups as defined by section 2807-A; and

(2) Other groups as defined by section 2808, except employee leasing companies registered pursuant to Title 32, chapter 125.

PART C

Sec. C-1. 24-A MRSA §2304-A, sub-§7, as repealed and replaced by PL 1991, c. 377, §10, is amended to read:

7. Except as provided in section 2304-C, a rate filing and its supporting data are confidential until the filing ~~becomes effective~~ is approved.

Sec. C-2. 24-A MRSA §2412, sub-§8, as enacted by PL 1997, c. 126, §4, is amended to read:

8. Confidentiality of form filings. Forms filed as required by this section and any supporting information are confidential until the filing ~~becomes effective. If an insurer does not provide an effective date for the filings, the forms and supporting information become public on the date the filing~~ is approved.

PART D

Sec. D-1. 24 MRSA §2332-A, sub-§3 is enacted to read:

3. Credit toward deductible. When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

Sec. D-2. 24-A MRSA §2723-A, sub-§3 is enacted to read:

3. Credit toward deductible. When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan,

payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

Sec. D-3. 24-A MRSA §2844, sub-§3 is enacted to read:

3. Credit toward deductible. When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

Sec. D-4. 24-A MRSA §4222-B, sub-§21 is enacted to read:

21. Section 2723-A, subsection 3 and section 2844, subsection 3 apply to health maintenance organizations.

PART E

Sec. E-1. 24-A MRSA §2808-B, sub-§2-C, ¶A, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

A. A block of small group health plans is considered credible if the anticipated average number of ~~member months~~ members during the period for which the rates will be in effect is at least 1,000 or if it meets credibility standards adopted by the superintendent by rule. The rate filing must state the anticipated average number of ~~member months~~ members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of ~~member months~~ members is likely to be less than 1,000 and the block does not satisfy any alternative credibility standards adopted by rule, the filing is subject to subsection 2-B, except as provided in paragraph A-1.

Sec. E-2. 24-A MRSA §2808-B, sub-§2-C, ¶A-1 is enacted to read:

A-1. A carrier that elected to file rates in accordance with this subsection prior to September 1, 2004 may continue to file rates in accordance with this subsection as long as the anticipated number of member months for a 12-month period is at least 1,000.

PART F

Sec. F-1. 24-A MRSA §2839-A, as enacted by PL 2001, c. 432, §7, is amended to read:

§2839-A. Notice of rate increase

1. Notice of rate increase on existing policies. An insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, must provide written notice by first class mail of a rate increase to all affected policyholders or others who are directly billed for group coverage at least 60 days before the effective date of any increase in premium rates. An increase in premium rates may not be implemented until 60 days after the notice is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

2. Notice of rate increase on new business. When an insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, quotes a rate for new business, it must disclose any rate increase that the insurer anticipates implementing within the following 90 days. If the quote is in writing, the disclosure must also be in writing. If such disclosure is not provided, an increase may not be implemented until at least 90 days after the date the quote is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

PART G

Sec. G-1. 24-A MRSA §2850-B, sub-§5 is enacted to read:

5. Association plans. The requirements of this subsection apply to group contracts that are subject to this section and that are issued to association groups pursuant to section 2805-A. Carriers shall renew coverage for association members if coverage through an association is terminated because the association ceases to exist, changes its membership eligibility criteria, fails to pay premiums, commits fraud or misrepresentation or voluntarily terminates the group policy.

A. If coverage to an employer through an association is terminated, the carrier shall renew the

coverage with the employer becoming the policyholder.

B. If coverage to an individual member of an association is terminated, the carrier shall renew the coverage with the individual becoming the policyholder. A carrier that has been granted an exemption pursuant to section 2736-C, subsection 9 does not lose that exemption simply by virtue of renewing coverage to individuals under this paragraph.

The requirements of this subsection do not apply if the employer or individual fails to pay premiums, commits fraud or misrepresentation, voluntarily terminates membership in the association or ceases to qualify for membership for reasons other than a change in the association's membership eligibility criteria.

PART H

Sec. H-1. 24-A MRSA §2848, sub-§1-B, as amended by PL 2001, c. 258, Pt. E, §5, is further amended to read:

1-B. Federally creditable coverage. "Federally creditable coverage" is defined as follows.

A. "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. "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. "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. "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. "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~~, but is not counted as a period of actual coverage unless the individual has other federally creditable coverage during this period. For purposes of this subsection and subsection 1-C, "group health plan" has the same meaning as specified in the federal Public Health Service Act, Title XXVII, Section 2791(a).

PART I

Sec. I-1. 24-A MRSA §2744, sub-§§1 and 2, as amended by PL 2003, c. 65, §1 and affected by §5, are further amended to read:

1. Notwithstanding any provision of a health insurance policy subject to this chapter, whenever the policy provides for payment or reimbursement for services that are within the lawful scope of practice of a ~~psychologist licensed to practice in this State; a certified social worker licensed for the independent practice of social work in this State who has at least a masters degree in social work from an accredited educational institution, has been employed in social work for at least 2 years, and who, after January 1, 1985, must be licensed as a clinical social worker in this State; a licensed clinical professional counselor licensed for the independent practice of counseling who has at least a masters degree in counseling from an accredited educational institution, has been employed in counseling for at least 2 years and, after January 1, 2002, must be licensed as a clinical professional counselor in this State, or a licensed nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing~~ professional listed in subsection 2-A, any person covered by the policy is entitled to reimbursement for these services if the services are performed by a physician~~; a psychologist licensed to practice in this State; a certified social worker licensed for the independent practice of social work who has at least a masters degree in social work from an accredited educational institution, who has been employed in social work for at least 2 years, and who, after January 1, 1985, must be licensed as a clinical social worker in this State; a licensed clinical professional counselor licensed for the independent practice of counseling who has at least a masters degree in counseling from an accredited educational institution, has been employed in counseling for at least 2 years and, after January 1, 2002, must be licensed as a clinical professional counselor in this State; or a licensed nurse certified by the American Nurses' Association as a clinical specialist in adult or child and adolescent psychiatric and mental health nursing~~ or a professional listed in subsection 2-A. Payment or reimbursement for services rendered by ~~clinical social workers licensed in this State, licensed clinical professional counselors licensed in this State or licensed nurses certified by the American Nurses' Association as clinical specialists in adult or child and adolescent~~

~~psychiatric and mental health nursing~~ a professional listed in subsection 2-A, paragraph B, C or D may not be conditioned upon prior diagnosis or referral by a physician or other health care professional, except in cases where diagnosis of the condition for which the services are rendered is beyond the scope of their licensure.

2. Nothing in subsection 1 may be construed to require a health insurance policy subject to this chapter to provide for reimbursement of services that are within the lawful scope of practice of a ~~psychologist licensed to practice in this State, a clinical social worker licensed in this State, a clinical professional counselor licensed to practice in this State, a certified social worker licensed to practice in this State, or a certified nurse licensed to practice in this State~~ professional listed in subsection 2-A.

Sec. I-2. 24-A MRSA §2744, sub-§2-A is enacted to read:

2-A. Subsections 1 and 2 apply with respect to the following types of professionals:

A. A psychologist licensed to practice in this State;

B. A certified social worker licensed for the independent practice of social work in this State who has at least a master's degree in social work from an accredited educational institution, who has been employed in social work for at least 2 years and who, after January 1, 1985, is licensed as a clinical social worker in this State;

C. A licensed clinical professional counselor licensed for the independent practice of counseling who has at least a master's degree in counseling from an accredited educational institution, who has been employed in counseling for at least 2 years and who, after January 1, 2002, is licensed as a clinical professional counselor in this State; and

D. A licensed nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing.

Sec. I-3. 24-A MRSA §2835, sub-§1, as amended by PL 2003, c. 517, Pt. B, §13, is further amended to read:

1. Notwithstanding any provision of a health insurance policy or certificate issued under a group policy subject to this chapter, whenever the policy provides for payment or reimbursement for services that are within the lawful scope of practice of a ~~psychologist licensed to practice in this State; a certified social worker licensed for the independent practice of social work in this State who has at least a masters degree in social work from an accredited educational institution, has been employed in social work for at least 2 years, and who, after January 1, 1985, must be licensed as a clinical social worker in this State; a licensed clinical professional counselor licensed for the independent practice of counseling who has at least a masters degree in counseling from an accredited educational institution, has been employed in counseling for at least 2 years and, after January 1, 2002, must be licensed as a clinical professional counselor in this State; or a licensed nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing~~ professional listed in subsection 2-A, any person covered by the policy is entitled to reimbursement for these services if the services are performed by a physician~~; a psychologist licensed to practice in this State; a certified social worker licensed for independent practice in this State who has at least a masters degree in social work from an accredited educational institution, who has been employed in social work for at least 2 years, and who, after January 1, 1985, must be licensed as a clinical social worker in this State; a licensed clinical professional counselor licensed for the independent practice of counseling who has at least a masters degree in counseling from an accredited educational institution, has been employed in counseling for at least 2 years and, after January 1, 2002, must be licensed as a clinical professional counselor in this State; or a licensed nurse certified by the American Nurses' Association as a clinical specialist in adult or child and adolescent psychiatric and mental health nursing~~ or a professional listed in subsection 2-A. Payment or reimbursement for services rendered by ~~clinical social workers licensed in this State, licensed clinical professional counselors licensed in this State or licensed nurses certified by the American Nurses' Association as clinical specialists in adult or child and adolescent psychiatric and mental health nursing~~ a professional listed in subsection 2-A, paragraph B, C or D may not be conditioned upon prior diagnosis or referral by a physician or other health care professional, except in cases where diagnosis of the condition for which the services are rendered is beyond the scope of their licensure.

Sec. I-4. 24-A MRSA §2835, sub-§2, as amended by PL 2003, c. 65, §2 and affected by §5, is further amended to read:

2. Nothing in subsection 1 may be construed to require a health insurance policy subject to this chapter to provide for reimbursement of services that are within the lawful scope of practice of a ~~psychologist licensed to practice in this State, a clinical social worker licensed in this State, a clinical professional~~

~~counselor licensed in this State, a certified social worker licensed to practice in this State, or a nurse certified and licensed to practice in this State~~ professional listed in subsection 2-A.

Sec. I-5. 24-A MRSA §2835, sub-§2-A is enacted to read:

2-A. Subsections 1 and 2 apply with respect to the following types of professionals:

A. A psychologist licensed to practice in this State;

B. A certified social worker licensed for the independent practice of social work in this State who has at least a master's degree in social work from an accredited educational institution, who has been employed in social work for at least 2 years and who, after January 1, 1985, is licensed as a clinical social worker in this State;

C. A licensed clinical professional counselor licensed for the independent practice of counseling who has at least a master's degree in counseling from an accredited educational institution, who has been employed in counseling for at least 2 years and who, after January 1, 2002, is licensed as a clinical professional counselor in this State; and

D. A licensed nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing.

See title page for effective date.

CHAPTER 122

H.P. 1035 - L.D. 1472

An Act To Amend the Laws Governing the Rural Medical Access Program

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

Sec. 1. 24-A MRSA §6303, sub-§3, as enacted by PL 1989, c. 931, §5, is amended to read:

3. Self-insured. "Self-insured" means any physician, hospital or physician's employer insured against the physician's professional negligence or the hospital's professional liability through any entity other than an insurer as defined in subsection 1. For purposes of this chapter, a physician, hospital or physician's employer that does not purchase insurance is considered self-insured.

Sec. 2. 24-A MRSA §6304, first ¶, as enacted by PL 1989, c. 931, §5, is amended to read:

To provide funds for the Rural Medical Access Program, insurers may collect pursuant to this chapter assessments from physicians~~,~~ licensed and practicing medicine in this State and hospitals and physician's employers located in the State.

Sec. 3. 24-A MRSA §6304, sub-§4, as amended by PL 1993, c. 600, Pt. B, §§21 and 22 and PL 2003, c. 689, Pt. B, §6, is further amended to read:

4. Determination of assessments paid. After review of the records provided by the Board of Licensure in Medicine, the Board of Osteopathic Licensure and the Department of Health and Human Services, Division of Licensure and Certification, and the assessment receipts of the malpractice insurers, the superintendent shall ~~certify~~ determine those physicians, hospitals and ~~physicians'~~ physician's employers that have paid the required assessments.

Sec. 4. 24-A MRSA §6305, sub-§1, ¶C, as enacted by PL 1989, c. 931, §5, is amended to read:

C. The amount of the assessment for policy years beginning on or after July 1, 1991~~,~~ is 50% of the amount of the savings determined under paragraph A, but not exceeding $500,000. This paragraph is repealed June 30, 2006.

Sec. 5. 24-A MRSA §6305, sub-§1, ¶D, as enacted by PL 1989, c. 931, §5, is repealed.

Sec. 6. 24-A MRSA §6305, sub-§2, as amended by PL 1999, c. 668, §113, is repealed.

Sec. 7. 24-A MRSA §6305, sub-§3 is enacted to read:

3. Assessment rates; program fund balance. For assessment years prior to July 1, 2006, the assessment is 1.25% of premium. For assessment years commencing July 1, 2006 and after, the assessment is .75% of premium unless adjusted pursuant to this subsection. The assessment rate is intended to result in collections no greater than $500,000 per assessment year. When the program fund balance is $50,000 or less, the assessment rate must increase to 1% of premium. When the program fund balance is more than $50,000, the assessment rate must decrease to .75% of premium. The superintendent shall notify affected parties of any assessment rate adjustment and the effective date of that adjustment.