MAINE STATE LEGISLATURE

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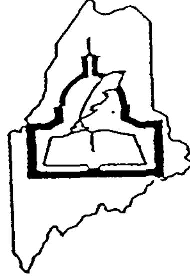
STATE OF MAINE
114TH LEGISLATURE
FIRST REGULAR SESSION



BILL SUMMARY
JOINT STANDING COMMITTEE
ON
BANKING AND INSURANCE

JULY 1989

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ONE HUNDRED AND FOURTEENTH LEGISLATURE
FIRST REGULAR SESSION

JOINT STANDING COMMITTEE
BILL SUMMARIES
AUGUST 1989

This document is a compilation of the bill summaries prepared by this office for the Joint Standing Committees and Joint Select Committees of the Maine Legislature. The summaries are arranged by LD number for each committee.

All Adopted Amendments are listed, by paper number (e.g., H-584 or S-222), together with the sponsor for floor amendments. Final action is listed to the right of the title. If final House and Senate action differ, both are listed. Committee Reports and Floor Action are abbreviated as follows:

OTP	Ought to Pass
OTP-ND	Ought to Pass in New Draft
OTP-ND-NT	Ought to Pass in New Draft, New Title
OTP-A	Ought to Pass as Amended
ONTP	Ought Not to Pass
LVWD	Leave to Withdraw
INDEF PP	Indefinitely Postponed

Each individual summary was prepared by the analyst assigned, as noted for each committee. But, this document was produced by the efforts of all the office staff, including Research Assistant Barbara McGinn, and secretaries: Charlene Brann, and Valarie Parlin, and especially Laurette Knox who coordinated preparation of the overall document.

Please give us your suggestions and comments on these summaries and tell us of any inaccuracies.

LD 982 **An Act to Amend the Provisions for Exclusion from Motor Vehicle Insurance** **LV/WD**

SPONSOR(S)	COMMITTEE REPORT	AMENDMENTS ADOPTED
WHITMORE	LV/WD	
COLLINS		
THERIAULT		

SUMMARY
24-A MRSA §2914 specifies the reasons for which an automobile insurance policy may be cancelled, 24-A MRSA §2916-A specifies the allowable reasons for nonrenewal, and 24-A MRSA §2916-B allows the exclusion of operators for any of those reasons. The bill reiterates that operators may not be excluded for other causes. It also prohibits a surcharge on a family insurance policy for a youthful operator who is the named insured on another policy. A civil penalty up to $2,500 is included.

LD 984 **An Act Related to Improving Access to Long-term Health Care Insurance** **LV/WD**

SPONSOR(S)	COMMITTEE REPORT	AMENDMENTS ADOPTED
PRAY	LV/WD	
CLARK N		
MARTIN J		
GWADOSKY		

SUMMARY
The bill establishes specific criteria for long-term care insurance, which is insurance to provide for long-term care in a setting other than an acute care unit of a hospital. The criteria are based on those set forth in administrative rules of the Bureau of Insurance. The bill includes group long-term care insurance in the requirements of statute, and enacts tax incentives for certified long-term care insurance. If the superintendent of insurance determines that the insurance policy meets the statutory and administrative standards, any person purchasing the insurance, employers who pay for the insurance for their employees and insurance companies that issue the policies would receive tax benefits. The bill also requires the Superintendent of Insurance to establish a consumer education program concerning long-term care insurance and requires the Department of Administration to conduct a cost-benefit study of providing long-term health care insurance to state employees.

The contents of LD 984, as amended by the committee, are included in LD 758. The amendment includes criteria for long-term health care insurance; subjects group policies to regulation beginning October 1, 1990; and includes life insurance policy riders in the category of policies which may qualify as long-term care policies.

LD 998 **An Act to Register 3rd-party Medical Reimbursement Review Entities** **LV/WD**

SPONSOR(S)	COMMITTEE REPORT	AMENDMENTS ADOPTED
MATTHEWS	LV/WD	
BURKE		
PINES		
RANDALL		

SUMMARY
The bill requires companies performing medical utilization review services to register with the Bureau

of Insurance and to report annually to the Bureau of Insurance the types of utilization review services they are providing. The bill would require the Bureau of Insurance to adopt criteria for registration and would require the entity to pay an annual $100 registration fee.

A utilization review entity is a person, partnership or corporation that, on behalf of an insurer, nonprofit services organization or self-insuring employer, reviews the utilization, appropriateness or quality of medical services provided to a person whose expenses are paid by the insurer, nonprofit services organization or employer. The bill also clarifies the utilization review data requirements applicable to group health insurance.

Provisions requiring licensure of utilization review entities are included in LD 758. LD 758 requires all entities which review medical utilization to be licensed by the Bureau of Insurance. The amendment also provides specific standards which these review entities would be required to meet, including requirements that an adverse decision by the reviewer must be provided to the insured within a time period to be specified by the superintendent; that licensees must have a procedure for insureds to seek reconsideration of determinations; that representatives of the licensee must be accessible to insured; that the review entities meet the requirement for state and federal laws relating to confidentiality of medical records.

The superintendent would be authorized to conduct periodic reviews of entities to assure that they continue to comply with rules adopted under the law and the superintendent is authorized to impose penalties for noncompliance, including imposition of civil penalties and revocation of licenses.

LD 1040 An Act to Simplify Reporting Requirements for Workers' Compensation Insurers and Self-insurers **PUBLIC 434**

SPONSOR(S)	COMMITTEE REPORT	AMENDMENTS ADOPTED
BRANNIGAN	OTP-AM	S-298

SUMMARY

This bill allows data on each claim to be provided to the Superintendent of Insurance by workers' compensation insurers and by the statistical advisory organization for self-insurers as aggregate payments within 3 categories: physicians, hospitals and all other, not detailed for each payment, as at present. It allows outstanding liability to be reported in 3 broad areas: medical care, indemnity and vocational rehabilitation, and eliminates more detailed reporting requirements. It authorizes the Superintendent of Insurance to prescribe the schedule for the reports filed by the statistical advisory organization.

CA (S-298) This amendment replaces the bill with elements from LD 1040, LD 726, and LD 188.

Sec 1 deletes a requirement for the Bureau of Insurance to collect data on any offer made by an employer or insurer and on the expectations of an employee in Workers Compensation proceedings.

Sec 2 replaces the requirement for reporting information on each payment by a requirement for the aggregate payments to each provider for a given claim. The superintendent could still require individual payment data on a specific case. Also, estimates of outstanding liability on open claims could be presented in broader categories; and claims below a threshold value (now $250) are exempt.

Sec 3 and 9 delete reporting requirements from Title 39 that are duplicated in 24-A and vice versa.

Secs 4, 5, 6, 7, and 8 modify other reporting requirements. Authority is granted to the superintendent to issue special data calls. The superintendent is authorized to set the schedule for reports from members to a statistical advisory organization and for reports from such organizations to the Bureau of