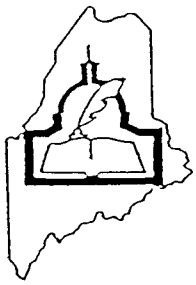
STATE OF MAINE
114TH LEGISLATURE
SECOND REGULAR SESSION



BILL SUMMARIES
JOINT STANDING COMMITTEE
ON
BANKING AND INSURANCE

JUNE 1990

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One Hundred and Fourteenth Legislature
Second Regular Session

Joint Standing Committee
Bill Summaries

June 1990

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. 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 or analysts assigned to the committee. But, this document was produced by the efforts of all the office staff, including secretaries: Charlene Raymond, 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 2269 **An Act to Prohibit the Imposition of Percentage Fees and Application Fees on Residential Mortgages** **LV/WD**

SPONSOR(S)	COMMITTEE REPORT	AMENDMENTS ADOPTED
DIPIETRO	LV/WD	
PLOURDE		

SUMMARY

The bill would amend the Consumer Credit Code to prohibit "financial institutions" from charging nonrefundable percentage fees or application fees for residential mortgages.

The committee voted LWD but will request the Bureau of Banking and Consumer Credit, the bankers associations and the real estate associations to review the issue.

LD 2274 **An Act to Ensure Continuity of Health Insurance Coverage** **PUBLIC 867**

SPONSOR(S)	COMMITTEE REPORT	AMENDMENTS ADOPTED
RYDELL	OTP-AM	H-1090
THERIAULT		S-675 THERIAULT
BUSTIN		
MANNING		

SUMMARY

The bill would have prohibited health insurance plans from imposing pre-existing condition screening, exclusions or waiting periods when an individual or group switches from one plan to another. The prohibitions would apply to persons switching to coverage by commercial insurers, nonprofit service organizations, health maintenance organizations, or preferred provider arrangements, and to persons or groups switching from any of those types of carriers or from self-insured plans. The bill would also prohibit insurers from providing excess insurance to any self-insured plan that contains provisions inconsistent with the bill. Finally, the bill would have limited pre-existing condition exclusions for any individual to 3 months, and would have prohibited the application of an exclusion for conditions other than those diagnosed or treated within 3 months before the person enrolls or is eligible to enroll in the plan.

The committee amendment (H-1090) replaces the bill with language combining concepts of all three of the committee's health insurance continuity bills: LDs 1979, 2250 and 2274. It provides continuity of health insurance benefits for people when their coverage changes because their group plan changes carriers, or because they as individuals move from group to group, or from individual coverage to group coverage. When a group plan changes carriers, the new carrier may not impose pre-existing condition screening, a pre-existing condition exclusion, or a waiting period on any person who was covered under the prior plan at any time during the 90 days before the prior plan was discontinued. The plan may, however, impose a short exclusion period for any person covered for fewer than 90 days under the prior plan. The bill also requires all group contracts to provide a reasonable extension of benefits for persons who are totally disabled on the date the group plan is discontinued. As a result of Senate Amendment "B" (S-675) to the Committee Amendment, these provisions apply to all policies or contracts continued, issued or renewed by commercial insurers, health maintenance organizations or nonprofit service organizations on or after October 1, 1990.

When an individual moves from group to group or from individual coverage to group coverage, the new group plan must waive medical underwriting or pre-existing condition exclusions to the extent the person would have had coverage for that condition under their prior plan. This applies only if the gap between the person's loss of coverage under the prior plan and the date of eligibility under the new plan is not more than 3 months. Also, the person is not protected if they fail to enroll in the plan during the initial enrollment period, unless their failure to do so is a result of specified reasons set forth in the bill. The bill prohibits insurers from increasing premiums to smaller employers by more than 10% as a result of

a claim for a pre-existing condition by a person protected under this provision. These provisions apply to contracts and policies issued or renewed by commercial insurers, health maintenance organizations, or nonprofit service organizations on or after April 1, 1991 and to policies and contracts in force on that date. It also requires policies and contracts in force on that date to cover, from that date forward, all persons who were previously denied coverage, but who would have been covered if the law had been in effect on the date the person became eligible to enroll in the plan. This application rule was added by Senate Amendment "B" (S-675) to the Committee Amendment.

The bill limits pre-existing condition exclusions in most individual health care contracts to 6 months, except that a pre-existing condition that requires ongoing medical observation or treatment may be excluded for up to 24 months. As a result of Senate Amendment "B" (S-675), this limit is applicable to individual policies and contracts issued or renewed by commercial insurers, nonprofit service organizations or health maintenance organizations on or after December 1, 1990.

Finally, the bill creates the Task Force on Health Insurance Continuity, to study all reasonable proposals to ensure continuous health insurance coverage for as many Maine citizens as possible.

LD 2274 was one of three bills relating to continuity of health insurance coverage. See LD 1979 (LV/WD) and LD 2250 (LV/WD).

LD 2291 **An Act to Protect Health Insurance Coverage for Citizens on Jury Duty** **PUBLIC 801**

SPONSOR(S)	COMMITTEE REPORT	AMENDMENTS ADOPTED
RYDELL	OTP-AM	H-920
THERIAULT		
HOBBINS		
PARADIS P		

SUMMARY

LD 2291 prevents an employee from losing health insurance coverage as a result of absence from work to perform jury service, makes termination of coverage as a result of jury service a crime and permits the employee to sue for lost health insurance benefits. The bill also provides that an insurer may not issue a group or blanket health care contract of any kind for residents of this state that contains any provision permitting the termination of coverage if a person covered is called to serve on a jury. The prohibitions on termination of employee health insurance coverage due to jury service take effect on and apply to contracts issued, executed or renewed after January 1, 1991.

The Committee Amendment (H-920) clarifies that employees are protected when they receive or respond to a summons for jury duty only, not for other types of summonses, clarifies terminology, and adds a fiscal note.

LD 2297 **An Act to Help Reduce the Incidence of Breast Cancer Mortality in the State and to Revise the Laws Relating to the Mandated Benefits Advisory Commission** **INDEF PP**

SPONSOR(S)	COMMITTEE REPORT	AMENDMENTS ADOPTED
ANDREWS	OTP-AM	S-645
RYDELL		
CLARK N		
CAHILL P		

SUMMARY

LD 2297 requires all health insurance contracts and policies to include coverage for screening mammograms