An Act To Clarify and Update the Laws Related to 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 §5002-B, sub-§1, ¶A, as amended by PL 2003, c. 157, §1, is further amended to read:

A. That person, including a person entitled to Medicare benefits due to disability, has been covered under a policy that supplemented benefits under Medicare or has been covered under a Medicare Advantage plan with no gap in coverage greater than 90 days beginning with the person's open enrollment period. A policy supplementing benefits payable under Medicare may include an individual health policy, a group health plan, a Medicare supplement policy or other coverage issued by the same or a different carrier.

PART B

Sec. B-1. 24-A MRSA §2713-A, as enacted by PL 1989, c. 556, Pt. D, §2, is amended to read:

§ 2713-A.Explanation and notice to parent

If the insured is ~~a minor under 18 years of age~~covered as a dependent child, and if the insurer is so requested by a parent of the insured ~~who is not paying the premiums on the policy~~, the insurer shall provide that parent with:

1. Payment or denial of claim. An explanation of the payment or denial of any claim filed on behalf of the insured ~~minor~~, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent;

2. Change in terms and conditions. An explanation of any proposed change in the terms and conditions of the policy; or

3. Notice of lapse. Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified.

In addition, any parent who is able to provide the information necessary for the insurer to process a claim ~~shall~~must be permitted to authorize the filing of any claims under the policy.

Sec. B-2. 24-A MRSA §2823-A, as enacted by PL 1989, c. 556, Pt. D, §3, is amended to read:

§ 2823-A.Explanation and notice to parent

If the insured is ~~a minor under 18 years of age~~covered as a dependent child, and if the insurer is so requested by ~~either of the minor's parents~~a parent of the insured, the insurer shall provide that parent with:

1. Payment or denial of claim. An explanation of the payment or denial of any claim filed on behalf of the insured ~~minor~~, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent;

2. Change in terms and conditions. An explanation of any proposed change in the terms and conditions of the policy; or

3. Notice of lapse. Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified.

In addition, any parent who is able to provide the information necessary for the insurer to process a claim ~~shall~~must be permitted to authorize the filing of any claims under the policy.

Sec. B-3. 24-A MRSA §4222-B, sub-§22 is enacted to read:

22. Sections 2713-A and 2823-A, relating to explanation and notice to parents, apply to health maintenance organizations.

PART C

Sec. C-1. 24 MRSA §2321, sub-§1, as amended by PL 2003, c. 428, Pt. F, §1, is further amended to read:

1. Filing of rate information. Every nonprofit hospital and medical service organization shall file with the superintendent every rate, rating formula and every modification of any of the foregoing that it proposes to use in connection with individual health insurance contracts, group Medicare supplement contracts as defined in Title 24-A, chapter 67, group nursing home or long-term care contracts as defined in Title 24-A, chapter 68 or 68-A, and certain group contracts included within the definition of "individual health plan" in Title 24-A, section 2736-C, subsection 1, paragraph C. Every filing under this subsection must state the effective date of the filing. Every filing under this subsection must be made not less than 60 days in advance of the stated effective date unless the 60-day requirement is waived by the superintendent for a period of time not to exceed 30 days. ~~In the case of a filing that meets the criteria in subsection 4, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests.~~

Sec. C-2. 24 MRSA §2321, sub-§4, as amended by PL 2001, c. 432, §2, is repealed.

Sec. C-3. 24 MRSA §2321, sub-§5, as amended by PL 2001, c. 432, §3, is repealed.

Sec. C-4. 24-A MRSA §2735-A, sub-§1, as enacted by PL 2001, c. 432, §4, is amended to read:

1. Notice of rate filing or rate increase on existing policies. An insurer offering individual health plans as defined in section 2736-C must provide written notice by first class mail of a rate filing to all affected policyholders at least 60 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks or modification of any formula or classification of risks. The notice must also inform policyholders of their right to request a hearing pursuant to section 229 ~~or a special rate hearing pursuant to section 2736, subsection 4 or Title 24, section 2321, subsection 5~~. The notice must show the proposed rate and state that the rate is subject to regulatory approval. The superintendent may not take final action on a rate filing until 40 days after the date notice is mailed by an insurer. An increase in premium rates may not be implemented until 60 days after the notice is provided or until the effective date under section 2736, whichever is later.

Sec. C-5. 24-A MRSA §2736, sub-§1, as amended by PL 2003, c. 428, Pt. F, §2, is further amended to read:

1. Filing of rate information. Every insurer shall file with the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. Every such filing must state the effective date of the filing. Every such filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. ~~In the case of a filing that meets the criteria in subsection 3, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests.~~

Sec. C-6. 24-A MRSA §2736, sub-§3, as amended by PL 2007, c. 629, Pt. M, §1, is repealed.

Sec. C-7. 24-A MRSA §2736, sub-§4, as amended by PL 2007, c. 629, Pt. M, §2, is repealed.

Sec. C-8. 24-A MRSA §2808-B, sub-§2-A, ¶A, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

A. Every filing must state the effective date of the filing. Every filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent. The effective date may be suspended by the superintendent for a period of time not to exceed 30 days. ~~In the case of a filing that meets the criteria in subsection 2-B, paragraph E, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the carrier satisfactorily responds to any reasonable discovery requests.~~

Sec. C-9. 24-A MRSA §2808-B, sub-§2-B, ¶E, as enacted by PL 2003, c. 469, Pt. E, §16, is repealed.

Sec. C-10. 24-A MRSA §2808-B, sub-§2-B, ¶F, as amended by PL 2007, c. 629, Pt. M, §9, is repealed.

PART D

Sec. D-1. 24-A MRSA §2159-C, sub-§1, ¶D is enacted to read:

D. "Carrier" means an insurer, nonprofit hospital and medical service organization or health maintenance organization.

Sec. D-2. 24-A MRSA §2159-C, sub-§2, as enacted by PL 1997, c. 677, §2, is repealed and the following enacted in its place:

2. Discrimination in health, hospital and dental insurance. A carrier that issues individual or group hospital, health or dental insurance is subject to the requirements of this subsection. This subsection does not apply to accidental injury, specified disease, hospital indemnity, disability, long-term care and other limited benefit health insurance policies and contracts.

A. A carrier may not discriminate against an individual or eligible dependent on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual or eligible dependent received a genetic test or genetic counseling in the issuance, withholding, extension or renewal of any hospital confinement or other health insurance, as defined by the superintendent, by rule, or in the fixing of the rates, terms or conditions for insurance, or in the issuance or acceptance of any application for insurance.

B. Except as provided in this paragraph, a carrier may not request or require an individual to undergo a genetic test.

(1) Nothing in this subsection limits the authority of a health care professional who is providing health care services to an individual to request that that individual undergo a genetic test.

(2) A carrier may request, but not require, that an individual undergo a genetic test if the conditions described in this subparagraph are met:

(a) The request is made pursuant to research that complies with 45 Code of Federal Regulations, Part 46 or equivalent federal regulations and any applicable state or local laws, rules or regulations for the protection of human subjects in research;

(b) The carrier clearly indicates to the individual to whom the request is made, or in the case of a minor child to the legal guardian of the individual, that compliance with the request is voluntary and noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) Genetic information collected or acquired under this subparagraph is not used for purposes of determining eligibility for benefits, computing premium or contribution amounts, applying any preexisting condition exclusion or any other activities related to the creation, renewal or replacement of a health insurance contract; and

(d) The carrier complies with all applicable federal laws and regulations.

C. A carrier may not request, require or purchase genetic information for purposes of determining eligibility for benefits, computing premium or contribution amounts, applying any preexisting condition exclusion or any other activities related to the creation, renewal or replacement of a health insurance contract.

D. A carrier may not request, require or purchase genetic information with respect to an individual prior to the individual's enrollment under the plan or coverage in connection with the enrollment.

E. If a carrier obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning an individual, the request, requirement or purchase is not considered a violation of paragraph D if the request, requirement or purchase is not in violation of paragraph C.

F. A reference in this subsection to genetic information concerning an individual includes:

(1) With respect to an individual who is a pregnant woman, genetic information of any fetus carried by that individual; and

(2) With respect to an individual using an assisted reproductive technology, genetic information of any embryo legally held by the individual.

PART E

Sec. E-1. 24-A MRSA §2834-C is enacted to read:

§ 2834-C. Compliance with federal law

1. Application. This section applies to all group and blanket medical insurance policies issued by nonprofit hospital or medical service organizations, insurers or health maintenance organizations except hospital indemnity, specified accident, specified disease and long-term care policies.

2. Requirement. Policies subject to this section must comply with the federal Children's Health Insurance Program Reauthorization Act of 2009, Section 311 concerning special enrollment periods in case of termination of coverage under a Medicaid plan or a state child health plan or eligibility for assistance in the purchase of employment-based coverage.

Sec. E-2. 24-A MRSA §2849, sub-§3, ¶C, as amended by PL 1997, c. 370, Pt. B, §2, is further amended to read:

C. ~~To the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect, impose~~Impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section; or

Sec. E-3. 24-A MRSA §2849, sub-§3-A is enacted to read:

3-A. Persons subject to a preexisting condition exclusion. Notwithstanding subsection 3, paragraph C, an insurer or health maintenance organization may impose a preexisting condition exclusion period on a person who was subject to a preexisting condition exclusion under the replaced contract or policy. The preexisting condition exclusion period under the replacement policy or contract must end no later than the date the preexisting condition exclusion period would have ended under the replaced contract or policy.

Sec. E-4. 24-A MRSA §2849-B, sub-§3-A is enacted to read:

3-A. Prohibition against discontinuity in group policies. Except as provided in this section, in a group policy subject to this section, the insurer or health maintenance organization shall, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

Sec. E-5. 24-A MRSA §2849-B, sub-§3-B is enacted to read:

3-B. Persons subject to a preexisting condition exclusion. Notwithstanding subsection 3-A, an insurer or health maintenance organization may impose a preexisting condition exclusion period on a person who was subject to a preexisting condition exclusion under the prior contract or policy. The preexisting condition exclusion period under the succeeding policy or contract must end no later than the date the preexisting condition exclusion period would have ended under the prior contract or policy.

Sec. E-6. 24-A MRSA §2849-B, sub-§4, as amended by PL 2007, c. 199, Pt. A, §5, is further amended to read:

4. Prohibition against discontinuity in individual and blanket policies. Except as provided in this section, in an individual~~, group~~ or blanket policy subject to this section, the insurer or health maintenance organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect or to the extent that benefits would have been payable under the prior contract or policy if not for the operation of a lifetime limit on all benefits. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

Sec. E-7. 24-A MRSA §2850, sub-§2, ¶A, as amended by PL 1999, c. 256, Pt. L, §9, is further amended to read:

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~~6-month period ending on the earlier of the date of enrollment in the contract and the date of enrollment in a prior contract covering the same group if there has not been a gap in coverage of greater than 90 days between contracts. An exclusion may not be imposed relating to pregnancy as a preexisting condition.

PART F

Sec. F-1. 24-A MRSA §2701, sub-§2, ¶C, as amended by PL 2005, c. 121, Pt. B, §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~~ as to any employer subgroups of the association group when the employer is a member of the group and provides coverage through the group as a bona fide employee benefit;

(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.~~:

(a) Employee leasing companies registered pursuant to Title 32, chapter 125; and

(b) As to any employer subgroups of the other group when the employer provides coverage to its employees through the group as a bona fide employee benefit.

Sec. F-2. 24-A MRSA §2808-B, sub-§1, ¶H, as amended by PL 1997, c. 445, §13 and affected by §32, is further amended to read:

H. "Subgroup" means an employer with 50 or fewer employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract. For group policies issued to an employee leasing company as defined in Title 32, chapter 125, each client having 50 or fewer employees is considered a separate subgroup.

PART G

Sec. G-1. 24-A MRSA §2736, sub-§1, as amended by PL 2003, c. 428, Pt. F, §2, is further amended to read:

1. Filing of rate information. Every insurer shall file ~~with~~for approval by the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. Every such filing must state the effective date of the filing. Every such filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection 3, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests.

Sec. G-2. 24-A MRSA §2808-B, sub-§2-B, ¶A, as amended by PL 2007, c. 629, Pt. M, §7, is further amended to read:

A. Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any payments paid pursuant to former section 6913 must be treated as incurred claims.

PART H

Sec. H-1. 24-A MRSA §2436, sub-§1, as amended by PL 1999, c. 256, Pt. I, §1, is further amended to read:

1. A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery 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. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue. If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim is not 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 must be 60 days, as provided in section 3002.~~:

A. 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 must be 60 days, as provided in section 3002; and

B. The time period applicable to individual life insurance must be 2 months as provided in section 2513.

PART I

Sec. I-1. 24-A MRSA §2501, as amended by PL 1995, c. 375, Pt. C, §5, is further amended to read:

§ 2501.Scope of chapter

This chapter applies only to contracts of life insurance and annuities, other than reinsurance, group life insurance and group annuities, except that ~~section 2537 (separate accounts) also applies as to group life insurance and group annuity contracts.~~:

1. Section 2537 also applies as to group life insurance and group annuity contracts; and

2. Sections 2541 to 2551 apply to group annuities other than those exempted by section 2542.

SUMMARY

This bill protects those who switch from one Medicare supplement plan to another from losing protection against medical underwriting or preexisting condition exclusions if during a past period they were covered under a Medicare Advantage plan rather than traditional Medicare with a Medicare supplement plan.

This bill expands the current law regarding notice to parents regarding coverage of dependent children to apply to adult children as well as minors, as long as the adult child consents. It also makes the requirement applicable to health maintenance organizations.

This bill repeals the provisions for special rate hearings on individual, small group, and Medicare supplement insurance. These provisions provide for shifting the burden of proof as to whether rates are excessive from the insurer to the Department of Professional and Financial Regulation, Bureau of Insurance or other party asserting they are excessive if certain conditions are met. Under the bill, the burden of proof remains with the insurer.

This bill amends and strengthens the law prohibiting discrimination in insurance based on genetic information. The amendments conform state law to the federal Genetic Information Nondiscrimination Act of 2008.

This bill amends the State's continuity of coverage law with respect to group health insurance to conform to the federal Health Insurance Portability and Accountability Act of 1996. The current law waives medical underwriting and preexisting condition exclusions only to the extent that benefits would have been payable under a prior contract or policy. As amended, medical underwriting and preexisting condition exclusions in group health insurance policies are waived entirely in most cases as long as there was some prior coverage. This bill also specifies, consistent with the federal Health Insurance Portability and Accountability Act of 1996, that when a group policy is replaced by another group policy, the "look-back" period for preexisting exclusions is measured from the date of enrollment in the first policy. In addition, this bill adds a provision to the Maine Insurance Code to require compliance with the federal Children's Health Insurance Program Reauthorization Act of 2009, Section 311.

This bill clarifies the applicability of individual and small group rating laws to group health insurance policies issued to associations and other groups. Coverage of employees of small employers, including those covered through employee leasing companies, is subject to small group rating laws. Coverage of individuals not covered through employment is subject to individual rating laws.

This bill clarifies that rates for individual health insurance and certain small group health insurance are subject to approval by the Superintendent of Insurance. Current law provides for disapproval of rates but does not explicitly refer to approval of rates.

This bill clarifies that the period of time after which interest is payable on an individual life insurance claim is 2 months.

This bill clarifies that the Standard Nonforfeiture Law for Individual Deferred Annuities applies to certain group annuities.