An Act To Establish a Health Care Bill of Rights

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

PART A

Sec. A-1. 24-A MRSA §2809-A, sub-§1-A, ¶B-2 is enacted to read:

B-2. All notices of cancellation sent to certificate holders pursuant to paragraph B-1 must include a toll-free telephone number that certificate holders can call to determine if the policy has been cancelled for nonpayment of premium or if the policy has been reinstated because the premium has been paid.

Sec. A-2. 24-A MRSA §4302, sub-§1, ¶A, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type; ~~and~~

(4) Health care services that are or may be provided only by referral; and

(5) Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics;

Sec. A-3. 24-A MRSA §4303, sub-§12 is enacted to read:

12. Publication of policies by carriers. A carrier must publish at least 5 individual health plans with the highest level of enrollment and at least 5 small group health plans with the highest level of enrollment on the carrier's publicly accessible website in a manner that will allow consumers to review the coverage offered under each policy. The policies posted on the website must be updated when changes are made to the policies by the carrier. The appearance of the policy on the website must duplicate the appearance of a paper copy of the policy. The bureau shall provide a link from its website to each carrier's

website. A carrier must review annually which policies to post and make any necessary changes on its website. A carrier must post the required policies on its website within 90 days after the effective date of this subsection.

Sec. A-4. 24-A MRSA §4303, sub-§13 is enacted to read:

13. Explanation of benefits. A carrier offering an individual expense-incurred health plan to residents of this State or an expense-incurred group health plan to an employer in this State shall provide individual policyholders and group certificate holders with clear written explanations of benefit documents in response to the filing of any claim providing for coverage of hospital or medical expenses. The explanation of benefits must include all of the following information:

A. The date of service;

B. The provider of the service;

C. An identification of the service for which the claim is made;

D. Any amount the insured is obligated to pay under the policy for copayment or coinsurance;

E. A telephone number and address where the insured may obtain clarification of the explanation of benefits;

F. A notice of appeal rights; and

G. A notice of the right to file a complaint with the bureau after exhausting any appeals under a carrier's internal appeals process.

The superintendent shall establish by rule the minimum information and standards for explanation of benefits forms used by carriers, taking into consideration any input from stakeholders and any national standards for explanation of benefits forms. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. This subsection applies to any explanation of benefits form issued on or after January 1, 2010.

Sec. A-5. 24-A MRSA §4303, sub-§14 is enacted to read:

14. Policy terms. The superintendent may by rule define standard policy terms that must be used in all policies issued by carriers offering health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-6. Appropriations and allocations. The following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Insurance - Bureau of 0092

Initiative: Allocates funds for the one-time costs of required rule-making proceedings.

OTHER SPECIAL REVENUE FUNDS	2009-10	2010-11
All Other	$2,100	$0
OTHER SPECIAL REVENUE FUNDS TOTAL	$2,100	$0

PART B

Sec. B-1. 24-A MRSA §4301-A, sub-§16-A is enacted to read:

16-A. Provider profiling program. "Provider profiling program" means a program that uses provider data in order to rate or rank provider quality or efficiency of care by the use of a grade, star, tier, rating or any other form of designation.

Sec. B-2. 24-A MRSA §4302, sub-§1, ¶J, as enacted by PL 1999, c. 742, §5, is amended to read:

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter; ~~and~~

Sec. B-3. 24-A MRSA §4302, sub-§1, ¶K, as enacted by PL 1999, c. 742, §5, is amended to read:

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended.~~.~~; and

Sec. B-4. 24-A MRSA §4302, sub-§1, ¶L is enacted to read:

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating.

Sec. B-5. 24-A MRSA §4303, sub-§2, ¶E is enacted to read:

E. A carrier with a provider profiling program shall:

(1) Disclose to providers the methodologies, criteria, data and analysis used to evaluate provider quality, performance and cost-efficiency ratings;

(2) Create and share with providers their provider profile at least 60 days prior to using or publicly disclosing the results of the provider profiling program;

(3) Afford providers the opportunity to correct errors, submit additional information for consideration and seek review of data and performance ratings; and

(4) Afford providers due process appeal rights to challenge the profiling determination described in this subsection and by Bureau of Insurance Rule Chapter 850, Health Plan Accountability.

If a carrier has a provider profiling program that includes out-of-network providers, a carrier must meet the requirements of this paragraph with regard to an out-of-network provider as well as for a provider in a carrier's network.

PART C

Sec. C-1. 24-A MRSA §2736, sub-§1, as amended by PL 2009, c. 14, §4 and c. 244, Pt. G, §1, is repealed and the following enacted in its place:

1. Filing of rate information. Every insurer shall file 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. If the filing applies to individual health plans as defined in section 2736-C, the insurer shall simultaneously file a copy with the Attorney General. 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. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. C-2. 24-A MRSA §2736, sub-§2, as amended by PL 1997, c. 344, §8, is further amended to read:

2. Filing; information. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records ~~within the meaning of~~notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to section 2736-A.

Sec. C-3. 24-A MRSA §2736-A, first ¶, as amended by PL 2007, c. 629, Pt. M, §3, is further amended to read:

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate, unfairly discriminatory or not in compliance with ~~former~~ section 6913 or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual health plan as defined in section 2736-C, the superintendent shall cause a hearing to be held at the request of the Attorney General. In any hearing conducted under this section, the insurer has the burden of proving rates are not excessive, inadequate or unfairly discriminatory and in compliance with section 6913.

PART D

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

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records ~~except as provided by~~notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to subsection 2-B, ~~paragraphs~~paragraph B or F.

Sec. D-2. 24-A MRSA §2808-B, sub-§6, ¶A, as amended by PL 2001, c. 410, Pt. A, §6, is further amended to read:

A. Each carrier must actively market small group health plan coverage, including any standardized plans required to be offered pursuant to subsection 8-A, to eligible groups in this State.

Sec. D-3. 24-A MRSA §2808-B, sub-§8-A is enacted to read:

8-A. Authority of the superintendent. The superintendent may by rule define one or more standardized small group health plans that must be offered by all carriers offering small group health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. D-4. Superintendent of Insurance report. The Superintendent of Insurance shall review possible ways to improve the availability and affordability of the State's individual health insurance market, including, but not limited to, increases in the minimum loss-ratio standards applicable to that market and consideration of an insurer's loss experience in all lines of insurance marketed by a carrier in this State when reviewing health insurance rate filings. The superintendent shall report the results of the review, including any recommendations for legislation, to the Joint Standing Committee on Insurance and Financial Services no later than February 1, 2010. The joint standing committee may report out a bill based on the report to the Second Regular Session of the 124th Legislature.

PART E

Sec. E-1. 24-A MRSA §221, sub-§5 is enacted to read:

5. Examination of health carriers. The superintendent shall examine the market conduct of each domestic health carrier, as defined in section 4301-A, subsection 3, and each foreign health carrier with at least 1,000 covered lives in this State, offering a health plan as defined in section 4301-A, subsection 7, no less frequently than once every 5 years. An examination under this subsection may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination. In lieu of an examination conducted by the superintendent, the superintendent may participate in a multistate examination, or, in the case of a foreign company, approve an examination by the company's domiciliary regulator upon a finding that the examination and report adequately address relevant aspects of the company's market conduct within this State.

Sec. E-2. Transition. The Superintendent of Insurance shall begin conducting the market conduct examinations required by the Maine Revised Statutes, Title 24-A, section 221, subsection 5 during calendar year 2010, and all health carriers subject to the examination requirement must be examined at least once before January 1, 2015.

PART F

Sec. F-1. 24-A MRSA §4303, sub-§7-A is enacted to read:

7-A. Continuity of prescriptions. If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee's coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee's prescribing provider. Policies must include a notice of the right to request a review with the enrollee's provider, and the replacing carrier must honor the prior carrier's authorization for a period not to exceed 6 months if the enrollee's provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy.

Effective September 12, 2009