

24-A §2736-C. INDIVIDUAL HEALTH PLANS

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1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue individual health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all individual health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

B. "Community rate" means the rate charged to all eligible individuals for individual health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

C. "Individual health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. It includes both individual contracts and certificates issued under group contracts specified in section 2701, subsection 2, paragraph C. "Individual health plan" does not include the following types of insurance:

- (1) Accident;
- (2) Credit;
- (3) Disability;
- (4) Long-term care or nursing home care;
- (5) Medicare supplement;
- (6) Specified disease;
- (7) Dental or vision;
- (8) Coverage issued as a supplement to liability insurance;
- (9) Workers' compensation;
- (10) Automobile medical payment; or
- (11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance. [1995, c. 332, Pt. J, §2 (AMD).]

C-1. "Legally domiciled" means a person who lives in this State and who satisfies the criteria contained in 2 of the following subparagraphs.

- (1) The person has a motor vehicle operator's license or nondriver identification card from this State.
- (2) The person has a valid passport or visa and is lawfully admitted to the United States.
- (3) The person is registered to vote in this State.
- (4) The person has a permanent dwelling place in this State.
- (5) The person submits a written sworn affidavit declaring that person's intent to reside in this State.
- (6) The person files an income tax return for this State that declares the person is a Maine resident.

A person may establish that that person is legally domiciled in this State by providing evidence of other relevant criteria associated with residency. A child is legally domiciled in this State if at least one of the child's parents or the child's legal guardian is legally domiciled in this State. A person with a developmental or other disability that prevents that person from obtaining a motor vehicle operator's license, registering to vote or filing an income tax return is legally domiciled in this State by living in this State. [2005, c. 493, §1 (RPR).]

C-2. "Resident" means a person who is legally domiciled in this State and has been for at least the last 60 days. [1997, c. 445, §8 (NEW); 1997, c. 445, §32 (AFF).]

D. "Premium rate" means the rate charged to an individual for an individual health plan. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

E. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as amended. [1997, c. 370, Pt. E, §2 (NEW).]

[2005, c. 493, §1 (AMD) .]

2. Rating practices. The following requirements apply to the rating practices of carriers providing individual health plans.

A. A carrier issuing an individual health plan after December 1, 1993 must file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent prior to issuance of any individual health plan. [1993, c. 547, §3 (AMD).]

B. A carrier may not vary the premium rate due to the gender, health status, occupation or industry, claims experience or policy duration of the individual. [2007, c. 629, Pt. A, §3 (AMD).]

C. A carrier may vary the premium rate due to smoking status and family membership. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts based on smoking status. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [2001, c. 410, Pt. A, §1 (AMD); 2001, c. 410, Pt. A, §10 (AFF).]

D. A carrier may vary the premium rate due to age and geographic area in accordance with the limitations set out in this paragraph.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and June 30, 2009, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2009, for each health benefit plan offered by a carrier, the highest premium rate for each rating tier may not exceed 2.5 times the premium rate that could be charged to an eligible individual with the lowest premium rate for that rating tier in a given rating period. For purposes of this subparagraph, "rating tier" means each category of individual or family composition for which a carrier charges separate rates.

(a) In determining the rating factor for geographic area pursuant to this subparagraph, the ratio between the highest and lowest rating factor used by a carrier for geographic area may not exceed 1.5 and the ratio between highest and lowest combined rating factors for age and geographic area may not exceed 2.5.

(b) In determining rating factors for age and geographic area pursuant to this subparagraph, no resulting rates, taking into account the savings resulting from the reinsurance program created by chapter 54, may exceed the rates that would have resulted from using projected claims and expenses and the rating factors applicable prior to July 1, 2009, as determined without taking into account the savings resulting from the Maine Individual Reinsurance Association established in chapter 54.

(c) The superintendent shall adopt rules setting forth appropriate methodologies regarding determination of rating factors pursuant to this subparagraph. Rules adopted pursuant to this division are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2007, c. 629, Pt. A, §4 (AMD).]

E. A separate community rate may be established for individuals eligible for Medicare Part A without paying a premium; however, this rate may not be applied if both the Medicare eligibility date and the issue date are prior to July 1, 2000. [1999, c. 44, §1 (AMD); 1999, c. 44, §2 (AFF).]

F. A carrier that adjusts its rate shall account for the savings offset payment or any recovery in that offset payment in its experience consistent with this section and former section 6913. [2007, c. 629, Pt. M, §4 (AMD).]

G. A carrier that adjusts its rate shall account in its experience for the effect of the annual reimbursements paid to the carrier by the Maine Individual Reinsurance Association established in chapter 54. [2007, c. 629, Pt. A, §5 (NEW).]

H. A carrier that offered individual health plans prior to July 1, 2009 may close its individual book of business sold prior to July 1, 2009 and may establish a separate community rate for individuals applying for coverage under an individual health plan on or after July 1, 2009. A carrier must merge the closed book with its open book by the earlier of:

(1) July 1, 2012; and

(2) When the number of subscribers remaining in a carrier's closed individual book of business is less than 25% of the carrier's individual health plan subscriber total as of June 30, 2009. In order to administer this subparagraph, a carrier shall compare the number of current individual health plan subscribers in its closed book of business to its individual health plan subscriber total as of June 30, 2009 on an annual basis.

The superintendent shall establish by rule procedures and policies that facilitate the implementation of this paragraph, including, but not limited to, notice requirements for policyholders and experience pooling requirements of individual health products. When establishing rules regarding experience pooling requirements, the superintendent shall ensure, to the greatest extent possible, the availability of affordable options for individuals transitioning from the closed book of business. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The superintendent shall direct the Consumer Health Care Division, established in section 4321, to work with carriers and health advocacy organizations to provide information about comparable alternative insurance options to individuals in a carrier's closed book of business and upon request to assist individuals to facilitate the transition to an individual health plan in that carrier's or another carrier's open book of business. [2007, c. 629, Pt. A, §6 (NEW).]

[2007, c. 629, Pt. A, §§3-6 (AMD); 2007, c. 629, Pt. M, §4 (AMD) .]

2-A. Reinsurance requirement. Carriers providing individual health plans are subject to the requirements of chapter 54.

[2007, c. 629, Pt. A, §7 (NEW) .]

3. Guaranteed issuance and guaranteed renewal. Carriers providing individual health plans must meet the following requirements on issuance and renewal.

A. Coverage must be guaranteed to all residents of this State other than those eligible without paying a premium for Medicare Part A. On or after January 1, 1998, coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. Except for federally eligible individuals, coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months.

When a managed care plan, as defined by section 4301-A, provides coverage a carrier may:

- (1) Deny coverage to individuals who neither live nor reside within the approved service area of the plan for at least 6 months of each year; and
- (2) Deny coverage to individuals if the carrier has demonstrated to the superintendent's satisfaction that:
 - (a) The carrier does not have the capacity to deliver services adequately to additional enrollees within all or a designated part of its service area because of its obligations to existing enrollees; and
 - (b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this paragraph may not enroll individuals residing within the area subject to denial of coverage or groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage. [2001, c. 1, §30 (COR).]

B. Renewal is guaranteed, pursuant to section 2850-B. [1997, c. 445, §32 (AFF); 1997, c. 445, §10 (RPR).]

C. A carrier is exempt from the guaranteed issuance requirements of paragraph A provided that the following requirements are met.

- (1) The carrier does not issue or deliver any new individual health plans on or after the effective date of this section;
- (2) If any individual health plans that were not issued on a guaranteed renewable basis are renewed on or after December 1, 1993, all such policies must be renewed by the carrier and renewal must be guaranteed after the first such renewal date; and
- (3) The carrier complies with the rating practices requirements of subsection 2. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

D. Notwithstanding paragraph A, carriers offering supplemental coverage for the Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are not required to issue this coverage if the applicant for insurance does not have CHAMPUS coverage. [1999, c. 256, Pt. D, §1 (NEW).]

[2001, c. 1, §30 (COR) .]

4. Cessation of business. Carriers that provide individual health plans after the effective date of this section that plan to cease doing business in the individual health plan market must comply with the following requirements.

- A. Notice of the decision to cease doing business in the individual health plan market must be provided to the bureau 3 months prior to the cessation unless a shorter notice period is approved by the superintendent. If existing contracts are nonrenewed, notice must be provided to the policyholder or contract holder 6 months prior to nonrenewal. [2001, c. 258, Pt. B, §1 (AMD).]
- B. Carriers that cease to write new business in the individual health plan market continue to be governed by this section. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

C. Carriers that cease to write new business in the individual health plan market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent unless the superintendent waives this requirement for good cause shown. [2001, c. 258, Pt. B, §2 (AMD).]

[2001, c. 258, Pt. B, §§1, 2 (AMD) .]

5. Loss ratios. For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% 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.

[2007, c. 629, Pt. M, §5 (AMD) .]

6. Fair marketing standards. Carriers providing individual health plans must meet the following standards of fair marketing.

A. Each carrier must actively market individual health plan coverage, including any standardized plans defined pursuant to subsection 8, to individuals in this State. [1995, c. 332, Pt. K, §1 (AMD).]

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

- (1) Encouraging or directing individuals to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; or
- (2) Encouraging or directing individuals to seek coverage from another carrier because of any of the rating factors listed in subsection 2. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of an individual health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

E. Denial by a carrier of an application for coverage from an individual must be in writing and must state the reason or reasons for the denial. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

F. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of individual health plans in this State. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

G. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of individual health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

[1995, c. 332, Pt. K, §1 (AMD) .]

7. Applicability. This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after December 1, 1993 with the exception of short-term contracts, as defined in section 2849-B. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

[1997, c. 445, §11 (AMD); 1997, c. 445, §32 (AFF) .]

8. Authority of the superintendent. The superintendent may by rule define one or more standardized individual health plans that must be offered by all carriers offering individual health plans in the State, other than carriers offering only CHAMPUS supplemental coverage.

[1999, c. 256, Pt. D, §2 (AMD) .]

9. Exemption for certain associations. The superintendent may exempt a group health insurance policy or group nonprofit hospital or medical service corporation contract issued to an association group, organized pursuant to section 2805-A, from the requirements of subsection 3, paragraph A; subsection 6, paragraph A; and subsection 8 if:

A. Issuance and renewal of coverage under the policy or contract is guaranteed to all members of the association who are residents of this State and to their dependents; [1995, c. 570, §7 (NEW) .]

B. Rates for the association comply with the premium rate requirements of subsection 2 or are established on a nationwide basis and substantially comply with the purposes of this section, except that exempted associations may be rated separately from the carrier's other individual health plans, if any; [1995, c. 570, §7 (NEW) .]

C. The group's anticipated loss ratio, as defined in subsection 5, is at least 75%; [1995, c. 570, §7 (NEW) .]

D. The association's membership criteria do not include age, health status, medical utilization history or any other factor with a similar purpose or effect; [1995, c. 570, §7 (NEW) .]

E. The association's group health plan is not marketed to the general public; [1995, c. 570, §7 (NEW) .]

F. The association does not allow insurance agents or brokers to market association memberships, accept applications for memberships or enroll members, except when the association is an association of insurance agents or brokers organized under section 2805-A; [1995, c. 570, §7 (NEW) .]

G. Insurance is provided as an incidental benefit of association membership and the primary purposes of the association do not include group buying or mass marketing of insurance or other goods and services; and [1995, c. 570, §7 (NEW) .]

H. Granting an exemption to the association does not conflict with the purposes of this section. [1995, c. 570, §7 (NEW) .]

[1995, c. 570, §7 (NEW) .]

10. Pilot projects; persons under 30 years of age. The superintendent shall authorize pilot projects in accordance with this subsection that allow a health insurance carrier that offers individual insurance, is marketing an individual insurance policy in this State and has a medical-loss ratio of at least 70% in the individual market to offer individual medical insurance products to persons under 30 years of age beginning July 1, 2009.

A. The superintendent shall review pilot project proposals submitted in accordance with rules adopted pursuant to paragraph E. The superintendent shall approve a pilot project proposal if it meets the minimum benefit requirements set forth in rules adopted pursuant to paragraph E and may not approve a proposal that does not provide such minimum benefit requirements. [2007, c. 629, Pt. I, §1 (NEW).]

B. Notwithstanding any requirements in this Title for specific health services, specific diseases and certain providers of health care services, the superintendent may adopt minimum benefit requirements that exclude certain benefits if determined by the superintendent to provide affordable and attractive individual health plans for persons under 30 years of age. [2007, c. 629, Pt. I, §1 (NEW).]

C. A pilot project approved by the superintendent pursuant to this subsection qualifies as creditable coverage under this Title. Notwithstanding section 2849-B, subsection 4, a policy that replaces coverage issued under a pilot project approved under this subsection is not subject to any preexisting conditions exclusion provisions. Each carrier that offers an individual product pursuant to a pilot project approved under this subsection must combine the experience for that product with other individual products offered by that carrier as filed with the bureau when determining premium rates. The experience of a carrier's closed pool may not be taken into account in determining pilot project premium rates. [2007, c. 629, Pt. I, §1 (NEW).]

D. Beginning in 2010, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance matters on the status of any pilot project approved by the superintendent pursuant to this subsection. The report must include an analysis of the effectiveness of the pilot project in encouraging persons under 30 years of age to purchase insurance and an analysis of the impact of the pilot project on the broader insurance market, including any impact on premiums and availability of coverage. [2007, c. 629, Pt. I, §1 (NEW).]

E. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this subsection, including, but not limited to, a process for submitting a pilot project proposal, minimum requirements for approval of a pilot project and any requirements for minimum benefits. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than 90 days after the effective date of this subsection. [2007, c. 629, Pt. I, §1 (NEW).]

[2007, c. 629, Pt. I, §1 (NEW) .]

SECTION HISTORY

1993, c. 477, §C1 (NEW). 1993, c. 546, §1 (AMD). 1993, c. 547, §3 (AMD). 1993, c. 645, §§A3,B2 (AMD). 1993, c. 477, §F1 (AFF). 1995, c. 177, §1 (AMD). 1995, c. 332, §§J2,K1 (AMD). 1995, c. 342, §§4,5 (AMD). 1995, c. 570, §7 (AMD). 1997, c. 370, §§E2-4 (AMD). 1997, c. 445, §§8-11 (AMD). 1997, c. 445, §32 (AFF). 1999, c. 44, §1 (AMD). 1999, c. 256, §§C1,D1,2 (AMD). 1999, c. 44, §2 (AFF). 2001, c. 258, §§B1,2,E2 (AMD). 2001, c. 410, §§A1,2 (AMD). 2001, c. 410, §A10 (AFF). RR 2001, c. 1, §30 (COR). 2003, c. 428, §H3 (AMD). 2003, c. 469, §§E12,13 (AMD). 2005, c. 493, §1 (AMD). 2007, c. 629, Pt. A, §§3-7 (AMD). 2007, c. 629, Pt. I, §1 (AMD). 2007, c. 629, Pt. M, §§4, 5 (AMD).

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