

24-A §4303. PLAN REQUIREMENTS

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A carrier offering or renewing a health plan in this State must meet the following requirements.
[2007, c. 199, Pt. B, §4 (AMD).]

1. Demonstration of adequate access to providers. Except as provided in paragraphs A, B and C, a carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the superintendent. These standards must consider the geographical and transportation problems in rural areas. All managed care plans covering residents of this State must provide reasonable access to providers consistent with the access-to-services requirements of any applicable bureau rule.

A.

[2007, c. 199, Pt. B, §5 (AMD); T. 24-A, §4303, sub-§1(A) (RP).]

B. Upon approval of the superintendent, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:

- (1) The entire network meets overall access standards pursuant to Bureau of Insurance Rule Chapter 850;
- (2) The health plan is consistent with product design guidelines for Bureau of Insurance Rule Chapter 750, but only if the health plan is offered by a health maintenance organization;
- (3) The health plan does not include financial provisions designed to encourage members to use designated providers of primary, preventive, maternity, obstetrical, ancillary or emergency care services, as defined in Bureau of Insurance Rule Chapter 850;
- (4) The financial provisions may apply to all of the enrollees covered under the carrier's health plan;
- (5) The carrier establishes to the satisfaction of the superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The superintendent may consult with other state entities, including the Department of Health and Human Services, Bureau of Health and the Maine Quality Forum established in section 6951, to determine whether the carrier has met the requirements of this subparagraph. The superintendent shall adopt rules regarding the criteria used by the superintendent to determine whether the carrier meets the quality requirements of this subparagraph; and
- (6) The financial provisions may not permit travel at a distance that exceeds the standards established in Bureau of Insurance Rule Chapter 850 for mileage and travel time by 100%.

[2009, c. 357, §1 (NEW).]

C. A carrier may develop and file with the superintendent for approval a pilot program that allows carriers to reward providers for quality and efficiency through tiered benefit networks and providing incentives to members. The upper tier, or the upper tiers if there are 3 or more tiers, under a pilot program approved pursuant to this paragraph is exempt from geographic access requirements set forth in this subsection or in rules adopted by the superintendent. Any carrier offering a health plan under the pilot program must collect data on the impact of the pilot program on premiums paid by enrollees, payments made to providers, quality of care received and access to health care services by individuals enrolled in health plans under the pilot program and must submit that data annually to the superintendent.

The superintendent shall report annually beginning January 15, 2010 to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on any approval of a pilot program pursuant to this paragraph.

The basis for tiering benefits under a pilot program must be to provide incentives for higher-quality care, improved patient safety or improved efficiency or a combination of those factors. The superintendent shall consult with the Maine Quality Forum under section 6951 in assessing quality. The superintendent shall disapprove or withdraw approval of a pilot program if the superintendent finds that approval or continued operation would cause undue hardship to enrollees in the pilot program or reduce their quality of care.

The superintendent shall consider the experience of approved pilot programs, including consumer complaints and examinations, provider behavior and efficiency, in determining whether or not to reapprove subsequent pilot program applications. [2009, c. 357, §1 (NEW).]

[2009, c. 357, §1 (AMD) .]

2. Credentialling. The credentialling of providers by a carrier is governed by this subsection.

A. The granting of credentials must be based on objective standards that are available to providers upon application for credentialling. A carrier shall consult with appropriately qualified health care professionals in developing its credentialling standards. [1997, c. 163, §1 (AMD).]

B. All credentialling decisions, including those granting, denying or withdrawing credentials, must be in writing. The provider must be provided with all reasons for the denial of an application for credentialling or the withdrawal of credentials. A withdrawal of credentials must be treated as a provider termination and is subject to the requirements of subsection 3-A. [1997, c. 163, §1 (AMD).]

C. A carrier shall establish and maintain an appeal procedure, including the provider's right to a hearing, for dealing with provider concerns relating to the denial of credentialling for not meeting the objective credentialling standards of the plan and the contractual relationship between the carrier and the provider. The superintendent shall determine whether the process provided by a carrier is fair and reasonable. This procedure must be specified in every contract between a carrier and a provider or between a carrier and a provider network if a carrier does not contract with providers individually. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

D. A carrier shall make credentialling decisions, including those granting or denying credentials, within 60 days of receipt of a completed credentialling application from a provider. The time period for granting or denying credentials may be extended upon written notification from the carrier within 60 days following submission of a completed application stating that information contained in the application requires additional time for verification. All credentialling decisions must be made within 180 days of receipt of a completed application. For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialling application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. A carrier shall review the entire application before returning it to the provider for corrections with a comprehensive list of all corrections needed at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application. [2003, c. 108, §1 (NEW) .]

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. [2009, c. 439, Pt. B, §5 (NEW).]

[2009, c. 439, Pt. B, §5 (AMD) .]

3. Provider's right to advocate for medically appropriate care. A carrier offering or renewing a managed care plan may not terminate or otherwise discipline a participating provider because the provider advocates for medically appropriate health care. A carrier may not restrict a provider from disclosing to any enrollee any information the provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, the availability of other therapy, consultations or tests or the decision of any plan to authorize or deny health care services or benefits.

A. For the purposes of this section, "to advocate for medically appropriate health care" means to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service pursuant to an established grievance or appeal procedure; or to protest a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by reputable providers, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

B. Nothing in this subsection may be construed to prohibit a plan from making a determination not to pay for a particular medical treatment or service or to enforce reasonable peer review or utilization review protocols. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

[2007, c. 199, Pt. B, §6 (AMD) .]

3-A. Termination of participating providers. A carrier offering or renewing a managed care plan may not terminate or nonrenew a contract with a participating provider unless the carrier provides the provider with a written explanation prior to the termination or nonrenewal of the reasons for the proposed contract termination or nonrenewal and provides an opportunity for a review or hearing in accordance with this subsection. The existence of a termination without cause provision in a carrier's contract with a provider does not supersede the requirements of this subsection. This subsection does not apply to termination cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, a final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a provider to practice. A review or hearing of proposed contract termination must meet the following requirements.

A. The notice of the proposed contract termination or nonrenewal provided by the carrier to the participating provider must include:

- (1) The reason or reasons for the proposed action in sufficient detail to permit the provider to respond;
- (2) Reference to the evidence or documentation underlying the carrier's decision to pursue the proposed action. A carrier shall permit a provider to review this evidence and documentation upon request;
- (3) Notice that the provider has the right to request a review or hearing before a panel appointed by the carrier;
- (4) A time limit of not less than 30 days from the date the provider receives the notice within which a provider may request a review or hearing; and

(5) A time limit for a hearing date that must be not less than 30 days after the date of receipt of a request for a hearing.

Termination or nonrenewal may not be effective earlier than 60 days from the receipt of the notice of termination or nonrenewal. [1997, c. 163, §2 (NEW).]

B. A hearing panel must be composed of at least 3 persons appointed by the carrier and one person on the hearing panel must be a clinical peer in the same discipline and the same or similar specialty of the provider under review. A hearing panel may be composed of more than 3 persons if the number of clinical peers on the hearing panel constitutes 1/3 or more of the total membership of the panel. [1997, c. 163, §2 (NEW).]

C. A hearing panel shall render a written decision on the proposed action in a timely manner. This decision must be either the reinstatement of the provider by the carrier, the provisional reinstatement of the provider subject to conditions established by the carrier or the termination or nonrenewal of the provider. [1997, c. 163, §2 (NEW).]

D. A decision by a hearing panel to terminate or nonrenew a contract with a provider may not become effective less than 60 days after the receipt by the provider of the hearing panel's decision or until the termination date in the provider's contract, whichever is earlier. [1997, c. 163, §2 (NEW).]

[2007, c. 199, Pt. B, §7 (AMD) .]

3-B. Prohibition on financial incentives. A carrier offering or renewing a managed care plan may not offer or pay any type of material inducement, bonus or other financial incentive to a participating provider to deny, reduce, withhold, limit or delay specific medically necessary health care services covered under the plan to an enrollee. This subsection may not be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or risk-sharing agreements that are made with respect to providers or groups of providers or that are made with respect to groups of enrollees.

[2007, c. 199, Pt. B, §8 (AMD) .]

4. Grievance procedure for enrollees. A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following:

(1) Notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed;

(2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier;

(3) Procedures for the submission of relevant information and enrollee participation;

(4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; and

(5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance. [2007, c. 199, Pt. B, §9 (AMD).]

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the plan, of a provider of the same specialty participating in the plan. If a provider of the same specialty does not participate in the plan, then the 2nd opinion must be given by a nonparticipating provider. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection. [1999, c. 742, §9 (NEW).]

D. Notwithstanding this subsection, a group health plan sponsored by an agricultural cooperative association located outside of this State that provides health insurance coverage to members of one or more agricultural cooperative associations located within this State may employ a grievance procedure for enrollees in the group health plan that meets the requirements of the state in which the group health plan is located if enrollees in the group health plan that reside in this State have the right to independent external review in accordance with section 4312 following any adverse health care treatment decision. Any difference in the grievance procedure requirements between those of the state in which the group health plan is located and those of this State must be limited to the number of days required for notification of prior authorization for nonemergency services and the number of days required for the issuance of a decision following the filing of an appeal of an adverse health care treatment decision. Enrollees in the group health plan that reside in this State must be notified as to the grievance procedure used by the group health plan and their right to independent external review in accordance with section 4312. [2003, c. 309, §1 (NEW).]

[2007, c. 199, Pt. B, §9 (AMD) .]

5. Identification of services provided by certified nurse practitioners and certified nurse midwives.

All claims for coverage of services provided by certified nurse practitioners and certified nurse midwives must identify the certified nurse practitioners and certified nurse midwives who provided those services. A carrier offering or renewing a health plan in this State shall assign identification numbers or codes to certified nurse practitioners and certified nurse midwives who provide covered services for enrollees covered under that plan. A claim submitted for payment to a carrier by a health care provider or facility must include the identification number or code of the certified nurse practitioner or certified nurse midwife who provided the service and may not be submitted using the identification number or code of a physician or other health care provider who did not provide the covered service.

[2007, c. 199, Pt. B, §10 (AMD) .]

6. Standing referrals to specialists. A carrier shall establish and maintain a procedure to allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier's network for treatment of that special condition. If the carrier or the enrollee's primary care provider, in consultation with the carrier's medical director, determines that a standing referral is appropriate, the carrier shall ensure that the enrollee receives such a referral to a specialist. If a specialist able to treat the enrollee's special condition does not participate in the carrier's network, then the carrier shall ensure that the enrollee receives a standing referral to a nonparticipating specialist. A standing referral must be made pursuant to a treatment plan approved by the carrier's medical director in consultation with the enrollee's primary care provider. After the standing referral is made, the specialist is authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care provider, subject to the terms of the treatment plan.

[1999, c. 742, §10 (NEW) .]

7. Continuity of care. If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C. This section does not apply to provider terminations exempt from the requirements of subsection 3-A.

If a managed care contract for the provision of health insurance coverage between a plan sponsor and a carrier is replaced within the meaning of section 2849 with a different managed care contract and a health care provider that has been providing health care services to an enrollee is not in the replacement carrier's network, the replacement carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C in the same manner as if the provider had been terminated from the replacement carrier's network as of the date of the policy replacement, but only with respect to benefits that are covered under the replacement contract.

A. The carrier shall notify an enrollee of the termination of the provider's contract at least 60 days in advance of the date of termination. When circumstances related to the termination render such notice impossible, the carrier shall provide affected enrollees as much notice as is reasonably possible. The notice given to the enrollee must include instructions on obtaining an alternate provider and must offer the carrier's assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the enrollee's ongoing treatment. [1999, c. 742, §10 (NEW).]

B. The carrier shall permit the enrollee to continue or be covered, with respect to the course of treatment with the provider, for a transitional period of at least 60 days from the date of notice to the enrollee of the provider's termination except that if an enrollee is in the 2nd trimester of pregnancy at the time of the provider's termination and the provider is treating the enrollee during the pregnancy, the transitional period must extend through the provision of postpartum care directly related to the pregnancy. [1999, c. 742, §10 (NEW).]

C. A carrier may make coverage of continued treatment by a provider under paragraph B conditional upon the provider's agreeing to the following terms and conditions.

(1) The provider agrees to accept reimbursement from the carrier at rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to the enrollee in an amount that would exceed the cost-sharing that could have been imposed if the contract between the carrier and the provider had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the carrier responsible for payment and to provide the carrier necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the carrier's policies and procedures, including procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by the carrier. [1999, c. 742, §10 (NEW).]

[1999, c. 742, §10 (NEW) .]

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.

[2009, c. 439, Pt. F, §1 (NEW) .]

8. Maximum allowable charges. All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.

A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:

- (1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and
- (2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. [2001, c. 410, Pt. B, §5 (NEW) .]

B. The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service. [2001, c. 410, Pt. B, §5 (NEW) .]

[2001, c. 410, Pt. B, §5 (NEW) .]

9. (REALLOCATED TO T. 24-A, §4303, sub-§11) Absolute discretion clauses.

[2003, c. 110, §1 (NEW); 2003, c. 1, §21 (RAL) .]

9. Notice of amendments to provider agreements. A carrier offering or renewing a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment.

[2007, c. 199, Pt. B, §11 (AMD) .]

10. Limits on retrospective denials. A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. The carrier has provided the reason for the retrospective denial in writing to the provider; and [2003, c. 218, §9 (NEW) .]

B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:

- (1) The claim was submitted fraudulently;
- (2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;

- (3) The health care services identified in the claim were not delivered by the provider;
- (4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;
- (5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or
- (6) The claim payment is the subject of legal action. [2007, c. 106, §1 (AMD) .]

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.

[2007, c. 106, §1 (AMD) .]

11. (REALLOCATED FROM T. 24-A, §4303, sub-§9) Absolute discretion clauses. The use and enforcement of an absolute discretion clause is governed by this subsection.

A. A policy, contract, certificate or agreement offered, delivered, issued or renewed for delivery in this State by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may not contain a provision purporting to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [2003, c. 1, §21 (RAL) .]

B. A carrier may not enforce a provision in a policy, contract, certificate or agreement that was offered, delivered or issued for delivery in this State and has been continued or renewed by a group policy holder or individual enrollee in this State that purports to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [2003, c. 1, §21 (RAL) .]

[2003, c. 1, §21 (RAL) .]

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.

[2009, c. 439, Pt. A, §3 (NEW) .]

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; [2009, c. 439, Pt. A, §4 (NEW) .]
- B. The provider of the service; [2009, c. 439, Pt. A, §4 (NEW) .]

C. An identification of the service for which the claim is made; [2009, c. 439, Pt. A, §4 (NEW).]

D. Any amount the insured is obligated to pay under the policy for copayment or coinsurance; [2009, c. 439, Pt. A, §4 (NEW).]

E. A telephone number and address where the insured may obtain clarification of the explanation of benefits; [2009, c. 439, Pt. A, §4 (NEW).]

F. A notice of appeal rights; and [2009, c. 439, Pt. A, §4 (NEW).]

G. A notice of the right to file a complaint with the bureau after exhausting any appeals under a carrier's internal appeals process. [2009, c. 439, Pt. A, §4 (NEW).]

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.

[2009, c. 439, Pt. A, §4 (NEW).]

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.

[2009, c. 439, Pt. A, §5 (NEW).]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1997, c. 163, §§1,2 (AMD). 1999, c. 396, §5 (AMD). 1999, c. 742, §§6-10 (AMD). 1999, c. 396, §7 (AFF). 2001, c. 288, §5 (AMD). 2001, c. 410, §B5 (AMD). 2003, c. 108, §1 (AMD). 2003, c. 110, §1 (AMD). 2003, c. 218, §9 (AMD). 2003, c. 309, §1 (AMD). 2003, c. 469, §E20 (AMD). RR 2003, c. 1, §21 (COR). 2003, c. 689, §B6 (REV). 2007, c. 106, §1 (AMD). 2007, c. 199, Pt. B, §§4-11 (AMD). 2009, c. 357, §1 (AMD). 2009, c. 439, Pt. A, §§3-5 (AMD). 2009, c. 439, Pt. B, §5 (AMD). 2009, c. 439, Pt. F, §1 (AMD). MRSA T. 24-A, §4303, sub-1, ¶A (AMD).

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