



# 129th MAINE LEGISLATURE

## FIRST REGULAR SESSION-2019

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Legislative Document

No. 1

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S.P. 10

In Senate, January 2, 2019

### **An Act To Protect Health Care Coverage for Maine Families**

(EMERGENCY)

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Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

A handwritten signature in black ink, appearing to read 'D M Grant'.

DAREK M. GRANT  
Secretary of the Senate

Presented by President JACKSON of Aroostook.  
Cosponsored by Speaker GIDEON of Freeport.



1 (6) For all policies, contracts or certificates that are executed, delivered, issued  
2 for delivery, continued or renewed in this State between January 1, 2014 and  
3 December 31, 2014, the maximum rate differential due to age filed by the carrier  
4 as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable  
5 Care Act. The limitation does not apply for determining rates for an attained age  
6 of less than 19 years of age or more than 65 years of age.

7 (7) For all policies, contracts or certificates that are executed, delivered, issued  
8 for delivery, continued or renewed in this State on or after January 1, 2015, the  
9 maximum rate differential due to age filed by the carrier as determined by ratio is  
10 5 3 to 1 ~~to the extent permitted by the federal Affordable Care Act~~. The  
11 limitation does not apply for determining rates for an attained age of less than 19  
12 years of age or more than 65 years of age.

13 (8) For all policies, contracts or certificates that are executed, delivered, issued  
14 for delivery, continued or renewed in this State on or after July 1, 2012, the  
15 maximum rate differential due to tobacco use filed by the carrier as determined  
16 by ratio is 1.5 to 1.

17 **Sec. A-2. 24-A MRSA §2736-C, sub-§11**, as enacted by PL 2013, c. 271, §1, is  
18 amended to read:

19 **11. Open enrollment; rules.** Notwithstanding subsection 3, on or after January 1,  
20 2014, a carrier may restrict enrollment in individual health plans to open enrollment  
21 periods and special enrollment periods ~~consistent with requirements of the federal~~  
22 ~~Affordable Care Act~~ to the extent not inconsistent with applicable federal law. The  
23 superintendent may adopt rules establishing minimum open enrollment dates and  
24 minimum criteria for special enrollment periods for all individual health plans offered in  
25 this State. Rules adopted pursuant to this subsection are routine technical rules as defined  
26 in Title 5, chapter 375, subchapter 2-A.

27 **Sec. A-3. 24-A MRSA §2742-B**, as amended by PL 2007, c. 514, §§1 to 5, is  
28 further amended to read:

29 **§2742-B. Mandatory offer to extend coverage for dependent children up to 26 years**  
30 **of age**

31 **1. Dependent child; definition.** As used in this section, "dependent child" means  
32 the child of a person covered under an individual health insurance policy when that child:

- 33 A. Is unmarried;
- 34 B. Has no dependent of the child's own; and
- 35 C. Is a resident of this State or is enrolled as a full-time student at an accredited  
36 public or private institution of higher education.

37 **2. Offer of coverage.** Notwithstanding section 2703, subsection 3, an individual  
38 health insurance policy that offers coverage for a dependent child must offer such  
39 coverage, at the option of the policyholder, until the dependent child ~~is 25~~ attains 26 years  
40 of age. An insurer may require, as a condition of eligibility for coverage in accordance

1 with this section, that a person seeking coverage for a dependent child provide written  
2 documentation on an annual basis that the dependent child meets the requirements in  
3 subsection 1.

4 **Sec. A-4. 24-A MRSA §2808-B, sub-§2, ¶D**, as amended by PL 2011, c. 638,  
5 §2, is further amended to read:

6 D. A carrier may vary the premium rate due to age, group size and tobacco use only  
7 under the following schedule and within the listed percentage bands.

8 (1) For all policies, contracts or certificates that are executed, delivered, issued  
9 for delivery, continued or renewed in this State between July 15, 1993 and July  
10 14, 1994, the premium rate may not deviate above or below the community rate  
11 filed by the carrier by more than 50%.

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

16 (3) For all policies, contracts or certificates that are executed, delivered, issued  
17 for delivery, continued or renewed in this State between July 15, 1995 and  
18 September 30, 2011, the premium rate may not deviate above or below the  
19 community rate filed by the carrier by more than 20%.

20 (4) For all policies, contracts or certificates that are executed, delivered, issued  
21 for delivery, continued or renewed in this State between October 1, 2011 and  
22 September 30, 2012, the maximum rate differential due to age filed by the carrier  
23 as determined by ratio is 2 to 1. The limitation does not apply for determining  
24 rates for an attained age of less than 19 years of age or more than 65 years of age.

25 (5) For all policies, contracts or certificates that are executed, delivered, issued  
26 for delivery, continued or renewed in this State between October 1, 2012 and  
27 December 31, 2013, the maximum rate differential due to age and group size  
28 filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not  
29 apply for determining rates for an attained age of less than 19 years of age or  
30 more than 65 years of age.

31 (6) For all policies, contracts or certificates that are executed, delivered, issued  
32 for delivery, continued or renewed in this State between January 1, 2014 and  
33 December 31, 2014, the maximum rate differential due to age and group size  
34 filed by the carrier as determined by ratio is 3 to 1 to the extent permitted by the  
35 federal Affordable Care Act. The limitation does not apply for determining rates  
36 for an attained age of less than 19 years of age or more than 65 years of age.

37 (7) For all policies, contracts or certificates that are executed, delivered, issued  
38 for delivery, continued or renewed in this State between January 1, 2015 and  
39 December 31, 2015, the maximum rate differential due to age and group size  
40 filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the  
41 federal Affordable Care Act. The limitation does not apply for determining rates  
42 for an attained age of less than 19 years of age or more than 65 years of age.

1 (8) For all policies, contracts or certificates that are executed, delivered, issued  
2 for delivery, continued or renewed in this State on or after January 1, 2016, the  
3 maximum rate differential due to age and group size filed by the carrier as  
4 determined by ratio is ~~5 3~~ to 1 ~~to the extent permitted by the federal Affordable~~  
5 ~~Care Act~~. The limitation does not apply for determining rates for an attained age  
6 of less than 19 years of age or more than 65 years of age.

7 (9) For all policies, contracts or certificates that are executed, delivered, issued  
8 for delivery, continued or renewed in this State on or after October 1, 2011, the  
9 maximum rate differential due to tobacco use filed by the carrier as determined  
10 by ratio is 1.5 to 1.

11 **Sec. A-5. 24-A MRSA §2833-B**, as amended by PL 2007, c. 514, §§6 to 10, is  
12 further amended to read:

13 **§2833-B. Mandatory offer to extend coverage for dependent children up to 26 years**  
14 **of age**

15 **1. Dependent child; definition.** As used in this section, "dependent child" means  
16 the child of a person covered under a group health insurance policy when that child:

17 A. Is unmarried;

18 B. Has no dependent of the child's own; and

19 C. Is a resident of this State or is enrolled as a full-time student at an accredited  
20 public or private institution of higher education.

21 **2. Offer of coverage.** Notwithstanding section 2822, a group health insurance  
22 policy that offers coverage for a dependent child must offer such coverage, at the option  
23 of the policyholder, until the dependent child ~~is 25~~ attains 26 years of age. An insurer  
24 may require, as a condition of eligibility for coverage in accordance with this section, that  
25 a person seeking coverage for a dependent child provide written documentation on an  
26 annual basis that the dependent child meets the requirements in subsection 1.

27 **Sec. A-6. 24-A MRSA §2849-B, sub-§8**, as amended by PL 2011, c. 90, Pt. G,  
28 §2, is repealed.

29 **Sec. A-7. 24-A MRSA §2850, sub-§2**, as amended by PL 2011, c. 364, §18, is  
30 further amended to read:

31 **2. Limitation.** An individual, group or blanket contract issued by an insurer may not  
32 impose a preexisting condition exclusion ~~except as provided in this subsection. A~~  
33 ~~preexisting condition exclusion may not exceed 12 months from the date of enrollment,~~  
34 ~~including the waiting period, if any. For purposes of this subsection, "waiting period"~~  
35 ~~includes any period between the time a substantially complete application for an~~  
36 ~~individual or small group health plan is filed and the time the coverage takes effect. A~~  
37 ~~preexisting condition exclusion may not be more restrictive than as follows. This~~  
38 ~~subsection does not limit a carrier's ability to restrict enrollment in an individual contract~~  
39 to open enrollment and special enrollment periods in accordance with section 2736-C,  
40 subsection 11.

1           A. ~~In a group contract, a preexisting condition exclusion may relate only to~~  
2           ~~conditions for which medical advice, diagnosis, care or treatment was recommended~~  
3           ~~or received during the 6-month period ending on the earlier of the date of enrollment~~  
4           ~~in the contract and the date of enrollment in a prior contract covering the same group~~  
5           ~~if there has not been a gap in coverage of greater than 90 days between contracts. An~~  
6           ~~exclusion may not be imposed relating to pregnancy as a preexisting condition.~~

7           B. ~~In an individual contract not subject to paragraph C, or in a blanket policy, a~~  
8           ~~preexisting condition exclusion may relate only to conditions manifesting in~~  
9           ~~symptoms that would cause an ordinarily prudent person to seek medical advice,~~  
10          ~~diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment~~  
11          ~~was recommended or received during the 12 months immediately preceding the date~~  
12          ~~of application or to a pregnancy existing on the effective date of coverage.~~

13          C. ~~An individual policy issued on or after January 1, 1998 to a federally eligible~~  
14          ~~individual as defined in section 2848 may not contain a preexisting condition~~  
15          ~~exclusion.~~

16          D. ~~A routine preventive screening or test yielding only negative results may not be~~  
17          ~~considered to be diagnosis, care or treatment for the purposes of this subsection.~~

18          E. ~~Genetic information may not be used as the basis for imposing a preexisting~~  
19          ~~condition exclusion in the absence of a diagnosis of the condition relating to that~~  
20          ~~information. For the purposes of this paragraph, "genetic information" has the same~~  
21          ~~meaning as set forth in the Code of Federal Regulations.~~

22          F. ~~Except for individual health plans in effect on March 23, 2010 that have~~  
23          ~~grandfathered status under the federal Affordable Care Act, a carrier as defined in~~  
24          ~~section 4301-A, subsection 3 offering a health plan as defined in section 4301-A,~~  
25          ~~subsection 7 may not apply a preexisting condition exclusion to any enrollee under 19~~  
26          ~~years of age. A preexisting condition exclusion may not be imposed on any enrollee~~  
27          ~~after January 1, 2014 to the extent prohibited by the federal Affordable Care Act.~~

28           **Sec. A-8. 24-A MRSA §4233-B**, as amended by PL 2007, c. 514, §§11 to 15, is  
29           further amended to read:

30           **§4233-B. Mandatory offer to extend coverage for dependent children up to 26 years**  
31           **of age**

32           **1. Dependent child; definition.** As used in this section, "dependent child" means  
33           the child of a person covered under an individual or group health maintenance  
34           organization contract when that child:

35           A. Is unmarried;

36           B. Has no dependent of the child's own; and

37           C. Is a resident of this State or is enrolled as a full-time student at an accredited  
38           public or private institution of higher education.

39           **2. Offer of coverage.** An individual or group health maintenance organization  
40           contract that offers coverage for a dependent child ~~shall~~ **must** offer such coverage, at the  
41           option of the contract holder, until the dependent child ~~is 25~~ **attains 26** years of age. An

1 insurer may require, as a condition of eligibility for coverage in accordance with this  
2 section, that a person seeking coverage for a dependent child provide written  
3 documentation on an annual basis that the dependent child meets the requirements in  
4 subsection 1.

5 **Sec. A-9. 24-A MRSA §4318**, as amended by PL 2011, c. 364, §33, is repealed.

6 **Sec. A-10. 24-A MRSA §4320**, as enacted by PL 2011, c. 364, §34, is amended  
7 to read:

8 **§4320. No lifetime or annual limits on health plans**

9 ~~Notwithstanding the requirements of section 4318, a~~ A carrier offering a an  
10 individual or group health plan subject to the federal Affordable Care Act may not:

11 **1. Establish lifetime limits.** Establish lifetime limits on the dollar value of benefits  
12 for any participant or beneficiary; or

13 **2. Establish annual limits.** Establish annual limits on the dollar value of essential  
14 benefits, ~~except that, prior to January 1, 2014, health plans may include restricted annual~~  
15 ~~limits on essential benefits consistent with the requirements of the federal Affordable~~  
16 ~~Care Act and may establish annual limits consistent with waivers granted by the~~  
17 ~~Secretary of the United States Department of Health and Human Services as determined~~  
18 ~~by the superintendent to the extent not inconsistent with applicable federal law.~~

19 **PART B**

20 **Sec. B-1. 24-A MRSA §4320-D**, as enacted by PL 2011, c. 364, §34, is amended  
21 to read:

22 **§4320-D. Comprehensive health coverage**

23 Notwithstanding any other requirements of this Title, a carrier offering a health plan  
24 ~~subject to the requirements of the federal Affordable Care Act in this State~~ shall, at a  
25 minimum, provide coverage that incorporates an essential health benefits and cost-  
26 sharing limitations package consistent with the requirements of ~~the federal Affordable~~  
27 ~~Care Act~~ this section.

28 **1. Essential health benefits package; definition.** As used in this section, "essential  
29 health benefits package" means, with respect to any health plan, coverage that:

30 A. Provides for the essential health benefits defined by the superintendent under  
31 subsection 2;

32 B. Limits cost sharing for coverage in accordance with subsection 4; and

33 C. Provides for levels of coverage in accordance with subsection 5.

34 **2. Substantially similar to federal Affordable Care Act; required categories.**  
35 The superintendent shall ensure that the scope of the essential health benefits required  
36 under this section is substantially similar to that of the essential health benefits required

1 for a health plan subject to the federal Affordable Care Act as of January 1, 2019. The  
2 superintendent shall define the essential health benefits required for a health plan, except  
3 that such benefits must include at least the following general categories and the items and  
4 services covered within the categories:

5 A. Ambulatory patient services;

6 B. Emergency services;

7 C. Hospitalization;

8 D. Maternity and newborn care;

9 E. Mental health and substance use disorder services, including behavioral health  
10 treatment;

11 F. Prescription drugs;

12 G. Rehabilitative and habilitative services and devices;

13 H. Laboratory services;

14 I. Preventive and wellness services and chronic disease management; and

15 J. Pediatric services, including oral and vision care.

16 **3. Required elements for consideration.** In defining essential health benefits under  
17 this section, the superintendent shall:

18 A. Ensure that such essential health benefits reflect an appropriate balance among  
19 the categories described in subsection 2, so that benefits are not unduly weighted  
20 toward any category;

21 B. Ensure that coverage decisions, determination of reimbursement rates,  
22 establishment of incentive programs and designation of benefits are done in ways that  
23 do not discriminate against individuals because of their age, disability or expected  
24 length of life;

25 C. Take into account the health care needs of diverse segments of the population,  
26 including women, children, persons with disabilities and other groups;

27 D. Ensure that health benefits established as essential are not subject to denial to  
28 individuals against their wishes on the basis of the individuals' age or expected length  
29 of life or of the individuals' present or predicted disability, degree of medical  
30 dependency or quality of life;

31 E. Provide that a qualified health plan may not be treated as providing coverage for  
32 the essential health benefits package described in subsection 1 unless the plan  
33 provides that:

34 (1) Coverage for emergency department services will be provided without  
35 imposing any requirement under the plan for prior authorization of services or  
36 any limitation on coverage where the provider of services does not have a  
37 contractual relationship with the plan for the providing of services that is more  
38 restrictive than the requirements or limitations that apply to emergency



1 department services received from providers who do have such a contractual  
2 relationship with the plan; and

3 (2) If emergency department services are provided out of network, the cost-  
4 sharing requirement, expressed as a copayment amount or coinsurance rate, is the  
5 same requirement that would apply if such services were provided in network;

6 F. Provide that if a plan is offered through an exchange, another health plan offered  
7 through that exchange may not fail to be treated as a qualified health plan solely  
8 because the plan does not offer coverage of benefits offered through the stand-alone  
9 plan that are otherwise required under subsection 2, paragraph J;

10 G. Periodically review the essential health benefits package under subsection 1 and  
11 provide a report to the Legislature and the public that contains:

12 (1) An assessment of whether enrollees are facing any difficulty accessing  
13 needed services for reasons of coverage or cost;

14 (2) An assessment of whether the essential health benefits package needs to be  
15 modified or updated to account for changes in medical evidence or scientific  
16 advancement;

17 (3) Information on how the essential health benefits package will be modified to  
18 address any gaps in access or changes in the evidence base; and

19 (4) An assessment of the potential of additional or expanded benefits to increase  
20 costs and the interactions between the addition or expansion of benefits and  
21 reductions in existing benefits to meet actuarial limitations; and

22 H. Periodically update the essential health benefits package under subsection 1 to  
23 address any gaps in access to coverage or changes in the evidence base the  
24 superintendent identifies in the review conducted under paragraph G.

25 **4. Cost-sharing limitations.** The superintendent shall establish annual limitations  
26 on cost sharing and deductibles that are substantially similar to the limitations for health  
27 plans subject to the federal Affordable Care Act as of January 1, 2019. The  
28 superintendent may increase the annual limitation as needed to reflect any premium  
29 adjustment percentage. For purposes of this subsection, "premium adjustment percentage"  
30 means the percentage, if any, by which the average per capita premium for health  
31 insurance coverage in the United States for the preceding calendar year as estimated by  
32 the superintendent no later than October 1st of such preceding calendar year exceeds such  
33 average per capita premium for 2019.

34 **5. Levels of coverage.** The superintendent shall define levels of coverage that are  
35 substantially similar to the levels of coverage required for health plans subject to the  
36 federal Affordable Care Act as of January 1, 2019.

37 **6. Report.** Within 30 days of defining essential health benefits as required under  
38 this section or within 30 days after adopting any changes to the definition of essential  
39 health benefits, the superintendent shall submit a report summarizing the definition of  
40 essential health benefits to the joint standing committee of the Legislature having  
41 jurisdiction over health coverage, insurance and financial services matters.

1 **7. Rule of construction.** This section may not be construed to prohibit a health plan  
2 from providing benefits in excess of the essential health benefits described in this section.

3 **8. Rules.** Rules adopted pursuant to this section are major substantive rules as  
4 defined in Title 5, chapter 375, subchapter 2-A.

5 **Emergency clause.** In view of the emergency cited in the preamble, this  
6 legislation takes effect when approved.

7 **SUMMARY**

8 The purpose of this bill is to ensure that consumer protections related to health  
9 insurance coverage included in the federal Patient Protection and Affordable Care Act are  
10 codified in state law.

11 In Part A, the bill does the following.

12 1. It makes clear that individual and group health plans may not impose any  
13 preexisting condition exclusion on an enrollee. The bill does permit a carrier to restrict  
14 enrollment in individual health plans to open enrollment and special enrollment periods  
15 established in rule.

16 2. It clarifies that carriers offering individual or group health plans may not establish  
17 lifetime or annual limits on the dollar value of benefits. The bill specifies that the  
18 provision prohibiting annual limits on the dollar value of benefits applies to the dollar  
19 value of essential health benefits as determined by the Superintendent of Insurance.

20 3. It allows children, until they attain 26 years of age, to remain on their parents'  
21 health insurance policy.

22 4. It changes the maximum rate differential due to age that may be filed by the  
23 carrier to the rate differential that is permitted under the federal Patient Protection and  
24 Affordable Care Act.

25 In Part B, the bill requires that, at a minimum, health plans cover essential health  
26 benefits that are substantially similar to those benefits required for health plans subject to  
27 the federal Patient Protection and Affordable Care Act as of January 1, 2019. The bill  
28 directs the Superintendent of Insurance to define essential health benefits in rule and  
29 designates those rules as major substantive and subject to legislative review and approval.