An Act To Clarify and Update the Laws Related to Health Insurance

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

PART A

Sec. A-1. 24-A MRSA §2834-B, sub-§3, as amended by PL 1999, c. 256, Pt. B, §1, is further amended to read:

3. Requirement. If a policy makes coverage available with respect to dependents of certificate holders, the policy must provide for a dependent special enrollment period when a person becomes a dependent of an eligible individual through marriage, birth or adoption or placement for adoption ~~or~~, if a court order is issued changing custody of a child or if a dependent who has other coverage loses eligibility under that coverage. During this period, the dependent may be enrolled under the plan as a dependent of the eligible individual and, in the case of the birth or adoption of a child, the spouse of the eligible individual may be enrolled as a dependent if otherwise eligible for coverage. If the eligible individual is not already enrolled or is enrolled in a different benefit package, the individual may enroll during this period.

Sec. A-2. 24-A MRSA §2834-B, sub-§4, as amended by PL 1999, c. 256, Pt. B, §2, is further amended to read:

4. Length of period. A dependent special enrollment period under this section must be a period of not less than 30 days and must begin on the ~~later~~latest of:

A. The date dependent coverage is made available; ~~or~~

B. The date of the marriage, birth or adoption or placement for adoption or the date of the court order.; and

C. The date a dependent loses other coverage.

Sec. A-3. 24-A MRSA §2834-B, sub-§5, as amended by PL 1999, c. 256, Pt. B, §§3 and 4, is further amended to read:

5. No waiting period. If an individual seeks to enroll a dependent during the first 30 days of a dependent special enrollment period, the coverage of the dependent becomes effective:

A. In the case of marriage, no later than the first day of the first month beginning after the date the completed request for enrollment is received;

B. In the case of a dependent's birth, as of the date of the birth;

C. In the case of a dependent's adoption or placement for adoption, as of the date of the adoption or placement for adoption; ~~or~~

D. In the case of a court order changing custody of a child, as of the date of the order~~.~~; or

E. In the case of a dependent who loses other coverage, as of the date of application for enrollment.

Sec. A-4. 24-A MRSA §2849-B, sub-§3, ¶A-1 is enacted to read:

A-1. That person incurs a claim under a prior contract or policy that would meet or exceed that contract or policy's lifetime limit on all benefits, and a request for enrollment is made not later than 30 days after a claim is denied in whole or in part due to the operation of a lifetime limit on all benefits.

Sec. A-5. 24-A MRSA §2849-B, sub-§4, as amended by PL 1993, c. 477, Pt. A, §13 and affected by Pt. F, §1, is further amended to read:

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

Sec. A-6. 24-A MRSA §2849-C, sub-§2, ¶B, as enacted by PL 2001, c. 258, Pt. C, §1, is amended to read:

B. The certification described in this paragraph is a written certification of:

(1) The period of federally creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision; ~~and~~

(2) The waiting period, if any, imposed with respect to the individual for any coverage under the plan~~.~~; and

(3) An educational statement regarding the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, consistent with federal law.

Sec. A-7. 24-A MRSA §2849-C, sub-§4, as enacted by PL 2001, c. 258, Pt. C, §1, is amended to read:

4. Notice. A carrier may not impose a preexisting condition exclusion before ~~notifying the individual~~providing the individual with notice consistent with federal law of the individual's continuity rights and giving the individual an opportunity to provide a certification as described in subsection 2 or alternative evidence of prior coverage as described in subsection 3.

Sec. A-8. 24-A MRSA §2850, sub-§2, as amended by PL 2001, c. 258, Pt. D, §3, is further amended to read:

2. Limitation. An individual ~~or~~, group or blanket contract issued by an insurer may not impose a preexisting condition exclusion except as provided in this subsection. A preexisting condition exclusion may not exceed 12 months from the date of enrollment, including the waiting period, if any. For purposes of this subsection, "waiting period" includes any period between the time ~~an individual files~~ a substantially complete application for an individual or small group health plan is filed and the time the coverage takes effect. A preexisting condition exclusion may not be more restrictive than as follows.

A. In a group contract, a preexisting condition exclusion may relate only to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the date of enrollment. An exclusion may not be imposed relating to pregnancy as a preexisting condition.

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

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

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

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

PART B

Sec. B-1. 24-A MRSA §4301-A, sub-§1, as enacted by PL 1999, c. 742, §3, is amended to read:

1. Adverse health care treatment decision. "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering or renewing a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee.

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

To offer or renew a health plan in this State, a carrier must comply with the following requirements.

Sec. B-3. 24-A MRSA §4302, sub-§2, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

2. Plan complaint; adverse decisions; prior authorization statistics. A carrier shall provide annually to the superintendent information for each health plan that it offers or renews on plan complaints, adverse decisions and prior authorization statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received by the plan to the total number of enrollees, reported by type of complaint and category of enrollee;

B. The ratio of the number of adverse decisions issued by the plan to the number of complaints received, reported by category;

C. The ratio of the number of prior authorizations denied by the plan to the number of prior authorizations requested, reported by category;

D. The ratio of the number of successful enrollee appeals to the total number of appeals filed;

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and

F. Enrollee satisfaction statistics, including provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints.

Sec. B-4. 24-A MRSA §4303, first ¶, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

A carrier offering or renewing a health plan in this State must meet the following requirements.

Sec. B-5. 24-A MRSA §4303, sub-§1, as amended by PL 2003, c. 469, Pt. E, §20 and c. 689, Pt. B, §6, is further amended to read:

1. Demonstration of adequate access to providers. Except as provided in paragraph A, 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 transportational 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. 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;

(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 provisionally adopt rules by January 1, 2004 regarding the criteria used by the superintendent to determine whether the carrier meets the quality requirements of this subparagraph and present those rules for legislative review during the Second Regular Session of the 121st Legislature; 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%.

This paragraph takes effect January 1, 2004 and is repealed July 1, 2007.

Sec. B-6. 24-A MRSA §4303, sub-§3, as enacted by PL 1995, c. 673, Pt. C, §1 and affected by §2, is amended to read:

3. Provider's right to advocate for medically appropriate care. A carrier offering <u>or renewing</u> 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.

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.

Sec. B-7. 24-A MRSA §4303, sub-§3-A, as enacted by PL 1997, c. 163, §2, is amended to read:

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.

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.

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.

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.

Sec. B-8. 24-A MRSA §4303, sub-§3-B, as amended by PL 2001, c. 288, §5, is further amended to read:

3-B. Prohibition on financial incentives. A carrier offering <u>or renewing</u> 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.

Sec. B-9. 24-A MRSA §4303, sub-§4, as amended by PL 2003, c. 309, §1, is further amended to read:

4. Grievance procedure for enrollees. A carrier offering <u>or renewing</u> 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.

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.

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.

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.

Sec. B-10. 24-A MRSA §4303, sub-§5, as enacted by PL 1999, c. 396, §5 and as affected by §7, is amended to read:

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.

Sec. B-11. 24-A MRSA §4303, sub-§9, as enacted by PL 2003, c. 218, §9, is amended to read:

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.

Sec. B-12. 24-A MRSA §4304, first ¶, as amended by PL 1999, c. 742, §11, is further amended to read:

The following requirements apply to health plans doing business in this State that require prior authorization by the plan of health care services or otherwise subject payment of health care services to review for clinical necessity, appropriateness, efficacy or efficiency. A carrier offering or renewing a health plan subject to this section that contracts with other entities to perform utilization review on the carrier's behalf is responsible for ensuring compliance with this section and chapter 34.

Sec. B-13. 24-A MRSA §4304, sub-§1, as amended by PL 2001, c. 288, §6, is further amended to read:

1. Requirements for medical review or utilization review practices. A carrier must appoint a medical director who is responsible for reviewing and approving the carrier's policies governing the clinical aspects of coverage determinations by any health plan that it offers or renews. A carrier's medical review or utilization review practices must be governed by the standard of medically necessary health care as defined in this chapter.

Sec. B-14. 24-A MRSA §4305, first ¶, as amended by PL 1999, c. 742, §14, is further amended to read:

A carrier offering or renewing a health plan that subjects payment of benefits for otherwise covered services to review for clinical necessity, appropriateness, efficacy or efficiency must meet the following requirements relating to quality of care.

Sec. B-15. 24-A MRSA §4306, as amended by PL 1999, c. 742, §15, is further amended to read:

§ 4306. Enrollee choice of primary care provider

A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A, to serve as primary care providers for managed care plans. A carrier is not required to contract with certified nurse practitioners or physicians as primary care providers in any manner that exceeds the access and provider network standards required in this chapter or chapter 56, or any rules adopted pursuant to those chapters. A carrier ~~must~~shall allow enrollees in a managed care plan to change primary care providers without good cause at least once annually and to change with good cause as necessary. When an enrollee fails to choose a primary care provider, the carrier may assign the enrollee a primary care provider located in the same geographic area in which the enrollee resides.

Sec. B-16. 24-A MRSA §4308, first ¶, as enacted by PL 1999, c. 742, §18, is amended to read:

A contract between a carrier offering or renewing a health plan and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with ~~any~~a claim or action brought against the health plan based on the carrier's own fault. Nothing in this section may be construed to remove responsibility of a carrier or provider for expenses or liabilities caused by the carrier's or provider's own negligent acts or omissions or intentional misconduct.

Sec. B-17. 24-A MRSA §4312, first ¶, as enacted by PL 1999, c. 742, §19, is amended to read:

An enrollee has the right to an independent external review of a carrier's adverse health care treatment decision made by or on behalf of a carrier offering or renewing a health plan in accordance with the requirements of this section. An enrollee's failure to obtain authorization prior to receiving an otherwise covered service may not preclude an enrollee from exercising the enrollee's rights under this section.

Sec. B-18. 24-A MRSA §4313, sub-§1, as enacted by PL 1999, c. 742, §19, is amended to read:

1. Duty of ordinary care; cause of action. An enrollee may maintain a cause of action against a carrier offering or renewing a health plan in accordance with the following.

A. A carrier has the duty to exercise ordinary care when making health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee and is liable for damages as provided in this section for harm to an enrollee proximately caused by the failure of the carrier or its agents to exercise such ordinary care.

B. A carrier is also liable for damages as provided in this section for harm to an enrollee proximately caused by the health care treatment decisions made by its agents who are acting on the carrier's behalf and over whom the carrier exercised control or influence in the health care treatment decisions that result in the failure to exercise ordinary care.

PART C

Sec. C-1. 24-A MRSA §2850-B, sub-§3, ¶F-1 is enacted to read:

F-1. When the carrier ceases offering individual health plans in compliance with section 2736-C, subsection 4 and does not renew an existing policy in that market;

PART D

Sec. D-1. 24-A MRSA §2849, sub-§1, as amended by PL 1995, c. 332, Pt. F, §3, is further amended to read:

1. Policies subject to this section. Notwithstanding any other provision of law, this section applies to all group and blanket medical insurance policies issued by insurers or health maintenance organizations to policyholders who are obtaining coverage for a group or subgroup to replace coverage under a different contract or policy issued by ~~any~~a nonprofit hospital or medical service organization, insurer or health maintenance organization, or to replace coverage under an uninsured employee benefit plan that provides payment for health services received by employees or their dependents if the policyholder has applied for coverage under the replacement policy within 90 days after termination of coverage under the contract or policy being replaced. For purposes of this section, the group or blanket policy issued to replace the prior contract or policy is the "replacement policy." The group or blanket contract or policy or uninsured employee benefit plan, or a number of individual contracts or policies if the premiums were paid by the employer or by payroll deduction, being replaced is the "replaced contract or policy."

Sec. D-2. 24-A MRSA §2849-A, sub-§2, as amended by PL 1999, c. 256, Pt. L, §6, is further amended to read:

2. Requirement. Every group or blanket policy subject to this section must provide a reasonable extension of benefits for a person who is totally disabled on the date the group or blanket policy is discontinued, or on the date coverage for a subgroup in the policy is discontinued. A premium may not be charged during the period of extension. For a policy providing hospital or medical expense coverage, an

extension of benefits provision is reasonable if it provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement.

Sec. D-3. 24-A MRSA §2849-A, sub-§4-A, as enacted by PL 1997, c. 604, Pt. H, §2, is amended to read:

4-A. Coordination of benefits. If replacement coverage is secured by the group or blanket policyholder from ~~any~~an insurer, nonprofit hospital or medical service organization or health maintenance organization and a totally disabled person is covered under ~~such~~the replacement coverage, the replacement coverage must pay as primary coverage and the replaced coverage must pay as secondary coverage for the covered expenses directly relating to the condition causing total disability during the extension of benefits required under this section.

Sec. D-4. 24-A MRSA §2849-B, sub-§2, as amended by PL 2001, c. 258, Pt. E, §7, is further amended to read:

2. Persons provided continuity of coverage. Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under an individual ~~or a,~~ group or blanket insurance policy or health maintenance organization policy if:

A. That person was covered under an individual ~~or,~~ group or blanket contract or policy issued by ~~any~~a nonprofit hospital or medical service organization, insurer, health maintenance organization~~,~~ or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program, including, but not limited to, those listed in section 2848, subsection 1-B, paragraph A, subparagraphs (3) to (10). For purposes of this section, the individual ~~or,~~ group or blanket policy under which the person is seeking coverage is the "succeeding policy." The group, blanket or individual contract or policy, uninsured employee benefit plan or governmental program that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within 90 days before the date the person enrolls or is eligible to enroll in the succeeding contract.

A period of ineligibility for ~~any~~a health plan imposed by terms of employment may not be considered in determining whether the coverage ended within a time period specified under this section.

This section does not apply to replacements of group or blanket coverage within the scope of section 2849 or if the succeeding policy is an individual policy and the prior contract or policy was a short-term policy.

PART E

Sec. E-1. 24-A MRSA §409, sub-§3, as enacted by PL 1991, c. 385, §1, is amended to read:

3. Life or health insurer. A life or health insurer is authorized to transact life insurance, life and annuity insurance or health insurance as defined in sections 702 to ~~704~~704-A. A life insurer, health insurer or a life and health insurer does not become an all lines insurer merely by transacting specific lines of casualty insurance that life or health insurers are expressly authorized by law to transact.

PART F

Sec. F-1. 24-A MRSA §2809-A, sub-§1-B, as amended by PL 2003, c. 156, §4, is further amended to read:

1-B. Notification of availability of individual coverage. An insurer ~~must~~shall provide forms to group policyholders and certificate holders ~~as~~when required ~~in~~by subsection 1-A for the purpose of informing terminating group members of their right to purchase any individual health plan available in this State. An adequate supply of forms must be provided to each group policyholder when the policy is issued and at least annually ~~thereafter~~after the policy is issued. The superintendent may prescribe the content of the form by routine technical rule pursuant to Title 5, chapter 375, subchapter 2-A. The form must include at least the following:

A. A statement that all state residents not eligible for Medicare have a right to purchase any individual health plan available in this State;

B. A statement that in order to avoid a gap in coverage, the individual should apply for individual coverage prior to termination of group coverage;

C. A statement that if more than 90 days pass between the time the group coverage ends and the time individual coverage begins, the individual coverage may exclude preexisting conditions for one year; and

D. A statement that information concerning individual coverage is available from the Bureau of Insurance. The bureau's toll-free telephone number must also be provided.

PART G

Sec. G-1. 24-A MRSA §2696, sub-§2, as enacted by PL 2001, c. 410, Pt. C, §1, is amended to read:

2. Exclusion based on preexisting condition limited after 6 months. Notwithstanding the provisions of subsection 1 and section 2706, subsection 2, division (b), an insurer that issues a specified disease policy or certificate~~, regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form~~ may not deny a claim for any covered loss that begins after the policy or certificate has been in force for at least 6 months, unless that loss results from a preexisting condition that was diagnosed by a physician before the date of application for coverage or that first manifested itself within the 6 months immediately preceding the application date. ~~Except for rescission for misrepresentation,~~Other defenses based upon preexisting conditions are not permitted except for rescission for misrepresentation. This subsection applies regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form.

SUMMARY

This bill amends various provisions of law concerning health insurance in order to comply with final federal rules published in December 2004 to clarify the federal Health Insurance Portability and Accountability Act of 1996. It also provides that a waiting period in a small group health plan includes a period between the time a substantially complete application is filed and the time the coverage takes effect.

This bill requires that second level appeals of health insurance claims be completed within 30 days when the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier. It also clarifies that provisions of the health plan improvement laws applying to carriers offering health plans apply to carriers renewing health plans even if the plans are no longer sold.

This bill amends the list of exceptions to the law concerning guaranteed renewal of individual health insurance to include withdrawal from the market.

This bill amends the law concerning continuity of health insurance to clarify that it applies to blanket coverage.

This bill clarifies that a life and health insurer can be licensed to issue health maintenance organization contracts.

This bill clarifies the law requiring notice of group health termination.

This bill clarifies the law regarding permissible limitations on coverage of preexisting conditions in specified disease policies.