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INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

125TH LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT " " to H.P. 1254, L.D. 1702, Bill, "An Act To Correct Inconsistencies and Ambiguities in the Maine Guaranteed Access Reinsurance Association Act"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

'**Sec. 1. 24-A MRSA §2736-C, sub-§3,** as amended by PL 2011, c. 90, Pt. B, §6 and affected by §10, is further amended to read:

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

A. Coverage must be guaranteed to all residents of this State other than those eligible without paying a premium for Medicare Part A ~~and may be reinsured through the Maine Guaranteed Access Reinsurance Association established pursuant to chapter 54-A. On or after July 1, 2012, coverage~~ Coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. Except for federally eligible individuals, coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months. When a managed care plan, as defined by section 4301-A, provides coverage a carrier may:

(1) Deny coverage to individuals who neither live nor reside within the approved service area of the plan for at least 6 months of each year; and

(2) Deny coverage to individuals if the carrier has demonstrated to the superintendent's satisfaction that:

(a) The carrier does not have the capacity to deliver services adequately to additional enrollees within all or a designated part of its service area because of its obligations to existing enrollees; and

(b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this ~~paragraph~~ subparagraph may not enroll individuals residing within the area subject to denial of coverage or groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage.

B. Renewal is guaranteed, pursuant to section 2850-B.

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

(1) The carrier does not issue or deliver any new individual health plans on or after the effective date of this section;

(2) If any individual health plans that were not issued on a guaranteed renewable basis are renewed on or after December 1, 1993, all such policies must be renewed by the carrier and renewal must be guaranteed after the first such renewal date; and

(3) The carrier complies with the rating practices requirements of subsection 2.

D. Notwithstanding paragraph A, carriers offering supplemental coverage for the Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are not required to issue this coverage if the applicant for insurance does not have CHAMPUS coverage.

E. ~~A~~ As part of the application process for individual health coverage, a carrier ~~may evaluate the health status of~~ shall require an individual ~~for purposes of designating that individual for reinsurance through the Maine Guaranteed Access Reinsurance Association established in chapter 54-A. For individual health plans issued on or after July 1, 2012, the carrier shall use~~ to complete the health statement developed by the Board of Directors of the Maine Guaranteed Access Reinsurance Association pursuant to section 3955, subsection 1, paragraph E ~~to make a designation and may not use any other method to determine the health status of an individual. For purposes of this subsection, "health statement" means any information intended to inform the carrier or an insurance producer acting on behalf of a carrier of the health status of an enrollee or prospective enrollee in an individual health plan~~. A carrier may not deny coverage or refuse to renew or cancel an individual health plan on the basis of an individual's complete or incomplete health statement, claims history or risk scores or on the basis of any omission of material information from a health statement or misrepresentation of an individual's health status. The rejection of an application for individual health coverage by a carrier because an individual has not submitted a completed health statement is not a denial of coverage for the purposes of this paragraph.

Sec. 2. 24-A MRSA §3955, sub-§1, ¶E, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

E. Develop a health statement to be used ~~by a member insurer to designate a resident~~ in evaluating a person for designation for reinsurance pursuant to section 3959.

Protected health information included in a health statement submitted to the association that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or covered by chapter 24 remains confidential and is not open to public inspection; and

Sec. 3. 24-A MRSA §3957, sub-§5, ¶B, as enacted by PL 2011, c. 90, Pt. B, §8, is repealed.

Sec. 4. 24-A MRSA §3958, sub-§1, ¶A, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

A. ~~The~~ Beginning July 1, 2012, the association ~~may not~~ shall reimburse a member insurer for claims incurred with respect to ~~claims of~~ a person designated for reinsurance by the member insurer pursuant to section 3959 ~~until~~ or 3961 after the insurer has incurred an initial level of claims for that person of $7,500 for covered benefits in a calendar year. In addition, the insurer is responsible for 10% of the next $25,000 of claims paid during a calendar year. The ~~association shall reimburse insurers for claims paid~~ amount of reimbursement is 90% of the amount incurred between $7,500 and $32,500 and 100% of the amount incurred in excess of $32,500 for claims incurred in that calendar year with respect to that person. For calendar year 2012, only claims incurred on or after July 1st are considered in determining the member insurer's reimbursement. The association may annually adjust the initial level of claims and the maximum limit to be retained by the insurer to reflect increases in costs and utilization within the standard market for individual health plans within the State. The adjustments may not be less than the annual change in the Consumer Price Index for medical care services unless the superintendent approves a lower adjustment factor as requested by the association.

Sec. 5. 24-A MRSA §3958, sub-§2, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

2. Premium rates. The association, as part of the plan of operation under section 3953, subsection 3, shall establish a methodology for determining premium rates to be charged member insurers to reinsure persons eligible for coverage under this chapter. The methodology must include a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C, together with any additional rating factors the association determines to be appropriate. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that ~~reasonably approximate gross premiums charged for individual health plans and that are adjusted to reflect retention levels required under this Title~~, together with other funds available to the association, will be sufficient to meet the anticipated costs of the association. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by an insurer.

Sec. 6. 24-A MRSA §3959, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

§3959. Designation for reinsurance

1. Designation. The association shall provide reinsurance to a member insurer for ~~persons~~ a person designated for reinsurance by a member insurer ~~using the health statement developed by the board pursuant to section 3955, subsection 1, paragraph F.~~, if the designation was made:

A. By using the health statement developed by the board pursuant to section 3955, subsection 1, paragraph E or by using the person's claims history or risk scores or any other reasonable means;

B. As a mandatory designation pursuant to subsection 2 on the basis of the existence or history of any medical or health condition on the list developed by the board pursuant to subsection 2; or

C. On the basis of an omission of material information from the health statement developed by the board pursuant to section 3955, subsection 1, paragraph E or misrepresentation of the person's health status on the health statement.

2. Mandatory designation. The board shall develop a list of medical or health conditions for which a person ~~is automatically~~ must be designated for reinsurance by a member insurer. ~~A person who demonstrates~~ If a person's health statement, claims history or risk scores demonstrate the existence or history of any medical or health conditions on the list developed by the board ~~may not be required to complete the health statement specified in subsection 1~~ at the time the plan is issued or when the person is added to the plan, the member insurer shall designate the person for reinsurance. The board may amend the list from time to time as appropriate.

3. Enrolling additional persons. A member insurer may designate a person for reinsurance pursuant to this section when the person is added to an individual health plan.

4. Designation effective date and premium. The designation of a person for reinsurance is effective as of the effective date of the primary coverage provided by the member insurer, except that the earliest effective date for any reinsurance is July 1, 2012. A member insurer's premium for reinsurance begins to accrue as of the effective date of the designation.

Sec. 7. 24-A MRSA §3961, sub-§1, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

1. Reimbursement. A member insurer may seek reimbursement from the association and the association shall reimburse the member insurer with respect to a person insured through a member insurer's closed book of business to the extent claims made by a covered person ~~on a calendar year basis after July 1, 2012 exceed the amounts otherwise~~ are eligible for reimbursement pursuant to section 3958, subsection 1, paragraph A, if:

A. The ~~member insurer sold an individual health plan to the~~ covered person ~~between~~ is insured under a policy sold on or after December 1, 1993 and in force as of July 1, 2012, ~~the individual health plan that was sold has been continuously renewed by the covered person~~ and the member insurer has closed its book of business for individual health plans sold between December 1, 1993 and July 1, 2012; ~~and~~

B. The member insurer is able to determine through the use of individual health statements, claims history, risk scores or any reasonable means that~~, between December 1, 1993 and July 1, 2012, while the person received coverage under an individual health plan issued by the member insurer,~~ the covered person ~~would have been designated~~ currently qualifies for designation by the member insurer pursuant to section 3959, subsection 1~~.~~; and

C. The member insurer seeks to designate the covered person for reimbursement from the association by October 1, 2012.

This subsection applies only to the individual health plans described and is not intended to limit the ability of a member insurer to designate a covered person for reinsurance pursuant to section 3959.

Sec. 8. 24-A MRSA §3961, sub-§1-A is enacted to read:

1-A. Premium. A member insurer seeking reimbursement under subsection 1 is liable to the association for reinsurance premium rates determined in accordance with section 3958, subsection 2.'

SUMMARY

This amendment replaces the bill and is the majority report of the committee. It makes technical corrections to address inconsistencies and ambiguities in the Maine Guaranteed Access Reinsurance Association Act.

1. It clarifies that reimbursement is based on the calendar year in which the claim was incurred, except that the initial claim reimbursement period for the first year of the program is the period beginning July 1, 2012 and ending December 31, 2012.

2. It allows a member insurer to designate a person for reinsurance through the use of claims history, risk scores and other reasonable means, in addition to the use of a health statement. It also allows a member insurer to designate a person for reinsurance in the event the person omitted material information from the health statement or misrepresented the person's health status on the health statement. It clarifies that a person's health statement, claims history or risk scores or the omission of material information from the health statement or misrepresentation of a person's health status may not be used by a carrier as a basis for denying, cancelling or refusing to renew an individual health plan.

3. It allows a member insurer to designate a person for reinsurance if the person is added to a policy.

4. It clarifies that protected health information obtained by the association that is confidential under federal and state law remains confidential and is not open to public inspection.

5. It clarifies that the Maine Revised Statutes, Title 24-A, section 3961 applies to the closed book of business for individual health plans sold between December 1, 1993 and July 1, 2012, and that reimbursement to member insurers with respect to closed books of business is subject to the same claims reimbursement periods and retention levels as open books of business. It also clarifies that Title 24-A, section 3961 is not intended to limit

the ability of a member insurer to designate a covered person for reinsurance pursuant to Title 24-A, section 3959.

6. It requires a member insurer who seeks reimbursement with respect to a covered person who is in the member insurer's closed book of business for individual health plans to designate the member insurer for reinsurance by October 1, 2012.

7. It clarifies that member insurers are required to pay reinsurance premium rates with respect to covered persons designated under Title 24-A, section 3961.

FISCAL NOTE REQUIRED

(See attached)