L.D. 1373

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HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

131ST LEGISLATURE

FIRST SPECIAL SESSION

COMMITTEE AMENDMENT " " to H.P. 887, L.D. 1373, "An Act to Allow Employers to Shop for Competitive Health Plan Options by Expanding the Disclosure of Health Claims Information"

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

'**Sec. 1. 24-A MRSA §2803-A,** as amended by PL 2015, c. 420, §2, is further amended to read:

§2803-A. Loss information

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

A. "Insurance policy" means the insurance policy relating to the loss information requested pursuant to this section.

A-1. "High-cost claimant" means an individual insured whose aggregate claims exceed $50,000 during the 12-month period preceding the request for loss information.

B. "Loss information" means the aggregate claims experience of the group insurance policy or contract. "Loss information" includes the amount of premium received, the amount of claims paid and the loss ratio. "Loss information" does not include any information or data pertaining to the medical diagnosis, treatment or health status that identifies an individual covered under the group contract or policy.

C. "Loss ratio" means the ratio between the amount of premium received and the amount of claims paid by the insurer under the group insurance contract or policy.

2. Disclosure of basic loss information. Upon written request, every insurer shall provide loss information, in accordance with the minimum requirements of paragraph A, concerning a group policy or contract to its policyholder, to a former policyholder or to a school administrative unit pursuant to Title 20-A, section 1001, subsection 14, paragraph E within 21 business days of the date of the request. This subsection does not apply to a former policyholder whose coverage terminated more than 18 months prior to the date of

a request. For the purposes of this subsection, "school administrative unit" has the same meaning as in Title 20-A, section 1, subsection 26.

The loss information provided by an insurer must include:

A. A minimum of 24 months of claims data or, if that period is less than 24 months, claims data for the period the policyholder, former policyholder or school administrative unit has been insured by the insurer;

B. The aggregate claims and loss ratio by month with the total medical and pharmacy claims provided separately for each month; and

C. High-cost claimant reports when there are more than 25 enrollees covered under the group policy. High-cost claimant reports must coincide with the time frames of any loss ratio reports and must include, at a minimum, enrollment status of active or terminated insureds and primary diagnosis.

3. Transmittal of request. An insurance contractor or producer ~~or other authorized representative~~ who receives a request for loss information in accordance with this section shall transmit the request for loss information to the insurer within 4 business days. An insurer receiving a disclosure request under subsection 2 may transmit high-cost claimant data directly to another insurer or underwriter, or to a contractor or producer that has signed with that insurer a business associate agreement that is in accordance with 45 Code of Federal Regulations, Sections 164.502(e) and 164.504(e), for the purpose of securing quotes, developing actuarial reports, facilitating claim management or other activities related to quoting or managing the group health plan sponsored by the requesting group policyholder.

4. Exception. An insurer is not required to provide the loss information described in this section for a group that is eligible for small group coverage pursuant to section 2808-B.'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment replaces the bill and makes the following changes.

1. It requires disclosure of aggregate claims and total medical and pharmacy claims separately by month.

2. It clarifies that reports related to high-cost claimants are required only when there are more than 25 enrollees covered under the group policy and removes the requirement in the bill that those reports include prognosis information.

3. It removes the requirement that loss information include information related to requests for hospital stays of 5 days or longer during the 30-day period preceding the report request.

4. It removes the authorization for a group policyholder to receive loss information.