L.D. 751

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HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

130TH LEGISLATURE

FIRST SPECIAL SESSION

COMMITTEE AMENDMENT " " to H.P. 556, L.D. 751, "An Act To Allow Employers To Shop for Competitive Health Plan Options"

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

'**Sec. 1. 24-A MRSA §2215, sub-§1, ¶L,** as enacted by PL 1997, c. 677, §3 and affected by §5, is amended to read:

L. To a group policyholder for the purpose of reporting claims experience or conducting an audit of the regulated insurance entity's operations or services, only if the information disclosed is aggregate information and reasonably necessary for the group policyholder to conduct the review or audit, and to a group policyholder or employer to the extent necessary for reporting loss information in compliance with section 2803-A;

Sec. 2. 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.

A. The loss information provided by an insurer must include:

(1) 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 with the insurer;

(2) The loss ratio by month with medical and pharmacy claims identified individually;

(3) High-cost claimant reports that coincide with the time frames of any loss ratio reports provided. Such reports must include, at a minimum, enrollment status of active or terminated insureds, primary diagnosis and sufficient data regarding prognosis, to the extent the prognosis is known, to estimate anticipated claim cost for the 12-month coverage period immediately following the report request; and

(4) A statement describing precertification requests for hospital stays of 5 days or longer that were made during the 30-day period preceding the date of the report request.

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.

A. 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 a business associate agreement with that insurer that is compliant 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 policyholder.

B. A group policyholder receiving any high-cost claimant reports shall take all precautions and actions required under 45 Code of Federal Regulations, Section 164.504(f) with respect to the privacy and security of protected health information of a high-cost claimant, notwithstanding any exemption that may apply to the policyholder under federal law. An insurer that has received a disclosure request under subsection 2 may not transmit high-cost claimant data to any group policyholder that is not in compliance with this paragraph.

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.~~:

A. For a group that is eligible for small group coverage pursuant to section 2808-B; or

B. If the insurer is otherwise prohibited from disclosing that information under state or federal law.'

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

SUMMARY

This amendment, which is the minority report of the committee, replaces the bill, which is a concept draft.

The amendment expands the scope of loss information that must be provided to an employer to facilitate an employer's shopping for group health insurance coverage, including disclosure of a minimum of 24 months of claims data, to the extent possible, and information related to high-cost claimants.