L.D. 1279

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INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

SENATE

128TH LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT " " to S.P. 431, L.D. 1279, Bill, "An Act To Ensure Patient Protections in the Health Insurance Laws"

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-§11,** as enacted by PL 2013, c. 271, §1, is amended to read:

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

Sec. 2. 24-A MRSA §2742-B, as amended by PL 2007, c. 514, §§1 to 5, is further amended to read:

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

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

A. Is unmarried;

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

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

2. Offer of coverage. Notwithstanding section 2703, subsection 3, an individual health insurance policy that offers coverage for a dependent child must offer such

coverage, at the option of the policyholder, until the dependent child ~~is 25~~ attains 26 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

Sec. 3. 24-A MRSA §2833-B, as amended by PL 2007, c. 514, §§6 to 10, is further amended to read:

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

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

A. Is unmarried;

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

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

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

Sec. 4. 24-A MRSA §2849-B, sub-§8, as amended by PL 2011, c. 90, Pt. G, §2, is repealed.

Sec. 5. 24-A MRSA §2850, sub-§2, as amended by PL 2011, c. 364, §18, is further amended to read:

2. Limitation. An individual, 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 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~~. This subsection does not limit a carrier's ability to restrict enrollment in an individual contract to open enrollment and special enrollment periods in accordance with section 2736-C, subsection 11.

~~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-month period ending on the earlier of the date of enrollment in the contract and the date of enrollment in a prior contract covering the same group if there has not been a gap in coverage of greater than 90 days between contracts. 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 notbe 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.~~

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

Sec. 6. 24-A MRSA §4233-B, as amended by PL 2007, c. 514, §§11 to 15, is further amended to read:

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

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

A. Is unmarried;

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

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

2. Offer of coverage. An individual or group health maintenance organization contract that offers coverage for a dependent child shall offer such coverage, at the option of the contract holder, until the dependent child ~~is 25~~ attains 26 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

Sec. 7. 24-A MRSA §4318, as amended by PL 2011, c. 364, §33, is repealed.

Sec. 8. 24-A MRSA §4320, as enacted by PL 2011, c. 364, §34, is amended to read:

§4320. No lifetime or annual limits on health plans

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

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

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

SUMMARY

This amendment is the minority report of the committee and replaces the bill. Like the bill, the amendment allows children younger than 26 years of age to remain on their parents' health insurance policy. The amendment adds provisions not included in the bill to make the change also applicable to group health plans and health maintenance organization individual and group health plans.

The amendment retains the provision in the bill prohibiting individual, group and blanket health plans from imposing a preexisting condition exclusion on any enrollee, but adds language to allow a carrier to restrict enrollment in individual health plans to open enrollment and special enrollment periods established in rule.

The amendment clarifies that carriers offering individual or group health plans may not establish lifetime or annual limits on the dollar value of benefits. The amendment specifies that the provision prohibiting annual limits on the dollar value of benefits applies to the dollar value of essential health benefits as determined by the Superintendent of Insurance to the extent not inconsistent with federal law.

FISCAL NOTE REQUIRED

(See attached)