CHAPTER 19

NONPROFIT HOSPITAL OR MEDICAL SERVICE ORGANIZATIONS

SUBCHAPTER 1

GENERAL PROVISIONS

§2301. Purposes

Any corporation organized under special Act of the Legislature, under Title 13, chapter 81 or as a public benefit corporation under Title 13-B for the following purposes may be authorized by the superintendent on the terms and conditions provided for in this chapter, except that when such a corporation was previously organized by special Act of the Legislature, this chapter does not apply when inconsistent with that Act as previously amended: [PL 2003, c. 171, §9 (AMD).]

1. Nonprofit hospital service plans. To establish, maintain and operate nonprofit hospital service plans whereby hospital care may be provided by hospitals or groups of hospitals with which such a corporation has a contract for that purpose to those persons or groups of persons who become subscribers to that plan under a contract that entitles each subscriber to certain hospital care, and the hospital or hospitals contracting with such a corporation are governed by this chapter and by the provisions of Title 24-A that are applicable as provided in this chapter;
[PL 1993, c. 702, Pt. A, §1 (AMD).]

2. Nonprofit medical service plans. To establish, maintain and operate nonprofit medical service plans whereby medical or surgical service is provided to those persons or groups of persons who become subscribers to such a plan under contracts with such a corporation, either in the capacity of principal or in the capacity of agent of other nonprofit medical service corporations or insurance companies authorized to do business in this State, and the physician or physicians contracting with such a corporation are governed by this chapter and by the provisions of Title 24-A that are applicable as provided in this chapter;
[PL 1993, c. 702, Pt. A, §1 (AMD).]

3. Nonprofit health care plans. To establish, maintain and operate nonprofit health care plans whereby health care services not covered under subsections 1 and 2 may be provided, by institutions or persons licensed for that purpose by the State, when licensure is required, with which such a corporation has a contract for that purpose, to those persons or groups of persons who become subscribers to such a plan under a contract that entitles each subscriber to certain specific health care, and the institution or persons contracting with such a corporation are governed by this chapter and by the provisions of Title 24-A that are applicable as provided in this chapter;
[PL 1993, c. 702, Pt. A, §1 (AMD).]

3-A. Integrated medical service plans; indemnity health care contracts; health care plan administration. A corporation subject to this chapter that maintains a nonprofit hospital service plan, a nonprofit medical service plan or a nonprofit health care plan in accordance with subsections 1, 2 or 3 may, in addition:

A. Issue and maintain in force indemnity health care contracts whereby persons or groups of persons who are contract holders may be indemnified by that corporation for expenses for hospital care, medical or surgical services or other health care services. An indemnity contract issued pursuant to the authority established by this section is subject to all the requirements relating to

content and interpretation of such policies and contracts that apply to policies of the same kind of insurance as set forth in Title 24-A; [PL 1993, c. 702, Pt. A, §1 (NEW).]

B. Issue and maintain in force employee benefit excess insurance as defined in Title 24-A, section 707, subsection 1, paragraph C-1 with respect to health insurance and underlying risks that the corporation is authorized to cover under this chapter; [PL 1999, c. 256, Pt. M, §1 (AMD).]

C. Issue and maintain in force hospital, medical service and health care plans and contracts that include health care benefits for workplace and nonworkplace injury and illness in accordance with Title 39-A, section 403, subsection 2; [PL 1993, c. 702, Pt. A, §1 (NEW).]

D. Receive or collect charges, contributions or premiums, adjust or settle claims, and perform related administrative, management, accounting, bookkeeping and advisory functions on behalf of any plan, fund or program established or maintained by a plan sponsor, health care services plan, health maintenance organization, health care provider or insurer, including plans, funds or programs established or maintained to provide through insurance or alternatives to insurance a type of life, annuity, health or workers' compensation benefit, except that nothing in this subsection may be interpreted as authorizing a nonprofit hospital, medical or health care service corporation to assume insurance risks not related to health care under contracts for life or workers' compensation insurance or annuities; [PL 1993, c. 702, Pt. A, §1 (NEW).]

E. Establish, maintain, own, merge with, organize and operate a health maintenance organization directly as a division or line of business of the corporation, or indirectly as a subsidiary or affiliate of the corporation, pursuant to Title 24-A, chapter 56, which health maintenance organization has all of the rights and powers and is subject to all of the duties and responsibilities of a separately organized health maintenance organization under that chapter. A corporation subject to this chapter that engages in such activities may not be deemed to be practicing medicine and is exempt from provisions of law relating to the practice of medicine; and [PL 1993, c. 702, Pt. A, §1 (NEW).]

F. Perform, on behalf of others, clerical, bookkeeping, accounting, statistical, management, personnel, marketing or similar services related to the provision of health care or health care financing, or establish, maintain, own and operate entities, independently or with others, to perform such services; [PL 1993, c. 702, Pt. A, §1 (NEW).]

[PL 1999, c. 256, Pt. M, §1 (AMD).]

3-B. Hospital and medical service business exclusive. A hospital or medical service corporation may not engage in a business other than the business of hospital or medical service corporations as set forth in this section and in business activities reasonably and necessarily related to that business, except that:

A. A hospital or medical service corporation may also engage in activities reasonably necessary to the management, supervision, servicing and protection of its lawful investments; [PL 1993, c. 702, Pt. A, §1 (NEW).]

B. A hospital or medical service corporation may own subsidiaries or subsidiaries owning other subsidiaries that may engage in the activities under Title 24-A, section 1157; and [PL 1993, c. 702, Pt. A, §1 (NEW).]

C. A hospital or medical service corporation may utilize its facilities to perform administrative services for a governmental body, unit or agency; [PL 1993, c. 702, Pt. A, §1 (NEW).]

[PL 1993, c. 702, Pt. A, §1 (NEW).]

3-C. Nonprofit purposes. A nonprofit hospital and medical service organization that is authorized to provide nonprofit hospital service plans under subsection 1, nonprofit medical service plans pursuant to subsection 2 or nonprofit health care plans pursuant to subsection 3 is a charitable and benevolent institution, in accordance with Title 5, section 194-A, and a public charity and its assets are held for the purpose of fulfilling the charitable purposes of the organization, which purposes may include, but are

not limited to, the following: providing access to medical care through affordable health insurance and affordable managed care products for persons of all incomes; identifying and addressing the State's unmet health care needs, particularly with respect to medically uninsured and underserved populations; making services and care available through participating providers; and improving the quality of care for medically uninsured and underserved populations.
[PL 2003, c. 171, §10 (AMD).]

4. Inadvertent payments. If direct payment is inadvertently made to a hospital, physician or other provider of medical services or health care by or on behalf of a subscriber or member, a corporation may reimburse the subscriber up to the amount payable under the plan to a hospital, a physician or other provider of medical services or health care;
[PL 1993, c. 702, Pt. A, §1 (AMD).]

5. Principal or agent. In order to maintain and operate such plans, contracts, facilities and services, a corporation may act either in the capacity of principal or agent of other nonprofit hospital service corporations, insurers, health maintenance organizations, health care services plans, employee benefit plans, health care and employee benefit plan sponsors and health care providers authorized to do business in this State;
[PL 1993, c. 702, Pt. A, §1 (AMD).]

6. Contracts and agreements. To contract with any similar corporations in other states for the joint administration of their business and to enter into reciprocal arrangements for the mutual benefit of their subscribers;
[PL 1993, c. 702, Pt. A, §1 (AMD).]

7. Administrative services. A corporation has the right to utilize its organization and facilities, either directly or through another legal entity owned by it and similar corporations located in other states, to perform services for the United States or State or the units or agencies of either; or any public charity involved in health care;
[PL 2003, c. 171, §11 (AMD).]

8. Right to contract. The State or any county, city, town or other quasi-municipal corporation has the same right to contract with a corporation subject to this chapter as it has under Title 24-A, section 4501 with respect to insurers;
[PL 1993, c. 702, Pt. A, §1 (AMD).]

8-A. Managed care plans. With respect to managed care plans that require subscribers to select primary care physicians, a corporation subject to this chapter must meet the following requirements:

A. The corporation shall offer to groups of all sizes health benefit plans that meet the requirements for standardized health plans specified in Bureau of Insurance Rules, Chapter 750; [PL 1993, c. 702, Pt. A, §1 (NEW).]

B. The managed care plan must provide a spectrum of providers and services that meets patient demand; [PL 1993, c. 702, Pt. A, §1 (NEW).]

C. The managed care plan must provide to its members reasonable access to health care services. The Superintendent of Insurance shall adopt rules that consider geographical and transportation problems in rural areas; and [PL 1993, c. 702, Pt. A, §1 (NEW).]

D. The managed care plan must demonstrate a plan for providing services for rural and underserved populations and for developing relationships with essential community providers. The corporation must make an annual report to the Superintendent of Insurance regarding the plan. [PL 1993, c. 702, Pt. A, §1 (NEW).]

[PL 1993, c. 702, Pt. A, §1 (NEW).]

9. Indemnity health care contracts.

[PL 1993, c. 702, Pt. A, §1 (RP).]

9-A. Investments. Investments by corporations subject to this chapter are governed by this paragraph.

A. A corporation subject to this chapter may invest funds in the same manner and to the same extent as domestic mutual insurers under the provisions of Title 24-A, chapter 13-A and shall maintain reserves for possible losses or fluctuation in the value of investments as contemplated in Title 24-A, section 901-A, subsection 2. Those reserves must comprehend, at a minimum, an asset valuation reserve and an income maintenance reserve calculated by methods that are consistent with standards that have been adopted by the superintendent for management of investment risk by life and health insurers. [PL 2001, c. 72, §1 (AMD).]

B. Any limitation stated in Title 24-A, chapter 13-A on the investment powers of a mutual domestic insurer expressed in relation to the "surplus" of that insurer must be applied to a corporation subject to this chapter in relation to that corporation's subscriber reserves. [PL 1993, c. 702, Pt. A, §1 (NEW).]

C. Notwithstanding the limitation stated in Title 24-A, section 1156, subsection 2, paragraph D, a hospital or medical service corporation may invest in real property or interests in real property that is located in the United States, held directly or evidenced by partnership interests, stock of corporations, trust certificates or other instruments and acquired:

(1) As an investment for the production of income or to be improved or developed for that investment purpose; or

(2) For the convenient accommodation of the corporation's business.

After giving effect to any of those investments, the aggregate amount of investments made under subparagraph (1) may not exceed 20% of the hospital or medical service corporation's total admitted assets; the aggregate amount of investments made under subparagraph (2) may not exceed 15% of the corporation's total admitted assets; and the aggregate amount of investments made under this paragraph may not exceed 25% of the corporation's total admitted assets. Investments under subparagraph (1) in any single property, including improvements on that property, may not in the aggregate exceed 2% of the corporation's total admitted assets. [PL 1993, c. 702, Pt. A, §1 (NEW).]

D. In addition to the investments permitted under paragraph C, a hospital or medical service corporation that operates and establishes, maintains, merges with or organizes a health maintenance organization not organized as a separate legal entity may invest in real estate, including leasehold estates, for the convenient accommodation of the health maintenance organization's business, including hospitals, medical clinics, medical professional buildings and any other facility that is to be used by a provider in the provision of health care or by any other health care provider under contract with the health maintenance organization, and that facility must be used in the provision of health care services to members of the health maintenance organization by that provider.

(1) A parcel of real estate acquired under this subsection may include excess space for rent to others if it is reasonably anticipated that that excess will be required for expansion or if the excess is reasonably required in order to have one or more buildings that function as an economic unit.

(2) Real estate subject to this subsection may be subject to a mortgage.

(3) The admitted value of the investment may not exceed the greater of the hospital or medical service corporation's subscriber reserve or 20% of the corporation's admitted assets, and the aggregate investment in real estate held under paragraph C and under this paragraph may not exceed 40% of the corporation's admitted assets, except with the approval of the superintendent

if the superintendent finds that those percentages of the corporation's admitted assets are insufficient to provide for the convenient accommodation of the health maintenance organization's business. Investments in any single property, including improvements on that property, may not in the aggregate exceed 5% of the corporation's total admitted assets. [PL 1993, c. 702, Pt. A, §1 (NEW).]

E. Notwithstanding any provisions of this section and Title 24-A, chapter 13-A allowing other investments, a corporation subject to this chapter shall maintain cash or investment grade obligations, as defined in Title 24-A, section 1151-A, that at all times have a fair market value of not less than 100% of the corporation's liability for claims payable, incurred, but not reported, claims payable, unpaid claims adjustment expenses, unearned premiums and, as applicable, any statutory, special or additional reserves provided by the corporation for the benefit of subscribers as of the close of the corporation's most recent calendar quarter prepared on the basis of statutory accounting principles. If the corporation's liability for these enumerated items increases more than 10% prior to the end of the calendar quarter, the corporation must, within 10 days of the determination, reallocate its investments to ensure compliance with this paragraph. [PL 1999, c. 715, §1 (AMD).]

F. The superintendent may establish risk-based capital standards applicable to corporations subject to this chapter, their subsidiaries and controlled affiliates that engage in health care related business activities that the parent corporation conducts. [PL 1993, c. 702, Pt. A, §1 (NEW).]

G. A director, officer or employee of a corporation subject to this chapter who receives, collects, disburses or invests funds in connection with the activities of that organization is responsible for those funds in a fiduciary relationship to the corporation. [PL 1993, c. 702, Pt. A, §1 (NEW).]

H. For corporations subject to this subsection, the following terms have the following meanings.

(1) "Admitted assets" means those assets owned by the corporation, recognized pursuant to Title 24-A, section 901-A, reduced in amount by any applicable provision of this Title or Title 24-A. For purposes of applying the investment limitations of Title 24-A, chapter 13-A, the asset value must be that contained in the annual statement of the corporation as of December 31st of the year next preceding the making of the investment or contained in an audited financial report, as defined in Title 24-A, section 221-A, of more current origin prepared on the basis of statutory accounting principles.

(2) "Subscriber reserves" means those reserves held by the corporation for the protection of subscribers that are the excess of the corporation's assets over its liabilities as set forth in the annual statement of the corporation as of December 31st of the year next preceding the making of the investment or contained in an audited financial report, as defined in Title 24-A, section 221-A, of more current origin prepared on the basis of statutory accounting principles; [PL 2001, c. 72, §2 (AMD).]

[PL 2001, c. 72, §§1, 2 (AMD).]

9-B. Conversion to mutual insurer.

[PL 2003, c. 171, §12 (RP).]

9-C. Health maintenance organizations. A corporation subject to this chapter is not required to maintain separate reserves or surplus with respect to the operations of a health maintenance organization that is not a separate legal entity. All assets of the corporation must be available to pay claims arising from corporate operations, with the exception of assets supporting reserves set aside in accordance with a plan for the continuation of benefits to health maintenance organization members under Title 24-A, section 4204, subsection 7 and assets supporting additional reserves to the extent required by rules adopted by the superintendent pursuant to Title 24-A, section 901-A. A hospital or medical service corporation that establishes and maintains a health maintenance organization not

organized as a separate legal entity shall maintain separate accounting for the health maintenance organization;
[PL 2001, c. 72, §3 (AMD).]

9-D. Conversion to a domestic stock insurer. Conversion of a nonprofit hospital and medical service organization as defined in paragraph B, subparagraph (8) to a domestic stock insurer is governed by this subsection.

A. A nonprofit hospital and medical service organization or other entity authorized by the superintendent or organized pursuant to this chapter may convert to a domestic stock insurer subject to the provisions of this subsection. [PL 2001, c. 550, Pt. B, §2 (AMD).]

B. As used in this subsection, unless the context otherwise indicates, the following terms have the following meanings.

(1) "Charitable trust" has the meaning set forth in Title 5, section 194-A, subsection 1, paragraph C.

(2) "Charitable trust plan" means the plan submitted to the Attorney General pursuant to Title 5, section 194-A, subsection 5.

(3) "Conversion" means the process by which an organization, with the approval of the superintendent, converts to a domestic stock insurer pursuant to this subsection.

(4) "Conversion plan" means a written plan that sets forth the provisions required by the superintendent, that is filed with the superintendent pursuant to this subsection, that sets forth a complete description of the proposed conversion and that contains sufficient detail to permit the superintendent to make the findings required under this subsection.

(5) "Converted stock insurer" means the domestic stock insurer resulting from a conversion pursuant to this subsection.

(6) "Fair market value" means the value of an organization or an affiliate or the value of the assets of such an entity determined as if the entity had voting stock outstanding and 100% of its stock were freely transferrable and available for purchase without restrictions. In determining fair market value, consideration must be given to value as a going concern, market value, investment or earnings value, net asset value and a control premium, if any.

(7) "Member" means a member of the organization entitled to vote under the articles or bylaws of the organization.

(8) "Nonprofit hospital and medical service organization" or "organization" means a corporation or other entity authorized by the superintendent or organized pursuant to this chapter for the purpose of providing nonprofit hospital service plans within the meaning of subsection 1, nonprofit medical service plans within the meaning of subsection 2 and any organization that provides only nonprofit health care plans within the meaning of subsection 3.

(10) "Subscriber" means an individual who has subscribed to one or more of the hospital, medical or health care service plans or contracts offered or issued by the organization or health insurance affiliate as defined in section 2308-A through an individual or family policy or group policy. [PL 2003, c. 171, §13 (AMD).]

C. A nonprofit hospital and medical service organization may, without the need for reincorporation, amend its charter pursuant to this subsection to become a domestic stock insurer under and pursuant to the terms and conditions of a conversion plan that complies with this subsection and is approved by the superintendent after an adjudicatory hearing on the proposed conversion. Notice of the hearing must be given to the public and the organization's directors or trustees, officers, employees, members and subscribers, all of whom have the right to appear and be heard at the hearing. Beginning on the date on which a conversion plan is filed with the

superintendent for approval, the conversion plan must be available for public inspection and copying at the office of the superintendent, at the principal executive office of the organization that filed the conversion plan and at other locations the superintendent designates. [PL 1997, c. 344, §4 (NEW).]

D. Concurrent with the filing of the conversion plan with the superintendent, the organization shall file a charitable trust plan with the Attorney General pursuant to Title 5, section 194-A and submit a copy to the superintendent. The organization shall file a copy of the conversion plan with the Attorney General at the time the organization files the conversion plan with the superintendent. The superintendent shall commence review of the conversion plan pursuant to this subsection upon receipt by the superintendent of the Superior Court's approval or approval with modifications of the charitable trust plan or at such earlier time as the superintendent determines necessary. [PL 1997, c. 344, §4 (NEW).]

E. The superintendent may not issue final approval of a conversion plan unless the superintendent finds that:

(1) The terms and conditions of the conversion plan are fair and equitable and, in determining what is fair and equitable, consideration may be given to, but is not limited to, the factors set forth in paragraph L;

(2) The conversion plan is subject to approval by the vote of not less than 2/3 of the organization's board of directors;

(3) The conversion plan provides for the issuance of capital stock or assets of the converted stock insurer or a combination of stock and assets, without consideration, to the charitable trust equal to 100% of the fair market value of the organization;

(5) Immediately after, and giving effect to the terms of, the conversion, the converted stock insurer would be in safe and sound financial condition and would have paid-in capital stock and surplus in amounts not less than the minimum paid-in capital stock and surplus set forth under Title 24-A, section 410 required of a domestic stock insurer authorized to transact like kinds of insurance;

(7) The conversion plan provides that during the first 3 years after the conversion, to avoid dilution of the value of the shares issued in the conversion, the converted stock insurer and its affiliates may not issue shares greater in seniority, including voting rights or dividends, than the shares issued under the conversion plan. The superintendent may waive the provisions contained in this subparagraph if the superintendent, in the superintendent's sole discretion, determines that the charitable trust has control, as defined in Title 24-A, section 222, of the converted stock insurer;

(8) The conversion plan is consistent with the charitable trust plan and does not adversely affect the distribution of the organization's value to the charitable trust; and

(9) The conversion plan complies with all applicable law. [PL 2003, c. 171, §14 (AMD).]

F. The conversion plan must include the proposed articles of incorporation and bylaws of the converted stock insurer and all references in this subsection to the conversion plan are deemed to include such instruments. [PL 1997, c. 344, §4 (NEW).]

G. [PL 2003, c. 171, §15 (RP).]

H. The conversion plan sets forth a comparative premium rate analysis of all the organization's plans and product offerings, comparing actual premium rates for the 3-year period before the filing of the conversion plan and projected premium rates for the 3-year period following the proposed conversion. The rate analysis must address the projected impact, if any, of the proposed conversion upon the cost to subscribers as well as the projected impact, if any, of the proposed conversion

upon the organization's underwriting profit, investment income, tax position and loss and claim reserves, including the effect, if any, of adverse market or risk selection on reserves. [PL 1997, c. 344, §4 (NEW).]

I. The conversion plan must include an appraisal of the fair market value, or range of values, of the aggregate equity of the converted stock insurer to be outstanding upon completion of the conversion plan and, if a range of values, the methodology for fixing a final value coincident with the completion of the transactions provided for in the conversion plan.

(1) The appraisal must enable determinations of value for purposes of the amount of cash or other assets that the charitable trust will be entitled to receive, without consideration, under the provisions of the conversion plan required by paragraph E, subparagraph (3).

(2) The appraisal required by this paragraph must be prepared by persons independent of the organization, experienced and expert in the area of corporate appraisal and acceptable to the superintendent. The appraisal must be in form and content acceptable to the superintendent and contain a complete and detailed description of the elements that make up the appraisal, justification for the methodology employed and sufficient support for the conclusions reached in the appraisal.

(3) To the extent that the appraisal is based on a capitalization of the pro forma income of the converted stock insurer, the appraisal must indicate the basis for determination of the income to be derived from any proceeds of the sale of stock and demonstrate the appropriateness of the earnings-multiple used, including assumptions made regarding future earnings growth.

(4) To the extent that the appraisal is based on the comparison of the capital stock of the converted stock insurer with outstanding capital stock of existing stock entities offering comparable insurance products, the existing stock entities must be reasonably comparable to the converting stock insurer in terms of such factors as size, market area, competitive conditions, profit history and expected future earnings.

(5) In those instances when the superintendent determines that the appraisal is materially deficient or substantially incomplete, the superintendent may deem the entire conversion plan materially deficient or substantially incomplete and decline to further process or reject the application for conversion.

(6) The converting organization shall submit to the superintendent information demonstrating to the satisfaction of the superintendent the independence and expertise of any person preparing the appraisal or related materials under this paragraph.

(7) An appraiser may not serve as an underwriter or selling agent under the same conversion plan and an affiliate of an appraiser may not act as an underwriter or selling agent unless procedures are followed and representations and warranties made to ensure that an appraiser is separate from the underwriter or selling agent affiliate and the underwriter or selling agent affiliate does not make recommendations or in any way have an impact on the appraisal.

(8) An appraiser may not receive any other fee except the fee for services rendered in connection with the appraisal. [PL 2003, c. 171, §16 (AMD).]

J. A director, officer, agent or employee of the organization or any other person may not receive any fee, commission or other valuable consideration whatsoever other than that person's usual and regular salary and compensation for in any manner aiding, promoting or assisting in a conversion under this section or any related transaction, except as set forth in the conversion plan and approved by the superintendent. For the purposes of this paragraph, "usual and regular salary and compensation" does not include any salary, compensation or other economic benefit that is in any way contingent on completion of the conversion. This paragraph does not prohibit the payment of reasonable fees and compensation to attorneys-at-law, accountants and actuaries for services

performed in the independent practice of their professions, even though also directors of the organization. [PL 1997, c. 344, §4 (NEW).]

K. For the purpose of determining whether a conversion plan meets the requirements of this subsection and any other relevant provisions of this Title and Title 24-A, the superintendent may employ staff personnel and outside consultants including, without limitation, financial advisors, investment bankers, actuaries, attorneys and accountants. All costs related to the review of a conversion plan, including those costs attributable to the use of staff personnel, must be borne by the organization making the filing. [PL 1997, c. 344, §4 (NEW).]

L. In making a determination under paragraph E, subparagraph (1) as to whether a conversion plan is fair and equitable, the superintendent shall consider, among other factors, the following:

(1) Whether the conversion plan complies with the provisions of and purposes of this subsection and any rules of the superintendent that may be adopted under this subsection; and

(2) Whether the conversion plan would adversely affect, in any manner, the services to be rendered to subscribers. [PL 1997, c. 344, §4 (NEW).]

M. The superintendent may aggregate any transactions that are part of a plan or series of like transactions to determine whether those transactions constitute a conversion. [PL 1997, c. 344, §4 (NEW).]

N. The superintendent, in the superintendent's sole discretion, may determine when an application for conversion under this subsection is complete and may request additional information from the organization as the superintendent determines necessary to review the application and conversion plan. The superintendent may also conduct an examination under Title 24-A, section 221 to obtain any information the superintendent determines necessary in connection with an application for conversion or transaction or series of transactions that the superintendent determines constitute a conversion under paragraph M. The failure of the organization to provide the information or cooperate in the examination, in addition to other applicable penalties, constitutes grounds for denial of the application for conversion. [PL 1997, c. 344, §4 (NEW).]

O. The Attorney General has the right to intervene as a party in a proceeding before the superintendent and, if the Attorney General intervenes, has the right to receive any documents or other information received by the superintendent in connection with the proceeding. The Attorney General is subject to all confidentiality provisions that apply to the superintendent. [PL 1997, c. 344, §4 (NEW).]

P. The superintendent may adopt rules, not inconsistent with the provisions of this subsection, the superintendent determines necessary or desirable and appropriate to effect the purposes of this subsection. Rules adopted under this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A. [PL 1997, c. 344, §4 (NEW).]

[PL 2003, c. 171, §§13-16 (AMD).]

10. Superintendent defined. As used in this chapter "superintendent" means the Superintendent of Insurance of this State; and

[PL 1993, c. 702, Pt. A, §1 (AMD).]

11. Separate accounts. A hospital or medical services corporation that issues indemnity contracts, contracts pursuant to hospital, medical or health care service plans or integrated medical service plans shall maintain separate accounting for each of these lines of business.

[PL 1993, c. 702, Pt. A, §1 (NEW).]

SECTION HISTORY

PL 1965, c. 458, §1 (RPR). PL 1965, c. 513, §44 (AMD). PL 1967, c. 114, §§1,2 (AMD). PL 1967, c. 494, §19 (RPR). PL 1969, c. 132, §§5,6 (AMD). PL 1969, c. 419, §1 (RPR). PL 1969,

c. 590, §§36-39 (AMD). PL 1971, c. 444, §1 (RPR). PL 1973, c. 585, §12 (AMD). PL 1977, c. 141 (AMD). PL 1979, c. 377 (AMD). PL 1993, c. 702, §A1 (AMD). PL 1997, c. 344, §§2-4 (AMD). PL 1999, c. 256, §M1 (AMD). PL 1999, c. 715, §1 (AMD). PL 2001, c. 72, §§1-3 (AMD). PL 2001, c. 550, §B2 (AMD). PL 2003, c. 171, §§9-16 (AMD).

§2301-A. Continuity of licensure; business combinations

When a health maintenance organization authorized pursuant to Title 24-A, chapter 56 merges or consolidates with a nonprofit hospital, medical or health care service organization and operations of the surviving entity include those of a health maintenance organization, the surviving entity succeeds on a continuing basis to the authority possessed by the merging entities if: [PL 1993, c. 702, Pt. A, §2 (NEW).]

1. Plan approved. The Superintendent has approved the plan of merger or consolidation pursuant to Title 24-A, section 4203;
[PL 1993, c. 702, Pt. A, §2 (NEW).]

2. Entity financially qualified. The entity is financially qualified pursuant to the provisions of Title 24-A, sections 410 and 4204-A; and
[PL 1993, c. 702, Pt. A, §2 (NEW).]

3. Entity otherwise qualified. The entity is otherwise qualified pursuant to this Title and Title 24-A, chapter 56.
[PL 1993, c. 702, Pt. A, §2 (NEW).]

SECTION HISTORY

PL 1993, c. 702, §A2 (NEW).

§2302. Incorporation

The articles of incorporation, and amendments thereto, of every corporation organized under this chapter shall be submitted to the superintendent for approval, which, if granted, shall be indorsed thereon before the same are filed with the Secretary of State. [PL 1971, c. 444, §2 (RPR); PL 1973, c. 585, §12 (AMD).]

There shall be not less than 14 directors, at least a majority of whom shall be consumer representatives. For purposes of this section, "consumer representative" means a person who does not derive more than 20% of annual income, whether directly or through that person's spouse, from the delivery of health care services. The remaining directors shall at all times be licensed health professionals who contract with the corporation for the direct provision of health services, or persons employed by participating health care institutions or organizations that contract with the corporation to provide health services to the corporation's subscribers, or persons employed by associations of providers and professionals of health care services. No director shall serve more than 3 consecutive 3-year terms. [PL 1975, c. 708, §1 (RPR).]

SECTION HISTORY

PL 1971, c. 444, §2 (AMD). PL 1973, c. 585, §12 (AMD). PL 1975, c. 708, §§1,2 (AMD).

§2302-A. Utilization review data

1. Report required. On or before April 1st of each year, every nonprofit hospital or medical service organization which issues or administers a program or contract in this State that contains a provision whereby in nonemergency cases the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed or ordered by a duly licensed

physician shall file a report on the results of that evaluation for the preceding year with the superintendent which shall contain the following:

A. The number and type of evaluations performed.

(1) For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: Presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service; [PL 1987, c. 168, §1 (NEW).]

B. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or whether benefits paid for the service were reduced by the organization; [PL 1987, c. 168, §1 (NEW).]

C. The number and result of any appeals by patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and [PL 1987, c. 168, §1 (NEW).]

D. Any complaints filed in a court of competent jurisdiction and served upon an organization filing under this section stating a cause of action against the organization on the basis of damages to patients alleged to have been proximately caused by a delay, reduction or denial of medical benefits by the organization, as determined through prospective evaluations, and the determination of liability or other disposition of the complaint. [PL 1987, c. 168, §1 (NEW).]

[PL 1987, c. 168, §1 (NEW).]

2. Maine residents. This section is applicable to evaluations, appeals and complaints relating to Maine residents only.

[PL 1987, c. 168, §1 (NEW).]

3. Confidentiality. Any information provided pursuant to this section may not identify the names of patients. If patient names are identified in information provided pursuant to this section, the patient names are confidential.

[PL 2023, c. 123, §1 (AMD).]

SECTION HISTORY

PL 1987, c. 168, §1 (NEW). PL 2023, c. 123, §1 (AMD).

§2302-B. Penalty for failure to notify of hospitalization

A contract issued by a nonprofit hospital or medical services organization may not include a provision permitting the organization to impose a penalty for the failure of any person to notify the organization of a covered person's hospitalization for emergency treatment. For purposes of this section, "emergency treatment" has the same meaning as defined in Title 22, section 1829. [PL 1995, c. 332, Pt. M, §1 (RPR).]

This section applies to contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after the effective date of this section. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. [PL 1995, c. 332, Pt. M, §1 (RPR).]

SECTION HISTORY

PL 1989, c. 767, §2 (NEW). PL 1993, c. 645, §B1 (NEW). PL 1995, c. 332, §M1 (RPR).

§2302-C. Penalty for noncompliance with utilization review programs

A contract issued or renewed by a nonprofit service organization after April 8, 1994 may not contain a provision that permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review

program. This section does not limit the right of nonprofit service organizations to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary. [PL 1995, c. 332, Pt. M, §2 (NEW).]

SECTION HISTORY

PL 1995, c. 332, §M2 (NEW).

§2303. Mental health services

1. Such corporation mentioned in section 2301 may enter into contracts for the rendering of health care to the subscribers only with institutions or persons licensed or accredited by the appropriate departments, commissions or boards of the several states. All contracts for the provision of health care issued by the corporation shall constitute direct obligations of the provider of health care with which the corporation has contracted for that care. Contracts issued under a health care plan shall provide that the private provider-patient relationship shall exist between the patient and provider of health care, that the patient shall have a free choice of any provider of health care able and willing to provide those services, all of which shall be based upon definite agreements covering health care provided through duly licensed providers, and any such provider of health care shall be free to refuse service for appropriate professional reasons. Nothing in this section may be construed to prohibit reciprocal arrangements for the exchange of health care between similar nonprofit hospital and medical service plans.
[PL 1983, c. 515, §1 (AMD).]

2. Mental health services provided by psychologists or certified social workers.
[PL 1999, c. 256, Pt. M, §2 (RP).]

3.
[PL 1983, c. 515, §2 (RP).]

4.
[PL 1999, c. 256, Pt. M, §3 (RP).]

5.
[PL 1999, c. 256, Pt. M, §4 (RP).]

SECTION HISTORY

PL 1969, c. 419, §2 (AMD). PL 1975, c. 581 (RPR). PL 1979, c. 415, §2 (AMD). PL 1983, c. 515, §§1,2 (AMD). PL 1983, c. 546, §1 (AMD). PL 1983, c. 805, §1 (AMD). PL 1987, c. 80, §1 (AMD). PL 1995, c. 561, §1 (AMD). PL 1999, c. 256, §§M2-4 (AMD).

§2303-A. Dentist included in definition of physician

(REPEALED)

SECTION HISTORY

PL 1975, c. 345, §1 (NEW). PL 1999, c. 256, §M5 (RP).

§2303-B. Optional coverage for chiropractic services

(REPEALED)

SECTION HISTORY

PL 1979, c. 335, §1 (NEW). PL 1981, c. 282, §1 (AMD). PL 1985, c. 516, §1 (RP).

§2303-C. Coverage for chiropractic services

(REPEALED)

SECTION HISTORY

PL 1985, c. 516, §2 (NEW). PL 1989, c. 141, §§1,2 (AMD). PL 1993, c. 669, §1 (AMD). PL 1999, c. 256, §M6 (RP).

§2304. Licenses

Application for the authority provided for in section 2305 must be made in the form required by the superintendent and must contain the information the superintendent considers necessary. The application must be accompanied by a copy of each of the following documents: [RR 2019, c. 2, Pt. B, §73 (COR).]

1. Certificate of incorporation. Certificates of incorporation;

2. Bylaws. Bylaws;

3. Proposed contracts. Proposed contracts between the corporation and participating providers of health care showing the terms under which the health care service is to be furnished to subscribers; [PL 1969, c. 419, §3 (AMD).]

4. Rates and benefits. Contracts to be issued to subscribers showing a table of the rates to be charged and the benefits to which they are entitled;

5. Financial statement. Financial statement of the corporation, including the contributions paid or agreed to be paid to the corporation for working capital, the name of each contributor, and the terms of each contribution. The contributions must total at least $5,000.

SECTION HISTORY

PL 1969, c. 419, §3 (AMD). PL 1971, c. 444, §3 (AMD). PL 1973, c. 585, §12 (AMD). RR 2019, c. 2, Pt. B, §73 (COR).

§2305. -- Issuance of

The superintendent shall issue a certificate of authority, which is continuous unless revoked or suspended by the superintendent, and collect payment of a fee, which is the same as for an insurer as provided in Title 24-A, section 601, if the applicant meets the following requirements: [PL 1997, c. 592, §1 (AMD).]

1. Plan. It is established to provide a bona fide nonprofit health care plan.
[PL 1969, c. 419, §5 (AMD).]

2. Contracts. The contracts between the applicant and the participating providers of health care obligate each participating party to render service to which each subscriber may be entitled under the terms of the contract issued to the subscribers and such contracts are otherwise reasonable.
[PL 1971, c. 444, §5 (AMD).]

3. Rates and benefits. The rates charged and benefits to be provided are as prescribed in sections 2316, 2321 and 2322.
[PL 1977, c. 493, §1 (AMD).]

4. Contributions. Contributions to the working funds of the applicant are repayable only out of earned premiums in excess of operating expenses, payments to participating providers, and an adequate reserve required by the superintendent.
[PL 1969, c. 419, §6 (AMD); PL 1973, c. 585, §12 (AMD).]

5. Money available. The money available for working capital must be sufficient to cover all acquisition costs and operating expenses for a reasonable time from the date of the issuance of the certificate of authority.
[PL 1971, c. 444, §6 (RPR).]

SECTION HISTORY

PL 1969, c. 132, §7 (AMD). PL 1969, c. 419, §§4-6 (AMD). PL 1971, c. 444, §§4-6 (AMD). PL 1973, c. 585, §12 (AMD). PL 1977, c. 493, §1 (AMD). PL 1997, c. 592, §1 (AMD).

§2305-A. Conditions of certificate of authority

1. Duration. A certificate of authority continues in force as long as the nonprofit hospital or medical service organization is entitled under this Title and until suspended or revoked by the superintendent or terminated at the organization's request.
[PL 1997, c. 592, §2 (NEW).]

2. Annual fee. The nonprofit hospital or medical service organization shall pay an annual fee, which is the same as for an insurer, as provided in Title 24-A, section 601.
[PL 1997, c. 592, §2 (NEW).]

3. Reinstatement. Upon payment by the nonprofit hospital or medical service organization of the fee for reinstatement specified in Title 24-A, section 601, the superintendent may, upon the organization's request made within 3 months after suspension, reinstate a certificate of authority that the superintendent suspended due to the organization's failure to pay the annual fee. Otherwise the organization may be granted another certificate of authority only after filing an application and meeting all other requirements as for an original certificate of authority in this State.
[PL 1997, c. 592, §2 (NEW).]

SECTION HISTORY

PL 1997, c. 592, §2 (NEW).

§2306. Reports

Every corporation organized under this chapter shall file in the office of the superintendent annual and quarterly financial statements substantially similar to those required of health insurers under Title 24-A, sections 423, 423-A and 423-D verified by at least 2 of the principal officers of that corporation. The statement must be on an annual or quarterly statement blank of the National Association of Insurance Commissioners for use by nonprofit hospital or medical service corporations, be prepared in accordance with the association's annual or quarterly statement instructions, follow practices and procedures prescribed by the association's accounting practices and procedures manual and be accompanied by any useful or necessary modification or adaptation and any additional information required by the superintendent. The superintendent may by rule or order require the filing of more frequent reports. [PL 2017, c. 169, Pt. A, §1 (AMD).]

A nonprofit hospital or medical service corporation that controls and operates a health maintenance organization as a division or line of business of the corporation shall file on a continuing basis any additional periodic financial reports required by Title 24-A, section 4208. [PL 2017, c. 169, Pt. A, §1 (AMD).]

SECTION HISTORY

PL 1973, c. 585, §12 (AMD). PL 1993, c. 702, §A3 (AMD). PL 1997, c. 592, §3 (AMD). PL 2017, c. 169, Pt. A, §1 (AMD).

§2307. Examination

1. Examination by superintendent. The superintendent or the superintendent's designee has the power of visitation and examination into the affairs of any corporation described in section 2301 and has free access to the books, papers and documents that relate to the business of the corporation and may summon and qualify witnesses under oath and examine its officers, agents or employees or other persons in relation to the affairs, transactions and condition of the corporation.
[PL 1993, c. 702, Pt. A, §4 (NEW).]

2. Costs of examination. The reasonable costs of such an examination must be borne by the corporation examined.
[PL 1993, c. 702, Pt. A, §4 (NEW).]

3. Accountant's work papers. The superintendent may require a corporation subject to this section to make available the accountant's work papers created during an audit.

A. The superintendent may review the accountant's work papers upon timely notice to the corporation. The superintendent may photocopy or otherwise record the contents of work papers during the review. [PL 1993, c. 702, Pt. A, §4 (NEW).]

B. Work papers or copies of work papers under the superintendent's custody or control are confidential and are not subject to public inspection. [PL 1993, c. 702, Pt. A, §4 (NEW).]

C. The work papers of the corporation's subsidiaries, parent or other corporate affiliates are considered to be the corporation's work papers to the extent that the work papers reference transactions between the corporation and the subsidiary, parent or corporate affiliate and affect the corporation's final equity determination. [PL 1993, c. 702, Pt. A, §4 (NEW).]

D. The corporation shall, as a condition of an accountant's engagement, require the accountant:

(1) To retain the work papers prepared in connection with an audit of the corporation for at least 6 years after the close of a reporting period; and

(2) To provide the work papers, or a copy, to the corporation at the corporation's request. [PL 1993, c. 702, Pt. A, §4 (NEW).]

For purposes of this subsection, the term "work papers" includes, but is not limited to, schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, copies of company records or other documents prepared or obtained by the accountant and the accountant's employees in conducting the audit of the corporation.
[PL 1993, c. 702, Pt. A, §4 (NEW).]

SECTION HISTORY

PL 1971, c. 444, §7 (RPR). PL 1973, c. 585, §12 (AMD). PL 1993, c. 702, §A4 (RPR).

§2307-A. Rules

Subject to the Maine Administrative Procedure Act, the superintendent may make, adopt, amend and rescind reasonable rules to aid the administration or effectuation of the provisions of this Title. [PL 1993, c. 702, Pt. A, §5 (NEW).]

SECTION HISTORY

PL 1993, c. 702, §A5 (NEW).

§2307-B. Loss information

(REPEALED)

SECTION HISTORY

PL 1995, c. 71, §1 (NEW). PL 1997, c. 370, §E1 (AMD). PL 1999, c. 256, §M7 (RP).

§2308. Investments

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §34 (RP).

§2308-A. Health insurance affiliates

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

A. "Foreign health service plan" means a nonprofit hospital and medical service organization or similar nonprofit entity organized under the laws of another state. [PL 1997, c. 344, §5 (NEW).]

B. "Health insurance affiliate" means any domestic for-profit stock insurer required to be authorized under Title 24-A, section 404 to provide health insurance or any domestic for-profit stock health maintenance organization required to be licensed under Title 24-A, chapter 56 that is formed, acquired, invested in or otherwise established, whether directly or indirectly, by a nonprofit hospital and medical service organization. [PL 1997, c. 344, §5 (NEW).]

C. "Nonprofit hospital and medical service organization" or "organization" means a corporation or other entity authorized by the superintendent and organized pursuant to this chapter for the purpose of providing nonprofit hospital service plans within the meaning of section 2301, subsection 1, nonprofit medical service plans within the meaning of section 2301, subsection 2 and any organization that provides only nonprofit health care plans within the meaning of section 2301, subsection 3. [PL 2003, c. 171, §17 (AMD).]

D. "Ownership interest" means any equity interest in a health insurance affiliate, including, without limitation, capital stock, voting securities, securities convertible into voting securities, general partnership shares, limited partnership shares, surplus notes or other interests possessing voting rights. [PL 1997, c. 344, §5 (NEW).]

E. "Person" has the meaning set forth in Title 24-A, section 222, subsection 2, paragraph E. [PL 1997, c. 344, §5 (NEW).]

[PL 2003, c. 171, §17 (AMD).]

2. Authorization. A nonprofit hospital and medical service organization may not, directly or indirectly, form, acquire, invest in or otherwise establish a health insurance affiliate unless:

A. The organization has substantial control over the health insurance affiliate, which control for purposes of this section must be satisfied by:

(1) Ownership of 50% or more of the outstanding ownership interests of the health insurance affiliate;

(2) Ownership of or the power to vote, directly or indirectly, 50% or more of the voting securities of the health insurance affiliate;

(3) The legal authority to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the health insurance affiliate without its consent;

(4) The legal authority to prevent any change in the health insurance affiliate's legal status or trade names, the geographic area in which the health insurance affiliate operates or the fundamental type of business in which the health insurance affiliate engages without its consent; and

(5) Fifty percent or more control of the management policies or operations of the health insurance affiliate.

An organization that does not meet the requirements of subparagraphs (1), (2) and (5) is deemed to meet those requirements if the organization and one or more nonprofit hospital and medical service organizations or foreign health service plans, in the aggregate, meet the requirements of subparagraphs (1), (2) and (5). At all times the organization's ownership interest in the health insurance affiliate must exceed the aggregate ownership interests in the health insurance affiliate owned or controlled by any persons permitted to hold ownership interests pursuant to paragraph B; [PL 1997, c. 344, §5 (NEW).]

B. Individuals or nonprofit and noncharitable entities owning or controlling ownership interests in the health insurance affiliate are subject to the following limitations so that only:

(1) Up to a maximum of 25% of the ownership interests in the health insurance affiliate may be owned or controlled by individual physicians licensed to practice in this State, as long as the remaining ownership interests are owned or controlled by the organization under paragraph A, subparagraph (1), the organization and one or more organizations or foreign health service plans under paragraph A, subparagraph (2) or nonprofit charitable health care entities under paragraph C; or

(2) Up to a maximum of 20% of the ownership interests in the health insurance affiliate, in the aggregate, may be owned or controlled by nonprofit and noncharitable entities formed by physicians licensed to practice in this State and hospitals licensed in this State for the purpose of arranging for or delivering health care, or a combination of such an entity and individual physicians licensed to practice in this State as long as the remaining ownership interests are owned or controlled by the organization under paragraph A, subparagraph (1), the organization and one or more organizations or foreign health service plans under paragraph A, subparagraph (2) or nonprofit charitable health care entities under paragraph C; [PL 1997, c. 344, §5 (NEW).]

C. Any ownership interests not owned or controlled by the organization under paragraph A, subparagraph (1), the organization and one or more organizations or foreign health service plans under paragraph A or persons described under paragraph B are owned or controlled by nonprofit charitable entities that qualify for federal income tax exemption under the United States Internal Revenue Code of 1986, Section 501(c)(3) or (c)(4), as amended; [PL 1997, c. 344, §5 (NEW).]

D. The health insurance affiliate meets the following requirements with respect to its officers, directors and employees:

(1) No ownership interests of the health insurance affiliate are owned or controlled by officers, directors or employees of:

(a) The health insurance affiliate;

(b) Any person owning or controlling ownership interests in the health insurance affiliate; or

(c) Any affiliate of a person described in this subparagraph or subparagraph (2);

(2) Notwithstanding subparagraph (1), an individual that owns or controls an ownership interest in a health insurance affiliate, including an individual serving as an officer, director or employee of a person described in paragraph B that owns or controls an ownership interest in a health insurance affiliate, serves as a director of the health insurance affiliate, subject to the limitations set forth in subparagraph (4);

(3) Notwithstanding subparagraph (1), at any time, no more than one officer of the health insurance affiliate is an individual that owns or controls an ownership interest in a health insurance affiliate, or an individual serving as an officer, director or employee of a person described in paragraph B that owns or controls an ownership interest in a health insurance affiliate;

(4) The total percentage of directors of a health insurance affiliate who represent or are appointed by each person described in paragraph B that owns or controls an ownership interest in the health insurance affiliate does not exceed the total percentage ownership interests in the health insurance affiliate owned or controlled by persons described in paragraph B; and

(5) The health insurance affiliate has in place procedures and policies to prohibit conflicts of interest that may benefit the persons described in subparagraph (1), divisions (a), (b) and (c),

including, but not limited to, conflicts to the detriment of the health insurance affiliate's ability to fulfill its charitable purposes.

Nothing contained in this paragraph prohibits interlocking boards of directors between or among the person described in subparagraph (1), divisions (a), (b) and (c), provided no officer, director or employee of any person described in subparagraph (1), divisions (a), (b) and (c) owns or controls an ownership interest prohibited by this paragraph; [PL 1997, c. 344, §5 (NEW).]

E. The organization provides written notice to the superintendent at least 60 days prior to forming, acquiring, investing in or otherwise establishing a health insurance affiliate; and [PL 1997, c. 344, §5 (NEW).]

F. At all times when the organization owns or controls an ownership interest in the health insurance affiliate, the organization or the health insurance affiliate, together or separately, does not inappropriately stratify risks. For the purpose of this paragraph, the superintendent may treat the organization and the health insurance affiliate as a single person. If the superintendent determines that this paragraph has been violated, the superintendent shall provide the organization and the health insurance affiliate with notice of the violation and a reasonable opportunity to cure the violation. [PL 1997, c. 344, §5 (NEW).]

[PL 1997, c. 344, §5 (NEW).]

3. Application of Title 24-A. The provisions of Title 24-A apply to a health insurance affiliate in accordance with the following:

A. A health insurance affiliate that is a health insurer is subject to all the following provisions:

(1) Title 24-A, section 222;

(2) Title 24-A, section 423-C;

(3) Title 24-A, section 425;

(4) Title 24-A, chapter 47, subchapter IV;

(5) Title 24-A, section 4614, subsections 4 and 6; and

(6) All other applicable provisions of Title 24-A; [PL 1997, c. 344, §5 (NEW).]

B. A health insurance affiliate that is a health maintenance organization is subject to all the following provisions:

(1) Title 24-A, section 222, subsections 2 to 10 and Title 24-A, section 222, subsections 13-A to 18;

(2) Title 24-A, section 423-C;

(3) Title 24-A, section 425;

(4) Title 24-A, sections 3474 to 3476;

(5) Title 24-A, section 3483; and

(6) All other applicable provisions of Title 24-A; and [PL 2023, c. 405, Pt. A, §82 (AMD).]

C. The provisions of Title 24-A, section 4214 do not apply to a health insurance affiliate. [PL 1997, c. 344, §5 (NEW).]

[PL 2023, c. 405, Pt. A, §82 (AMD).]

4. Control. For the purposes of this section and Title 24-A, section 222, a health insurance affiliate is presumed to be controlled by the nonprofit hospital and medical service organization, notwithstanding that the organization may not have actual control. Notwithstanding that the organization is presumed to control the health insurance affiliate under this subsection, the superintendent may determine that one or more other persons also control the health insurance affiliate.

The superintendent, in the superintendent's sole discretion, may determine that a health insurance affiliate is not controlled by an organization that owns or controls less than 50% of the ownership interests of a health insurance affiliate pursuant to subsection 2, paragraph A.
[PL 1997, c. 344, §5 (NEW).]

5. Continuing obligations; penalties. In addition to all requirements for obtaining or maintaining a certificate of authority from the superintendent under Title 24-A, a health insurance affiliate must continuously meet all requirements of this section and Title 5, section 194-A, subsection 7. The superintendent's determination that a health insurance affiliate has failed to meet the requirements of this section or Title 5, section 194-A, subsection 7 constitutes grounds for suspension or revocation of the health insurance affiliate's certificate of authority under Title 24-A, section 417 and grounds for commencement of delinquency proceedings under Title 24-A, chapter 57. Upon any such failure, the superintendent may require any person who owns or controls any ownership interest in the health insurance affiliate to dispose of that ownership interest within the later of 18 months after the date of the failure as determined by the superintendent, 18 months after the superintendent's determination that a failure has occurred or such other time as the superintendent may prescribe. The superintendent may permit one owner to dispose of its ownership interest to another owner.
[PL 1997, c. 344, §5 (NEW).]

6. Capital contributions. Any person who acquires any ownership interests in the health insurance affiliate shall make capital contributions in cash or the cash equivalent in proportion to that person's ownership interests in the health insurance affiliate. The superintendent, in the superintendent's sole discretion, may permit other forms of capital contributions that do not have the effect of diluting the ownership or control of the health insurance affiliate by the nonprofit hospital and medical service organization.
[PL 1997, c. 344, §5 (NEW).]

7. Transactions with related persons. In addition to the requirements contained under Title 24-A and other applicable law, all transactions between a health insurance affiliate and any related person must be consistent with fair market value in an arm's length transaction. For purposes of this subsection, a "related person" means:

A. Any person who owns or controls an ownership interest in a health insurance affiliate; [PL 1997, c. 344, §5 (NEW).]

B. Any person who is a beneficial owner, as defined in Title 24-A, section 222, subsection 2, paragraph A-1, of any ownership interest in the health insurance affiliate; [PL 1997, c. 344, §5 (NEW).]

C. Any person who, directly or indirectly, has the power to control the management, policies or operations of the health insurance affiliate; or [PL 1997, c. 344, §5 (NEW).]

D. Any affiliate of the health insurance affiliate or of any person described in paragraphs A to C. [PL 1997, c. 344, §5 (NEW).]

[PL 1997, c. 344, §5 (NEW).]

8. Distribution of working capital and surplus. No less frequently than annually, a health insurance affiliate shall distribute to those persons who own or control any ownership interest providing for the right to receive dividends or distributions any excess working capital and surplus, subject to rules adopted and decisions issued by the superintendent. Nothing in this subsection limits the authority of the Superior Court under Title 5, section 194-A, subsection 7.
[PL 1997, c. 344, §5 (NEW).]

9. Investment restrictions. Any investment by a nonprofit hospital and medical service organization in a health insurance affiliate under this section is subject to all applicable investment restrictions, including, without limitation, Title 24-A, section 222 and Title 24-A, chapter 13-A. A

health insurance affiliate in which an organization owns or controls 50% or more ownership interest is deemed to be a subsidiary of the organization for purposes of Title 24-A, section 1157, subsection 5, paragraph B.
[PL 1997, c. 344, §5 (NEW).]

10. Aggregate transactions. The superintendent may aggregate any transactions that are part of a plan or series of like transactions to determine whether those transactions comply with this section and other applicable laws.
[PL 1997, c. 344, §5 (NEW).]

11. Oversight. In addition to other applicable provisions of this Title and Title 24-A, any person whose domicile is outside the State that owns or controls an ownership interest in a health insurance affiliate and any affiliate of that organization:

A. Is subject to the jurisdiction of the superintendent and the courts of this State; and [PL 1997, c. 344, §5 (NEW).]

B. Must appoint the superintendent as lawful agent for receipt of service of process. [PL 1997, c. 344, §5 (NEW).]

[PL 1997, c. 344, §5 (NEW).]

12. Attorney General to intervene. In any proceeding before the superintendent involving the health insurance affiliate in which the Attorney General intervenes, the Attorney General has the right to review all documents or other information received by the superintendent or in connection with the proceeding. The Attorney General is subject to all confidentiality provisions for those documents or information that apply to the superintendent.
[PL 1997, c. 344, §5 (NEW).]

13. Rules. The superintendent may adopt rules to carry out the purposes of this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.
[PL 1997, c. 344, §5 (NEW).]

SECTION HISTORY

PL 1997, c. 344, §5 (NEW). PL 2003, c. 171, §17 (AMD). PL 2023, c. 405, Pt. A, §82 (AMD).

§2309. Disputes

Any dispute arising between a corporation subject to this chapter and any provider of health care with which such corporation has a contract for health care may be submitted to the superintendent for the superintendent's decision with respect thereto. Any decision and findings of the superintendent made under this chapter are not a bar to constituted legal procedure for the review of such proceedings in a court of competent jurisdiction. [RR 2019, c. 2, Pt. B, §74 (COR).]

SECTION HISTORY

PL 1969, c. 419, §7 (AMD). PL 1973, c. 585, §12 (AMD). RR 2019, c. 2, Pt. B, §74 (COR).

§2310. Dissolution

Any dissolution or liquidation of a corporation subject to this chapter must be conducted under the supervision of the superintendent, who has all power with respect thereto granted to the superintendent under Title 24-A with respect to the dissolution and liquidation of insurance companies. [RR 2019, c. 2, Pt. B, §75 (COR).]

SECTION HISTORY

PL 1971, c. 444, §8 (AMD). PL 1973, c. 585, §12 (AMD). RR 2019, c. 2, Pt. B, §75 (COR).

§2311. Taxation

Every corporation subject to this chapter is declared to be a charitable and benevolent institution and its funds and property shall be exempt from taxation.

§2312. Agents

(REPEALED)

SECTION HISTORY

PL 1969, c. 419, §8 (AMD). PL 1971, c. 444, §9 (RPR). PL 1971, c. 622, §78 (AMD). PL 1973, c. 585, §12 (AMD). PL 1997, c. 457, §4 (RP). PL 1997, c. 457, §55 (AFF).

§2313. Licenses; fees

(REPEALED)

SECTION HISTORY

PL 1969, c. 132, §8 (AMD). PL 1969, c. 419, §9 (AMD). PL 1971, c. 444, §9 (RPR). PL 1973, c. 585, §12 (AMD). PL 1977, c. 682, §2 (AMD). PL 1997, c. 457, §5 (RP). PL 1997, c. 457, §55 (AFF).

§2314. Suspension or revocation of certificate of authority

Notwithstanding Title 4, chapter 5 and Title 5, section 10051, the superintendent may suspend or revoke a certificate of authority granted under this chapter for cause at any time pursuant to a hearing held in accordance with Title 5, chapter 375, subchapter IV. [PL 1999, c. 547, Pt. B, §43 (AMD); PL 1999, c. 547, Pt. B, §80 (AFF).]

SECTION HISTORY

PL 1971, c. 444, §10 (RPR). PL 1973, c. 585, §12 (AMD). PL 1977, c. 694, §382 (RPR). PL 1997, c. 592, §4 (AMD). PL 1999, c. 547, §B43 (AMD). PL 1999, c. 547, §B80 (AFF).

§2315. Penalties

Any person, firm, association or corporation, or any officer, agent, servant or employee thereof, who shall violate any of the provisions of this chapter shall be punished by the fines and penalties provided in Title 24-A applicable to health insurers. [PL 1971, c. 444, §10 (RPR).]

SECTION HISTORY

PL 1971, c. 444, §10 (RPR).

§2316. Certificates or contracts; approval by superintendent

A nonprofit hospital and medical service organization may not issue or deliver in this State any certificate or other evidence of any contract unless and until the form used, together with the form of application and all riders or endorsements for use in connection with the certificate or other evidence of a contract, have been filed with and approved by the superintendent as conforming to reasonable rules and regulations from time to time made by the superintendent and as consistent with any other provisions of law. The superintendent shall, within a reasonable time after the filing of any such form, notify the organization filing the form either of the approval or of the disapproval of the form. The superintendent may approve any form that in the superintendent's opinion contains provisions on any one or more of the several requirements made by the superintendent that are more favorable to the subscribers than the one or ones required. The superintendent is authorized to make, alter and supersede reasonable regulations prescribing the required, optional and prohibited provisions in any contracts, and such regulations must conform, as far as practicable, to Title 24-A, chapters 33 and 35. If the superintendent determines those chapters to be inapplicable, either in part or in their entirety, the superintendent may prescribe the portions or summary of the contract to be printed on the certificate issued to the subscriber. Any filing made in accordance with this section is deemed approved unless disapproved within 60 days from the date of the filing. [PL 1999, c. 256, Pt. M, §8 (AMD).]

SECTION HISTORY

PL 1971, c. 444, §11 (NEW). PL 1973, c. 585, §12 (AMD). PL 1979, c. 267, §1 (AMD). PL 1979, c. 541, §B30 (AMD). PL 1981, c. 205, §1 (AMD). PL 1997, c. 369, §1 (AMD). PL 1999, c. 256, §M8 (AMD).

§2317. Other provisions applicable

The following chapters and provisions of Title 24-A, where and to the extent not inconsistent with this chapter and the reasonable implications thereof, shall apply to such corporations only to the extent provided for by rules and regulations issued by the superintendent to such corporations: [PL 1973, c. 585, §12 (AMD).]

1. Chapter 1. General definitions and provisions.
[PL 1971, c. 444, §11 (NEW).]

2. Chapter 3. The Insurance Superintendent.
[PL 1971, c. 444, §11 (NEW); PL 1973, c. 585, §12 (AMD).]

3. Chapter 23. Trade practices and frauds.
[PL 1971, c. 444, §11 (NEW).]

4. Chapter 49. Continuity of management.
[PL 1971, c. 444, §11 (NEW).]

5. Chapter 57. Delinquent insurers; rehabilitation and liquidation.
[PL 1971, c. 444, §11 (NEW).]

SECTION HISTORY

PL 1971, c. 444, §11 (NEW). PL 1973, c. 585, §12 (AMD).

§2317-A. Explanation and notice to parent of minor

(REPEALED)

SECTION HISTORY

PL 1989, c. 556, §D1 (NEW). PL 1997, c. 592, §5 (AMD). PL 1999, c. 256, §M9 (RP).

§2317-B. Applicability of provisions

The following provisions of Title 24-A are applicable to each nonprofit hospital or medical service organization or health care plan licensed under this Title. [PL 1999, c. 256, Pt. M, §10 (NEW).]

1. Title 24-A, section 707, subsection 3. Employee benefit excess insurance, Title 24-A, section 707, subsection 3;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

1-A. Title 24-A, section 423-C. Reports of material transactions, Title 24-A, section 423-C;
[PL 2017, c. 169, Pt. A, §2 (NEW).]

1-B. Title 24-A, section 423-G. Corporate governance annual disclosure, Title 24-A, section 423-G;
[PL 2017, c. 169, Pt. A, §2 (NEW).]

2. Title 24-A, section 2436. Interest on overdue payments, Title 24-A, section 2436;
[PL 1999, c. 790, Pt. A, §27 (AMD).]

3. Title 24-A, section 2437. The practice of dentistry, Title 24-A, section 2437;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

4. Title 24-A, sections 2438 to 2445. Policy language simplification, Title 24-A, sections 2438 to 2445;

[PL 1999, c. 790, Pt. A, §27 (AMD).]

5. Title 24-A, section 2450. Diethylstilbestrol, commonly referred to as DES, Title 24-A, section 2450;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

6. Title 24-A, sections 2713-A and 2823-A. Minor children, Title 24-A, sections 2713-A and 2823-A;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

7. Title 24-A, section 2729. Renewability, Title 24-A, section 2729;
[PL 2015, c. 329, Pt. A, §12 (AMD).]

7-A. Title 24-A, sections 2735-A and 2839-A. Notice of rate filings and rate increases, Title 24-A, sections 2735-A and 2839-A;
[PL 2001, c. 432, §1 (NEW).]

8. Title 24-A, section 2736-C. Individual health plans, Title 24-A, section 2736-C;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

9. Title 24-A, sections 2744 and 2835. Mental health services, Title 24-A, sections 2744 and 2835;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

10. Title 24-A, section 2747. Arbitration of disputed claims, Title 24-A, section 2747;
[PL 2001, c. 258, Pt. G, §1 (AMD).]

11. Title 24-A, sections 2748 and 2840-A. Coverage for chiropractic services, Title 24-A, sections 2748 and 2840-A;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

12. Title 24-A, section 2752. Any legislative measure that proposes a mandated health benefit applicable to nonprofit hospital or medical services organizations, to the extent the requirements apply to proposals applicable to insurers governed by Title 24-A, section 2752;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

12-A. Title 24-A, sections 2759 and 2847-J. Hospice care, palliative care and end-of-life care, Title 24-A, sections 2759 and 2847-J;
[PL 2001, c. 358, Pt. LL, §1 (NEW); PL 2001, c. 358, Pt. LL, §5 (AFF).]

12-B. Title 24-A, sections 2762, 2847-O and 4255. Coverage for hearing aids, Title 24-A, sections 2762, 2847-O and 4255;
[PL 2007, c. 695, Pt. C, §11 (AMD).]

12-C. Title 24-A, sections 2763, 2847-N and 4254.
[PL 2007, c. 695, Pt. C, §12 (RP).]

12-D. Title 24-A, sections 2764, 2847-P and 4256. Coverage for medically necessary infant formula, Title 24-A, sections 2764, 2847-P and 4256;
[RR 2007, c. 2, §10 (COR).]

12-E. Title 24-A, sections 2765, 2847-Q and 4257. Coverage for services provided by independent practice dental hygienists or dental hygienists, Title 24-A, sections 2765, 2847-Q and 4257;
[PL 2025, c. 478, §1 (AMD).]

12-F. Title 24-A, sections 2766 and 2847-R. Enrollment of dependent children in dental coverage, Title 24-A, sections 2766 and 2847-R;
[PL 2011, c. 420, Pt. A, §18 (RPR).]

12-G. Title 24-A, sections 2767, 2847-S and 4258. Coverage for children's early intervention services, Title 24-A, sections 2767, 2847-S and 4258;
[PL 2011, c. 420, Pt. A, §19 (NEW).]

12-H. Title 24-A, sections 2768, 2847-T and 4259. Coverage for diagnosis and treatment of autism spectrum disorders, Title 24-A, sections 2768, 2847-T and 4259;
[PL 2011, c. 420, Pt. A, §20 (NEW).]

12-I. Title 24-A, sections 2770-A, 2847-X and 4261. Fees for covered dental care services, Title 24-A, sections 2770-A, 2847-X and 4261;
[PL 2025, c. 298, §1 (NEW).]

13. Title 24-A, section 2803. Categories of group health insurance, Title 24-A, section 2803;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

14. Title 24-A, section 2803-A. Provision of loss information, Title 24-A, section 2803-A;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

15. Title 24-A, section 2808-B. Small group health plans, Title 24-A, section 2808-B;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

15-A. Title 24-A, section 2809-A. Conversion on termination of policy or eligibility, Title 24-A, section 2809-A;
[PL 2003, c. 428, Pt. B, §1 (AMD).]

16. Title 24-A, section 2834-B. Dependent special enrollment, Title 24-A, section 2834-B;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

16-A. Title 24-A, section 2845. Cardiac rehabilitation coverage; Title 24-A, section 2845;
[PL 2001, c. 258, Pt. G, §2 (NEW).]

16-B. Title 24-A, chapter 11. Assets and liabilities, Title 24-A, chapter 11;
[PL 2017, c. 169, Pt. A, §3 (NEW).]

17. Title 24-A, chapter 32. Preferred provider arrangements, Title 24-A, chapter 32;
[PL 1999, c. 790, Pt. A, §27 (AMD).]

18. Title 24-A, chapter 36. Continuity of health insurance coverage, Title 24-A, chapter 36;
[PL 1999, c. 256, Pt. M, §10 (NEW).]

19. Title 24-A, chapter 67. Medicare supplement insurance policies, Title 24-A, chapter 67;
[PL 2013, c. 575, §2 (AMD).]

20. Title 24-A, chapters 68 and 68-A. Long-term care insurance, nursing home care insurance and home health care insurance, Title 24-A, chapters 68 and 68-A;
[PL 2019, c. 274, §2 (AMD).]

21. Title 24-A, sections 2765-A and 2847-U. The practice of dental therapy by a dental therapist, Title 24-A, sections 2765-A and 2847-U;
[PL 2019, c. 605, §2 (RPR).]

22. Title 24-A, section 4320-M. Coverage for abortion services, Title 24-A, section 4320-M; and
[PL 2019, c. 605, §3 (AMD).]

23. Title 24-A, sections 2766-A and 2847-W. The prohibition on a dental benefit waiting period for persons under 19 years of age, Title 24-A, sections 2766-A and 2847-W.
[PL 2019, c. 605, §4 (NEW).]

SECTION HISTORY

PL 1999, c. 256, §M10 (NEW). PL 1999, c. 790, §A27 (AMD). PL 2001, c. 258, §§G1,2 (AMD). PL 2001, c. 358, §LL1 (AMD). PL 2001, c. 358, §LL5 (AFF). PL 2001, c. 432, §1 (AMD). PL

2003, c. 156, §1 (AMD). PL 2003, c. 428, §§B1,G1 (AMD). RR 2007, c. 2, §10 (COR). PL 2007, c. 452, §1 (AMD). PL 2007, c. 516, §1 (AMD). PL 2007, c. 516, §5 (AFF). PL 2007, c. 595, §1 (AMD). PL 2007, c. 595, §5 (AFF). PL 2007, c. 695, Pt. C, §§11-13 (AMD). PL 2009, c. 307, §1 (AMD). PL 2009, c. 307, §6 (AFF). PL 2009, c. 578, §1 (AMD). PL 2009, c. 578, §4 (AFF). PL 2009, c. 634, §1 (AMD). PL 2009, c. 634, §5 (AFF). PL 2009, c. 635, §1 (AMD). PL 2009, c. 635, §6 (AFF). PL 2011, c. 420, Pt. A, §§18-20 (AMD). PL 2013, c. 575, §§2-4 (AMD). PL 2013, c. 575, §10 (AFF). PL 2015, c. 329, Pt. A, §12 (AMD). PL 2017, c. 169, Pt. A, §§2, 3 (AMD). PL 2019, c. 274, §2-4 (AMD). PL 2019, c. 388, §2 (AMD). PL 2019, c. 605, §§2-4 (AMD). PL 2025, c. 298, §1 (AMD). PL 2025, c. 478, §1 (AMD).

§2318. Maternity benefits and dependent coverage

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the subscriber, member or spouse of the subscriber or member. [PL 1993, c. 666, Pt. A, §1 (NEW).]

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption. [PL 1993, c. 666, Pt. A, §1 (NEW).]

[PL 1993, c. 666, Pt. A, §1 (RPR).]

2. Maternity benefits. All individual or group contracts issued by any nonprofit hospital or medical service organization operating pursuant to this chapter must provide to unmarried subscribers or members and minor dependents of the subscribers or members the same minimum maternity benefits and the same option for additional maternity benefits, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to married subscribers or members. This requirement applies to all individual or group contracts issued or renewed after the effective date of this subsection.

[PL 1991, c. 200, Pt. B, §1 (NEW).]

3. Coverage. All individual or group contracts issued in accordance with the requirements of this section must provide unmarried subscribers with the same benefits or option of benefits for dependent children as is extended to dependent children of married subscribers, at appropriate rates and under the same terms and conditions.

[PL 1991, c. 200, Pt. B, §1 (NEW).]

4. Financial dependency. Financial dependency of dependent children on the subscriber or member or the spouse of the subscriber or member may not be required as a condition for eligibility for coverage.

[PL 1991, c. 200, Pt. B, §1 (NEW).]

5. Adopted children. All individual or group contracts issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the subscriber or spouse of the subscriber under the same terms and conditions as apply to natural dependent children or stepchildren of the subscriber or spouse of the subscriber, irrespective of whether the adoption has become final.

[PL 1993, c. 666, Pt. A, §2 (NEW).]

6. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 2003, c. 517, Pt. B, §1 (NEW).]

REVISOR'S NOTE: §2318. Newborn children coverage (REPEALED BY PL 1975, c. 700, §100)

SECTION HISTORY

PL 1975, c. 276, §1 (NEW). PL 1975, c. 428, §1 (NEW). PL 1975, c. 770, §100 (RP). PL 1991, c. 200, §B1 (RPR). PL 1993, c. 666, §§A1,2 (AMD). PL 2003, c. 517, §B1 (AMD).

§2318-A. Maternity and routine newborn care

A nonprofit hospital or medical service organization that issues individual and group contracts and certificates providing maternity benefits, including benefits for childbirth, shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section. [PL 2003, c. 517, Pt. B, §2 (AMD).]

SECTION HISTORY

PL 1995, c. 615, §1 (NEW). PL 2001, c. 258, §A1 (AMD). PL 2003, c. 517, §B2 (AMD).

§2319. Newborn children coverage

All individual and group nonprofit hospital and medical service organization contracts and certificates must provide that benefits are payable with respect to a newly born child from the moment of birth. [PL 2003, c. 517, Pt. A, §1 (AMD); PL 2003, c. 517, Pt. A, §13 (AFF).]

The coverage for newly born children must consist of coverage of injury, sickness or other benefits provided by the contract, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. [PL 1997, c. 604, Pt. C, §1 (AMD).]

If payment of a specific subscription fee is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required fees must be furnished to the nonprofit hospital or medical service organization within 31 days after the date of birth in order to have the coverage continue beyond that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 2318-A must be paid regardless of whether coverage under this section is elected. [PL 1997, c. 604, Pt. C, §1 (AMD).]

The requirements of this section apply to all subscriber contracts delivered or issued for delivery in this State more than 120 days after the effective date of this Act. [PL 1997, c. 604, Pt. C, §1 (AMD).]

SECTION HISTORY

PL 1975, c. 770, §101 (NEW). PL 1995, c. 332, §N1 (AMD). PL 1997, c. 604, §C1 (AMD). PL 2003, c. 517, §A1 (AMD). PL 2003, c. 517, §A13 (AFF).

§2319-A. Mandated offer of domestic partner benefits

1. Definition.

[PL 2021, c. 567, §26 (RP).]

2. Mandated offer of domestic partner benefits. All individual or group contracts issued by any nonprofit hospital or medical service organization operating pursuant to this chapter must make available to an individual or group policyholder the option for additional benefits for the domestic

partner of a subscriber or member, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married subscribers or members covered under an individual or group policy.
[PL 2001, c. 347, §1 (NEW); PL 2001, c. 347, §5 (AFF).]

3. Financial dependency. Financial dependency of a domestic partner on the subscriber or member may not be required as a condition for eligibility for coverage.
[PL 2001, c. 347, §1 (NEW); PL 2001, c. 347, §5 (AFF).]

4. Evidence of domestic partnership. As a condition of eligibility for coverage, a nonprofit hospital and medical service organization or a group policyholder may require a subscriber or member and the subscriber's or member's domestic partner to sign an affidavit attesting that the subscriber or member and the subscriber's or member's domestic partner meet the definition of domestic partner under Title 1, section 72, subsection 2-C and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.
[PL 2021, c. 567, §27 (AMD).]

5. Preexisting conditions. A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of a subscriber or member.
[PL 2001, c. 347, §1 (NEW); PL 2001, c. 347, §5 (AFF).]

6. Termination of domestic partner benefits. A nonprofit hospital and medical service organization may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of a subscriber or member upon notification by the subscriber or member that the domestic partner relationship has terminated.
[PL 2021, c. 567, §28 (AMD).]

7. Construction. This section does not prohibit a nonprofit hospital and medical service organization from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.
[PL 2001, c. 347, §1 (NEW); PL 2001, c. 347, §5 (AFF).]

SECTION HISTORY

PL 2001, c. 347, §1 (NEW). PL 2001, c. 347, §5 (AFF). PL 2021, c. 567, §§26-28 (AMD).

§2320. Home health care coverage

Every nonprofit hospital and medical service organization which issues group and individual health care contracts providing coverage for inpatient hospital care to residents of this State shall make available coverage for home health services by a home health care provider which has contracted with the nonprofit hospital or medical service organization under terms and conditions which the organization deems satisfactory to its membership. [PL 1977, c. 696, §201 (AMD).]

The contract providing coverage for home health care services may contain reasonable limitation on the number of home care visits and other services provided, but the number of such visits shall not be less than 90 in any continuous period of 12 months for each person covered under the contract. Each visit by an individual member of a home health care provider shall be considered as one home care visit. [PL 1977, c. 470, §1 (NEW).]

1. Home health care services. "Home health care services" means those health care services rendered in a place of residence on a part-time basis to a covered person only if:

A. Hospitalization or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, 42 U.S.C. § 1395, et seq., would otherwise have been required if home health care was not provided; and [PL 1977, c. 470, §1 (NEW).]

B. The plan covering the home health services is established as prescribed in writing by a physician. [PL 1977, c. 470, §1 (NEW).]

There may not be a requirement that hospitalization be an antecedent to coverage under the policy. [RR 2019, c. 2, Pt. B, §76 (COR).]

2. Home health care services included. Home health care services shall include:

A. Visits by a registered nurse or licensed practical nurse to carry out treatments prescribed, or supportive nursing care and observation as indicated; [PL 1977, c. 470, §1 (NEW).]

B. A physician's home or office visits or both; [PL 1977, c. 470, §1 (NEW).]

C. Visits by a registered physical, speech, occupational, inhalation or dietary therapist for services or for evaluation of consultation with and instruction of nurses in carrying out such therapy prescribed by the attending physician, or both; [PL 1977, c. 470, §1 (NEW).]

D. Any prescribed laboratory tests and x-ray examination using hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a physician but only to the extent that such charges would have been covered under the contract if the covered person had remained in the hospital; and [PL 1977, c. 470, §1 (NEW).]

E. Visits by persons who have completed a home health aide training course under the supervision of a registered nurse for the purpose of giving personal care to the patient and performing light household tasks as required by the plan of care, but not including services. [PL 1977, c. 470, §1 (NEW).]

[PL 1977, c. 470, §1 (NEW).]

3. Home health care provider. "Home health care provider" means a home health care agency which is certified under Title XVIII of the Social Security Act of 1965, as amended, which:

A. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services; [PL 1977, c. 470, §1 (NEW).]

B. Has standards, policies and rules established by a professional group, associated with the agency or organization, which professional group must include at least one physician and one registered nurse; [PL 1977, c. 470, §1 (NEW).]

C. Is available to provide the care needed in the home 7 days a week and has telephone answering service available 24 hours per day; [PL 1977, c. 470, §1 (NEW).]

D. Has the ability to and does provide, either directly or through contract, the services of a coordinator responsible for case discovery and planning and assuring that the covered person receives the services ordered by the physician; [PL 1977, c. 470, §1 (NEW).]

E. Has under contract the services of a physician-advisor licensed by the State or a physician; [PL 1977, c. 470, §1 (NEW).]

F. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and [PL 1977, c. 470, §1 (NEW).]

G. Maintains a complete medical record on each patient. [PL 1977, c. 470, §1 (NEW).]

[PL 1977, c. 470, §1 (NEW).]

4. Exclusions.

A. No contract shall require home health care coverage to persons eligible for medicare; and [PL 1977, c. 470, §1 (NEW).]

B. No payment shall be made for services provided by a person who resides in the covered person's residence or who is a member of the covered person's family. [PL 1977, c. 470, §1 (NEW).]

[PL 1977, c. 470, §1 (NEW).]

SECTION HISTORY

PL 1977, c. 470, §1 (NEW). PL 1977, c. 696, §201 (AMD). RR 2019, c. 2, Pt. B, §76 (COR).

§2320-A. Screening mammograms

1. Definition. For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast.
[PL 1989, c. 875, Pt. I, §2 (NEW).]

2. Required coverage. All individual and group nonprofit hospital and medical services plan contracts must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Health and Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

A. [PL 1997, c. 408, §1 (RP); PL 1997, c. 408, §8 (AFF).]

B. [PL 1997, c. 408, §1 (RP); PL 1997, c. 408, §8 (AFF).]
[PL 1997, c. 408, §1 (RPR); PL 1997, c. 408, §8 (AFF); PL 2003, c. 689, Pt. B, §6 (REV).]

3. Application. This section applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. B, §3 (AMD).]

4. Reports. Each nonprofit hospital and medical care service organization subject to this section shall report to the superintendent its experience for each calendar year beginning with 1991 not later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.
[PL 1991, c. 701, §2 (AMD).]

5. No cost-sharing requirements. A nonprofit hospital and medical care service organization may not impose any cost-sharing requirements on a screening mammogram performed by a provider in accordance with this section. This subsection does not apply to an individual policy offered for use with a health savings account unless the United States Internal Revenue Service determines that the requirements in this subsection are permissible in a high deductible health plan as defined in the United States Internal Revenue Code of 1986, Section 223(c)(2).
[PL 2025, c. 348, §1 (NEW).]

SECTION HISTORY

PL 1989, c. 875, §I2 (NEW). PL 1991, c. 701, §2 (AMD). PL 1997, c. 408, §1 (AMD). PL 1997, c. 408, §8 (AFF). PL 2003, c. 517, §B3 (AMD). PL 2003, c. 689, §B6 (REV). PL 2025, c. 348, §1 (AMD).

§2320-B. Acupuncture services

All individual and group nonprofit medical services plan contracts and certificates and all nonprofit health care plan contracts and certificates providing coverage for acupuncture must provide coverage for those services when performed by an acupuncturist licensed pursuant to Title 32, chapter 113-B, subchapter 2, under the same conditions that apply to the services of a licensed physician. [PL 2003, c. 517, Pt. B, §4 (AMD).]

SECTION HISTORY

PL 1991, c. 647, §1 (NEW). PL 1995, c. 671, §8 (AMD). PL 2003, c. 517, §B4 (AMD).

§2320-C. Coverage for breast cancer treatment

1. Inpatient care. All individual and group nonprofit hospital and medical services plan contracts providing coverage for medical and surgical benefits must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, after providing notice to the patient regarding the coverage required by this subsection and in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual and group nonprofit hospital and medical services plan contract may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual and group nonprofit hospital and medical services plan contracts must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier. The notice must also be made available to any physician participating in the insurer's provider network.
[PL 2015, c. 227, §1 (AMD); PL 2015, c. 227, §5 (AFF).]

2. Reconstruction. All individual and group nonprofit hospital and medical services plan contracts providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.
[PL 1997, c. 408, §2 (NEW); PL 1997, c. 408, §8 (AFF).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. B, §5 (NEW).]

SECTION HISTORY

RR 1995, c. 1, §13 (COR). PL 1995, c. 295, §1 (NEW). PL 1995, c. 369, §1 (NEW). PL 1997, c. 408, §2 (RPR). PL 1997, c. 408, §8 (AFF). PL 2003, c. 517, §B5 (AMD). PL 2015, c. 227, §1 (AMD). PL 2015, c. 227, §5 (AFF).

§2320-D. Medical food coverage for inborn error of metabolism

1. Inborn error of metabolism; special modified low-protein food product. As used in this section, "inborn error of metabolism" means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. As used in this section, "special modified low-protein food product" means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.
[PL 1995, c. 369, §1 (NEW).]

2. Required coverage. All individual and group nonprofit medical services plan policies and contracts and all nonprofit health care plan policies and contracts must provide coverage for metabolic

formula and special modified low-protein food products that have been prescribed by a licensed physician for a person with an inborn error of metabolism. The policies and contracts must reimburse:

A. For metabolic formula; and [PL 1995, c. 369, §1 (NEW).]

B. Up to $3,000 per year for special modified low-protein food products. [PL 1995, c. 369, §1 (NEW).]

[PL 1995, c. 369, §1 (NEW).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 1995, c. 369, §1 (NEW).]

SECTION HISTORY

RR 1995, c. 1, §13 (RNU). PL 1995, c. 369, §1 (NEW).

§2320-E. Coverage for Pap tests

All group nonprofit medical service plan contracts and certificates and all nonprofit health care plan contracts and certificates must provide coverage for screening Pap tests recommended by a physician. [PL 2003, c. 517, Pt. A, §2 (AMD); PL 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY

PL 1995, c. 617, §1 (NEW). PL 1995, c. 617, §6 (AFF). PL 2003, c. 517, §A2 (AMD). PL 2003, c. 517, §A13 (AFF).

§2320-F. Off-label use of prescription drugs for cancer

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

A. "Medically accepted indication" includes any use of a drug that has been approved by the federal Food and Drug Administration and includes another use of the drug if that use is supported by one or more citations in the standard reference compendia or if the nonprofit hospital and medical service organization involved, based upon guidance provided by the federal Department of Health and Human Services Medicare program pursuant to 42 United States Code, Section 1395x(t), determines that that use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. [PL 1997, c. 701, §1 (NEW).]

B. "Off-label use" means the prescription and use of drugs for medically accepted indications other than those stated in the labeling approved by the federal Food and Drug Administration. [PL 1997, c. 701, §1 (NEW).]

C. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [PL 1997, c. 701, §1 (NEW).]

D. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [PL 1997, c. 701, §1 (NEW).]

[PL 1997, c. 701, §1 (NEW).]

2. Required coverage for off-label use. All individual and group nonprofit hospital and medical services plan contracts and nonprofit health care plan contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Individual and group nonprofit hospital and medical services plan contracts and nonprofit health care plan contracts that provide coverage for prescription drugs may not exclude coverage for any such drug used for the treatment of cancer for a medically accepted indication on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that use of that drug is a medically accepted indication for the treatment of cancer. [PL 1997, c. 701, §1 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [PL 1997, c. 701, §1 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [PL 1997, c. 701, §1 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [PL 1997, c. 701, §1 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [PL 1997, c. 701, §1 (NEW).]

[PL 1997, c. 701, §1 (NEW).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 1997, c. 701, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 701, §1 (NEW).

§2320-G. Off-label use of prescription drugs for HIV or AIDS

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

A. "Off-label use" means the prescription and use of drugs for indications other than those stated in the labeling approved by the federal Food and Drug Administration. [PL 1997, c. 701, §1 (NEW).]

B. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [PL 1997, c. 701, §1 (NEW).]

C. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [PL 1997, c. 701, §1 (NEW).]

[PL 1997, c. 701, §1 (NEW).]

2. Required coverage for off-label use. All individual and group nonprofit hospital and medical services plan contracts and nonprofit health care plan contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Individual and group nonprofit hospital and medical services plan contracts and nonprofit health care plan contracts that provide coverage for prescription drugs may not exclude coverage for any such drug used for the treatment of HIV or AIDS on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that drug is recognized for the treatment of that indication in one of the standard reference compendia or in peer-reviewed medical literature. [PL 1997, c. 701, §1 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [PL 1997, c. 701, §1 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [PL 1997, c. 701, §1 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [PL 1997, c. 701, §1 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [PL 1997, c. 701, §1 (NEW).]

[PL 1997, c. 701, §1 (NEW).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 1997, c. 701, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 701, §1 (NEW).

§2321. Rate filings on individual subscriber and membership contracts

1. Filing of rate information. Every nonprofit hospital and medical service organization shall file with the superintendent every rate, rating formula and every modification of any of the foregoing that it proposes to use in connection with individual health insurance contracts, group Medicare supplement contracts as defined in Title 24-A, chapter 67, group nursing home or long-term care contracts as defined in Title 24-A, chapter 68 or 68-A, and certain group contracts included within the definition of "individual health plan" in Title 24-A, section 2736-C, subsection 1, paragraph C. Every filing under this subsection must state the effective date of the filing. Every filing under this subsection must be made not less than 60 days in advance of the stated effective date unless the 60-day requirement is waived by the superintendent for a period of time not to exceed 30 days.

[PL 2009, c. 244, Pt. C, §1 (AMD).]

2. Filing information. When a filing is not accompanied by the information upon which the organization supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that the rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the organization to furnish the information upon which it supports the filing. A filing and supporting information are public records within the

meaning of Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to section 2322. For the purpose of determining whether the filing produces rates that are not excessive, inadequate or unfairly discriminatory, the superintendent and the Attorney General each may employ consultants, including actuaries, and the reasonable costs of the consultants, including actuaries, which must include costs of testifying at any hearing held pursuant to section 2322, must be borne by the organization making such filing. The organization is not responsible for any costs from the Attorney General exceeding $40,000 for any filing.
[PL 1997, c. 344, §6 (AMD).]

3. Three-year review.
[PL 1997, c. 344, §6 (RP).]

4. Criteria for special rate hearings.

[PL 2009, c. 244, Pt. C, §2 (RP).]

5. Special rate hearing.

[PL 2009, c. 244, Pt. C, §3 (RP).]

SECTION HISTORY

PL 1977, c. 493, §2 (NEW). PL 1979, c. 558, §§1,2 (AMD). PL 1985, c. 648, §1 (AMD). PL 1991, c. 9, §G5 (AMD). PL 1991, c. 48, §§1,2 (AMD). PL 1997, c. 344, §6 (AMD). PL 2001, c. 432, §§2,3 (AMD). PL 2003, c. 428, §F1 (AMD). PL 2009, c. 244, Pt. C, §§1-3 (AMD).

§2321-A. Standards for when filings are inadequate

In reviewing rates and rate modifications filed by a nonprofit hospital and medical service organization in accordance with this Title, the superintendent may not require the organization to charge rates that, taking into account investment income and the appropriate level of subscriber reserves, are inadequate to enable it to recover reasonably anticipated claims and administrative expenses and make reasonable contributions to subscriber reserves. [PL 1997, c. 344, §7 (NEW).]

SECTION HISTORY

PL 1997, c. 344, §7 (NEW).

§2321-B. Appropriate level of subscriber reserves

The superintendent may adopt rules establishing the appropriate level of subscriber reserves. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [PL 1997, c. 344, §7 (NEW).]

SECTION HISTORY

PL 1997, c. 344, §7 (NEW).

§2322. Hearing

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of Title 24-A, chapter 23, to the extent it is applicable pursuant to section 2317, the superintendent shall cause a hearing to be held. [RR 2019, c. 2, Pt. B, §77 (COR).]

Hearings held under this section shall conform to the procedural requirement set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV. [PL 1979, c. 558, §3 (RPR).]

SECTION HISTORY

PL 1977, c. 493, §2 (NEW). PL 1977, c. 694, §383 (AMD). PL 1979, c. 330, §1 (AMD). PL 1979, c. 558, §3 (RPR). RR 2019, c. 2, Pt. B, §77 (COR).

§2323. Order

The superintendent shall issue an order or decision within 30 days after the close of the hearing, or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the organization to submit a new filing in accordance with the terms of the order or decision. [PL 1989, c. 269, §1 (AMD).]

SECTION HISTORY

PL 1977, c. 493, §2 (NEW). PL 1979, c. 558, §4 (RPR). PL 1989, c. 269, §1 (AMD).

§2324. Certified ambulatory health care center outpatient coverage

1. Contract coverage. Every nonprofit hospital and medical service organization which issues group and individual health care contracts providing coverage for inpatients and outpatient hospital care to residents of the State shall make available coverage for outpatient health care to subscribers with health care facilities certified by the Department of Health and Human Services for purposes of reimbursement under the United States Rural Health Clinic Services Act, Public Law 95-210, or its successor, and with incorporated nonprofit health centers engaged in the delivery of comprehensive primary care provided the health care facility or nonprofit health center providing the care has contracted with the organization on terms and conditions which the organization deems satisfactory to its membership.
[PL 1979, c. 376 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

2. Services required. Services provided under such contract to certified rural health clinics shall include, but need not be limited to, services presently provided for under group and individual health care contracts to hospitals or groups of hospitals presently licensed under Title 22, chapter 405, or its successor. In no way shall services provided under such contracts to these health clinics be construed to require a nonprofit hospital or medical services organization to provide contract coverage for a service in a particular rural health clinic which does not meet state qualifications or criteria.
[PL 1979, c. 376 (NEW).]

SECTION HISTORY

PL 1979, c. 376 (NEW). PL 2003, c. 689, §B6 (REV).

§2325. Community health services coverage

(REPEALED)

SECTION HISTORY

PL 1979, c. 419, §1 (NEW). PL 1979, c. 663, §139 (AMD). PL 1983, c. 515, §3 (RP).

§2325-A. Mental health services coverage

1. Findings. The Legislature finds that:

A. Mental illness affects nearly 170,000 Maine people each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families; [PL 1983, c. 515, §4 (NEW).]

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by Maine businesses in accidents, absenteeism, nonproductivity and turnover. Excessive stress and anxiety and other forms of mental illness clearly contribute to general health problems and costs; [PL 1983, c. 515, §4 (NEW).]

C. Typical health coverage in this State discriminates against mental illness, the victims and affected families with nonexistent or limited benefits compared to provisions for other illnesses; and [PL 1983, c. 515, §4 (NEW).]

D. Experience in this State and several other states demonstrates that the risk of mental illness can be insured at reasonable cost and with adequate controls on quality and utilization of treatment. [PL 1983, c. 515, §4 (NEW).]

[PL 1983, c. 515, §4 (NEW).]

2. Policy and purpose. The Legislature declares that it is the policy of this State to:

A. Promote equitable and nondiscriminatory health coverage benefits for all forms of illness, including mental and emotional disorders, which are of significant consequence to the health of Maine people and which can be treated in a cost-effective manner; [PL 1983, c. 515, §4 (NEW).]

B. Assure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in least restrictive settings; [PL 1983, c. 515, §4 (NEW).]

C. Assure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and [PL 1983, c. 515, §4 (NEW).]

D. Assure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits shall be provided. [PL 1983, c. 515, §4 (NEW).]

[PL 1983, c. 515, §4 (NEW).]

3. Definitions. For purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Day treatment services" includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours per day. [PL 1983, c. 515, §4 (NEW).]

A-1. "Diagnostic and statistical manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association. [PL 2003, c. 20, Pt. VV, §1 (NEW); PL 2003, c. 20, Pt. VV, §25 (AFF).]

A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

(1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;

(2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and

(3) The services are prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [PL 2003, c. 20, Pt. VV, §1 (NEW); PL 2003, c. 20, Pt. VV, §25 (AFF).]

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Health and Human Services or accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting. [PL 1983, c. 515, §4 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

B-1. "Medically necessary health care" has the same meaning as in Title 24-A, section 4301-A, subsection 10-A. [PL 2003, c. 20, Pt. VV, §2 (NEW); PL 2003, c. 20, Pt. VV, §25 (AFF).]

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups. [PL 1983, c. 515, §4 (NEW).]

D. "Person suffering from a mental illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being. [PL 2003, c. 20, Pt. VV, §3 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

E. "Provider" means those individuals included in Title 24-A, section 2744, subsection 1, and a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Health and Human Services. All agency or institutional providers named in this paragraph shall ensure that services are supervised by a psychiatrist or licensed psychologist. [PL 1999, c. 256, Pt. O, §1 (AMD); PL 2001, c. 354, §3 (AMD); PL 2003, c. 689, Pt. B, §6 (REV).]

[PL 2003, c. 20, Pt. VV, §§1-3 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF); PL 2003, c. 689, Pt. B, §6 (REV).]

4. Requirement. Every nonprofit hospital and medical service organization that issues group health care contracts providing coverage to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

[PL 2003, c. 20, Pt. VV, §4 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

5. Services. Each group contract must provide for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, the following services for a person suffering from a mental illness:

A. Inpatient care; [PL 1983, c. 515, §4 (NEW).]

B. Day treatment services; [PL 2003, c. 20, Pt. VV, §4 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

C. Outpatient services; and [PL 2003, c. 20, Pt. VV, §4 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

D. Home health care services; and [PL 2003, c. 20, Pt. VV, §4 (NEW); PL 2003, c. 20, Pt. VV, §25 (AFF).]

[PL 2003, c. 20, Pt. VV, §4 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

5-A. Exceptions. This section shall not apply to employee group insurance contracts issued to employers with 20 or fewer employees insured under the group contract or to group contracts designed primarily to supplement the Civilian Health and Medical Program of the Uniformed Services, as defined in the United States Code, Title 10, Section 1072, subsection 4.

[PL 1989, c. 490, §1 (AMD).]

5-B. Coverage for certain mental illness treatment.

[PL 1991, c. 881, §8 (RP).]

5-C. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A-1 is subject to this subsection.

A. [PL 2003, c. 20, Pt. VV, §5 (RP); PL 2003, c. 20, Pt. VV, §25 (AFF).]

A-1. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;

(2) Dissociative disorders;

(3) Mood disorders;

(4) Anxiety disorders;

(5) Personality disorders;

(6) Paraphilias;

(7) Attention deficit and disruptive behavior disorders;

(8) Pervasive developmental disorders;

(9) Tic disorders;

(10) Eating disorders, including bulimia and anorexia; and

(11) Substance use disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [PL 2017, c. 407, Pt. A, §93 (AMD).]

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must provide benefits that meet the requirements of this paragraph.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital and medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

(3) If benefits and coverage for treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.

(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.

(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance

requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.

(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits. [PL 2003, c. 20, Pt. VV, §5 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.
[PL 2017, c. 407, Pt. A, §93 (AMD).]

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group nonprofit hospital and medical service organization health care plan contracts is subject to this subsection.

A. All individual and group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder. [PL 2003, c. 20, Pt. VV, §6 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

B. Every nonprofit hospital and medical service organization and nonprofit health care plan must make available coverage in all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State that provides benefits meeting the requirements of this paragraph.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital and medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract. [PL 2003, c. 20, Pt. VV, §6 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]
[PL 2003, c. 20, Pt. VV, §6 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

6. Contracts; providers. Subject to the approval by the Superintendent of Insurance pursuant to section 2305, a nonprofit hospital and a medical service organization incorporated under this chapter

shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.
[PL 2003, c. 20, Pt. VV, §7 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

7. Limits; coinsurance; deductibles. Any policy or contract which provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.
[PL 1983, c. 515, §4 (NEW).]

8. Reports to the Superintendent of Insurance. Every nonprofit hospital or medical service organization subject to this section shall report its experience for each calendar year to the superintendent not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all nonprofit hospital or medical service organizations in an annual report.
[PL 1995, c. 407, §3 (AMD).]

9. Application; expiration.
[PL 1995, c. 407, §4 (RP).]

10. Application. Except as otherwise provided in this section, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. B, §6 (NEW).]

SECTION HISTORY

PL 1983, c. 515, §4 (NEW). PL 1987, c. 480, §2 (AMD). PL 1989, c. 490, §1 (AMD). PL 1991, c. 881, §§1,2 (AMD). PL 1991, c. 881, §§7,8 (AFF). PL 1993, c. 441, §§1,2 (AMD). PL 1993, c. 586, §§1,2 (AMD). PL 1995, c. 19, §1 (AMD). PL 1995, c. 332, §G1 (AMD). PL 1995, c. 407, §§1-4 (AMD). PL 1995, c. 560, §K82 (AMD). PL 1995, c. 560, §K83 (AFF). PL 1995, c. 625, §B6 (AMD). PL 1995, c. 625, §B7 (AFF). PL 1995, c. 637, §§1,2 (AMD). PL 1999, c. 256, §O1 (AMD). PL 2001, c. 354, §3 (AMD). PL 2003, c. 20, §§VV1-7 (AMD). PL 2003, c. 20, §VV25 (AFF). PL 2003, c. 517, §B6 (AMD). PL 2003, c. 689, §B6 (REV). PL 2017, c. 407, Pt. A, §93 (AMD).

§2325-B. Mandated Benefits Advisory Commission

(REPEALED)

SECTION HISTORY

PL 1987, c. 480, §3 (NEW). PL 1989, c. 503, §B104 (AMD). PL 1989, c. 556, §A2 (RPR). PL 1989, c. 878, §A65 (AMD). PL 1991, c. 701, §3 (RP).

§2325-C. Coverage for prostate cancer screening

1. Definition. As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:

A. A digital rectal examination; and [PL 1997, c. 754, §1 (NEW).]

B. A prostate-specific antigen test. [PL 1997, c. 754, §1 (NEW).]
[PL 1997, c. 754, §1 (NEW).]

2. Required coverage for prostate cancer screening. All individual and group nonprofit hospital and medical services plan contracts must provide coverage for services for the early detection of

prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72.
[PL 1997, c. 754, §1 (NEW).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 1997, c. 754, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 754, §1 (NEW).

§2326. Appeals from order or decision of the superintendent

Any person whose interests are substantially and directly affected and aggrieved by an order or decision of the superintendent or any party to a hearing held pursuant to section 2322 may appeal therefrom as provided in Title 24-A, section 236. [PL 1979, c. 558, §5 (NEW).]

SECTION HISTORY

PL 1979, c. 558, §5 (NEW).

§2327. Group rates

A group health care contract may not be issued by a nonprofit hospital or medical service organization in this State until a copy of the group rates to be used in calculating the premium for these contracts has been filed for informational purposes with the superintendent. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care contracts and for certain group contracts included within the definition of "individual health plan" in Title 24-A, section 2736-C, subsection 1, paragraph C must be filed in accordance with section 2321 and rates for small group health plans as defined by Title 24-A, section 2808-B must be filed in accordance with that section. [PL 2003, c. 469, Pt. E, §1 (AMD).]

SECTION HISTORY

PL 1979, c. 558, §5 (NEW). PL 1985, c. 648, §2 (AMD). PL 2003, c. 428, §E1 (AMD). PL 2003, c. 469, §E1 (AMD).

§2327-A. Applicability

(REPEALED)

SECTION HISTORY

PL 1989, c. 422, §1 (NEW). PL 1991, c. 861, §1 (AMD). PL 1991, c. 861, §4 (AFF). PL 1995, c. 332, §L1 (AMD). PL 1997, c. 445, §1 (AMD). PL 1997, c. 445, §32 (AFF). PL 1997, c. 604, §B1 (AMD). PL 1999, c. 256, §M11 (RP).

§2327-B. Rating practices in individual insurance

(REPEALED)

SECTION HISTORY

PL 1993, c. 547, §1 (NEW). PL 1999, c. 256, §M12 (RP).

§2327-C. Continuity of health insurance coverage

(REPEALED)

SECTION HISTORY

PL 1997, c. 445, §2 (NEW). PL 1997, c. 445, §32 (AFF). PL 1999, c. 256, §M13 (RP).

§2328. Health care contracts; supplementing Medicare; compliance with provisions of Title 24-A, chapter 67

(REPEALED)

SECTION HISTORY

PL 1981, c. 234, §1 (NEW). PL 1981, c. 254, §1 (NEW). PL 1981, c. 698, §107 (RAL). PL 1999, c. 256, §M14 (RP).

§2328-A. Nursing home and long-term care contracts; compliance with Title 24-A, chapter 68

(REPEALED)

SECTION HISTORY

PL 1985, c. 648, §3 (NEW). PL 1999, c. 256, §M15 (RP).

§2329. Equitable health care for substance use disorder treatment

1. Purpose. The Legislature recognizes that substance use disorder constitutes a major health problem in the State and in the Nation. The Legislature further recognizes that substance use disorder is a disease that can be effectively treated. As such, substance use disorder warrants the same attention from the health care industry as other serious diseases and illnesses. The Legislature further recognizes that health care contracts, at times, fail to provide adequate benefits for the treatment of substance use disorder, which results in more costly health care for treatment of complications caused by the lack of early intervention and other treatment services for persons suffering from substance use disorder. This situation causes a higher health care, social, law enforcement and economic cost to the citizens of this State than is necessary, including the need for the State to provide treatment to some subscribers at public expense. To assist the many citizens of this State who suffer from this illness in a more cost-effective way, the Legislature declares that certain health care coverage providing benefits for the treatment of the illness of substance use disorder must be included in all group health care contracts. [PL 2017, c. 407, Pt. A, §94 (AMD).]

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

A. "Outpatient care" means care rendered by a state-licensed, approved or certified detoxification, residential treatment or outpatient program, or partial hospitalization program on a periodic basis, including, but not limited to, patient diagnosis, assessment and treatment, individual, family and group counseling and educational and support services. [PL 1983, c. 527, §1 (NEW).]

B. "Residential treatment" means services at a facility that provides care 24 hours daily to one or more patients, including, but not limited to, the following services: room and board; medical, nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services, including a designated unit of a licensed health care facility providing any and all other services specified in this paragraph to patients with substance use disorder. [PL 2017, c. 407, Pt. A, §94 (AMD).]

C. "Treatment plan" means a written plan initiated at the time of admission, approved by a Doctor of Medicine, a Doctor of Osteopathy or a Licensed Substance Abuse Counselor employed by a certified or licensed substance use disorder program, including, but not limited to, the patient's medical and substance use disorder history; record of physical examination; diagnosis; assessment of physical capabilities; mental capacity; orders for medication, diet and special needs for the

patient's health or safety and treatment, including medical, psychiatric, psychological, social services, individual, family and group counseling; and educational, support and referral services. [RR 2017, c. 2, §7 (COR).]

[RR 2017, c. 2, §7 (COR).]

3. Requirement. Every nonprofit hospital or medical service organization that issues group health care contracts providing coverage for hospital care to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for the treatment of substance use disorder pursuant to a treatment plan.

[PL 2017, c. 407, Pt. A, §94 (AMD).]

4. Services; providers. Each group contract must provide, at a minimum, for the following coverage, pursuant to a treatment plan:

A. Residential treatment at a hospital or free-standing residential treatment center that is licensed, certified or approved by the State; and [PL 2017, c. 407, Pt. A, §94 (AMD).]

B. Outpatient care rendered by state licensed, certified or approved providers who have contracted with the nonprofit hospital or medical service organization under terms and conditions that the organization considers satisfactory to its membership. [PL 2017, c. 407, Pt. A, §94 (AMD).]

Treatment or confinement at any facility may not preclude further or additional treatment at any other eligible facility, provided that the benefit days used do not exceed the total number of benefit days provided for under the contract.

[PL 2017, c. 407, Pt. A, §94 (AMD).]

5. Exceptions. This section does not apply to employee group insurance contracts issued to employers with 20 or fewer employees insured under the group contract or to group contracts designed primarily to supplement the Civilian Health and Medical Program of the Uniformed Services, as defined in the United States Code, Title 10, Section 1072, subsection 4.

[PL 2017, c. 407, Pt. A, §94 (AMD).]

6. Limits; coinsurance; deductibles. Any policy or contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance, and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[PL 2017, c. 407, Pt. A, §94 (AMD).]

7. Notice. At the time of delivery or renewal, the nonprofit hospital or medical service organization shall provide written notification to all individuals eligible for benefits under group policies or contracts of substance use disorder benefits.

[PL 2017, c. 407, Pt. A, §94 (AMD).]

8. Confidentiality. Substance use disorder treatment patient records are confidential.

[PL 2017, c. 407, Pt. A, §94 (AMD).]

9. Reports to the Superintendent of Insurance. Every nonprofit hospital or medical service organization subject to this section shall report its experience for each calendar year beginning with 1984 to the superintendent not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and must include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient and outpatient services. The superintendent shall compile this data for all nonprofit hospital or medical service organizations in an annual report.

[PL 2017, c. 407, Pt. A, §94 (AMD).]

10. Application; expiration. The requirements of this section apply to all policies and any certificates or contracts executed, delivered, issued for delivery, continued or renewed in this State on

or after January 1, 1984. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2017, c. 407, Pt. A, §94 (AMD).]

SECTION HISTORY

PL 1981, c. 319, §1 (NEW). PL 1983, c. 527, §1 (RPR). PL 1987, c. 480, §4 (AMD). PL 1987, c. 735, §41 (AMD). PL 1989, c. 490, §2 (AMD). PL 2011, c. 320, Pt. A, §2 (AMD). PL 2017, c. 407, Pt. A, §94 (AMD). RR 2017, c. 2, §7 (COR).

§2330. Conversion on termination of contracts or eligibility

(REPEALED)

SECTION HISTORY

PL 1981, c. 606, §1 (NEW). PL 1983, c. 91, §1 (AMD). PL 1985, c. 684, §1 (AMD). PL 1987, c. 25, §§1,2 (AMD). PL 1989, c. 447, §1 (AMD). PL 1991, c. 668, §1 (AMD). PL 1991, c. 822, §§1,2 (AMD). PL 1991, c. 822, §6 (AFF). PL 1991, c. 885, §§E21,22 (AMD). PL 1991, c. 885, §E47 (AFF). PL 1995, c. 189, §1 (AMD). PL 1995, c. 189, §4 (AFF). PL 1995, c. 332, §§A1-7 (AMD). PL 1997, c. 393, §A25 (AMD). PL 1997, c. 604, §B2 (RP).

§2331. Optional coverage for optometric services

1. Coverage required to be made available. Every nonprofit hospital or medical service organization which issues group health care contracts providing coverage for the services of a "physician" or "doctor" to residents of this State shall make available coverage for such services when performed by an optometrist to the extent the services are within the lawful scope of practice of an optometrist licensed to practice in this State, provided that the optometrist performing the services has contracted with the organization under terms and conditions which the organization deems satisfactory to its membership.
[PL 1981, c. 698, §107 (RAL).]

2. Contract. The group contract making available coverage for the services referred to in this section shall contain provisions for maximum benefits and coinsurance, and reasonable limitations, deductibles and exclusions.
[PL 1981, c. 698, §107 (RAL).]

SECTION HISTORY

PL 1981, c. 698, §107 (RAL).

§2332. Assessment for the recoupment of expenses related to the regulation of nonprofit hospital or medical service organizations and nonprofit health care plans

The Superintendent of Insurance shall levy an assessment annually upon nonprofit hospital or medical service organizations and nonprofit health care plans licensed to do business in this State in proportion to their respective subscription income derived from business operations in this State during the year ending December 31st immediately preceding the fiscal year for which assessment is made. The annual assessment upon all hospital or medical service organizations and health care plans must be applied to the budget of the bureau for the fiscal year commencing July 1st. For any biennial period, total assessment must be in an amount not exceeding .00015 of subscription income. When the superintendent calculates the amount of the annual assessment, the superintendent shall consider, among other factors, the staffing level required to administer the nonprofit health care regulatory program of the bureau. [PL 1991, c. 334, §1 (AMD).]

1. Expense of examination. The expense of examination of any corporation described in section 2301 shall continue to be borne by the corporation examined. The expense of examination consistent

with section 2307 shall not be considered when determining the assessment for the recoupment of expenses related to the nonprofit health care regulatory program of the bureau.
[PL 1985, c. 446, §1 (NEW).]

2. Subscription income. Based on the annual statement filed by each nonprofit hospital or medical service organization or health care plan pursuant to section 2306, the superintendent shall ascertain the amount of subscription income received in that year. For the purpose of this section only, "subscription income" means and includes subscription premium and other considerations received by hospital or medical service organizations and health care plans, on account of certificates or contracts covering risks located, resident or to be performed in this State, after deducting subscription or other contract consideration returns. "Subscription income" does not include direct gross written premium used to calculate the assessment, pursuant to Title 24-A, section 237, for a health maintenance organization operated and organized as a division or line of business of a nonprofit hospital or medical or health care service organization.
[PL 1997, c. 79, §1 (AMD).]

3. Minimum assessment. In any year in which a nonprofit hospital or medical service organization or health care plan has no subscription income derived from business operations in this State, or in which subscription income is not sufficient to produce at the rate prescribed an amount equal to or in excess of $100, the minimum assessment payable shall be $100.
[PL 1985, c. 446, §1 (NEW).]

4. Notification of assessment. On or before July 1st of each year, the superintendent shall forward to each nonprofit hospital or medical service organization and health care plan an itemized bill of the amount due for the annual assessment, the amount due for the filing of the annual statement and the amount due for the certificate of authority annual fee pursuant to Title 24-A, section 601.
[PL 1997, c. 592, §6 (AMD).]

5. Time of payment. Payment for the annual assessment, the annual statement filing fee and the annual fee must be made on or before August 10th.
[PL 1997, c. 592, §6 (AMD).]

6. Revocation or suspension. If the assessment, annual statement filing fee or annual fee is not paid to the superintendent on or before the prescribed date, the certificate of authority of any nonprofit hospital or medical service organization or health care plan to transact business in this State may be revoked or suspended by the superintendent, after a hearing thereon or upon waiver of hearing by the nonprofit hospital or medical service organization or health care plan, until the assessment is paid.
[PL 1997, c. 592, §7 (AMD).]

7. Recalculation of assessment. Immediately following the close of the fiscal year ending June 30, 1987, and at the close of each 2nd succeeding fiscal year, the superintendent shall recalculate the assessment made against each party assessed after giving recognition to actual expenditures for the nonprofit health care regulatory program of the bureau during the preceding biennial period. On or before October 1st, the superintendent shall render to each party assessed a statement showing the difference between their respective recalculated assessment and the amount they had paid with respect to the preceding biennium. Any overpayment of annual assessment resulting from complying with the requirements of this section shall be refunded or, at the option of the assessed party, applied as a credit against the assessment for the succeeding fiscal year. Any overpayment of $100 or less shall be applied as a credit against the assessment for the succeeding fiscal year.
[PL 1985, c. 446, §1 (NEW).]

8. Deposit with Treasurer of State. The superintendent shall deposit all payments made pursuant to this section with the Treasurer of State. The money shall be used for the sole purpose of recouping the expenses related to the nonprofit health care regulatory program of the Bureau of Insurance.
[PL 1985, c. 446, §1 (NEW).]

9. Applicability. This section applies with respect to fiscal years commencing on or after July 1, 1986.
[PL 1985, c. 446, §1 (NEW).]

10. Filing fees. The superintendent may require nonprofit hospital or medical service organizations and nonprofit health care plans to pay filing fees for form and rate approval on a quarterly, biennial or annual basis.
[PL 1997, c. 457, §6 (NEW).]

SECTION HISTORY

PL 1985, c. 446, §1 (NEW). PL 1991, c. 334, §§1,2 (AMD). PL 1997, c. 79, §1 (AMD). PL 1997, c. 457, §6 (AMD). PL 1997, c. 592, §§6,7 (AMD).

§2332-A. Coordination of benefits

1. Authorization. Provisions contained in group and nongroup nonprofit hospital, medical service or health care subscriber contracts relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which the subscriber or the subscriber's dependents may be covered must conform to rules adopted by the superintendent. The rules may establish uniformity in the permissive use of coordination of benefits provisions to ensure that the subscriber receives full benefits for covered medical services, to enhance cost containment through avoidance of windfall payments and to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among the several insurers and nonprofit hospital, medical service and health care plans.
[PL 1993, c. 666, Pt. B, §1 (NEW).]

1-A. Coordination with Medicare. Coordination of benefits is governed by the following provisions.

A. The contract may not coordinate benefits with Medicare Part A unless:

(1) The insured is enrolled in Medicare Part A;

(2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or

(4) The insured is eligible for Medicare Part A without paying a premium and the contract states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage. [PL 1997, c. 604, Pt. G, §1 (NEW).]

B. The contract may not coordinate benefits with Medicare Part B unless:

(1) The insured is enrolled in Medicare Part B;

(2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or

(4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the contract was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The content of the notification must be approved by the bureau. The notification must state that the contract will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B and state that the insured may contact the bureau, the Health Insurance Consumer Assistance Program established in Title 24-A, section 4326 or another relevant

organization or agency for assistance in understanding coordination of benefits with Medicare Part B under the insured's contract. [PL 2023, c. 104, §1 (AMD).]

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B. [PL 1997, c. 604, Pt. G, §1 (NEW).]

[PL 2023, c. 104, §1 (AMD).]

2. Medicaid and Children's Health Insurance Program. Nonprofit service organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," or Title 22, section 3174-T, referred to as the "Children's Health Insurance Program," when considering coverage eligibility or benefit calculations for subscribers and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program or the Children's Health Insurance Program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the covered subscriber or family member to payment by the nonprofit service organization for those health care items or services. Upon presentation of proof that the Medicaid program or the Children's Health Insurance Program has paid for covered items or services, the nonprofit service organization shall make payment to the Medicaid program or the Children's Health Insurance Program according to the coverage provided in the contract or certificate. [PL 2023, c. 597, §16 (AMD).]

B. A nonprofit service organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid or Children's Health Insurance Program coverage and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual. [PL 2023, c. 597, §16 (AMD).]

[PL 2023, c. 597, §16 (AMD).]

3. Credit toward deductible. When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

[PL 2005, c. 121, Pt. D, §1 (NEW).]

SECTION HISTORY

PL 1987, c. 402, §A149 (NEW). PL 1991, c. 200, §B2 (AMD). PL 1993, c. 666, §B1 (RPR). PL 1997, c. 604, §G1 (AMD). PL 1997, c. 777, §B1 (AMD). PL 2005, c. 121, §D1 (AMD). PL 2005, c. 683, §A38 (AMD). PL 2023, c. 104, §1 (AMD). PL 2023, c. 597, §16 (AMD).

§2332-B. Acquired Immune Deficiency Syndrome

1. Definitions. As used in this section, "HIV" and "antibody to HIV" have the same meanings as set out in Title 5, section 19201.

[PL 1991, c. 3, §2 (NEW).]

2. Prohibitions. No individual or group hospital, medical or health care service contract delivered or issued for delivery in this State, other than a contract that provides benefits for specific diseases or accidental injuries only, may provide more restrictive coverage for Acquired Immune Deficiency Syndrome, or AIDS, AIDS Related Complex, or ARC, HIV-related diseases or for related services, than for any other disease or sickness, or exclude coverage for AIDS, ARC or HIV-related diseases, except through an exclusion under which all diseases and sicknesses are treated equally.

[PL 1991, c. 3, §2 (NEW).]

3. Test results. No nonprofit hospital or medical services organization or nonprofit health care plan may request any person to reveal whether the person has obtained a test for the presence of

antibodies to HIV or a test to measure the virus or to reveal the results of such tests taken prior to an application for coverage.
[PL 1991, c. 3, §2 (NEW).]

SECTION HISTORY

PL 1989, c. 176, §1 (NEW). PL 1991, c. 3, §2 (RPR).

§2332-C. Assessment of mandated benefits proposals

(REPEALED)

SECTION HISTORY

PL 1989, c. 556, §A3 (NEW). PL 1991, c. 701, §4 (AMD). PL 1999, c. 256, §M16 (RP).

§2332-D. Jury service

1. Prohibition. A nonprofit hospital or medical service organization that issues group health care contracts providing coverage for medical care to residents of this State may not terminate coverage for any person covered under those contracts because the person has been summonsed for or is engaged in jury service under Title 14, chapter 305, subchapter I-A.
[PL 1989, c. 801, §2 (NEW).]

2. Application. This section applies to all policies and any certificate executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1991. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 1989, c. 801, §2 (NEW).]

SECTION HISTORY

PL 1989, c. 801, §2 (NEW).

§2332-E. Standardized claim forms

All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically, and any claims for facility services must identify the physical location, including hospital off-campus locations, where services are provided. A nonprofit hospital or medical service organization or nonprofit health care plan may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to section 2985. [PL 2023, c. 521, §1 (AMD).]

SECTION HISTORY

PL 1993, c. 477, §D5 (NEW). PL 1993, c. 477, §F1 (AFF). PL 2003, c. 218, §1 (AMD). PL 2003, c. 469, §D1 (AMD). PL 2003, c. 469, §D9 (AFF). PL 2023, c. 521, §1 (AMD).

§2332-F. Coverage for diabetes supplies

All individual and group nonprofit hospital and medical services plan policies, contracts and certificates and all nonprofit health care plan policies, contracts and certificates must provide coverage for the medically appropriate and necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational

services used to treat diabetes, if: [PL 2003, c. 517, Pt. A, §3 (AMD); PL 2003, c. 517, Pt. A, §13 (AFF).]

1. Certification of medical necessity. The subscriber's treating physician or a physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and [PL 1995, c. 592, §1 (NEW).]

2. Provision of medical services. The diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.
[PL 1995, c. 592, §1 (NEW).]

REVISOR'S NOTE: §2332-F. Gynecological and obstetrical services (As enacted by PL 1995, c. 617, §2 and affected by §6 is REALLOCATED TO TITLE 24, SECTION 2332-G)

SECTION HISTORY

RR 1995, c. 2, §49 (RAL). RR 1995, c. 2, §50 (AFF). PL 1995, c. 592, §1 (NEW). PL 1995, c. 617, §2 (NEW). PL 1995, c. 617, §6 (AFF). PL 2003, c. 517, §A3 (AMD). PL 2003, c. 517, §A13 (AFF).

§2332-G. Gynecological and obstetrical services

(REALLOCATED FROM TITLE 24, SECTION 2332-F)

1. Coverage in managed care plans. With respect to managed care plans that require subscribers to select primary care physicians, a nonprofit hospital and medical service organization that issues group contracts and certificates must meet the following requirements.

A. The organization must permit a physician who specializes in obstetrics and gynecology to serve as a primary care physician if the physician qualifies under the organization's credentialling policy. [RR 1995, c. 2, §49 (RAL); RR 1995, c. 2, §50 (AFF).]

B. All group plan contracts must provide coverage for an annual gynecological examination, including routine pelvic and clinical breast examinations, performed by a physician, certified nurse practitioner or certified nurse midwife participating in the plan, without requiring the prior approval of the primary care physician. [RR 1995, c. 2, §49 (RAL); RR 1995, c. 2, §50 (AFF).]

C. If the examination specified in paragraph B reveals a gynecological condition for which another visit to the physician participating in the plan is medically required and appropriate, or for any gynecological care beyond the annual examination, the carrier may require the patient or the examining physician, certified nurse practitioner or certified nurse midwife to secure from the patient's primary care physician a referral to the participating physician, certified nurse practitioner or certified nurse midwife from whom such care may be obtained. [RR 1995, c. 2, §49 (RAL); RR 1995, c. 2, §50 (AFF).]
[PL 2003, c. 517, Pt. A, §4 (AMD); PL 2003, c. 517, Pt. A, §13 (AFF).]

2. Application. This section applies to all contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. A, §4 (AMD); PL 2003, c. 517, Pt. A, §13 (AFF).]

This section does not prohibit a carrier from requiring a physician, certified nurse practitioner or certified nurse midwife participating in the plan to inform a woman's primary care physician prior to each treatment pursuant to this section. [RR 1995, c. 2, §49 (RAL); RR 1995, c. 2, §50 (AFF).]

SECTION HISTORY

RR 1995, c. 2, §49 (RAL). RR 1995, c. 2, §50 (AFF). PL 2003, c. 517, §A4 (AMD). PL 2003, c. 517, §A13 (AFF).

§2332-H. Assignment of benefits

All contracts providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the contract. [PL 1999, c. 21, §1 (AMD).]

SECTION HISTORY

PL 1997, c. 604, §E1 (NEW). PL 1999, c. 21, §1 (AMD).

§2332-I. Effective date of cancellation

Contracts that do not provide for any refund of premium when a subscriber requests cancellation prior to the end of the period for which premiums have been paid must state that no refund is payable and that the cancellation will take effect at the end of the period for which premiums have been paid unless the subscriber requests an earlier cancellation date. If a subscriber requests cancellation of a contract before the end of the period for which premiums have been paid, then the nonprofit hospital or medical service organization must inform the subscriber in writing that no refund is payable and give the subscriber an opportunity to amend the cancellation request to take effect at the end of the period for which premiums have been paid. [PL 1997, c. 604, Pt. F, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 604, §F1 (NEW).

§2332-J. Coverage for contraceptives

1. Coverage requirements. All individual and group nonprofit hospital and medical services plan policies and contracts and all nonprofit health care plan policies and contracts that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives, nonprescription oral hormonal contraceptives and nonprescription emergency contraceptives approved by the federal Food and Drug Administration or for outpatient contraceptive services in accordance with the requirements of this section. For purposes of this section, "outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. This section may not be construed to apply to prescription drugs or devices that are designed to terminate a pregnancy.
[PL 2025, c. 445, §1 (AMD); PL 2025, c. 445, §14 (AFF).]

2. Exclusion for religious employer. A religious employer may request and a nonprofit hospital or medical service organization or nonprofit health care service organization shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide prospective insureds and those individuals insured under its policy written notice of the exclusion. This section may not be construed as authorizing a nonprofit hospital or medical service organization or nonprofit health care service organization to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes or for prescription contraception that is necessary to preserve the life or health of a covered person. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121 (w) (3) (A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c) (3).
[PL 1999, c. 341, §1 (NEW); PL 1999, c. 341, §5 (AFF).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. B, §7 (NEW).]

4. Coverage of contraceptive supplies. Coverage required under this section must include coverage for contraceptive supplies in accordance with the following requirements. For purposes of this section, "contraceptive supplies" means all contraceptive drugs, devices and products approved by the federal Food and Drug Administration to prevent an unwanted pregnancy, including nonprescription oral hormonal contraceptives and nonprescription emergency contraceptives.

A. Coverage must be provided without any deductible, coinsurance, copayment or other cost-sharing requirement. [PL 2021, c. 609, §1 (NEW); PL 2021, c. 609, §5 (AFF).]

B. If the federal Food and Drug Administration has approved one or more therapeutic equivalents of a contraceptive supply, an insurer is not required to cover all those therapeutically equivalent versions in accordance with this subsection, as long as at least one is covered without any deductible, coinsurance, copayment or other cost-sharing requirement in accordance with this subsection. [PL 2021, c. 609, §1 (NEW); PL 2021, c. 609, §5 (AFF).]

C. Coverage must be provided for the furnishing or dispensing of prescribed contraceptive supplies and nonprescription oral hormonal contraceptive supplies intended to last for a 12-month period, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider for prescribed contraceptive supplies. [PL 2025, c. 445, §2 (AMD); PL 2025, c. 445, §14 (AFF).]

D. A prescription is not required to obtain a nonprescription oral hormonal contraceptive or nonprescription emergency contraceptive. [PL 2025, c. 445, §2 (NEW); PL 2025, c. 445, §14 (AFF).]

E. A nonprofit hospital or medical service organization or nonprofit health care service organization shall establish mechanisms to ensure that an enrollee who seeks coverage for a nonprescription oral hormonal contraceptive or nonprescription emergency contraceptive at a pharmacy has the option to obtain the nonprescription oral hormonal contraceptive or nonprescription emergency contraceptive at the point of sale without payment of any cost-sharing amount or to make the purchase at the pharmacy counter through an out-of-pocket payment at the point of sale and submit a claim for reimbursement. [PL 2025, c. 445, §2 (NEW); PL 2025, c. 445, §14 (AFF).]

F. The superintendent shall monitor compliance with the requirements for coverage of nonprescription oral hormonal contraceptives and nonprescription emergency contraceptives and any rules adopted in accordance with subsection 5, including any complaints or barriers to implementation. [PL 2025, c. 445, §2 (NEW); PL 2025, c. 445, §14 (AFF).]
[PL 2025, c. 445, §2 (AMD); PL 2025, c. 445, §14 (AFF).]

5. Rules. The superintendent may adopt rules as necessary to implement the requirements of this section, including rules related to mechanisms to ensure coverage for nonprescription oral hormonal contraceptives and nonprescription emergency contraceptives and rules regarding notice to enrollees about how to access coverage for nonprescription oral hormonal contraceptives and nonprescription emergency contraceptives. Rules adopted pursuant to this subsection are routine technical rules as described in Title 5, chapter 375, subchapter 2-A.
[PL 2025, c. 445, §3 (NEW); PL 2025, c. 445, §14 (AFF).]

REVISOR'S NOTE: §2332-J. Coverage for services of certified nurse practitioners; certified nurse midwives (As enacted by PL 1999, c. 396, §1 and affected by §7 is REALLOCATED TO TITLE 24, SECTION 2332-K)

REVISOR'S NOTE: §2332-J. Coverage for services provided by registered nurse first assistants (As enacted by PL 1999, c. 412, §1 is REALLOCATED TO TITLE 24, SECTION 2332-L)

SECTION HISTORY

RR 1999, c. 1, §§30,31 (RAL). PL 1999, c. 341, §1 (NEW). PL 1999, c. 341, §5 (AFF). PL 1999, c. 396, §1 (NEW). PL 1999, c. 396, §7 (AFF). PL 1999, c. 412, §1 (NEW). PL 2003, c. 517, §B7 (AMD). PL 2021, c. 609, §1 (AMD). PL 2021, c. 609, §5 (AFF). PL 2025, c. 445, §§1-3 (AMD). PL 2025, c. 445, §14 (AFF).

§2332-K. Coverage for services of certified nurse practitioners; certified midwives; certified nurse midwives

(REALLOCATED FROM TITLE 24, SECTION 2332-J)

1. Required coverage for services upon referral of primary care provider. A nonprofit hospital or a medical service organization that issues individual and group health care contracts shall provide coverage under those contracts for services performed by a certified nurse practitioner, certified midwife or certified nurse midwife to a patient who is referred to the certified nurse practitioner, certified midwife or certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse practitioner, certified midwife or certified nurse midwife.
[PL 2021, c. 79, §1 (AMD); PL 2021, c. 79, §6 (AFF).]

2. Required coverage for self-referred services. With respect to individual and group health care contracts that do not require the selection of a primary care provider, a nonprofit hospital or medical service organization shall provide coverage under those contracts for services performed by a certified nurse practitioner, certified midwife or certified nurse midwife when those services are covered services and when they are within the lawful scope of practice of the certified nurse practitioner, certified midwife or certified nurse midwife.
[PL 2021, c. 79, §1 (AMD); PL 2021, c. 79, §6 (AFF).]

3. Limits; coinsurance; deductibles. Any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.
[RR 1999, c. 1, §30 (RAL).]

4. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. B, §8 (NEW).]

SECTION HISTORY

RR 1999, c. 1, §30 (RAL). PL 2003, c. 517, §B8 (AMD). PL 2021, c. 79, §1 (AMD). PL 2021, c. 79, §6 (AFF).

§2332-L. Coverage for services provided by registered nurse first assistants

(REALLOCATED FROM TITLE 24, SECTION 2332-J)

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

A. "Perioperative nursing" means a practice of nursing in which the nurse provides preoperative, intraoperative and postoperative nursing care to surgical patients. [RR 1999, c. 1, §31 (RAL).]

B. "Recognized program" means a program that addresses all content of the core curriculum for registered nurse first assistants as established by the Association of Operating Room Nurses or its successor organization. [RR 1999, c. 1, §31 (RAL).]

C. "Registered nurse first assistant," or "RNFA," means a person who:

(1) Is licensed as a registered nurse under Title 32, chapter 31;

(2) Is experienced in perioperative nursing; and

(3) Has successfully completed a recognized program. [RR 1999, c. 1, §31 (RAL).]

[RR 1999, c. 1, §31 (RAL).]

2. Institutional powers. Each health care institution, as defined in Title 22, chapter 405, may establish specific procedures for the appointment and reappointment of registered nurse first assistants and for granting, renewing and revising their clinical privileges.
[RR 1999, c. 1, §31 (RAL).]

3. Required coverage for services. Notwithstanding any other provisions of this chapter, a nonprofit hospital and medical service organization that issues individual and group health care contracts that provide coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications. The provisions of this subsection apply only if reimbursement for an assisting physician would be covered and a registered nurse first assistant who performed those services is used as a substitute.
[RR 1999, c. 1, §31 (RAL).]

4. Limits; coinsurance; deductibles. Any contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.
[RR 1999, c. 1, §31 (RAL).]

5. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. B, §9 (NEW).]

SECTION HISTORY

RR 1999, c. 1, §31 (RAL). PL 2003, c. 517, §B9 (AMD).

§2332-M. Coverage for general anesthesia for dentistry

1. Enrollee defined. For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under an individual or group health insurance contract provided by a nonprofit hospital and medical service organization.
[PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

2. General anesthesia and associated facility charges. All individual and group nonprofit hospital and medical service organization contracts must provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The nonprofit hospital and medical service organization may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.
[PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

3. Limitations on coverage. This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; [PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; [PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and [PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised. [PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

[PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

4. Dental procedures and dentist's fee not covered. This section does not require a nonprofit hospital and medical service organization to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the individual or group contract that apply generally to other benefits.

[PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

5. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the nonprofit hospital and medical service organization is the secondary payer.

[PL 2001, c. 423, §1 (NEW); PL 2001, c. 423, §5 (AFF).]

6. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 2003, c. 517, Pt. B, §10 (NEW).]

SECTION HISTORY

PL 2001, c. 423, §1 (NEW). PL 2001, c. 423, §5 (AFF). PL 2003, c. 517, §B10 (AMD).

§2332-N. Offer of coverage for breast reduction surgery and symptomatic varicose vein surgery

All individual and group nonprofit hospital and medical services plan policies, contracts and certificates and all nonprofit health care plan policies, contracts and certificates must make available coverage for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary health care as defined in Title 24-A, section 4301-A, subsection 10-A. [PL 2005, c. 128, §1 (NEW); PL 2005, c. 128, §5 (AFF).]

SECTION HISTORY

PL 2005, c. 128, §1 (NEW). PL 2005, c. 128, §5 (AFF).

SUBCHAPTER 2

NONPROFIT SERVICE ORGANIZATIONS PREFERRED PROVIDER ARRANGEMENT ACT OF 1986

(REPEALED)

§2333. Short title

(REPEALED)

SECTION HISTORY

PL 1985, c. 526, §1 (NEW). PL 1985, c. 704, §2 (NEW). PL 1987, c. 402, §A150 (RPR). PL 1999, c. 256, §M17 (RP).

§2333-A. Cardiac rehabilitation coverage

(REPEALED)

SECTION HISTORY

PL 1987, c. 293, §1 (NEW). PL 1999, c. 256, §M17 (RP).

§2334. Definitions

(REPEALED)

SECTION HISTORY

PL 1985, c. 704, §2 (NEW). PL 1999, c. 256, §M17 (RP).

§2335. Selective contracting authorized

(REPEALED)

SECTION HISTORY

PL 1985, c. 704, §2 (NEW). PL 1999, c. 256, §M17 (RP).

§2336. Contracts; agreements or arrangements with incentives or limits on reimbursement authorized

(REPEALED)

SECTION HISTORY

PL 1985, c. 704, §2 (NEW). PL 1989, c. 588, §A44 (RPR). PL 1999, c. 256, §M17 (RP). PL 1999, c. 256, §O2 (AMD). PL 1999, c. 790, §A28 (RP).

§2337. Filing for approval; disclosure

(REPEALED)

SECTION HISTORY

PL 1985, c. 704, §2 (NEW). PL 1989, c. 588, §A45 (AMD). PL 1999, c. 256, §M17 (RP).

§2338. Risk sharing

(REPEALED)

SECTION HISTORY

PL 1985, c. 704, §2 (NEW). PL 1989, c. 588, §A46 (AMD). PL 1999, c. 256, §M17 (RP).

§2339. Alternative health care benefits

(REPEALED)

SECTION HISTORY

PL 1985, c. 704, §2 (NEW). PL 1987, c. 34, §1 (AMD). PL 1989, c. 588, §A47 (RPR). PL 1993, c. 600, §B18 (AMD). PL 1999, c. 256, §M17 (RP).

§2340. Utilization review

(REPEALED)

SECTION HISTORY

PL 1985, c. 704, §2 (NEW). PL 1999, c. 256, §M17 (RP).

§2340-A. Annual report

(REPEALED)

SECTION HISTORY

PL 1989, c. 588, §A48 (NEW). PL 1999, c. 256, §M17 (RP).

§2341. Utilization review data

(REPEALED)

SECTION HISTORY

PL 1987, c. 168, §2 (NEW). PL 1999, c. 256, §M17 (RP).

SUBCHAPTER 2-A

LICENSURE OF MEDICAL UTILIZATION REVIEW ENTITIES

§2342. Review entities

1. Licensure. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or an employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers, shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that Title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.
[PL 1995, c. 332, Pt. M, §3 (AMD).]

2. Listing. The Bureau of Insurance shall compile and maintain a current listing of persons, partnerships or corporations licensed pursuant to this section.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

3. Information required. Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

A. The process by which the entity carries out its utilization review services, including the categories of health care personnel that perform any activities coming under the definition of

utilization review and whether or not these individuals are licensed in the State; [PL 1989, c. 556, Pt. C, §1 (NEW).]

B. The process used by the entity for addressing beneficiary or provider complaints; [PL 1989, c. 556, Pt. C, §1 (NEW).]

C. The types of utilization review programs offered by the entity, such as:

(1) Second opinion programs;

(2) Prehospital admission certification;

(3) Preinpatient service eligibility determination; or

(4) Concurrent hospital review to determine appropriate length of stay; and [PL 1989, c. 556, Pt. C, §1 (NEW).]

D. The process chosen by the entity to preserve beneficiary confidentiality of medical information. [PL 1989, c. 556, Pt. C, §1 (NEW).]

As part of its initial application, the entity shall submit copies of all materials to be used to inform beneficiaries and providers of the requirements of its utilization review plans and their rights and responsibilities under the plan.
[PL 1991, c. 200, Pt. A, §1 (AMD).]

4. Transition for existing entities. Notwithstanding subsection 1, persons, partnerships or corporations performing utilization review services on the effective date of this section shall have 90 days from its effective date to submit an application to the superintendent. The superintendent shall act upon those applications within 6 months of the date of receipt of the application, during which time the review entities may continue to perform medical utilization review services.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

SECTION HISTORY

PL 1989, c. 556, §C1 (NEW). PL 1989, c. 878, §B21 (AMD). PL 1991, c. 200, §A1 (AMD). PL 1993, c. 602, §1 (AMD). PL 1995, c. 332, §M3 (AMD).

§2343. Minimum standards

A utilization review program of the applicant must meet the following minimum standards. [PL 1989, c. 556, Pt. C, §1 (NEW).]

1. Notification of adverse decisions. Notification of an adverse decision by the utilization review agent must be provided to the insured or other party designated by the insured within a time period to be determined by the superintendent through rulemaking.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

2. Reconsideration of determination. All licensees shall maintain a procedure by which insureds, patients or providers may seek reconsideration of determinations of the licensee.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

3. Accessibility of representatives. A representative of the licensee must be accessible by telephone to insureds, patients or providers and the superintendent may adopt standards of accessibility by rule.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

4. Information materials; confidentiality. A copy of the materials designed to inform applicable patients of the requirements of the utilization plan and the responsibilities and rights of patients under the plan and an acknowledgment that all applicable state and federal laws to protect the confidentiality of individual medical records are followed must be filed with the bureau.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

5. Prohibited activities. A medical utilization review entity shall ensure that an employee does not perform medical utilization review services involving a health care provider or facility in which that employee has a financial interest.
[PL 1993, c. 602, §2 (NEW).]

SECTION HISTORY

PL 1989, c. 556, §C1 (NEW). PL 1993, c. 602, §2 (AMD).

§2344. Utilization review services

As used in this subchapter, unless the context indicates otherwise, "utilization review services" or "medical utilization review services" means a program or process by which a person, partnership or corporation, on behalf of an insurer, nonprofit service organization, 3rd-party administrator, or health maintenance organization, preferred provider organization or employer that is a payor for or that arranges for payment of medical services, seeks to review the utilization, appropriateness or quality of medical services provided to a person whose medical services are paid for, partially or entirely, by that insurer, nonprofit service organization, 3rd-party administrator, health maintenance organization, preferred provider organization or employer. The terms include these programs or processes whether they apply prospectively or retrospectively to medical services. Utilization review services include, but are not limited to, the following: [PL 1993, c. 602, §3 (AMD).]

1. Second opinion programs. Second opinion programs;
[PL 1989, c. 556, Pt. C, §1 (NEW).]

2. Prehospital admission certification. Prehospital admission certification;
[PL 1989, c. 556, Pt. C, §1 (NEW).]

3. Preinpatient service eligibility certification. Preinpatient service eligibility certification; and
[PL 1989, c. 556, Pt. C, §1 (NEW).]

4. Concurrent hospital review. Concurrent hospital review to determine appropriate length of stay.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

SECTION HISTORY

PL 1989, c. 556, §C1 (NEW). PL 1993, c. 602, §3 (AMD).

§2345. Enforcement

The following provisions govern enforcement of this chapter. [PL 1989, c. 556, Pt. C, §1 (NEW).]

1. Periodic reviews. The superintendent may conduct periodic reviews of the operations of the entities licensed pursuant to this subchapter to ensure that they continue to meet the minimum standards set forth in section 2343 and any applicable rules adopted by the superintendent. The superintendent may perform periodic telephone audits of licensees to determine if representatives of the licensee are reasonably accessible, as required by section 2343.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

2. Action against licensee. The superintendent is authorized to take appropriate action against a licensee which fails to meet the standards of this subchapter or any rules adopted by the superintendent, or who fails to respond in a timely manner to corrective actions ordered by the superintendent. The superintendent may impose a civil penalty not to exceed $1,000 for each violation, as permitted by Title 24-A, section 12-A or may deny, suspend or revoke the license.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

3. Opportunity to provide information and request hearing. Before taking the actions authorized by this section to deny, suspend or revoke the license, the superintendent shall provide the

licensee with reasonable time to supply additional information demonstrating compliance with the requirements of this subchapter and the opportunity to request a hearing to be held consistent with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

4. Authority to adopt rules. The superintendent may adopt rules necessary to implement the provisions of this subchapter.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

5. Rulings on appropriateness of medical judgments not authorized. Nothing in this subchapter requires or authorizes the superintendent to rule on the appropriateness of medical decisions or judgments rendered by review entities and their agents.
[PL 1989, c. 556, Pt. C, §1 (NEW).]

SECTION HISTORY

PL 1989, c. 556, §C1 (NEW).

SUBCHAPTER 2-B

COMMUNITY OF HEALTH INSURANCE COVERAGE

§2346. Definitions

(REPEALED)

SECTION HISTORY

PL 1989, c. 867, §§1,10 (NEW). PL 1991, c. 695, §1 (AMD). PL 1997, c. 445, §3 (RP). PL 1997, c. 445, §32 (AFF).

§2347. Continuity on replacement of group contract

(REPEALED)

SECTION HISTORY

PL 1989, c. 867, §§1,10 (NEW). PL 1991, c. 695, §§2,3 (AMD). PL 1993, c. 666, §D1 (AMD). PL 1995, c. 332, §F1 (AMD). PL 1997, c. 445, §4 (RP). PL 1997, c. 445, §32 (AFF).

§2348. Extension of benefits for disabled persons

(REPEALED)

SECTION HISTORY

PL 1989, c. 867, §§1,10 (NEW). PL 1997, c. 445, §5 (RP). PL 1997, c. 445, §32 (AFF).

§2349. Continuity of coverage for individual who changes groups

(REPEALED)

SECTION HISTORY

PL 1989, c. 867, §§1,10 (NEW). PL 1991, c. 695, §4 (AMD). PL 1993, c. 477, §§A1-6 (AMD). PL 1993, c. 477, §F1 (AFF). PL 1993, c. 547, §2 (AMD). PL 1993, c. 666, §D2 (AMD). PL 1995, c. 77, §1 (AMD). PL 1995, c. 332, §F2 (AMD). PL 1995, c. 342, §§1-3 (AMD). PL 1995, c. 673, §B1 (AMD). PL 1997, c. 370, §§C1-3 (AMD). PL 1997, c. 445, §6 (RP). PL 1997, c. 445, §32 (AFF). PL 1997, c. 683, §B12 (RP).

§2349-A. Medical child support

A corporation organized pursuant to this chapter must comply with 42 United States Code, Section 1396g-1. [PL 1995, c. 418, Pt. C, §1 (NEW).]

SECTION HISTORY

PL 1995, c. 418, §C1 (NEW).

§2350. Limitations on exclusion and waiting periods

(REPEALED)

SECTION HISTORY

PL 1989, c. 867, §§1,10 (NEW). PL 1993, c. 477, §A7 (AMD). PL 1993, c. 477, §F1 (AFF). PL 1997, c. 445, §7 (RP). PL 1997, c. 445, §32 (AFF).

SUBCHAPTER 3

INVESTMENTS

(REPEALED)

§2351. Investments in general

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

§2352. Definitions

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

§2353. Government unit bonds

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

§2354. Corporate securities

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1987, c. 769, §A88 (AMD). PL 1993, c. 702, §A6 (RP).

§2355. Financial institution stock and other obligations

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

§2356. Other securities investments

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

§2357. Other prudent securities

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

§2358. Retention of unauthorized securities

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

§2359. Real estate

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

§2360. Related corporations

(REPEALED)

SECTION HISTORY

PL 1987, c. 405, §35 (NEW). PL 1993, c. 702, §A6 (RP).

SUBCHAPTER 4

NOTIFICATION

§2370. Notification prior to cancellation

The superintendent shall, by January 1, 1991, adopt rules in accordance with the Maine Administrative Procedure Act, to provide for notification of the subscriber and another person, if designated by the subscriber, prior to cancellation of health care coverage for nonpayment of premiums, and to provide restrictions on cancellation of coverage when a subscriber suffers from organic brain disease. [PL 1989, c. 835, §1 (NEW).]

The rules may include, but are not limited to, definitions, minimum disclosure requirements, notice provisions and cancellation restrictions. [PL 1989, c. 835, §1 (NEW).]

SECTION HISTORY

PL 1989, c. 835, §1 (NEW).

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