Bulletin 301

CLARIFICATION OF HEALTH INSURANCE LAWS

In response to questions that have arisen, this bulletin is intended to clarify various statutes and rules concerning medical insurance.

Data reporting for small group and individual medical coverage

Bureau of Insurance Rule 940, "Requirements for Health Insurance Rate Filings and Data Reporting," became effective on March 1, 2000. Appendix A of the rule requires annual data reporting on or before April 30 by carriers offering small group or individual medical insurance in Maine. The first reports are due April 30, 2000. However, for this year only, an automatic one-month extension is hereby granted. It is not necessary to request an extension as long as reports are submitted by May 31, 2000. Reports are preferred in electronic form in Microsoft Excel format. Lotus 1-2-3 format with a .wk4 extension is also acceptable. Completed reports may be e-mailed to richard.h.diamond@state.me.us or mailed on disk. Blank forms will be provided by e-mail if request by e-mail to the same address. We also intend to enable reporting through the internet, but this may not be available in time for this year's reports. When available, the reporting forms will be posted to our web site, MaineInsuranceReg.org.

One-life groups

Under Maine's small group law [Title 24-A M.R.S.A. § 2808-B], a business with only one eligible employee is eligible for small group coverage. A carrier offering both small group and individual coverage can choose to offer only individual coverage to sole proprietors with no other employees. However, if the business has more than one employee, the carrier must issue a small group policy as long as the carrier's participation requirements are met, even if only one of the employees is applying for coverage and even if that employee is the owner of the business. As specified in the law, the participation requirement can be no more stringent than 75% of employees and their dependents, excluding those who have other coverage. For example, consider a business with three employees where two of them have coverage through their spouses' employers. If the employer applies for a small group policy to cover the remaining employee, the carrier cannot substitute an individual policy.

Commissions

Carriers offering small group or individual medical coverage are reminded that the following restrictions apply to commission scales:

- Within the small group market, the commission payable for a smaller group must be as least as high on a percentage basis as that payable for a larger group. For example, if a 10% commission is payable for a 40-life group, the commission on a two-life group must be at least 10%. The rationale for this requirement was previously set forth in Bulletin 212.
- Section 10 of Bureau of Insurance Rule 750 contains the following restrictions:
    - For all individual standardized health plans, the producer commissApril 10, 2007ure of any other individual health plan offered by the carrier.
    - For all individual standardized health plans, the producer commission structure may be no less than the producer commission structure of any small group health plan offered by the carrier unless the carrier has been granted a waiver from this requirement. A carrier will be granted a waiver if it demonstrates to the satisfaction of the Superintendent that it has an effective alternative marketing mechanism in the individual market.
    - For all small group standardized health plans, the producer commission structure may be no less than the producer commission structure of any other small group health plan offered by the carrier.

Extension of Benefits When Hospitalized

Title 24-A M.R.S.A. § 2849-A requires an extension of benefits for those who are totally disabled when a group policy terminates. The statute specifies that if replacement coverage is secured, the new coverage is primary and the replaced coverage is secondary. Bureau of Insurance Rule 590 defines total disability for purposes of this requirement. From the definition, it is clear that someone who is hospitalized is totally disabled and therefore subject to this statute. Therefore, when replacement coverage is in effect, the new coverage is primary for the remainder of the hospitalization and the replaced coverage is secondary. Consistent with Title 24-A M.R.S.A. § 2849, the new coverage cannot contain an exclusion for existing hospitalizations. If the hospitalization lasts more than six months past the termination of the replaced policy, no further extension of benefits under that policy is required unless provided by the terms of the policy.

Benefit Modifications in Small Group and Individual Policies

Title 24-A M.R.S.A. § 2850-B requires most medical coverage to be guaranteed renewable, but the statute recognizes that it may be desirable to modify the benefits from time to time. Subsection 3(H) of the statute allows this for large group policies, but for small group or individual policies, benefit modifications are only permitted under subsection 3(G), which requires a finding by the Superintendent that the change is in the best interests of the policyholders. Subsection 3(G) also requires a 90-day notice to policyholders and insureds. Note: The statute would not override a contractual provision requiring the policyholder's consent to any contract changes.

Contraceptive Coverage

A new mandated benefit requires all policies that cover prescription drugs or outpatient medical services to cover prescription contraceptives and outpatient contraceptive services (except when the policy is provided as an employee benefit by a religious organization or religious school that has waived this coverage for religious reasons).1 The Bureau interprets this to mean the following:

- Policies that cover prescription drugs must cover prescription contraceptives.
- Policies that cover outpatient medical services must cover outpatient contraceptive services.
- The coverage must be on a comparable basis. For example, the policy cannot establish different copayment structures for contraceptives than for other drugs, nor can it require contraceptives to be obtained from a network pharmacy unless the same requirement applies equally to all other prescription drugs.
- Prescription contraceptives include Norplant and other implantable contraceptive products.

This contraceptive mandate applies to policies issued or renewed on or after March 1, 2000.

Small Employers Covered Through Association Groups

Small group carriers are reminded that Title 24-A M.R.S.A. § 2808-B requires any benefit plan offered to a small employer to be offered to all small employers. This means that a plan offered to small employer through an association must also be offered to small groups not in the association. As was previously stated in Bulletin 210, this requirement applies regardless of whether the association has been granted an exemption from the rating provisions under Title 24-A M.R.S.A. § 2808-B(2).

April 4, 2000 _____
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NOTE: This bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties or privileges nor is it intended to provide legal advice. Readers are encouraged to consult applicable statutes and regulations and to contact the Bureau of Insurance if additional information is needed.

124 M.R.S.A. § 2332-J; 24-A M.R.S.A. §§ 2756, 2847-G, 4247, enacted by P.L. 1999, ch. 341.