L.D. 1945

DATE: 4/4/16 (Filing No. H-950)

INSURANCE AND FINANCIAL SERVICES

Minority

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
122ND LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 1365, L.D. 1945, Bill, "An Act To Establish a High-risk Health Insurance Pool"

Amend the bill by inserting after the enacting clause and before section 1 the following:

'**Sec. 1. 24 MRSA §2317-B, sub-§14-A** is enacted to read:

14-A. Title 24-A, section 2808-C. Small group health plans, Title 24-A, section 2808-C;

Sec. 2. 24 MRSA §2317-B, sub-§15, as enacted by PL 1999, c. 256, Pt. M, §10, is repealed.

Sec. 3. 24 MRSA §2327, as amended by PL 2003, c. 469, Pt. E, §1, is further amended to read:

§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

COMMITTEE AMENDMENT

accordance with section 2321 and rates for small group health plans as defined by Title 24-A, section ~~2808-B~~ 2808-C must be filed in accordance with that section.

Sec. 4. 24-A MRSA §2736-C, sub-§2, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

B. A carrier may not vary the premium rate due to the gender, ~~health status,~~ claims experience or policy duration of the individual. A carrier may vary the premium rate based on health status, age and tobacco use only as permitted in paragraph D.

Sec. 5. 24-A MRSA §2736-C, sub-§2, ¶C, as amended by PL 2001, c. 410, Pt. A, §1 and affected by §10, is further amended to read:

C. A carrier may vary the premium rate due to ~~smoking status and~~ family membership. ~~The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts based on smoking status. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.~~

Sec. 6. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2001, c. 410, Pt. A, §2 and affected by §10, is further amended to read:

D. A carrier may vary the premium rate due to age, health status, occupation or industry ~~and~~, geographic area ~~only under the following schedule and within the listed percentage bands~~ and tobacco use in accordance with the following limitations.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after July 15, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after January 1, 2008, the maximum rate differential from the community rate filed by the carrier for age as determined by ratio is 4 to one. The limitation does not apply for determining rates for an attained age of less than 19 or more than 65 years.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after January 1, 2008, the maximum rate differential from the community rate filed by the carrier for health status as determined by ratio is 1.5 to one and the maximum rate differential for tobacco use as determined by ratio is 1.5 to one. Rate variations based on health status do not apply to rate variations based on an insured's status as a tobacco user.

(6) A variation in rate is not permitted on the basis of changes in health status after a policy, contract or certificate is issued or renewed.

Sec. 7. 24-A MRSA §2736-C, sub-§2, ¶G is enacted to read:

G. A carrier that offered individual health plans prior to January 1, 2008 may close its individual book of business sold prior to January 1, 2008 and may establish a separate community rate for individuals applying for coverage under an individual health plan after January 1, 2008.'

Further amend the bill by inserting after section 3 the following:

'**Sec. 4. 24-A MRSA §2736-C, sub-§3, ¶E** is enacted to read:

E. An individual may not be denied health insurance due to age or gender. This paragraph may not be construed to require a carrier to actively market health insurance to an individual 65 years of age or older.

Sec. 5. 24-A MRSA §2736-C, sub-§9, as enacted by PL 1995, c. 570, §7, is amended to read:

9. Exemption for certain associations. The superintendent may exempt a group health insurance policy or group nonprofit hospital or medical service corporation contract issued to an association group, organized pursuant to section 2805-A, from the requirements of ~~subsection 3, paragraph A~~, subsection 6, paragraph A, and subsection 8 if:

A. Issuance and renewal of coverage under the policy or contract is guaranteed to all members of the association who are residents of this State and to their dependents;

B. Rates for the association comply with the premium rate requirements of subsection 2 or are established on a nationwide basis and substantially comply with the purposes of this section, except that exempted associations may be rated separately from the carrier's other individual health plans, if any;

C. The group's anticipated loss ratio, as defined in subsection 5, is at least 75%;

D. The association's membership criteria do not include age, health status, medical utilization history or any other factor with a similar purpose or effect;

E. The association's group health plan is not marketed to the general public;

F. The association does not allow insurance agents or brokers to market association memberships, accept applications for memberships or enroll members, except when the association is an association of insurance agents or brokers organized under section 2805-A;

G. Insurance is provided as an incidental benefit of association membership and the primary purposes of the association do not include group buying or mass marketing of insurance or other goods and services; and

H. Granting an exemption to the association does not conflict with the purposes of this section.

Sec. 6. 24-A MRSA §2803-A, sub-§4, as amended by PL 2001, c. 410, Pt. B, §2, is further amended to read:

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

Sec. 7. 24-A MRSA §2804, sub-§3, as amended by PL 1999, c. 256, Pt. G, §1, is further amended to read:

3. Except as provided in section 2736-C, section ~~2808-B~~ 2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 8. 24-A MRSA §2805, sub-§3, as amended by PL 1999, c. 256, Pt. G, §2, is further amended to read:

3. Except as provided in section 2736-C, section ~~2808-B~~ 2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 9. 24-A MRSA §2805-A, sub-§4, as amended by PL 1999, c. 256, Pt. G, §3, is further amended to read:

4. Except as provided in section 2736-C, section ~~2808-B~~ 2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 10. 24-A MRSA §2806, sub-§3, as amended by PL 1999, c. 256, Pt. G, §4, is further amended to read:

3. Except as provided in section 2736-C, section ~~2808-B~~ 2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 11. 24-A MRSA §2807-A, sub-§3, as amended by PL 1999, c. 256, Pt. G, §5, is further amended to read:

3. Except as provided in section 2736-C, section ~~2808-B~~ 2808-C and chapter 36, an insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 12. 24-A MRSA §2808-B, as amended by PL 2005, c. 121, Pt. E, §§1 and 2, is repealed.

Sec. 13. 24-A MRSA §2808-C is enacted to read:

§2808-C. Small group health plans

1. Purpose. The purpose of this section is to promote the availability of health insurance coverage to small employers, to

prevent abusive rating practices, to require disclosure of rating practices to purchasers of small group health plans, to establish standards for continuity of coverage for small employers and their covered employees and to improve the efficiency and fairness of the small group market.

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

A. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the superintendent that a carrier offering small group health plans is in compliance with the provisions of subsection 4 based on the person's examination and review of the carrier's appropriate records and the actuarial assumptions and methods used by the carrier to establish premium rates for its small group health plans.

B. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by a small group carrier to small employers with similar case characteristics for health plans with the same or similar coverage.

C. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue small group health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all small group health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

D. "Case characteristics" means demographic or other relevant characteristics of a small employer as determined by a carrier that are considered by the carrier in the determination of the premium rates for the small employer. "Case characteristics" does not include claims experience, health status or duration of coverage.

E. "Class of business" means all or a distinct grouping of small employers in accordance with this paragraph to whom

the carrier provides coverage as demonstrated by the carrier's records.

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(a) Are marketed and sold through individuals and organizations that are not participating in the marketing or sale of other distinct groupings of small employers for the carrier;

(b) Have been acquired from another carrier as a distinct grouping of plans;

(c) Are provided through an association with membership of not less than 50 small employers that has been formed for purposes other than obtaining insurance; or

(d) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in subsection 4.

(2) A carrier may establish no more than 2 additional groupings under subparagraph (1) on the basis of underwriting criteria that are expected to produce substantial variation in the health care costs.

(3) The superintendent may approve the establishment of additional distinct groupings upon application to the superintendent and a finding by the superintendent that such action would enhance the efficiency and fairness of the small group health plan market.

F. "Index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

G. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A, B, C-1 or D.

H. "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

I. "Rating period" means the calendar period for which the premium rates established by a carrier are assumed to be in effect as determined by the carrier.

J. "Small employer" means any person, firm, corporation, partnership or association actively engaged in business that, on at least 50% of its working days during the preceding year, employed no more than 50 eligible employees and at least 2 eligible employees. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation must be considered one employer.

K. "Small group health plan" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering an eligible group. "Small group health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment; or

(11) Insurance under which benefits are payable with or without regard to fault and that is required

statutorily to be contained in any liability insurance policy or equivalent self-insurance.

3. Small group health plans subject to this section. The following small group health plans are subject to this section.

A. Except as provided in this paragraph, this section applies to any small group health plan that provides coverage to one or more employees of a small employer.

B. This section does not apply to individual health plans that are subject to section 2736-C.

4. Premium rates. Premium rates for small group health plans are subject to the following provisions.

A. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%. This paragraph does not apply to a class of business if any of the following apply:

(1) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the carrier's definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claims experience or health status;

(2) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

(3) The class of business is available for purchase.

B. For a class of business, the premium rate charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, may not vary from the index rate by more than 25% of the index rate.

C. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small

group carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(2) An adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claims experience, health status or duration of coverage or the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

D. In the case of health benefit plans issued prior to the effective date of this section, a premium rate for a rating period may exceed the ranges described in paragraphs A and B for a period of 5 years following the effective date of this section. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small group carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

E. A small group carrier may use any legitimate rating factor, including claims experience, health status or duration of coverage, in the determination of premium rates subject to this section, except that the maximum variation for all small employers in a class of business using all legitimate rating factors is 5 to one for the premium rate charged to any small employer in that class of business.

F. A small group carrier may not transfer a small employer involuntarily into or out of a class of business. A small group carrier may not transfer a small employer into or out of a class of business unless such offer is made to transfer

all small employers in the class of business without regard to any changes in case characteristics, claims experience, health status or duration of coverage since the first date of coverage.

5. Coverage for late enrollees. In providing coverage to late enrollees, small group health plan carriers are allowed to exclude or limit coverage for a late enrollee subject to the limitations set forth in section 2849-B, subsection 3.

6. Guaranteed issuance and guaranteed renewal. Carriers providing small group health plans must meet the following requirements on issuance and renewal.

A. Any small group health plan offered to any eligible group or subgroup must be offered to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups. In determining compliance with minimum participation requirements, eligible employees and their dependents that have existing health care coverage may not be considered in the calculation. If an employee declines coverage because the employee has other coverage, any dependents of that employee who are not eligible under the employee's other coverage are eligible for coverage under the small group health plan.

B. A carrier may deny coverage under a managed care plan, as defined by section 4301-A:

(1) To employers who have no employees who live, reside or work within the approved service area of the plan; and

(2) To employers if the carrier has demonstrated to the superintendent's satisfaction that:

(a) The carrier does not have the capacity to deliver services adequately to additional enrollees within all or a designated part of its service area because of its obligations to existing enrollees; and

(b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this subparagraph may not enroll individuals residing within the service area subject to denial of coverage, or

groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage.

7. Disclosure of rating practices and renewability provisions. Each small group carrier shall disclose the following in the sales and marketing materials provided to small employers:

A. The extent to which premium rates for a specific small employer are established or adjusted due to the claims experience, health status or duration of coverage of the employees and dependents of the small employer;

B. The ability of the carrier to change premium rates and rating factors, including case characteristics, that may affect changes in premium rates;

C. A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and

D. The small employer's rights regarding renewal of the small group health plan.

8. Maintenance of records. A small group carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. On or before March 1st annually, a carrier shall file with the superintendent an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of the certification must be retained by the carrier at its principal place of business. A carrier shall also make the information and documentation required in this subsection available to the superintendent upon request. The information provided to the superintendent pursuant to this subsection is proprietary and must be kept confidential by the superintendent. The information may not be disclosed except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

9. Discretion of superintendent. The superintendent may suspend all or any part of subsection 4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small group carrier and a finding by the superintendent that either the suspension is reasonable in light of the financial condition of the carrier or that the

suspension would enhance the efficiency and fairness of the marketplace for small group health plans.

10. Applicability. This section applies to all small group health plan policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2009. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.'

Further amend the bill by inserting after section 5 the following:

'**Sec. 6. 24-A MRSA §2850-B, sub-§2, ¶¶C and D,** as enacted by PL 1997, c. 445, §30 and affected by §32, are amended to read:

C. "Large group market" means groups not subject to section 2736-C or ~~2808-B~~ 2808-C.

D. "Small group market" means groups subject to section ~~2808-B~~ 2808-C.

Sec. 7. 24-A MRSA §2850-B, sub-§3, ¶G, as amended by PL 2003, c. 428, Pt. A, §1, is further amended to read:

G. When the carrier ceases offering a product and meets the following requirements:

(1) In the large group market:

(a) The carrier must provide notice to the policyholder and to the insureds at least 90 days before termination;

(b) The carrier must offer to each policyholder the option to purchase any other product currently being offered in the large group market; and

(c) In exercising the option to discontinue the product and in offering the option of coverage under division (b), the carrier must act uniformly without regard to the claims experience of the policyholders or the health status of the insureds or prospective insureds;

(2) In the small group market:

(a) The carrier shall replace the product with a product that complies with the requirements of

this section, including renewability, and with section ~~2808-B~~ 2808-C;

(b) The superintendent shall find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and to the insureds at least 90 days before replacement; or

(3) In the individual market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section 2736-C;

(b) The superintendent shall find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and, if a group policy, to the insureds at least 90 days before replacement;

Sec. 8. 24-A MRSA §2850-B, sub-§4, ¶B, as amended by PL 2001, c. 258, Pt. E, §11, is further amended to read:

B. Carriers that cease to write new small group business continue to be governed by section ~~2808-B~~ 2808-C with respect to small group contracts in force and their renewal or replacement contracts.'

Further amend the bill in section 6 in §3904 in subsection 2 by striking out all of paragraph A (page 5, lines 30 to 49 and page 6, lines 1 to 8 in L.D.) and inserting in its place the following:

'A. The board consists of 11 members appointed as follows:

(1) Six members appointed by the superintendent:

(a) Two members must be chosen from the general public and may not be associated with the medical profession, a hospital or an insurer;

(b) Two members must represent medical providers;

(c) One member must represent health insurance producers; and

(d) One member must represent a statewide association representing small businesses that receives the majority of its funding from persons and businesses in the State.

A board member appointed by the superintendent may be removed at any time without cause; and

(2) Five members appointed by the member insurers, at least 2 of whom are domestic insurers and at least 2 of whom are self-insured or 3rd-party administrators.'

Further amend the bill in section 6 in §3906 in subsection 2 in paragraph N in last line (page 9, line 23 in L.D.) by striking out the following: "and"

Further amend the bill in section 6 in §3906 in subsection 2 in paragraph O in the last line (page 9, line 27 in L.D.) by striking out the following: "." and inserting in its place the following: '; and'

Further amend the bill in section 6 in §3906 in subsection 2 by inserting at the end the following:

'P. Develop a plan to subsidize low-income individuals. The association shall submit that plan to the joint standing committee of the Legislature having jurisdiction over health insurance matters no later than February 1, 2008. If necessary, the joint standing committee may report out legislation to the Second Regular Session of the 123rd Legislature to implement the plan submitted by the association.'

Further amend the bill by inserting after section 6 the following:

'**Sec. 7. 24-A MRSA §4202-A, sub-§10, ¶B,** as amended by PL 1993, c. 645, Pt. A, §5, is further amended to read:

B. Is compensated, except for reasonable copayments, for basic health care services to enrolled participants solely on a predetermined periodic rate basis, except that the organization is not prohibited from having a provision in a group contract allowing an adjustment of premiums based upon the actual health services utilization of the enrollees covered under the contract, and except that such a contract may not be sold to an eligible group subject to the ~~community~~ rating requirements of section ~~2808-B~~ 2808-C;

Sec. 8. 24-A MRSA §4207, sub-§5, as amended by PL 2003, c. 469, Pt. E, §19, is further amended to read:

5. A schedule or an amendment to a schedule of charge for enrollee health coverage for health care services may not be used by any health maintenance organization unless it complies with section 2736, ~~2808-B~~ 2808-C or 2839, whichever is applicable.

Sec. 9. 24-A MRSA §4210, sub-§1, as amended by PL 1995, c. 332, Pt. O, §4, is further amended to read:

1. After a health maintenance organization has been in operation 24 months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. To the extent not inconsistent with the requirements of chapter 36 and sections 2736-C and ~~2808-B~~ 2808-C as qualified by section 4222-B, subsection 3, a health maintenance organization may apply to the superintendent for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The superintendent shall approve or deny the application within 10 days of the receipt of that application from the health maintenance organization.

Sec. 10. 24-A MRSA §4212, sub-§2, ¶C, as enacted by PL 1995, c. 332, Pt. O, §6, is amended to read:

C. When the provisions of the State's community rating law are applicable, as provided by section 2736-C, subsection 3, paragraph B ~~and section 2808-B, subsection 4, paragraph B~~; or

Sec. 11. 24-A MRSA §4222-B, sub-§3, as enacted by PL 1995, c. 332, Pt. O, §8, is amended to read:

3. The requirements of sections 2736-C and ~~2808-B, community rating law,~~ 2808-C apply to health maintenance organizations, except that a health maintenance organization is not required to offer coverage or accept applications from an eligible group or individual located outside the health maintenance organization's approved service area.

Sec. 12. 24-A MRSA §4346, sub-§1, ¶D, as enacted by PL 2001, c. 708, §3, is amended to read:

D. "Eligible employee" or "employee" means an individual who:

(1) ~~Meets the definition of "eligible employee" set forth in section 2808-B, subsection 1, paragraph C~~ Works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not include employees who work on a temporary or substitute basis. An employer may elect to treat as eligible employees part-time employees who work a normal work week of 10 hours or more as long as at least one employee works a normal work week of 30 hours or more. An employer may elect to treat as eligible employees employees who retire from the employer's employment;

(2) Is a self-employed individual who:

(a) Works and resides in the State; and

(b) Is organized as a sole proprietorship or in any other legally recognized manner that a self-employed individual may organize, a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income, and who has filed the appropriate United States Internal Revenue Service form for the previous taxable year, and for whom a copy of the appropriate United States Internal Revenue Service form or forms and schedule has been filed with the plan or its administrator; or

(3) Is a sole employee of a nonprofit organization that has been determined by the Internal Revenue Service to be exempt from taxation under the United States Internal Revenue Code, Section 501(c)(3),(4) or (6) and who has a normal work week of at least 20 hours and is not covered under a public or private plan for health insurance or other health benefit arrangement.

Sec. 13. 24-A MRSA §4346, sub-§1, ¶G, as enacted by PL 2001, c. 708, §3, is amended to read:

G. "Small employer" means an eligible group as defined in section ~~2808-B~~ 2808-C, subsection ~~1~~ 2, paragraph ~~D~~ J.

Sec. 14. 24-A MRSA §6603, sub-§1, ¶H, as amended by PL 2001, c. 410, Pt. A, §9, is further amended to read:

H. May issue only health care benefit plans that comply with the requirements of section ~~2808-B~~ 2808-C with regard to rating practices, coverage for late enrollees and guaranteed renewal. An arrangement may not provide health care benefits that do not meet or exceed the requirements for mandated benefits applicable to comparable insured plans.'

Further amend the bill by striking out section 9 (page 18, lines 20 to 24 in L.D.) and inserting in its place the following:

'**Sec. 9. Department of Professional and Financial Regulation, Bureau of Insurance review of health insurance rate and form filing requirements.** The Department of Professional and Financial Regulation, Bureau of Insurance shall review the State's health insurance rate and form filing requirements and make recommendations for changes in the requirements to reduce the costs and resources expended for insurers seeking regulatory approval of new health insurance products. In its review, the bureau shall identify the typical costs and resources for insurers seeking regulatory approval for new health insurance products in this State and, to the extent possible, compare those to the costs and resources for the regulatory approval of new health insurance products in other states. The bureau shall submit a report with its review and recommendations to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters by January 15, 2007. In its report, the bureau shall include draft legislation to move the State to a file-and-use standard for health insurance rate and form filings. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters shall submit a bill to the First Regular Session of the 123rd Legislature based on the recommendations from the bureau's report.

Sec. 10. Appropriations and allocations. The following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Bureau of Insurance 0092

Initiative: Allocates funds for contracting the preparation of a grant application to secure federal funds for the purpose of operating a high-risk health insurance pool.

OTHER SPECIAL REVENUE FUNDS	**2005-06**	**2006-07**
All Other	$0	$15,000

R. & S.

OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$15,000

Sec. 11. Effective date. Those sections of this Act that repeal the Maine Revised Statutes, Title 24-A, section 2736-C, subsection 3, paragraphs A and C and amend Title 24-A, section 2848, subsection 1-B, paragraph A and section 2849-B, subsection 2, paragraph A take effect January 1, 2008. Those sections of this Act that amend Title 24-A, section 2736-C, subsection 2, paragraphs B to D and section 2736-C, subsection 9 and enact Title 24-A, section 2736-C, subsection 2, paragraph G and section 2736-C, subsection 3, paragraph E take effect January 1, 2008.

Sec. 12. Effective date. Those sections of this Act that amend the Maine Revised Statutes, Title 24, sections 2317-B and 2327 and Title 24-A, sections 2803-A, 2804, 2805, 2805-A, 2806, 2807-A, 2850-B, 4202-A, 4207, 4210, 4212, 4222-B, 4346 and 6603 take effect January 1, 2009. That section of this Act that repeals Title 24-A, section 2808-B takes effect January 1, 2009. That section of this Act that enacts Title 24-A, section 2808-C takes effect January 1, 2009.'

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

SUMMARY

This amendment is the minority report of the committee and makes the following changes to the bill.

The amendment broadens the community rating laws to allow carriers to vary premiums on the basis of age within a maximum rate differential on a ratio of 4 to one and on the basis of health status and tobacco use within a maximum rate differential on a ratio of 1.5 to one.

The amendment changes the composition of the board of directors of the high-risk pool by removing the legislative members and adding 2 additional members who are member insurers.

The amendment repeals the community rating law for small group health plans effective January 1, 2009 and enacts in its place provisions governing the rating of small group health plans based on a model act from the National Association of Insurance Commissioners.

COMMITTEE AMENDMENT "A" to H.P. 1365, L.D. 1945

The amendment requires the Department of Professional and Financial Regulation, Bureau of Insurance to conduct a study of the State's rate and form filing laws and make recommendations for changes to reduce the costs and resources expended by health insurance carriers seeking regulatory approval of new health insurance products.

This amendment also adds an appropriations and allocations section to the bill.

FISCAL NOTE REQUIRED
(See attached)

Approved: 03/29/06 mac

122nd MAINE LEGISLATURE

LD 1945 **LR 2814(02)**

An Act To Establish a High-risk Health Insurance Pool

Fiscal Note for Bill as Amended by Committee Amendment "A"
Committee: Insurance and Financial Services
Fiscal Note Required: Yes

Fiscal Note

	2005-06	2006-07	Projections 2007-08	Projections 2008-09
Appropriations/Allocations				
Other Special Revenue Funds	$0	$15,000	$0	$0

Fiscal Detail and Notes

The bill includes an allocation to the Bureau of Insurance in the Department of Professional and Financial Regulation of $15,000 in fiscal year 2006-07 for contracting the preparation of a grant application to secure federal funds for the purpose of operating a high-risk health insurance pool. The fiscal note assumes the Comprehensive Health Insurance Risk Pool Association would not require an appropriation or allocation of resources and would not result in transactions on the State's books because the Association would be established as an independent non-profit legal entity.