L.D. 1611

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
121ST LEGISLATURE
FIRST REGULAR SESSION

HOUSE AMENDMENT "G" to COMMITTEE AMENDMENT "A" to H.P. 1187, L.D. 1611, Bill, "An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs"

Amend the amendment by inserting at the end before the emergency clause the following:

PART I

Sec. I-1. 24-A MRSA §2736-C, sub-§3, as corrected by RR 2001, c. 1, §30, is amended to read:

3. Guaranteed issuance and guaranteed renewal. Carriers providing individual health plans must meet the following requirements on issuance and renewal.

~~A. Coverage must be guaranteed to all residents of this State other than those eligible without paying a premium for Medicare Part A. On or after January 1, 1998, coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. Except for federally eligible individuals, coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months. When a managed care plan, as defined by section 4301-A, provides coverage a carrier may:~~

~~(1) Deny coverage to individuals who neither live nor reside within the approved service area of the plan for at least 6 months of each year; and~~

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~~(2) Deny coverage to individuals 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 paragraph may not enroll individuals residing within the 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.~~

B. Renewal is guaranteed, pursuant to section 2850-B.

~~C. A carrier is exempt from the guaranteed issuance requirements of paragraph A provided that the following requirements are met.~~

~~(1) The carrier does not issue or deliver any new individual health plans on or after the effective date of this section;~~

~~(2) If any individual health plans that were not issued on a guaranteed renewable basis are renewed on or after December 1, 1993, all such policies must be renewed by the carrier and renewal must be guaranteed after the first such renewal date; and~~

~~(3) The carrier complies with the rating practices requirements of subsection 2.~~

D. ~~Notwithstanding paragraph A, carriers~~ Carriers offering supplemental coverage for the Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are not required to issue this coverage if the applicant for insurance does not have CHAMPUS coverage.

E. An individual may not be denied health insurance due to age or gender.

Nothing in this subsection may be construed to require a carrier

to market health insurance to individuals more than 65 years of age.

Sec. I-2. 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. I-3. 24-A MRSA §2848, sub-§1-B, ¶A, as amended by PL 1999, c. 256, Pt. L, §2, is further amended to read:

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HOUSE AMENDMENT "6" to COMMITTEE AMENDMENT "A" to H.P. 1187, L.D. 1611

A. "Federally creditable coverage" means health benefits or coverage provided under any of the following:

(1) An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, or a plan that would be an employee welfare benefit plan but for the "governmental plan" or "nonelecting church plan" exceptions, if the plan provides medical care as defined in subsection 2-A, and includes items and services paid for as medical care directly or through insurance, reimbursement or otherwise;

(2) Benefits consisting of medical care provided directly, through insurance or reimbursement and including items and services paid for as medical care under a policy, contract or certificate offered by a carrier;

(3) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

(4) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act or a state children's health insurance program under Title XXI of the Social Security Act;

(5) The Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55;

(6) A medical care program of the federal Indian Health Care Improvement Act, 25 United States Code, Section 1601 or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under the federal Employees Health Benefits Amendments Act, 5 United States Code, Chapter 89;

(9) A public health plan as defined in federal regulations authorized by the federal Public Health Service Act, Section 2701(c)(1)(I), as amended by Public Law 104-191; ~~or~~

(10) A health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code, Section 2504(e)~~.~~; or

(11) Insurance coverage offered by the Comprehensive Health Insurance Risk Pool Association pursuant to chapter 54.

Sec. I-4. 24-A MRSA §2849-B, sub-§2, ¶A, as amended by PL 2001, c. 258, Pt. E, §7, is further amended to read:

A. That person was covered under ~~an individual or~~ a group contract or policy issued by any nonprofit hospital or medical service organization, insurer~~,~~ or health maintenance organization, or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program, including, but not limited to, those listed in section 2848, subsection 1-B, paragraph A, subparagraphs (3) to (10). For purposes of this section, the individual or group policy under which the person is seeking coverage is the "succeeding policy." The group ~~or individual~~ contract or policy, uninsured employee benefit plan or governmental program that previously covered the person is the "prior contract or policy"; and

Sec. I-5. 24-A MRSA c. 54 is enacted to read:

CHAPTER 54

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

§3901. Short title

This chapter may be cited as "the Comprehensive Health Insurance Risk Pool Association Act."

§3902. Purpose

It is the purpose of this chapter to establish a mechanism to spread among all insurers doing business in this State the cost of providing health and accident insurance coverage to those residents of this State who because of health conditions consume unusually large amounts of health care and to ensure a competitive insurance market.

§3903. Definitions

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

1. Association. "Association" means the Comprehensive Health Insurance Risk Pool Association established in section 3904.

2. Board. "Board" means the board of directors of the association.

3. Covered person. "Covered person" means any individual resident of this State, not including dependents, who:

A. Is eligible to receive benefits from any insurer;

B. Is eligible for benefits under the federal Health Insurance Portability and Accountability Act of 1996; or

C. Has been certified as eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002.

4. Dependent. "Dependent" means a resident spouse or resident unmarried child under 19 years of age or a child who is a student under 23 years of age and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

5. Health maintenance organization. "Health maintenance organization" means any organization authorized under chapter 56 to operate a health maintenance organization in this State.

6. Insurer. "Insurer" means any entity that is authorized to write medical insurance or that provides medical insurance in this State. For the purposes of this chapter, "insurer" includes an insurance company, nonprofit hospital and medical service organization, fraternal benefit society, health maintenance organization, self-insurance arrangement that provides health care benefits in this State to the extent allowed under the federal Employee Retirement Income Security Act of 1974, 3rd-party administrator, multiple-employer welfare arrangement, any other entity providing medical insurance or health benefits subject to state insurance regulation and any reinsurer reinsuring health insurance in this State.

7. Medical insurance. "Medical insurance" means any hospital and medical expense-incurred policy, nonprofit hospital and medical service plan, health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. "Medical insurance" does not include accidental injury,

specified disease, hospital indemnity, dental, vision, disability income, long-term care or other limited benefit health insurance or credit insurance or Medicare supplement insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

8. Medicare. "Medicare" means coverage under both Parts A and B of Title XVIII of the federal Social Security Act, 42 United States Code, Section 1395 et seq., as amended.

9. Plan. "Plan" means the health insurance plan adopted by the board pursuant to this chapter.

10. Producer. "Producer" means a person who is licensed to sell health insurance in this State.

11. Resident. "Resident" means an individual who:

A. Is legally located in the United States and has been legally domiciled in this State for a period not to exceed one year to be established by the board and subject to the approval of the superintendent;

B. Is legally domiciled in this State on the date of application to the plan and is eligible for enrollment in the risk pool under this chapter as a result of the federal Health Insurance Portability and Accountability Act of 1996; or

C. Is legally domiciled in this State on the date of application to the plan and has been certified as eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002.

12. Reinsurer. "Reinsurer" means any insurer from whom any person providing health insurance for any Maine resident procures insurance for itself with the insurer with respect to all or part of the medical insurance risk of the person. "Reinsurer" includes an insurer that provides employee benefits excess insurance.

13. Third-party administrator. "Third-party administrator" means any entity that is paying or processing medical insurance claims for any resident.

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§3904. Comprehensive Health Insurance Risk Pool Association

1. Risk pool established. The Comprehensive Health Insurance Risk Pool Association is established as a nonprofit legal entity. As a condition of doing business, every insurer that has sold medical insurance within the previous 12 months or is actively marketing a medical insurance policy in this State must participate in the association.

2. Board of directors. The association is governed by a board of directors in accordance with the following.

A. The board consists of 9 members appointed as follows:

(1) Four members appointed by the superintendent, of whom 2 members must be chosen from the general public and may not be associated with the medical profession, a hospital or an insurer; one member must represent medical providers; and one member must represent health insurance producers. Any board member appointed by the superintendent may be removed at any time without cause;

(2) Three members appointed by the member insurers, at least 2 of whom are domestic insurers; and

(3) Two Legislators who serve as the Senate and House chairs of the joint standing committee of the Legislature having jurisdiction over health insurance matters, or the Legislators' designees, who serve as nonvoting, ex officio members of the board.

B. Of those members of the board appointed by the superintendent, one member shall serve for a term of one year, 2 members for a term of 2 years and one member for a term of 3 years. Of those members appointed by the member insurers, one member shall serve for a term of one year, one member shall serve for a term of 2 years and one member shall serve for a term of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment. All terms after the initial terms must be for 3 years.

C. The board shall elect one of its members as chair.

D. Board members may be reimbursed from funds of the association for actual and necessary expenses incurred by them as members but may not otherwise be compensated for their services.

3. Plan of operation. The association shall adopt a plan of operation in accordance with the requirements of this chapter and submit its articles, bylaws and operating rules to the superintendent for approval. If the association fails to adopt the plan of operation and suitable articles and bylaws within 90 days after the appointment of the board, the superintendent shall adopt rules to effectuate the requirements of this chapter and those rules remain in effect until superseded by a plan of operation and articles and bylaws submitted by the association and approved by the superintendent. Rules adopted pursuant to this subsection by the superintendent are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

4. Immunity. A board member is not liable and is immune from suit at law or equity for any conduct performed in good faith that is within the subject matter over which the board has been given jurisdiction.

§3905. Liability and indemnification

1. Liability. The board and its employees may not be held liable for any obligations of the association. A cause of action may not arise against the association; the board, its agents or its employees; any member insurer or its agents, employees or producers; or the superintendent for any action or omission in the performance of powers and duties pursuant to this chapter.

2. Indemnification. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

§3906. Duties and powers of association

1. Duties. The association shall:

A. Establish administrative and accounting procedures for the operation of the association;

B. Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board;

C. Select a plan administrator in accordance with section 3907;

D. Collect the assessments provided in section 3908. The level of payments must be established by the board. Assessments must be collected pursuant to the plan of operation approved by the board. In addition to the collection of such assessments, the association shall

collect an organizational assessment or assessments from all insurers as necessary to provide for expenses that have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments must be equal in amount for all insurers but may not exceed $500 per insurer for all such assessments. Assessments are due and payable within 30 days of receipt of the assessment notice by the insurer;

E. Require that all policy forms issued by the association conform to standard forms developed by the association. The forms must be approved by the superintendent and must comply with this Title; and

F. Develop and implement a program to publicize the existence of the plan, the eligibility requirements for the plan and the procedures for enrollment in the plan and to maintain public awareness of the plan.

2. Powers. The association may:

A. Exercise powers granted to insurers under the laws of this State;

B. Enter into contracts as necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the superintendent, to enter into contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

C. Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the association;

D. Take any legal actions necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association, to recover any amounts erroneously or improperly paid by the association, to recover any amounts paid by the association as a result of mistake of fact or law or to recover other amounts due the association;

E. Establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, producers' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the association in accordance with section 3910;

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F. Issue policies of insurance in accordance with the requirements of this chapter;

G. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design and any other function within the authority of the association;

H. Borrow money to effect the purposes of the association. Any notes or other evidence of indebtedness of the association not in default must be legal investments for insurers and may be carried as admitted assets;

I. Establish rules, conditions and procedures for reinsuring risks of member insurers desiring to issue plan coverage to individuals otherwise eligible for plan coverage in their own names;

J. Prepare and distribute application forms and enrollment instruction forms to insurance producers and to the general public;

K. Provide for reinsurance of risks incurred by the association. The provision of reinsurance may not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

L. Issue additional types of health insurance policies to provide optional coverage, including Medicare supplement health insurance;

M. Provide for and employ cost-containment measures and requirements, including, but not limited to, preadmission screening, 2nd surgical opinion, concurrent utilization review and individual case management for the purpose of making the benefit plan more cost-effective;

N. Design, utilize, contract or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements; and

O. Apply for funds or grants from public or private sources, including federal grants provided to qualified high-risk pools.

3. Additional duties and powers. The superintendent may, by rule, establish additional powers and duties of the board and

may adopt such rules as are necessary and proper to implement this chapter. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

4. Review for solvency. The superintendent shall review the association at least every 3 years to determine its solvency. If the superintendent determines that the funds of the association are insufficient to support enrollment of additional persons, the superintendent may order the association to increase its assessment or increase its premium rates. If the superintendent determines that the funds of the association are insufficient to support the enrollment of additional persons and that the cap of assessments in section 3908 is too low to support the enrollment of additional persons, the superintendent may order the association to charge an assessment in excess of the cap for a period not to exceed 12 months.

5. Annual report. The association shall report annually to the joint standing committee of the Legislature having jurisdiction over health insurance matters by March 15th. The report must include information on the benefits and rate structure of coverage offered by the association, the financial solvency of the association and the administrative expenses of the plan.

6. Audit. The association must be audited at least every 3 years. A copy of the audit must be provided to the superintendent and to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

§3907. Selection of plan administrator

1. Selection of plan administrator. The board shall select an insurer or 3rd-party administrator, through a competitive bidding process, to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board, including:

A. The insurer's proven ability to handle large group accident and health insurance;

B. The efficiency of the insurer's claims-paying procedures; and

C. An estimate of total charges for administering the plan.

2. Contract with plan administrator. The plan administrator selected pursuant to subsection 1 serves for a period of 3 years. At least one year prior to the expiration of

each 3-year period of service by a plan administrator, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the plan administrator for the succeeding 3-year period. The selection of the plan administrator for the succeeding period must be made at least 6 months prior to the ending of the 3-year period.

3. Duties of plan administrator. The plan administrator selected pursuant to subsection 1 shall:

A. Perform all eligibility and administrative claims-payment functions relating to the plan;

B. Pay a producer's referral fee as established by the board to each insurance producer who refers an applicant to the plan, if the applicant's application is accepted. The selling or marketing of the plan is not limited to the plan administrator or its producers. The plan administrator shall pay the referral fees from funds received as premiums for the plan;

C. Establish a premium billing procedure for collection of premiums from insured persons. Billings must be made periodically as determined by the board;

D. Perform all necessary functions to ensure timely payment of benefits to covered persons under the plan, including:

(1) Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions must be made;

(2) Evaluating the eligibility of each claim for payment under the plan; and

(3) Notifying each claimant within 45 days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected or compromised. The board shall establish reasonable reimbursement amounts for any services covered under the benefit plans;

E. Submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the reports must be as determined by the board;

F. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the

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reinsurance operations of the association and the incurred losses of the year and report this information to the superintendent; and

G. Pay claims expenses from the premium payments received from or on behalf of covered persons under the plan. If the payments by the plan administrator for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide the plan administrator with additional funds for payment of claims expenses.

4. Payment to plan administrator. The plan administrator selected pursuant to subsection 1 must be paid, as provided in the contract of the association, for its direct and indirect expenses incurred in the performance of its services. As used in this subsection, "direct and indirect expenses" includes that portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the plan administrator that are approved by the board as allocable to the administration of the plan and included in the bid specifications.

§3908. Assessments against insurers

1. Assessments. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess member insurers at such a time and for such amounts as the board finds necessary. Assessments must be due not less than 30 days after written notice to the member insurers and must accrue interest at 12% per annum on and after the due date.

2. Maximum assessment. Each insurer must be assessed an amount not to exceed $2 per covered person insured or reinsured by each insurer per month for medical insurance. A member insurer may not be assessed on policies or contracts insuring federal or state employees.

3. Determination of assessment. The board shall make reasonable efforts to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains excess or stop loss insurance to include in its count of covered persons all individuals whose coverage is insured, in whole or in part, through excess or stop loss coverage. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose

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of determining its assessment under this subsection. The board may verify each insurer's assessment based on annual statements and other reports determined to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

4. Excess funds. If assessments and other receipts by the association, board or plan administrator exceed the actual losses and administrative expenses of the plan, the board shall hold the excess as interest and may use those excess funds to offset future losses or to reduce plan premiums. As used in this subsection, "future losses" includes reserves for claims incurred but not reported.

5. Failure to pay assessment. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer that fails to pay an assessment. As an alternative, the superintendent may levy a penalty on any member insurer that fails to pay an assessment when due. In addition, the superintendent may use any power granted to the superintendent by this Title to collect any unpaid assessment.

§3909. Availability of coverage

The association shall offer a choice of 2 or more coverage options through the plan. The requirements of this plan become effective January 1, 2004. Policies offered through the association must be available for sale July 1, 2004. The association shall directly insure the coverage provided by the plan, and the policies must be issued through the plan administrator.

§3910. Requirements for coverage

1. Coverage offered. The plan must offer in an annually renewable policy the coverage specified in this section for each eligible person. If an eligible person is also eligible for Medicare coverage, the plan may not pay or reimburse any person for expenses paid by Medicare. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within 90 days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage is the date of termination of the previous coverage.

2. Major medical expense coverage. The plan must offer major medical expense coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the

plan, its schedule of benefits and exclusions and other limitations must be established by the board and may be amended from time to time subject to the approval of the superintendent. In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the State and medical economic factors as determined appropriate.

3. Rates. Rates for coverage issued by the association must meet the requirements of this subsection.

A. Rates may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

B. Rate schedules must comply with section 2736-C and are subject to approval by the superintendent.

C. Standard risk rates for coverage issued by the association must be established by the association, subject to approval by the superintendent, using reasonable actuarial techniques and must reflect anticipated experiences and expenses of such coverage for standard risks. The premium for the standard risk rates must range from a minimum of 125% to a maximum of 150% of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in similar medical insurance plans.

4. Compliance with state law. Products offered by the association must comply with the provisions of this Title that apply to similar insurance products.

5. Other sources primary. The association must be payer of last resort of benefits whenever any other benefit or source of 3rd-party payment is available. The coverage provided by the association must be considered excess coverage, and benefits otherwise payable under association coverage must be reduced by all amounts paid or payable through any other health insurance and by all hospital and medical expense benefits paid or payable under any short-term, accident, dental-only, vision-only, fixed indemnity, limited benefit or credit insurance; coverage issued as a supplement to liability insurance; workers' compensation coverage; automobile medical payment; or liability insurance whether or not provided on the basis of fault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

6. Recovery of claims paid. An amount paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may not be made or recognized as claims under such a policy or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available. The association has a cause of action against a participant for the recovery of the amount of any benefits paid to the participant that should not have been claimed or recognized as claims because of the provisions of this subsection or because the benefits are otherwise not covered. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this subsection.

§3911. Eligibility for coverage

1. Eligibility; application for coverage. An individual who is and continues to be a resident is eligible for coverage under the plan if evidence is provided of rejection, a requirement of restrictive riders, a rate increase or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one association member within 6 months of the date of the certificate, or if the individual meets other eligibility requirements adopted by rule by the superintendent that are not inconsistent with this chapter and that evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

2. Change of domicile. The board shall develop standards for eligibility for coverage by the association for any natural person who changes that person's domicile to this State and who at the time domicile is established in this State is insured by an organization similar to the association. The eligible maximum lifetime benefits for that covered person may not exceed the lifetime benefits available through the association, less any benefits received from a similar organization in the former domiciliary state.

3. Eligibility without application. The board shall develop a list of medical or health conditions for which a person is eligible for plan coverage without applying for health insurance under subsection 1. A person who can demonstrate the existence or history of any medical or health conditions on the list developed by the board may not be required to provide the

evidence specified in subsection 1. The board may amend the list from time to time as appropriate.

4. Exclusions from eligibility. A person is not eligible for coverage under the plan if:

A. The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy or would be eligible to have coverage if the person elected to obtain it, except that:

(1) A person may maintain other coverage for the period of time the person is satisfying a preexisting condition waiting period under a plan policy; and

(2) A person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;

B. The person is determined eligible for health care benefits under the MaineCare program pursuant to Title 22;

C. The person previously terminated plan coverage, unless 12 months have elapsed since the person's last termination;

D. The person has met the lifetime maximum benefit amount under the plan of $3,000,000;

E. The person is an inmate or resident of a public institution; or

F. The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

5. Termination of coverage. The coverage of any person ceases:

A. On the date a person is no longer a resident;

B. Upon the death of the covered person;

C. On the date state law requires cancellation of the policy; or

D. At the option of the association, 30 days after the

association makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately.

6. Unfair trade practice. It constitutes an unfair trade practice for any insurer, insurance producer, employer or 3rd-party administrator to refer an individual employee or a dependent of an individual employee to the association, or to arrange for an individual employee or a dependent of an individual employee to apply to the plan, for the purpose of separating such an employee or dependent from a group health benefits plan provided in connection with the employee's employment.

§3912. Actions against association or members based upon joint or collective actions

Participation in the association, the establishment of rates, forms or procedures or any other joint or collective action, required by this chapter may not be the basis of any legal action criminal or civil liability or penalty against the association or any member insurer.

§3913. Reimbursement of carriers

1. Reimbursement. A carrier may seek reimbursement from the association, and the association shall reimburse the carrier, to the extent claims made by a member after July 1, 2004 exceed premiums paid on a calendar year basis by the member to the carrier for a member who meets the following criteria:

A. The carrier sold an individual health plan to the member between December 1, 1993 and July 1, 2004 and the policy that was sold has been continuously renewed by the member; and

B. The carrier is able to determine through the use of individual health statements, claims history or any reasonable means that, at any time while the policy was in effect, the member was diagnosed with one of the following medical conditions: acquired immune deficiency syndrome or HIV/AIDS, angina pectoris, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease requiring open heart surgery,

Parkinson's disease, polycystic kidney disease, psychotic disorders, quadriplegia, stroke, syringomyelia and Wilson's disease.

2. Rules. The Superintendent of Insurance may adopt rules to facilitate payment to a carrier pursuant to this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. I-6. Application for federal grant. Within 30 days of the effective date of this Act, the Superintendent of Insurance shall submit an application to the federal Department of Health and Human Services, Health Resources and Services Administration for a federal seed grant to support the creation and initial operation of the Comprehensive Health Insurance Risk Pool Association established in the Maine Revised Statutes, Title 24-A, chapter 54.

Sec. I-7. Study of reinsurance. The Comprehensive Health Insurance Risk Pool Association established pursuant to the Maine Revised Statutes, Title 24-A, section 3904 shall conduct a study of the possibility of offering a reinsurance pool for the small group medical insurance market in order to spread the cost of high-risk individuals for the small group medical insurance market. The study must address the cost of the reinsurance pool, potential funding mechanisms and the effectiveness of a reinsurance pool. The association may address any other issues regarding a reinsurance pool that it determines are relevant in the study. The association shall submit its report to the joint standing committee of the Legislature having jurisdiction over health insurance matters by September 1, 2005.

Sec. I-8. Effective date. That section of this Part that amends the Maine Revised Statutes, Title 24-A, section 2736-C, subsection 3 takes effect July 1, 2005.'

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

SUMMARY

This amendment creates the Comprehensive Health Insurance Risk Pool Association to spread the cost of high-risk individuals among all health insurers. The high-risk pool is funded through an assessment on insurers. This amendment requires the State to submit an application to the Federal Government for federal

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HOUSE AMENDMENT "G" to COMMITTEE AMENDMENT "A" to H.P. 1187, L.D. 1611

assistance to create a high-risk pool.

This amendment also removes the guaranteed issuance requirement for individual health plans effective July 1, 2005.

FISCAL NOTE REQUIRED
(See attached)

SPONSORED BY: Lucille Snowe-Mello
(Representative SNOWE-MELLO)

TOWN: Poland

HOUSE AMENDMENT

Approved: 06/12/03 mac

121st Maine Legislature
Office of Fiscal and Program Review

LD 1611

An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs

LR 2137(12)
Fiscal Note for House Amendment " " to Committee Amendment "A"
Sponsor: Rep. Snowe-Mello
Fiscal Note Required: Yes

Fiscal Note

Minor cost increase - Other Special Revenue Funds