L.D. 1021

DATE: 4-13-06 (Filing No. S-608)

Reproduced and distributed under the direction of the Secretary of the Senate.

STATE OF MAINE
SENATE
122ND LEGISLATURE
SECOND REGULAR SESSION

SENATE AMENDMENT "B" to COMMITTEE AMENDMENT "B" to H.P. 706, L.D. 1021, Bill, "An Act To Implement Task Force Recommendations Relating to Parity and Portability of Benefits for Law Enforcement Officers and Firefighters"

Amend the amendment by inserting after the title the following:

'Amend the bill by striking out the title and substituting the following:

'An Act To Implement Task Force Recommendations Relating to Parity and Portability of Benefits for Law Enforcement Officers and Firefighters and To Establish a High-risk Health Insurance Pool''

Further amend the amendment in the first paragraph after the title in the first line (page 1, line 24 in amendment) by striking out the following: "Amend" and inserting in its place the following: 'Further amend'

Further amend the amendment in Part A in section 2 in subsection 11-A in paragraph C in the 4th line (page 2, line 48 in amendment) by striking out the following: "45%" and inserting in its place the following: '60%'

Further amend the amendment in Part A in section 3 in §286-M in subsection 6 in paragraph A in the 14th line (page 6, line 47 in amendment) by striking out the following: "45%" and inserting in its place the following: '60%'

SENATE AMENDMENT

SENATE AMENDMENT "B" to COMMITTEE AMENDMENT "B" to H.P. 706, L.D. 1021

Further amend the amendment in Part A in section 3 in §286-M in subsection 6 in paragraph B in the 15th line (page 7, line 22 in amendment) by striking out the following: "45%" and inserting in its place the following: '60%'

Further amend the amendment by inserting at the end before the summary the following:

'Further amend the bill by inserting after Part B the following:

'PART C

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 M, §10, is repealed.

Sec. C-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 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. C-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. C-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. C-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. C-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.

Sec. C-8. 24-A MRSA §2736-C, sub-§3, ¶A, as corrected by RR 2001, c. 1, §30, is repealed.

Sec. C-9. 24-A MRSA §2736-C, sub-§3, ¶C, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is repealed.

Sec. C-10. 24-A MRSA §2736-C, sub-§3, ¶D, as enacted by PL 1999, c. 256, Pt. D, §1, is amended to read:

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.

Sec. C-11. 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. C-12. 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. C-13. 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. C-14. 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. C-15. 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. C-16. 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. C-17. 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. C-18. 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. C-19. 24-A MRSA §2808-B, as amended by PL 2005, c. 121, Pt. E, §§1 and 2, is repealed.

Sec. C-20. 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.

Sec. C-21. 24-A MRSA §2848, sub-§1-B, ¶A, as amended by PL 1999, c. 256, Pt. L, §2, is further amended to read:

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. C-22. 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. C-23. 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. C-24. 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. C-25. 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.

Sec. C-26. 24-A MRSA c. 54 is enacted to read:

CHAPTER 54

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

§3901. Short title

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

§3902. Purpose

It is the purpose of this chapter to establish a mechanism to distribute among all insurers doing business in this State the costs 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 an individual resident of this State, exclusive of dependents, who:

A. Is eligible to receive benefits from an 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, 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 an organization authorized under chapter 56 to operate a health maintenance organization in this State.

6. Insurer. "Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in this State. "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 or any reinsurer reissuing health insurance in this State.

7. Medical insurance. "Medical insurance" means a 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, Medicare supplement, long-term care or other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; and 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 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 established by the board and subject to the approval of the superintendent and not to exceed one year;

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 an insurer from whom a person providing health insurance for a 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 an entity that is paying or processing medical insurance claims for a resident.

§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 shall 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 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.

B. Terms for initial appointments to the board are as follows. Of those members of the board appointed by the superintendent, 2 members serve for a term of one year, 2 members for a term of 2 years and 2 members for a term of 3 years. Of those members appointed by the member insurers, one member serves for a term of one year, one member serves for a term of 2 years and one member serves 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; rules. 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 in its bylaws or rules may provide 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 assessments as 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 in 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 a system to 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;

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 or 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 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 opinions, concurrent utilization review and individual case management for the purpose of making the 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;

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

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.

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 operations of 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 assessments 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 or the 3rd-party administrator's proven ability to handle large group accident and health insurance;

B. The efficiency of the insurer's or the 3rd-party administrator's claims-payment 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 is contracted 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 plan administrator, 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 expiration 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 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 of 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 expenses of administration pertaining to the

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 under subsection 2, for the plan administrator's direct and indirect expenses incurred in the performance of plan administrator's 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 specifications of a bid under subsection 2.

§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 are due not less than 30 days after receipt of written notice by member insurers and accrue interest at 12% per annum on and after the due date.

2. Maximum assessment. The board shall assess each insurer an amount not to exceed $3 per 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. This assessment begins January 1, 2007.

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 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, 2007. Policies offered through the association must be available for sale beginning on January 1, 2008. The association shall directly insure the coverage provided by the plan, and the policies must be issued through the plan administrator. At least one coverage option must be a standardized health plan as defined in Chapter 750 of the rules of the bureau.

§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 premiums 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 and 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 all relevant requirements of this Title applicable to individual health insurance policies, including requirements for mandated coverage for specific health services, for specific diseases and for certain providers of health care services.

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 government 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. 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 resident meets other eligibility requirements adopted by rule by the superintendent that are not inconsistent with this chapter and that indicate 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 a medical or health condition 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, 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 or 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 January 1, 2008 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 January 1, 2008, and the policy that was sold has been continuously renewed by the member;

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, angina pectoris, ascites, chemical dependency 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 or Wilson's disease; and

C. The carrier has closed its book of business for individual health plans sold prior to January 1, 2008.

2. Rules. The superintendent 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. C-27. 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. C-28. 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. C-29. 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. C-30. 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. C-31. 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. C-32. 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. C-33. 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. C-34. 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.

Sec. C-35. 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 costs, potential funding mechanisms and 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 March 1, 2008.

Sec. C-36. Application for funds. The Superintendent of Insurance shall apply for all available federal funds for the purpose of operating a high-risk health insurance pool.

Sec. C-37. 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. C-38. 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
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$15,000

Sec. C-39. Effective date. Those sections of this Part 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 Part 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. C-40. Effective date. Those sections of this Part 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 Part that repeals Title 24-A, section 2808-B takes effect January 1, 2009. That section of this Part that enacts Title 24-A, section 2808-C takes effect January 1, 2009.' '

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

SUMMARY

This amendment increases the state subsidy from 45% to 60%.

The amendment also requires the Department of Professional and Financial Regulation, Bureau of Insurance to apply for federal funds that Congress is offering states to create high-risk insurance pools. It repeals the requirement of guaranteed issue for individual health insurance and enacts the Comprehensive Health Insurance Risk Pool Association Act. The amendment also creates a study of a reinsurance pool for the small group market.

SPONSORED BY: Courtney
(Senator COURTNEY)

COUNTY: York

FISCAL NOTE REQUIRED
(See attached)

Approved: 04/12/06 mac

122nd MAINE LEGISLATURE

LD 1021 **LR 0263(09)**

An Act To Implement Task Force Recommendations Relating to Parity and Portability of Benefits for Law Enforcement Officers and Firefighters

Fiscal Note for Senate Amendment "B" to Committee Amendment "B"
Sponsor: Sen. Courtney
Fiscal Note Required: Yes

Fiscal Note

	2005-06	2006-07	Projections 2007-08	Projections 2008-09
Net Cost (Savings)				
General Fund		$0	$998,154	$1,097,970
Appropriations/Allocations				
General Fund		$0	$998,154	$1,097,970
Other Special Revenue Funds		$15,000	$0	$0

Fiscal Detail and Notes

The amounts above are the incremental differences between the committee amendment and this amendment. The amendment changes the State's health insurance subsidy from 45% to 60%, thereby increasing the 2008-2009 General Fund costs of the subsidy. The amendment also adds a FY 2006-07 Other Special Revenue Funds allocation of $15,000 for additional requirements for the Bureau of Insurance in the Department of Professional and Financial Regulation related to high-risk health insurance pools.

Funding Summary - as Amended

	Projections 2007-08	Projections 2008-09
Total Estimated Subsidy	$5,532,893	$6,086,182
Estimated Administrative Costs	$109,392	$111,894
Total Estimated Costs	$5,642,285	$6,198,076
Estimated Collections from 1.5% Assessment	($1,230,876)	($1,289,958)
General Fund Subsidy Net of Assessments	$4,411,409	$4,908,118