L.D. 1760

Date: 4-9-08 (Filing No. H-977)

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**STATE OF MAINE**

**HOUSE OF REPRESENTATIVES**

**123RD LEGISLATURE**

**FIRST SPECIAL SESSION**

HOUSE AMENDMENT "A" to COMMITTEE AMENDMENT "A" to H.P. 1226, L.D. 1760, Bill, "An Act To Restore Competition to Maine's Health Insurance Market"

Amend the amendment in the first indented paragraph in the first and last lines by striking out the following: "and inserting the following"

Amend the amendment by striking out all of section 1.

Amend the amendment by striking out all of the 6th and 7th indented paragraphs after the title (page 1, lines 31 to 33 and page 2, lines 1 to 3 in amendment) and inserting the following:

'Amend the bill in section 2 by striking out all of paragraph B (page 1, lines 19 to 22 in L.D.) and inserting the following:

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

Amend the bill in section 4 by striking out all of paragraph D (page 1, lines 32 to 38 and page 2, lines 1 to 23 in L.D.) and inserting the following:

'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, 2010, the premium rate may not deviate above or below the community rate filed by the carrier by more than 40%.

(5) 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.' '

Amend the amendment on page 2 by striking out all of paragraph G (page 2, lines 6 to 9 in amendment) and inserting the following:

'G. A carrier that offered individual health plans prior to January 1, 2010 may close its individual book of business sold prior to January 1, 2010 and may establish a separate community rate for individuals applying for coverage under an individual health plan on or after January 1, 2010.'

Amend the amendment on page 2 by inserting after the 3rd indented paragraph the following:

'Amend the bill in section 7 in §3902 by striking out all of subsection 4 (page 4, lines 20 to 23 in L.D.) and inserting the following:

'**4. Dependent.** "Dependent" means a resident spouse, a domestic partner as defined in section 2832-A, subsection 1 or a dependent child as defined in section 2742-B, subsection 1.'

Amend the bill in section 7 in §3902 in subsection 6 in the 8th line (page 4, line 34 in L.D.) by striking out the following: "reissuing" and inserting the following: 'reinsuring'

Amend the amendment on page 2 by striking out all of the last 4 indented paragraphs (page 2, lines 28 to 36 in amendment) and on page 3 by striking out all of the first indented paragraph (page 3, lines 1 to 3 in amendment) and inserting the following:

'Amend the bill in section 7 by striking out all of §3907 and inserting the following:

'**§3907. 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 written notice to the member insurers and accrue interest at 12% per annum on and after the due date.

**2. Maximum assessment.** Each insurer must be assessed by the board an amount not to exceed $2 per covered person insured or reinsured by each insurer per month for medical insurance. An 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 an 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. Assessments to cover net losses.** The board shall assess member insurers at such a time and for such amounts as the board finds necessary to cover any net loss in accordance with this subsection.

A. Prior to April 1st of each year, the association shall determine and report to the superintendent the association's net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses and any assessments transferred to the association pursuant to section 604-A and an estimate of the assessments needed to fund the loss incurred by the association in the previous calendar year.

B. Individual assessments of each insurer are determined by multiplying net losses, if net earnings are negative, by a fraction, the numerator of which is the insurer's total premiums earned in the preceding calendar year from all health benefit plans, including excess or stop loss coverage, and the denominator of which is the total premiums earned in the preceeding calendar year from all health benefit plans.

C. The association shall impose a penalty of interest for late payment of assessments.

**5. Deferral of assessment.** An insurer may apply to the superintendent for a deferral of all or part of an assessment imposed by the association under this section. The superintendent may defer all or part of the assessment if the superintendent determines that the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited from reinsuring any person through the association until such time as the insurer pays the assessments.

**6. 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.

**7. 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 insurer that fails to pay an assessment. As an alternative, the superintendent may levy a penalty on any 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.'

Amend the bill in section 7 in §3908 by striking out all of subsection 1 and inserting the following:

'**1. Approved coverage.** The association shall approve a choice of 2 or more coverage options for which reinsurance is available through the plan. Policies approved by the association must be available for sale beginning on January 1, 2010. At least one coverage option must be a standardized health plan as defined in Bureau of Insurance Rule Chapter 750. Any person whose medical 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.'

Amend the bill in section 7 in §3912 by striking out all of subsection 1 and inserting the following:

'**1. Reimbursement.** An insurer may seek reimbursement from the association and the association shall reimburse the insurer to the extent claims made by a member on or after January 1, 2010 exceed premiums paid on a calendar year basis by the member to the insurer for a member who meets the following criteria:

A. The insurer sold an individual health plan to the member on or after December 1, 1993 and before January 1, 2010, and the policy that was sold has been continuously renewed by the member;

B. The insurer 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 insurer has closed its book of business for individual health plans sold prior to January 1, 2010.' '

## SUMMARY

This amendment accomplishes the following.

1. It changes the funding mechanism for the Maine Individual High-risk Reinsurance Pool Association established in the bill from a 2% assessment on gross direct premiums of health maintenance organizations to a maximum assessment of $2 per person covered under health insurance policies.

2. Under the bill, a carrier is permitted to vary the premium rate due to the geographic area of the individual. This amendment prohibits a carrier from varying the premium rate due to geographic area. In addition, unlike the bill, which set out different maximum rate differentials for the different allowable variance factors, this amendment provides that the premium rate may not deviate above or below the community rate filed by the carrier by more than 40%.

3. This amendment changes the definition of "dependent" for purposes of the Maine Individual High-risk Reinsurance Pool Association to correspond with the definition of "dependent child" as used in the law governing health insurance contracts.

4. Committee Amendment "A" provides that a carrier that offered individual health plans prior to January 1, 2009 may close its individual book of business sold prior to January 1, 2009 and may establish a separate community rate for individuals applying for coverage under an individual health plan after January 1, 2009. This amendment changes those dates to January 1, 2010.

5. This amendment amends the provision concerning reimbursement of insurers to change the applicable dates to January 1, 2010.

**SPONSORED BY:** _____

**(Representative PILON)**

**TOWN: Saco**

FISCAL NOTE REQUIRED
(See attached)

Approved: 04/04/08 mac

# 123rd MAINE LEGISLATURE

**LD 1760** **LR 565(05)**

**An Act To Restore Competition to Maine's Health Insurance Market**

**Fiscal Note for House Amendment "A" to Committee Amendment "A"**
**Sponsor: Rep. Pilon of Saco**
**Fiscal Note Required: Yes**

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## Fiscal Note

| | 2007-08 | 2008-09 | Projections 2009-10 | Projections 2010-11 |
|---|---|---|---|---|
| **Net Cost (Savings)** | | | | |
| General Fund | $0 | ($135,781) | ($1,227,525) | ($1,424,540) |
| **Appropriations/Allocations** | | | | |
| Other Special Revenue Funds | $0 | $0 | ($16,022,197) | ($16,823,307) |
| **Revenue** | | | | |
| General Fund | $0 | $135,781 | $1,227,525 | $1,424,540 |
| Other Special Revenue Funds | $0 | $7,297 | ($15,954,864) | ($16,745,168) |

**Fiscal Detail and Notes**

The amendment modifies the funding mechanism for the Maine Individual High-risk Reinsurance Pool Association by removing the health maintenance organization assessment of 2% of gross direct premiums and replacing it with an assessment on Association member insurers with a maximum assessment of $2 per covered person. Because this assessment would be assessed and collected by the Association, a non-profit legal entity, there is no direct fiscal impact on State programs or accounts. The fiscal note reflects the incremental difference from eliminating the HMO tax.