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H.P. 1226 House of Representatives, March 27, 2007

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

Reference to the Committee on Insurance and Financial Services suggested and ordered printed.

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative PILON of Saco.
Cosponsored by Senator SULLIVAN of York and
Representatives: FISCHER of Presque Isle, PINGREE of North Haven, Senators: BOWMAN of York, President EDMONDS of Cumberland, MARTIN of Aroostook, SNOWE-MELLO of Androscoggin, TURNER of Cumberland.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §604-A is enacted to read:

§604-A. Premium assessment; health maintenance organizations

1. Assessment. A health maintenance organization authorized to do business in this State pursuant to chapter 56 shall pay an assessment of 2% per year on all gross direct premiums on all policies, contracts and certificates written on residents in this State. The assessment imposed by this section applies to all gross direct premiums collected or contracted for on health maintenance organization policies, contracts and certificates issued or renewed on or after January 1, 2008. Each health maintenance organization shall file an annual report on or before February 1st of each year with the superintendent containing a sworn statement of the gross direct premiums and shall pay to the superintendent an amount equal to 2% of those gross premiums.

2. Transfer to reinsurance pool. Beginning April 1, 2009 and annually by April 1st thereafter, the superintendent shall transfer all of the assessments paid by health maintenance organizations pursuant to subsection 1 to the Maine Individual High-risk Reinsurance Pool established in chapter 54.

Sec. 2. 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, occupation or industry, geographic area and tobacco use only as permitted in paragraph D.

Sec. 3. 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. 4. 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, occupation or industry or geographic area as determined by ratio is 5 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. 5. 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. 6. 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 offer all health plans approved by the Maine Individual High-risk Reinsurance Pool Association pursuant to section 3908, subsection 1 as a condition of offering individual health plans in this State. Carriers must meet the following requirements on issuance and renewal.

A. Coverage issued through the Maine Individual High-risk Reinsurance Pool Association established pursuant to chapter 54 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, such 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, such 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

(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 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. 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. 7. 24-A MRSA c. 54 is enacted to read:

CHAPTER 54

MAINE INDIVIDUAL HIGH-RISK REINSURANCE POOL ASSOCIATION

§3901. Short title

This chapter is known and may be cited as "the Maine Individual High-risk Reinsurance Pool Association Act."

§3902. Definitions

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

1. Association. "Association" means the Maine Individual High-risk Reinsurance Pool Association established in section 3903.

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, a domestic partner as defined in section 2832-A, subsection 1, a 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, any reinsurer reissuing health insurance in this State or the Dirigo Health Program established in chapter 87 or any other state-run or state-sponsored health benefit program whether fully insured or self-funded.

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 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; or 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 medical 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.

§3903. Maine Individual High-risk Reinsurance Pool Association

1. Risk pool established. The Maine Individual High-risk Reinsurance 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.

The Dirigo Health Program established in chapter 87 and any other state-run or state-sponsored health benefit program shall also 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, of whom:

(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;

(2) Three members appointed by insurers belonging to the association, 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. 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 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.

§3904. 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 insurer belonging to the association 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.

§3905. 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 3906;

D. Establish procedures for the handling and accounting of pool assets;

E. Collect assessments as provided in section 3907. 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; and

F. Comply with all reserve requirements and solvency requirements applicable to insurers that offer fully insured products in the event that the association offers a self-funded health 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. Define the health benefit plans for which reinsurance will be provided under this chapter;

F. 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;

G. 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;

H. Establish rules, conditions and procedures for reinsuring risks of insurers under the pool in accordance with section 3909;

I. 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; and

J. Apply for funds or grants from public or private sources, including federal grants provided to qualified high-risk reinsurance 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 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 the need for reinsurance, the superintendent may order the association to increase its assessments. If the superintendent determines that the funds of the association are insufficient, the superintendent may order the association to charge an additional assessment.

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.

§3906. 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.

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 administrative 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. 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;

D. 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

E. Pay reinsurance amounts as provided for in the plan of operation.

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 the plan administrator's services. As used in this subsection, "direct and indirect expenses" includes that portion of the audited administrative costs, printing 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.

§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 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.

2. 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.

3. 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.

4. 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.

§3908. Requirements for coverage

1. Approved coverage. The association shall approve a choice of 2 or more coverage options for which reinsurance is available through the plan. The requirements of this plan become effective January 1, 2008. Policies approved by the association must be available for sale beginning on January 1, 2009. 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.

2. Rates. Rates for coverage approved 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.

3. Compliance with state law. Products approved 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.

§3909. Reinsurance; premium rates

1. Reinsurance amount. Any insurer offering the coverage options approved by the association pursuant to section 3908, subsection 1 must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for the reinsurance premium rate established in accordance with subsection 2.

A. The association may not reimburse a reinsuring insurer with respect to claims of a reinsured person until the insurer has incurred an initial level of claims for that person of $5,000 for covered benefits in a calendar year. In addition, the reinsuring insurer is responsible for 10% of the next $25,000 of claims paid during a calendar year. The association shall reimburse reinsuring insurers for claims paid in excess of $25,000. The association may annually adjust the initial level of claims and the maximum limit to be retained by the reinsuring insurer to reflect increases in costs and utilization within the standard market for health plans within the State. The adjustments may not be less than the annual change in the medical component of the Consumer Price Index unless the superintendent approves a lower adjustment factor as requested by the association.

B. A reinsuring insurer shall apply all managed care, utilization review, case management, preferred provider arrangements, claims processing and other methods of operation without regard to whether claims paid for coverage are reinsured under this subsection.

2. Premium rates. The association, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged reinsuring insurers to reinsure

persons eligible for coverage under this chapter. The methodology must include a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that reasonably approximate gross premiums charged for individual health plans with similar benefits to the coverage options approved by the association pursuant to section 3908, subsection 1 and that are adjusted to reflect retention levels required under this Title. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by a reinsuring insurer.

§3910. 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 insurer belonging to the association 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 6 months have elapsed since the person's last termination;

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

E. 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.

§3911. 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 insurer belonging to the association.

§3912. Reimbursement of insurers

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 after

January 1, 2008 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 between December 1, 1993 and January 1, 2008, 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, 2009.

2. Rules. The superintendent may adopt rules to facilitate payment to an insurer pursuant to this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

SUMMARY

This bill establishes a reinsurance pool for the individual health insurance market and is modeled on a similar reinsurance pool in the state of Idaho. The bill also expands the community rating bands in the individual health insurance market. The bill requires health maintenance organizations to pay an assessment of 2% of premiums to partially support the costs of the reinsurance pool.