124th MAINE LEGISLATURE

FIRST REGULAR SESSION-2009

Legislative Document **No. 1206**

H.P. 831 House of Representatives, March 26, 2009

An Act To Fund the Dirigo Health Program through a High-risk Pool

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

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative RICHARDSON of Warren.
Cosponsored by Representatives: FOSSEL of Alna, WEAVER of York, Senator: McCORMICK of Kennebec.

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

PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§2, ¶B, as amended by PL 2007, c. 629, Pt. A, §3, is further amended to read:

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

Sec. A-2. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2007, c. 629, Pt. A, §4, is further amended to read:

D. A carrier may vary the premium rate due to age, health status and geographic area in accordance with the limitations set out in this paragraph.

(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 between July 15, 1995 and June 30, ~~2009~~ 2010, 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 on or after July 1, 2009, for each health benefit plan offered by a carrier, the highest premium rate for each rating tier may not exceed 2.5 times the premium rate that could be charged to an eligible individual with the lowest premium rate for that rating tier in a given rating period. For purposes of this subparagraph, "rating tier" means each category of individual or family composition for which a carrier charges separate rates.~~

~~(a) In determining the rating factor for geographic area pursuant to this subparagraph, the ratio between the highest and lowest rating factor used by a carrier for geographic area may not exceed 1.5 and the ratio between highest and lowest combined rating factors for age and geographic area may not exceed 2.5.~~

~~(b) In determining rating factors for age and geographic area pursuant to this subparagraph, no resulting rates, taking into account the savings resulting from the reinsurance program created by chapter 54, may exceed the rates that would have resulted from using projected claims and expenses and the~~

~~rating factors applicable prior to July 1, 2009, as determined without taking into account the savings resulting from the Maine Individual Reinsurance Association established in chapter 54.~~

~~(c) The superintendent shall adopt rules setting forth appropriate methodologies regarding determination of rating factors pursuant to this subparagraph. Rules adopted pursuant to this division are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.~~

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after July 1, 2010, the maximum rate differential filed by the carrier for age, occupation or industry or geographic area 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.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after July 1, 2010, the maximum rate differential filed by the carrier for health status as determined by ratio is 1.5 to one.

(7) 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. A-3. 24-A MRSA §2736-C, sub-§2, ¶G, as enacted by PL 2007, c. 629, Pt. A, §5, is repealed.

Sec. A-4. 24-A MRSA §2736-C, sub-§2, ¶H, as enacted by PL 2007, c. 629, Pt. A, §6, is repealed.

Sec. A-5. 24-A MRSA §2736-C, sub-§2, ¶I is enacted to read:

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

Sec. A-6. 24-A MRSA §2736-C, sub-§2-A, as enacted by PL 2007, c. 629, Pt. A, §7, is repealed.

Sec. A-7. 24-A MRSA §2736-C, sub-§3, ¶A, as corrected by RR 2001, c. 1, §30, is repealed.

Sec. A-8. 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. A-9. 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. A-10. 24-A MRSA §2736-C, sub-§10, as enacted by PL 2007, c. 629, Pt. I, §1, is amended to read:

10. Pilot projects; persons under 30 years of age. ~~The superintendent shall authorize pilot projects in accordance with this subsection that allow a~~ A health insurance carrier that offers individual insurance, is marketing an individual insurance policy in this State and has a medical-loss ratio of at least 70% in the individual market ~~to~~ shall offer individual medical insurance products to persons under 30 years of age beginning ~~July 1, 2009~~ January 1, 2010 in accordance with this subsection.

~~A. The superintendent shall review pilot project proposals submitted in accordance with rules adopted pursuant to paragraph E. The superintendent shall approve a pilot project proposal if it meets the minimum benefit requirements set forth in rules adopted pursuant to paragraph E and may not approve a proposal that does not provide such minimum benefit requirements.~~

B. Notwithstanding any requirements in this Title for specific health services, specific diseases and certain providers of health care services, ~~the superintendent may adopt minimum benefit requirements that~~ a carrier may exclude certain benefits if determined by the ~~superintendent~~ carrier to provide affordable and attractive individual health plans for persons under 30 years of age.

C. ~~A pilot project approved by the superintendent~~ An individual health plan authorized pursuant to this subsection qualifies as creditable coverage under this

Title. Notwithstanding section 2849-B, subsection 4, a policy that replaces coverage issued under ~~a pilot project approved~~ an individual health plan authorized under this subsection is not subject to any preexisting conditions exclusion provisions. ~~Each carrier that offers an individual product pursuant to a pilot project approved under this subsection must combine the experience for that product with other individual products offered by that carrier as filed with the bureau when determining premium rates. The experience of a carrier's closed pool may not be taken into account in determining pilot project premium rates.~~

D. Beginning in ~~2010~~ 2011, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance matters on the status of any ~~pilot project approved by the superintendent~~ individual health plans authorized pursuant to this subsection. The report must include an analysis of the effectiveness of the ~~pilot project~~ individual health plans in encouraging persons under 30 years of age to purchase insurance and an analysis of the impact of the ~~pilot project~~ individual health plans on the broader insurance market, including any impact on premiums and availability of coverage.

~~E. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this subsection, including, but not limited to, a process for submitting a pilot project proposal, minimum requirements for approval of a pilot project and any requirements for minimum benefits. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than 90 days after the effective date of this subsection.~~

Sec. A-11. 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-A.

Sec. A-12. 24-A MRSA §2849-B, sub-§2, ¶A, as amended by PL 2007, c. 199, Pt. D, §4, is further amended to read:

A. That person was covered under ~~an individual, group or~~ a blanket contract or policy issued by a nonprofit hospital or medical service organization, insurer, 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)~~ (11). For purposes of this section, the ~~individual~~, group or blanket policy under which the person is seeking coverage is the "succeeding policy." The group, blanket ~~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. A-13. 24-A MRSA c. 54, as amended, is repealed.

Sec. A-14. 24-A MRSA c. 54-A is enacted to read:

CHAPTER 54-A

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

§3921. Short title

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

§3922. 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 3923.

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

3. Covered person. "Covered person" means an individual resident of this State 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.

For the purposes of this chapter, "covered person" does not include a dependent of a covered person.

4. Dependent. "Dependent" means a resident spouse, 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, a nonprofit hospital and medical service organization, a fraternal benefit society, a health maintenance organization, a 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, a 3rd-party administrator, a multiple-employer welfare arrangement, an entity providing medical insurance or health benefits subject to state insurance regulation and a reinsurer that reinsures 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; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

11. 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.

12. 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 to be established by the board, not to exceed one year, subject to the approval of the superintendent;

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

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

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

§3923. 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, an insurer that has sold medical insurance within the previous 12 months or is actively marketing a medical insurance policy in this State must participate in the association.

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

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

(1) Six members appointed by the superintendent: 2 members chosen from the general public who are not associated with the medical profession, a hospital or an insurer; 2 members who represent medical providers; one member who represents a statewide organization that represents small businesses and that receives a majority of its funding from small businesses located in this State; and one member who represents producers. 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 one of whom is a 3rd-party administrator.

B. Members of the board serve for 3-year terms.

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

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

3. Plan of operation. The board 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 board 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 board and approved by the superintendent. Rules adopted by the superintendent pursuant to this subsection 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 scope of the board's jurisdiction.

§3924. 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; a member insurer or its agents, employees or producers; or the superintendent for any action or omission in the performance of powers and duties pursuant to this chapter.

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

§3925. 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 3926;

D. Collect the assessments provided in section 3927. The level of payments must be established by the board. Assessments must be collected pursuant to the plan of operation approved by the board and adopted pursuant to section 3923, subsection 3. 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 and may, with the approval of the superintendent, enter into contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

C. Sue or be sued, and may take legal actions necessary or proper to recover or collect assessments due the association;

D. Take 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 amounts paid by the association as a result of mistake of fact or law or to recover other amounts due the association;

E. Establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, producers' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the association in accordance with section 3929;

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

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

H. Borrow money to effect the purposes of the association. 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 in their own names plan coverage to individuals otherwise eligible for plan coverage;

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 opinion, concurrent utilization review and individual case management for the purpose of making the benefit plan more cost-effective;

N. Design, use, 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.

3. Additional duties and powers. The superintendent may, by rule, establish additional powers and duties of the board and may adopt such rules as are necessary and proper to implement this chapter. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

4. Review for solvency. The superintendent shall review the association at least every 3 years to determine its solvency. If the superintendent determines that the funds of the association are insufficient to support enrollment of additional persons, the superintendent may order the association to increase its 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 on assessments in section 3927 is too low to support the enrollment of additional persons, the superintendent may order the association to charge assessments 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.

§3926. Selection of plan administrator

1. Selection of plan administrator. The board shall select an insurer or 3rd-party administrator, through a competitive bidding process, to administer the plan. The board

shall evaluate bids submitted under this subsection based on criteria established by the board, including:

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

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

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

2. Contract with plan administrator. The plan administrator selected pursuant to subsection 1 serves for a period of 3 years pursuant to a contract with the association. At least one year prior to the expiration of that 3-year period of service, 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 board shall select the plan administrator for the succeeding period at least 6 months prior to the ending of the 3-year period.

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

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

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

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

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

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

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

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

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

F. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses of the year, and report this information to the superintendent; and

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

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

§3927. Assessments against insurers

1. Assessments. For the purpose of providing the funds necessary to carry out the powers and duties of the association and to support subsidies for the Dirigo Health Program pursuant to section 6912, 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 $10 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. Transfer of assessments to Dirigo Health. The board shall transfer an amount equal to 50% of the assessments paid by insurers to the Dirigo Health Enterprise Fund.

5. 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.

6. 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.

§3928. Availability to coverage

The association shall offer a choice of 2 or more coverage options through the plan as set out in section 3929, subsections 1 and 2. The plan becomes effective January 1, 2010. Policies offered through the association must be available for sale July 1, 2010. The association shall directly insure the coverage provided by the plan, and the policies must be issued through the plan administrator.

§3929. 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 a covered person is also eligible for Medicare coverage, the plan may not pay or reimburse any person for expenses paid by Medicare. A person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within 90 days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage is the date of termination of the previous coverage.

2. Major medical expense coverage. The plan must offer major medical expense coverage to every covered person who is not eligible for Medicare. The board shall establish the coverage to be issued by the plan, its schedule of benefits and exclusions and other limitations, which the board may amend from time to time subject to the approval of the superintendent. In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the State and medical economic factors as determined appropriate.

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

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

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

C. Subject to approval by the superintendent, standard risk rates for coverage issued by the association must be established by the association using reasonable actuarial techniques and must reflect anticipated experiences and expenses of such coverage for standard risks. The premium for the standard risk rates may not exceed 125% 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, including requirements for mandated coverage for specific health care services and 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 governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may not be made or recognized as a claim under such a policy or be recognized as or towards satisfaction of an applicable deductible or out-of-pocket maximum or to reduce the limits of benefits available under the plan. The association has a cause of action against a covered person for the recovery of the amount of any benefits paid to the covered person 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.

§3930. Eligibility for coverage

1. Eligibility; application for coverage. A resident is eligible for coverage under the plan if the resident provides evidence 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 member insurer 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 evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

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

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

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

(1) A covered 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 covered 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 $5,000,000;

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.

§3931. Actions against association or member insurers 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 a member insurer.

§3932. Reimbursement of member insurer

1. Reimbursement. A member insurer may seek reimbursement from the association and the association shall reimburse the member insurer to the extent claims made by a covered person after April 1, 2008 exceed premiums paid on a calendar-year basis by the covered person to the member insurer for a covered person who meets the following criteria:

A. The member insurer sold an individual health plan to the covered person between December 1, 1993 and July 1, 2010 and the policy that was sold has been continuously renewed by the covered person and the carrier has closed its book of business for individual health plans sold between December 1, 1993 and July 1, 2010; and

B. The member insurer is able to determine through the use of individual health statements, claims history or any reasonable means that at the time the person applied for insurance coverage with the member insurer, the covered person 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.

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.

3. Repeal. This section is repealed July 1, 2015.

Sec. A-15. Funding. By January 1, 2013, the Comprehensive Health Insurance Risk Pool Association shall determine whether the amount transferred to the association as provided in the Maine Revised Statutes, Title 24-A, section 6915 is adequate to meet the reinsurance requirements of Title 24-A, chapter 54-A. The association shall submit a report to the joint standing committee of the Legislature having jurisdiction over insurance matters with its recommendations, if any, for changes to the funding

percentage. The joint standing committee may submit legislation to the First Regular Session of the 126th Legislature relating to the funding.

Sec. A-16. Application for federal grant. Within 30 days of the effective date of this Act, the Superintendent of Insurance shall submit an application to the federal Department of Health and Human Services, Health Resources and Services Administration for a federal seed grant to support the creation and initial operation of the Comprehensive Health Insurance Risk Pool Association established in the Maine Revised Statutes, Title 24-A, chapter 54-A.

Sec. A-17. Comprehensive Health Insurance Risk Pool Association subsidy program. The board of directors of the Comprehensive Health Insurance Risk Pool Association shall develop a plan to subsidize low-income individuals as authorized under the Maine Revised Statutes, Title 24-A, section 3925, subsection 2, paragraph P. The board shall submit that plan to the Joint Standing Committee on Insurance and Financial Services no later than February 1, 2010. The Joint Standing Committee on Insurance and Financial Services may submit legislation to the Second Regular Session of the 124th Legislature to implement the plan submitted by the association.

Sec. A-18. Staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 3923, subsection 2, paragraph B of those members initially appointed by the Superintendent of Insurance, 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 and of those members initially appointed by the member insurers, one member serves for a term of one year, one member serves for a term of 2 years and 2 members serve for a term of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

Sec. A-19. Effective date. Those sections of this Part that amend the Maine Revised Statutes, Title 24-A, section 2736-C, subsection 2, paragraphs B and D take effect July 1, 2010. Those sections of this Part that repeal Title 24-A, section 2736-C, subsection 3, paragraphs A and C take effect July 1, 2010.

PART B

Sec. B-1. 24-A MRSA §6912, first ¶, as amended by PL 2005, c. 400, Pt. A, §7, is further amended to read:

Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health Program coverage paid by eligible individuals or employees ~~whose income is under 300% of the federal poverty level~~ in accordance with the eligibility requirements in subsection 2. Dirigo Health may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than 50 employees~~, whose income is under 300% of the federal poverty level~~ in accordance with the eligibility requirements in subsection 2.

Sec. B-2. 24-A MRSA §6912, sub-§2, as amended by PL 2005, c. 400, Pt. A, §8, is further amended to read:

2. Eligibility for subsidy. To be eligible for a subsidy an individual or employee must:

A. Be enrolled in the Dirigo Health Program, have an income under 300% of the federal poverty level and assets that do not exceed 3 times the limits established for MaineCare eligibility, be a resident of the State and complete an annual health assessment as required by Dirigo Health; or

B. Be enrolled in a health plan of an employer with more than 50 employees ~~and~~, have an income under 300% of the federal poverty level and have assets that do not exceed 3 times the limits established for MaineCare eligibility. The health plan must meet any criteria established by Dirigo Health. The individual must meet other eligibility criteria, including a requirement to complete an annual health assessment, established by Dirigo Health.

Sec. B-3. 24-A MRSA §6913, as amended by PL 2007, c. 1, Pt. X, §§1 and 2 and affected by §3, is repealed.

Sec. B-4. 24-A MRSA §6915, as amended by PL 2005, c. 386, Pt. D, §3, is further amended to read:

§6915. Dirigo Health Enterprise Fund

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, ~~any savings offset payments made pursuant to section 6913~~ assessments transferred pursuant to chapter 54-A, section 3927 by the Comprehensive Health Insurance Risk Pool Association and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter. Any funds received from assessments transferred pursuant to chapter 54-A, section 3927 by the Comprehensive Health Insurance Risk Pool Association may be used only for the purposes of providing subsidies pursuant to section 6912 and to support the Maine Quality Forum established in section 6951 and may not be used to support the general administrative expenses of Dirigo Health, except for general administrative expenses of the Maine Quality Forum.

Sec. B-5. 24-A MRSA §6951, first ¶, as amended by PL 2007, c. 629, Pt. L, §5, is further amended to read:

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within Dirigo Health. The forum is governed by the board with advice from the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded~~, at least in part, through the savings offset payments made pursuant to former section 6913 and the health access surcharge pursuant to section 6913-A~~ within the limitations of available funds. Except as provided in section 6907, subsection 2, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties.

PART C

Sec. C-1. Revisor's review; cross-references. The Revisor of Statutes shall review the Maine Revised Statutes and include in the errors and inconsistencies bill submitted to the Second Regular Session of the 124th Legislature pursuant to Title 1, section 94 any sections necessary to correct and update any cross-references in the statutes to provisions of law repealed in this Act.

SUMMARY

Part A allows a maximum rate differential for individual health plans on the basis of age, occupation or industry and geographic area of 4:1 and a maximum rate differential on the basis of health status of 1.5:1.

Part A eliminates the Maine Individual Reinsurance Association which lacks funding due to the repeal by people's veto of portions of Public Law 2007, chapter 629, and establishes the Comprehensive Health Insurance Risk Pool Association, a high-risk pool for the individual health insurance market. Part A repeals the guaranteed issuance requirement for individual health insurance; the high-risk pool will become the mechanism to provide guaranteed access to individual coverage. The Part requires insurers that provide medical insurance as defined in the bill to pay an assessment of up to $10 per covered person per month to support the costs of the high-risk pool and subsidy costs for the Dirigo Health Program.

Part A of the bill also authorizes the offering of individual health plans for young adults without the prior approval of the Superintendent of Insurance.

Part B of the bill requires that Dirigo Health apply an asset limit that is 3 times the limit applied by MaineCare to determine eligibility for subsidies in addition to the requirement that an individual's income be under 300% of the federal poverty level. Part B requires Dirigo Health enrollees to complete health assessments as a condition of receiving subsidies. Part B also repeals the savings offset payment as the source of funding for subsidies for the Dirigo Health Program and instead requires the Comprehensive Health Insurance Risk Pool Association to transfer 50% of revenues from insurer assessments to support subsidies.

Part C directs the Office of the Revisor of Statutes to include in the errors bill any sections necessary to correct cross-references to provisions of law repealed in this Act.