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J.S. McCarthy Company
Augusta, Maine
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by rule a model resident information confidentiality policy for entities subject to this section. Rules adopted under this paragraph are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

See title page for effective date.

CHAPTER 343

H.P. 1156 - L.D. 1620

An Act to Amend the Laws Regarding Intervenor Status for Foster Parents in Certain Cases of the Department of Human Services

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

Sec. 1. 22 MRSA §4005-A, sub-§1, ¶A, as enacted by PL 1985, c. 424, is amended to read:

A. "Foster parent" means a person who has had a child in ~~his~~ that person's home for at least ~~one year~~ 120 days and who has received a license for a family foster home as defined in section 8101, subsection 3, or who is a relative.

See title page for effective date.

CHAPTER 344

H.P. 1306 - L.D. 1849

An Act to Clarify the Charitable Status of Nonprofit Hospital and Medical Service Organizations, to Permit Their Creation of Health Insurance Affiliates and Their Conversion to Stock Insurers and to Ensure Regulatory Equity

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

Sec. 1. 5 MRSA §194-A is enacted to read:

§194-A. Nonprofit hospital and medical service organizations

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Affiliate" means a person who directly or indirectly controls or is controlled by or is under common control with the person specified.

B. "Charitable authority" means the Attorney General's authority over charities under section 194, under the Attorney General's corresponding common law authority and under the Maine Nonprofit Corporation Act, Title 13-B.

C. "Charitable trust" means the entity described in subsection 5, paragraph B, subparagraph (1).

D. "Contract holder" means the employer, labor union, association, trustee, creditor or other entity to which a group contract evidencing coverage is issued.

E. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services or otherwise unless the power is solely the result of an official position with or a corporate office held by the person.

F. "Conversion" means the process by which a nonprofit hospital and medical service organization, with the approval of the superintendent pursuant to Title 24, section 2301, subsection 9-D, converts to a domestic stock insurer.

G. "Fair market value" means the value of an organization or an affiliate or of the assets of such an entity determined, consistent with Title 24, section 2301, subsection 9-D, as if the entity had voting stock outstanding and 100% of its stock were freely transferrable and available for purchase without restrictions. In determining fair market value, consideration must be given to value as a going concern, market value, investment or earnings value, net asset value and a control premium, if any. If a charitable trust receives, at the time of conversion, 100% of the shares of the then-outstanding stock of the converted domestic stock insurer, the charitable trust is regarded as having acquired the fair market value of the organization unless the superintendent finds that such outstanding stock does not represent the fair market value of the organization.

H. "Health insurance affiliate" means any domestic for-profit stock insurer required to be authorized under Title 24-A, section 404 to provide health insurance or any domestic for-profit health maintenance organization required to be licensed under Title 24-A, chapter 56 that is formed, acquired, invested in or otherwise established, whether directly or indirectly, by a nonprofit hospital and medical service organization.

I. "Materially changes its form" or "material change in form" means any transaction that the superintendent or Attorney General determines has transferred control of the organization to a noncharitable organization, substantially changed the organization's legal or regulatory status or substantially changed the organization's purposes, including, but not limited to, conversion, dissolution, merger, division, consolidation, amalgamation, disposition of substantially all of an organization's business, line of business or assets, lease, exchange, restructuring or bulk reinsurance transfer.

J. "Member" means a member of the nonprofit hospital and medical service organization entitled to vote under the articles or bylaws of the organization.

K. "Nonprofit hospital and medical service organization" or "organization" means a corporation or other entity authorized by the superintendent or organized pursuant to Title 24 for the purpose of providing nonprofit hospital service plans within the meaning of Title 24, section 2301, subsection 1 and nonprofit medical service plans within the meaning of Title 24, section 2301, subsection 2. It does not include any organization that provides only nonprofit health care plans within the meaning of Title 24, section 2301, subsection 3 or a health insurance affiliate as defined in Title 24, section 2308-A. Nothing in this section may be construed to change, limit or affect the charitable status or obligations of nonprofit health care service plans organized under Title 24, section 2301, subsection 3.

L. "Subscriber" means an individual who has subscribed to one or more of the hospital, medical or health care service plans or contracts offered by the organization or health insurance affiliate as defined in Title 24, section 2308-A through an individual or family policy or group policy.

M. "Superintendent" means the Superintendent of Insurance.

2. Charitable status of organization. Any nonprofit hospital and medical service organization is a charitable and benevolent institution and a public charity and its assets are held for the purpose of fulfilling the charitable purposes of the organization. The charitable purposes include, but are not limited to, the following: providing access to medical care through affordable health insurance and affordable managed care products for persons of all incomes; identifying and addressing the State's unmet health care needs, particularly with regard to medically uninsured and underserved populations; making services and care available through participating providers; and improving the quality of care for medically uninsured and underserved populations. The following ownership interests apply in any proceeding in court or before the superintendent in which the ownership of the organization is at issue or is relevant.

A. If the organization materially changes its form on or before December 31, 2000, then 100% of the fair market value of the organization as of the date of the material change in form is owned by the charitable trust upon the approval or approval with modifications of the charitable trust plan or modified charitable trust plan by the court pursuant to subsection 5 or 6 and must be dedicated to the fulfillment of the charitable trust.

B. If the organization materially changes its form after December 31, 2000 and on or before December 31, 2005, then 95% of the fair market value of the organization as of the date of the material change in form is owned by the charitable trust upon the approval or approval with modifications of the charitable trust plan or modified charitable trust plan by the court pursuant to subsection 5 or 6 and must be dedicated to the fulfillment of the charitable trust; and the remaining 5% is owned by subscribers in aggregate. For purposes of this paragraph, subscribers include only those persons who were subscribers on any date in the 3-year period immediately prior to the material change in form, if in each case the person was a subscriber for period of no less than 3 consecutive months.

C. If the organization materially changes its form after December 31, 2005, then 90% of the fair market value of the organization as of the date of the material change in form is owned by the charitable trust upon the approval or approval with modifications of the charitable trust plan or modified charitable trust plan by the court pursuant to subsection 5 or 6 and must be dedicated to the fulfillment of the charitable trust; and the remaining 10% is owned by subscribers in aggregate. For purposes of this paragraph, subscribers include only those persons who were subscribers on any date in the 3-year period immediately prior to the material change in form, if in each case the person was a subscriber for period of no less than 3 consecutive months.

3. Determination of ownership interest and charitable purposes by the Superior Court. A nonprofit hospital and medical service organization shall file a statement of ownership interests and charitable purposes with the Attorney General by December 31, 1997.

A. The statement of ownership interests and charitable purposes must contain the following:

(1) A proposed notice, including, but not limited to, notice by publication in newspapers of general circulation in the State, and notice by letter sent through regular mail to the members and contract holders, containing, at a minimum:

(a) A description of the ownership interests in the organization as set forth in subsection 2;

(b) A description of the organization's charitable purposes as set forth in subsection 2; and

(c) A description of the process by which any person may file in Superior Court an objection to the ownership interests and charitable purposes set forth in subsection 2 and a claim of ownership interest in the organization; and

(2) A description of the process for providing the notice described in subparagraph (1) when required by the Superior Court under paragraph C.

B. Within 45 days after the organization has filed its statement of ownership interests and charitable purposes, the Attorney General shall file in Superior Court for Kennebec County an action under its charitable authority seeking approval or approval with modifications of the statement or any amended statement filed by the organization with the Attorney General's consent.

C. The Superior Court shall approve or approve with modifications the notice provisions in the statement and issue orders to accomplish that notice.

D. The organization shall pay the costs of providing the notice ordered by the Superior Court.

E. Any objection by any person to the designation of ownership interests or the description of charitable purposes and any claim of ownership interest in the organization must be filed within 90 days after issuance of the notice ordered by the Superior Court.

F. The Superior Court shall hold a hearing on any objections to the designation of ownership interests and charitable purposes set forth in subsection 2 and any claim of ownership interest in the organization and shall approve the designation of ownership interests and charitable purposes unless the court determines that the designation is unlawful.

G. The judgment of the Superior Court, after exhaustion of all appeals, is final, binding and conclusive as to all matters expressly determined in the judgment of the Superior Court. Any claim of rights, title and interest in or to the nonprofit hospital and medical service organization is barred except to the extent the claim is determined to be valid in the judgment of the Superior Court after exhaustion of all appeals. The sole remedy of persons claiming any right, title or interest in the nonprofit hospital and medical service organization is to seek adjudication of the claim pursuant to this subsection.

4. Representation of charitable interests. Except as provided in this subsection, the Attorney General is the sole person authorized to represent the charitable interests of beneficiaries of the charitable obligations of a nonprofit hospital and medical service organization and any health insurance affiliate in any proceeding before any court or any administrative agency. The Attorney General may enforce the organization's charitable obligations in an action in Superior Court under the Attorney General's charitable authority. Nothing in this subsection may be construed to limit the superintendent's authority with respect to the interests of subscribers or the public in enforcing the provisions of Title 24 and Title 24-A.

A. The board of directors of a nonprofit hospital and medical service organization has the responsibility to fulfill the organization's charitable obligation, subject only to the Attorney General's authority to represent the charitable interests of beneficiaries of the organization's charitable obligation, any applicable law and the superintendent's authority to enforce Title 24 and Title 24-A.

B. A nonprofit hospital and medical service organization shall reimburse the Attorney General and the superintendent for the costs of any experts or consultants retained by the Attorney General or the superintendent in connection with any matter before any court or any administrative agency relating to the organization's charitable value and charitable obligations.

5. Charitable trust plan required prior to conversion. A nonprofit hospital and medical service organization shall submit a charitable trust plan to the Attorney General at the same time that it submits a conversion plan to the superintendent for approval of a conversion to a domestic stock insurer pursuant to Title 24, section 2301, subsection 9-D.

A. Within 60 days of the organization's submission of the charitable trust plan to the Attorney General, the Attorney General shall file an action under the Attorney General's charitable authority in Superior Court seeking approval, approval with modifications, or disapproval of the charitable trust plan or of any amended charitable trust plan submitted to the Attorney General by the organization with the consent of the Attorney General.

B. An organization may not convert to a domestic stock insurer under Title 24, section 2301, subsection 9-D until the Superior Court has approved or approved with modifications the organization's charitable trust plan. The court may not approve or approve with modifications the charitable trust plan unless it finds that the charitable trust plan meets the following requirements.

(1) The plan must describe the charitable trust or trusts that will receive the ownership interest in the organization following its conversion to a domestic stock insurer. For purposes of this section, a charitable trust:

(a) Must be a new or existing trust or nonprofit corporation formed under the laws of this State, but may not include the organization or any person controlled by the organization;

(b) Must be a charitable entity that qualifies for federal income tax exemption under the United States Internal Revenue Code of 1986, as amended, Section 501 (c)(3) or (c)(4);

(c) May not be controlled by the converted domestic stock insurer;

(d) May not have more than one of its directors serve as a director of the domestic stock insurer;

(e) May not have as a director any person who has been a director or officer of the organization, the domestic stock insurer or any affiliate of either during the 3-year period preceding the date of appointment as a director of the charitable trust; and

(f) Must have a board of directors representing the people of the State including, but not limited to, persons representing the interests of the medically uninsured and underserved populations.

(2) The charitable mission of the charitable trust must include, but is not limited to, serving the State's unmet health care needs, particularly with regard to medically uninsured and underserved populations and providing access to care and improving quality of care for those populations.

(3) The charitable trust plan must provide for the fair and equitable use by the charitable trust of its ownership interest in the organization to fulfill the charitable mission of the charitable trust.

(4) The charitable trust plan must require the charitable trust to report annually to the Attorney General as to its charitable activities and grant making relating to the use of its ownership interest in the organization and to make that annual report available to the public at both the Department of the Attorney General and the office of the charitable trust.

(5) The charitable trust plan must require the charitable trust, at all times when the charitable trust owns stock in any converted stock insurer and for 5 calendar years after any such ownership, to provide audited financial statements on a calendar-year basis and other reports, as may be required, to the superintendent and the Attorney General at the time and in the manner as either the Attorney General or the superintendent prescribes.

(6) The charitable trust plan must state the ownership interests of the charitable trust approved by the Superior Court in the proceeding set forth in subsection 3.

(7) The charitable trust must have in place procedures and policies to prohibit conflicts of interest, including those associated with grant-making activities that may benefit the converted stock insurer, its affiliates, any person who owns or controls any ownership interest in either the converted stock insurer or its affiliates and any directors or officers of the converted stock insurer or its affiliates.

C. The superintendent has the right to intervene in the Superior Court proceeding.

D. In approving, disapproving or approving with modification the charitable trust plan, the Superior Court may not review or decide the methodologies for determining the fair market value of the organization, the methodology for allocating and transferring to the owners the ownership in-

terest identified in the statement of ownership interests and charitable purposes approved by the Superior Court or the fair market value of the organization. This paragraph does not in any way limit the appeal rights of any person under the Maine Rules of Civil Procedure, Rule 80(c) or under the Maine Administrative Procedure Act from the superintendent's final agency action on these matters pursuant to Title 24, section 2301, subsection 9-D.

6. Modified charitable trust plan required for a material change in form. An organization shall notify the Attorney General and the superintendent of the organization's intent to engage in any transaction described in subsection 1, paragraph I at least 60 days prior to engaging in that transaction. Upon the superintendent's or the Attorney General's determination that a transaction described in subsection 1, paragraph I is a material change in form, notice must be given to the organization and the Attorney General or superintendent, as applicable. Within 90 days after the superintendent or the Attorney General issues a notice of the determination that a transaction described in subsection 1, paragraph I is a material change in form, other than through conversion to a domestic stock insurer pursuant to Title 24, section 2301, subsection 9-D, the Attorney General shall file an action in Superior Court under the Attorney General's charitable authority requesting the court to order the organization to submit to the superintendent, the court and the Attorney General a modified charitable trust plan containing the provisions set forth in subsection 5, paragraph I as the court determines are reasonable under the circumstances, together with any additional provisions as the court determines are reasonably required to coordinate the modified charitable trust plan with any proceeding instituted or to be instituted by the superintendent in connection with the material change in form. The Superior Court, after hearing, shall approve, approve with modifications or disapprove the modified charitable trust plan. The superintendent has the right to intervene in the Superior Court proceeding. In the event that either the superintendent or the court determines that a valuation of the organization is necessary, the superintendent shall conduct the valuation consistent with Title 24, section 2301, subsection 9-D. The superintendent may hold proceedings as the superintendent determines necessary to review an organization's proposal to materially change its form. If the modified charitable trust plan includes the creation of a charitable trust or nonprofit corporation, the charitable trust or nonprofit corporation may not include the organization or any person controlled by the organization.

7. Affiliates providing health insurance. This subsection governs health insurance affiliates.

A. A nonprofit hospital and medical service organization shall notify the Attorney General at least 60 days prior to directly or indirectly forming, acquiring, investing in or otherwise establishing a health insurance affiliate.

B. Each health insurance affiliate shall expressly have corporate purposes that are consistent with or are in furtherance of the charitable and benevolent purposes of its nonprofit and charitable owners.

(1) Subject to subparagraph (2), the health insurance affiliate may further its purposes as described in this paragraph by:

(a) The provision of direct services that are consistent with or further the charitable and benevolent purposes of its nonprofit and charitable owners; or

(b) The payment of distributions or dividends to any nonprofit and charitable owner.

(2) The payment by the health insurance affiliate of distributions or dividends to any owner does not fulfill a health insurance affiliate's purposes as described in this paragraph if the payment of such distributions or dividends unreasonably interferes with the health insurance affiliate's ability to fulfill its purposes as described in this paragraph through the provision of direct services as described in subparagraph (1), division (a). Payment of dividends and distributions may be made to a for-profit owner consistent with this subparagraph but may not be considered to fulfill the health insurance affiliate's purposes as described in this paragraph.

(3) If the nonprofit hospital and medical service organization holding an ownership interest in a health insurance affiliate materially changes its form and the Superior Court has approved or approved with modifications a charitable trust plan or modified charitable trust plan, the purposes as described in this paragraph of the health insurance affiliate terminate unless the Superior Court determines otherwise.

C. Any charitable entity that owns or controls an ownership interest in a health insurance affiliate must be treated as having acquired that ownership interest in furtherance of the charitable purposes of the charitable entity.

D. The Attorney General may enforce the purposes as described in paragraph B of a health in-

surance affiliate under this subsection under the Attorney General's charitable authority to the same extent as if the health insurance affiliate were a nonprofit and charitable organization.

E. A nonprofit hospital and medical service organization shall file with the Attorney General and the superintendent a charitable activities plan at least 60 days prior to the organization's sale of any ownership interest in a health insurance affiliate or the sale or other disposition of substantially all the assets of the health insurance affiliate.

(1) The charitable activities plan must set forth the charitable activities that the nonprofit hospital and medical service organization intends to pursue with the revenues or proceeds received from the sale of any ownership interest in a health insurance affiliate or the sale or other disposition of substantially all the assets of the health insurance affiliate.

(2) If the Attorney General concludes that the charitable activities plan does not fairly and equitably fulfill the nonprofit hospital and medical service organization's charitable purposes, the Attorney General shall bring an action in Superior Court under the Attorney General's charitable authority to challenge the charitable activities plan. The Attorney General shall provide to the superintendent prior written notice of any such action. The superintendent has the right to intervene in such action. If the Superior Court determines that the organization's charitable activities plan does not fairly and equitably fulfill the organization's purposes as described in paragraph B, the court shall issue orders necessary to remedy the inadequacies in the charitable activities plan.

(3) If a nonprofit hospital and medical service organization sells its ownership interest in a health insurance affiliate and the charitable activities plan filed with the Attorney General in connection with the sale has been approved by the Attorney General or the Superior Court, then the purposes described in paragraph B of a health insurance affiliate terminate unless the Superior Court determines otherwise.

F. Each health insurance affiliate shall file an annual report with the Attorney General at the time and in the manner as the Attorney General shall establish describing the efforts that the affiliate has undertaken to fulfill its purposes as described in paragraph B, including, but not limited to, all direct services as described in paragraph B, subparagraph (1), division (a) and grant making.

G. The sale by an organization of its ownership interest in a health insurance affiliate for fair market value, as determined by the superintendent, does not constitute a diversion of charitable assets.

8. Annual report. The organization shall file an annual report with the Attorney General and the superintendent at the time and in the manner as the Attorney General establishes describing the efforts that the organization has undertaken to fulfill its charitable and benevolent purposes.

Sec. 2. 24 MRSA §2301, sub-§3-C is enacted to read:

3-C. Nonprofit purposes. A nonprofit hospital and medical service organization that is authorized to provide nonprofit hospital service plans under subsection 1 and nonprofit medical service plans pursuant to subsection 2 is a charitable and benevolent institution, in accordance with Title 5, section 194-A, and a public charity and its assets are held for the purpose of fulfilling the charitable purposes of the organization, which purposes include, but are not limited to, the following: providing access to medical care through affordable health insurance and affordable managed care products for persons of all incomes; identifying and addressing the State's unmet health care needs, particularly with respect to medically uninsured and underserved populations; making services and care available through participating providers; and improving the quality of care for medically uninsured and underserved populations.

Sec. 3. 24 MRSA §2301, sub-§9-B, ¶A, as enacted by PL 1993, c. 702, Pt. A, §1, is repealed and the following enacted in its place:

A. An organization that provides only nonprofit health care plans within the meaning of subsection 3 may become a mutual insurer under a plan and procedure approved by the superintendent after a hearing. An organization defined in subsection 9-D, paragraph B, subparagraph (8) may not convert to a mutual insurer.

Sec. 4. 24 MRSA §2301, sub-§9-D is enacted to read:

9-D. Conversion to a domestic stock insurer. Conversion of a nonprofit hospital and medical service organization as defined in paragraph B, subparagraph (8) to a domestic stock insurer is governed by this subsection.

A. A nonprofit hospital and medical service organization or other entity authorized by the superintendent or organized pursuant to this chapter for the purpose of providing nonprofit hospital service plans within the meaning of subsection 1 and nonprofit medical service plans within the meaning of subsection 2 may convert to a domestic stock insurer subject to the provisions of this subsection.

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

(1) "Charitable trust" has the meaning set forth in Title 5, section 194-A, subsection 1, paragraph C.

(2) "Charitable trust plan" means the plan submitted to the Attorney General pursuant to Title 5, section 194-A, subsection 5.

(3) "Conversion" means the process by which an organization, with the approval of the superintendent, converts to a domestic stock insurer pursuant to this subsection.

(4) "Conversion plan" means a written plan that sets forth the provisions required by the superintendent, that is filed with the superintendent pursuant to this subsection, that sets forth a complete description of the proposed conversion and that contains sufficient detail to permit the superintendent to make the findings required under this subsection.

(5) "Converted stock insurer" means the domestic stock insurer resulting from a conversion pursuant to this subsection.

(6) "Fair market value" means the value of an organization or an affiliate or the value of the assets of such an entity determined as if the entity had voting stock outstanding and 100% of its stock were freely transferrable and available for purchase without restrictions. In determining fair market value, consideration must be given to value as a going concern, market value, investment or earnings value, net asset value and a control premium, if any.

(7) "Member" means a member of the organization entitled to vote under the articles or bylaws of the organization.

(8) "Nonprofit hospital and medical service organization" or "organization" means a corporation or other entity authorized by the superintendent or organized pursuant to this chapter for the purpose of providing nonprofit hospital service plans within the meaning of subsection 1 and nonprofit medical service plans within the meaning of subsection 2. It does not include any organization that provides only nonprofit health care plans within the meaning of subsection 3 or a health insurance affiliate defined in section 2308-A. Nothing in this section may be construed to change, limit or affect the charitable status or obligations of nonprofit health care plans organized under subsection 3.

(9) "Statement of ownership interests and charitable purposes" means the statement filed with the Superior Court pursuant to Title 5, section 194-A, subsection 3.

(10) "Subscriber" means an individual who has subscribed to one or more of the hospital, medical or health care service plans or contracts offered or issued by the organization or health insurance affiliate as defined in section 2308-A through an individual or family policy or group policy.

C. A nonprofit hospital and medical service organization may, without the need for reincorporation, amend its charter pursuant to this subsection to become a domestic stock insurer under and pursuant to the terms and conditions of a conversion plan that complies with this subsection and is approved by the superintendent after an adjudicatory hearing on the proposed conversion. Notice of the hearing must be given to the public and the organization's directors or trustees, officers, employees, members and subscribers, all of whom have the right to appear and be heard at the hearing. Beginning on the date on which a conversion plan is filed with the superintendent for approval, the conversion plan must be available for public inspection and copying at the office of the superintendent, at the principal executive office of the organization that filed the conversion plan and at other locations the superintendent designates.

D. Concurrent with the filing of the conversion plan with the superintendent, the organization shall file a charitable trust plan with the Attorney General pursuant to Title 5, section 194-A and submit a copy to the superintendent. The organization shall file a copy of the conversion plan with the Attorney General at the time the organization files the conversion plan with the superintendent. The superintendent shall commence review of the conversion plan pursuant to this subsection upon receipt by the superintendent of the Superior Court's approval or approval with

modifications of the charitable trust plan or at such earlier time as the superintendent determines necessary.

E. The superintendent may not issue final approval of a conversion plan unless the superintendent finds that:

(1) The terms and conditions of the conversion plan are fair and equitable and, in determining what is fair and equitable, consideration may be given to, but is not limited to, the factors set forth in paragraph L;

(2) The conversion plan is subject to approval by the vote of not less than 2/3 of the organization's board of directors;

(3) The conversion plan provides for the issuance of capital stock or assets of the converted stock insurer or a combination of stock and assets, without consideration, to the charitable trust equal to the charitable interest set forth in the organization's statement of ownership interests and charitable purposes, exclusive of any shares issued pursuant to paragraph G;

(4) The conversion plan provides for the issuance of capital stock or assets of the converted stock insurer or a combination of stock and assets, without consideration, to persons who were subscribers of the organization on the date the conversion plan was filed with the superintendent or on any date in the 3-year period immediately prior to the date the conversion plan was filed, if in each case the person was a subscriber for a period of no less than 3 consecutive months, under a fair and reasonable formula consistent with and in the aggregate equal to the aggregate of the subscribers' interests set forth in the statement of ownership interests and charitable purposes, exclusive of any shares issued pursuant to paragraph G;

(5) Immediately after, and giving effect to the terms of, the conversion, the converted stock insurer would be in safe and sound financial condition and would have paid-in capital stock and surplus in amounts not less than the minimum paid-in capital stock and surplus set forth under Title 24-A, section 410 required of a domestic stock insurer authorized to transact like kinds of insurance;

(6) The organization's management has not, through reduction in volume of new business written or cancellation or through any other means, sought to reduce, limit, or affect the number or identity of the organization's subscribers to be entitled to participate in the conversion plan or to secure for the individuals comprising management any unfair advantage through the conversion plan;

(7) The conversion plan provides that during the first 3 years after the conversion, to avoid dilution of the value of the shares issued in the conversion, the converted stock insurer and its affiliates may not issue shares greater in seniority, including voting rights or dividends, than the shares issued under the conversion plan. The superintendent may waive the provisions contained in this subparagraph if the superintendent, in the superintendent's sole discretion, determines that the charitable trust has control, as defined in Title 24-A, section 222, of the converted stock insurer;

(8) The conversion plan is consistent with the charitable trust plan and does not adversely affect the distribution of the organization's value to the charitable trust; and

(9) The conversion plan complies with all applicable law.

F. The conversion plan must include the proposed articles of incorporation and bylaws of the converted stock insurer and all references in this subsection to the conversion plan are deemed to include such instruments.

G. Paragraph E, subparagraphs (3) and (4) do not prohibit the inclusion in the conversion plan of provisions under which the converted stock insurer would make a simultaneous offering of shares of its capital stock for cash to either or both of its directors, officers and employees as a group or the public, in each case under terms and conditions and pursuant to valuation procedures the superintendent approves. In no event may an excess of 3% of the aggregate shares of capital stock to be issued by the converted stock insurer pursuant to the conversion plan be offered for purchase by the directors, officers and employees, in the aggregate, of the organization and the

shares must be offered only on terms generally available to the public. All shares offered pursuant to any provisions of the conversion plan permitted by this paragraph must be priced in a manner consistent with the fair market value of the aggregate equity of the converted stock insurer to be outstanding following the completion of the conversion plan, established pursuant to paragraph I.

H. The conversion plan sets forth a comparative premium rate analysis of all the organization's plans and product offerings, comparing actual premium rates for the 3-year period before the filing of the conversion plan and projected premium rates for the 3-year period following the proposed conversion. The rate analysis must address the projected impact, if any, of the proposed conversion upon the cost to subscribers as well as the projected impact, if any, of the proposed conversion upon the organization's underwriting profit, investment income, tax position and loss and claim reserves, including the effect, if any, of adverse market or risk selection on reserves.

I. The conversion plan must include an appraisal of the fair market value, or range of values, of the aggregate equity of the converted stock insurer to be outstanding upon completion of the conversion plan and, if a range of values, the methodology for fixing a final value coincident with the completion of the transactions provided for in the conversion plan.

(1) The appraisal must enable determinations of value for purposes of:

(a) The amount of cash or other assets that subscribers or the charitable trust will be entitled to receive, without consideration, under the provisions of the conversion plan required by paragraph E, subparagraphs (3) and (4); and

(b) The price of any shares to be issued pursuant to the optional provisions of a conversion plan permitted by paragraph G.

(2) The appraisal required by this paragraph must be prepared by persons independent of the organization, experienced and expert in the area of corporate appraisal and acceptable to the superintendent. The appraisal must be in form and content acceptable to the superintendent and contain a complete and detailed description of the elements that make up the appraisal, justification for the methodology employed and sufficient support for the conclusions reached in the appraisal.

(3) To the extent that the appraisal is based on a capitalization of the pro forma income of the converted stock insurer, the appraisal must indicate the basis for determination of the income to be derived from any proceeds of the sale of stock and demonstrate the appropriateness of the earnings-multiple used, including assumptions made regarding future earnings growth.

(4) To the extent that the appraisal is based on the comparison of the capital stock of the converted stock insurer with outstanding capital stock of existing stock entities offering comparable insurance products, the existing stock entities must be reasonably comparable to the converting stock insurer in terms of such factors as size, market area, competitive conditions, profit history and expected future earnings.

(5) In those instances when the superintendent determines that the appraisal is materially deficient or substantially incomplete, the superintendent may deem the entire conversion plan materially deficient or substantially incomplete and decline to further process or reject the application for conversion.

(6) The converting organization shall submit to the superintendent information demonstrating to the satisfaction of the superintendent the independence and expertise of any person preparing the appraisal or related materials under this paragraph.

(7) An appraiser may not serve as an underwriter or selling agent under the same conversion plan and an affiliate of an appraiser may not act as an underwriter or selling agent unless procedures are followed and representations and warranties made to ensure that an appraiser is separate from the underwriter or selling agent affiliate and the underwriter or selling agent affiliate does not make recommendations or in any way have an impact on the appraisal.

(8) An appraiser may not receive any other fee except the fee for services rendered in connection with the appraisal.

J. A director, officer, agent or employee of the organization or any other person may not receive any fee, commission or other valuable consideration whatsoever other than that person's usual and regular salary and compensation for in any

manner aiding, promoting or assisting in a conversion under this section or any related transaction, except as set forth in the conversion plan and approved by the superintendent. For the purposes of this paragraph, "usual and regular salary and compensation" does not include any salary, compensation or other economic benefit that is in any way contingent on completion of the conversion. This paragraph does not prohibit the payment of reasonable fees and compensation to attorneys-at-law, accountants and actuaries for services performed in the independent practice of their professions, even though also directors of the organization.

K. For the purpose of determining whether a conversion plan meets the requirements of this subsection and any other relevant provisions of this Title and Title 24-A, the superintendent may employ staff personnel and outside consultants including, without limitation, financial advisors, investment bankers, actuaries, attorneys and accountants. All costs related to the review of a conversion plan, including those costs attributable to the use of staff personnel, must be borne by the organization making the filing.

L. In making a determination under paragraph E, subparagraph (1) as to whether a conversion plan is fair and equitable, the superintendent shall consider, among other factors, the following:

(1) Whether the conversion plan complies with the provisions of and purposes of this subsection and any rules of the superintendent that may be adopted under this subsection; and

(2) Whether the conversion plan would adversely affect, in any manner, the services to be rendered to subscribers.

M. The superintendent may aggregate any transactions that are part of a plan or series of like transactions to determine whether those transactions constitute a conversion.

N. The superintendent, in the superintendent's sole discretion, may determine when an application for conversion under this subsection is complete and may request additional information from the organization as the superintendent determines necessary to review the application and conversion plan. The superintendent may also conduct an examination under Title 24-A, section 221 to obtain any information the superintendent determines necessary in connection with an application for conversion or transaction or series of transactions that the superintendent determines constitute a conversion under paragraph M. The failure of the organization to provide the information or cooperate in the examination, in addition to other applicable penalties, constitutes grounds for denial of the application for conversion.

O. The Attorney General has the right to intervene as a party in a proceeding before the superintendent and, if the Attorney General intervenes, has the right to receive any documents or other information received by the superintendent in connection with the proceeding. The Attorney General is subject to all confidentiality provisions that apply to the superintendent.

P. The superintendent may adopt rules, not inconsistent with the provisions of this subsection, the superintendent determines necessary or desirable and appropriate to effect the purposes of this subsection. Rules adopted under this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

Sec. 5. 24 MRSA §2308-A is enacted to read:

§2308-A. Health insurance affiliates

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Foreign health service plan" means a nonprofit hospital and medical service organization or similar nonprofit entity organized under the laws of another state.

B. "Health insurance affiliate" means any domestic for-profit stock insurer required to be authorized under Title 24-A, section 404 to provide health insurance or any domestic for-profit stock health maintenance organization required to be licensed under Title 24-A, chapter 56 that is formed, acquired, invested in or otherwise established, whether directly or indirectly, by a nonprofit hospital and medical service organization.

C. "Nonprofit hospital and medical service organization" or "organization" means a corporation or other entity authorized by the superintendent and organized pursuant to this chapter for the purpose of providing nonprofit hospital service plans within the meaning of section 2301, subsection 1 and nonprofit medical service plans within the meaning of section 2301, subsection 2. It does not include any organization that provides only nonprofit health care plans within the meaning of section 2301, subsection 3 or a health insurance affiliate.

D. "Ownership interest" means any equity interest in a health insurance affiliate, including, without limitation, capital stock, voting securities, securities convertible into voting securities, general partnership shares, limited partnership shares, surplus notes or other interests possessing voting rights.

E. "Person" has the meaning set forth in Title 24-A, section 222, subsection 2, paragraph E.

2. Authorization. A nonprofit hospital and medical service organization may not, directly or indirectly, form, acquire, invest in or otherwise establish a health insurance affiliate unless:

A. The organization has substantial control over the health insurance affiliate, which control for purposes of this section must be satisfied by:

(1) Ownership of 50% or more of the outstanding ownership interests of the health insurance affiliate;

(2) Ownership of or the power to vote, directly or indirectly, 50% or more of the voting securities of the health insurance affiliate;

(3) The legal authority to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the health insurance affiliate without its consent;

(4) The legal authority to prevent any change in the health insurance affiliate's legal status or trade names, the geographic area in which the health insurance affiliate operates or the fundamental type of business in which the health insurance affiliate engages without its consent; and

(5) Fifty percent or more control of the management policies or operations of the health insurance affiliate.

An organization that does not meet the requirements of subparagraphs (1), (2) and (5) is deemed to meet those requirements if the organization and one or more nonprofit hospital and medical service organizations or foreign health service plans, in the aggregate, meet the requirements of subparagraphs (1), (2) and (5). At all times the organization's ownership interest in the health insurance affiliate must exceed the aggregate ownership interests in the health insurance affiliate owned or controlled by any persons permitted to hold ownership interests pursuant to paragraph B;

B. Individuals or nonprofit and noncharitable entities owning or controlling ownership interests in the health insurance affiliate are subject to the following limitations so that only:

(1) Up to a maximum of 25% of the ownership interests in the health insurance affiliate may be owned or controlled by individual physicians licensed to practice in this State, as long as the remaining ownership interests are owned or controlled by the organization under paragraph A, subparagraph (1), the organization and one or more organizations or foreign health service plans under paragraph A, subparagraph (2) or nonprofit charitable health care entities under paragraph C; or

(2) Up to a maximum of 20% of the ownership interests in the health insurance affiliate, in the aggregate, may be owned or controlled by nonprofit and noncharitable entities formed by physicians licensed to practice in this State and hospitals licensed in this State for the purpose of arranging for or delivering health care, or a combination of such an entity and individual physicians licensed to practice in this State as long as the remaining ownership interests are owned or controlled by the organization under paragraph A, subparagraph (1), the organization and one or more organizations or foreign health service plans under paragraph A, subparagraph (2) or nonprofit charitable health care entities under paragraph C;

C. Any ownership interests not owned or controlled by the organization under paragraph A, subparagraph (1), the organization and one or more organizations or foreign health service plans under paragraph A or persons described under paragraph B are owned or controlled by nonprofit charitable entities that qualify for federal income tax exemption under the United States Internal Revenue Code of 1986, Section 501(c)(3) or (c)(4), as amended;

D. The health insurance affiliate meets the following requirements with respect to its officers, directors and employees:

(1) No ownership interests of the health insurance affiliate are owned or controlled by officers, directors or employees of:

(a) The health insurance affiliate;

(b) Any person owning or controlling ownership interests in the health insurance affiliate; or

(c) Any affiliate of a person described in this subparagraph or subparagraph (2);

(2) Notwithstanding subparagraph (1), an individual that owns or controls an ownership interest in a health insurance affiliate, including an individual serving as an officer, director or employee of a person described in paragraph B that owns or controls an ownership interest in a health insurance affiliate, serves as a director of the health insurance affiliate, subject to the limitations set forth in subparagraph (4);

(3) Notwithstanding subparagraph (1), at any time, no more than one officer of the health insurance affiliate is an individual that owns or controls an ownership interest in a health insurance affiliate, or an individual serving as an officer, director or employee of a person described in paragraph B that owns or controls an ownership interest in a health insurance affiliate;

(4) The total percentage of directors of a health insurance affiliate who represent or are appointed by each person described in paragraph B that owns or controls an ownership interest in the health insurance affiliate does not exceed the total percentage ownership interests in the health insurance affiliate owned or controlled by persons described in paragraph B; and

(5) The health insurance affiliate has in place procedures and policies to prohibit conflicts of interest that may benefit the persons described in subparagraph (1), divisions (a), (b) and (c), including, but not limited to, conflicts to the detriment of the health insurance affiliate's ability to fulfill its charitable purposes.

Nothing contained in this paragraph prohibits interlocking boards of directors between or among the person described in subparagraph (1), divisions (a), (b) and (c), provided no officer, director or employee of any person described in subparagraph (1), divisions (a), (b) and (c) owns or controls an ownership interest prohibited by this paragraph;

E. The organization provides written notice to the superintendent at least 60 days prior to forming, acquiring, investing in or otherwise establishing a health insurance affiliate; and

F. At all times when the organization owns or controls an ownership interest in the health insurance affiliate, the organization or the health insurance affiliate, together or separately, does not inappropriately stratify risks. For the purpose of this paragraph, the superintendent may treat the organization and the health insurance affiliate as a single person. If the superintendent determines that this paragraph has been violated, the superintendent shall provide the organization and the health insurance affiliate with notice of the violation and a reasonable opportunity to cure the violation.

3. Application of Title 24-A. The provisions of Title 24-A apply to a health insurance affiliate in accordance with the following:

A. A health insurance affiliate that is a health insurer is subject to all the following provisions:

(1) Title 24-A, section 222;

(2) Title 24-A, section 423-C;

(3) Title 24-A, section 425;

(4) Title 24-A, chapter 47, subchapter IV;

(5) Title 24-A, section 4614, subsections 4 and 6; and

(6) All other applicable provisions of Title 24-A;

B. A health insurance affiliate that is a health maintenance organization is subject to all the following provisions:

(1) Title 24-A, section 222, subsections 2 to 10 and Title 24-A, section 222, subsections 12 to 18;

(2) Title 24-A, section 423-C;

(3) Title 24-A, section 425;

(4) Title 24-A, sections 3474 to 3476;

(5) Title 24-A, section 3483; and

(6) All other applicable provisions of Title 24-A; and

C. The provisions of Title 24-A, section 4214 do not apply to a health insurance affiliate.

4. Control. For the purposes of this section and Title 24-A, section 222, a health insurance affiliate is presumed to be controlled by the nonprofit hospital and medical service organization, notwithstanding that the organization may not have actual control. Notwithstanding that the organization is presumed to control the health insurance affiliate under this subsection, the superintendent may determine that one or more other persons also control the health insurance

affiliate. The superintendent, in the superintendent's sole discretion, may determine that a health insurance affiliate is not controlled by an organization that owns or controls less than 50% of the ownership interests of a health insurance affiliate pursuant to subsection 2, paragraph A.

5. Continuing obligations; penalties. In addition to all requirements for obtaining or maintaining a certificate of authority from the superintendent under Title 24-A, a health insurance affiliate must continuously meet all requirements of this section and Title 5, section 194-A, subsection 7. The superintendent's determination that a health insurance affiliate has failed to meet the requirements of this section or Title 5, section 194-A, subsection 7 constitutes grounds for suspension or revocation of the health insurance affiliate's certificate of authority under Title 24-A, section 417 and grounds for commencement of delinquency proceedings under Title 24-A, chapter 57. Upon any such failure, the superintendent may require any person who owns or controls any ownership interest in the health insurance affiliate to dispose of that ownership interest within the later of 18 months after the date of the failure as determined by the superintendent, 18 months after the superintendent's determination that a failure has occurred or such other time as the superintendent may prescribe. The superintendent may permit one owner to dispose of its ownership interest to another owner.

6. Capital contributions. Any person who acquires any ownership interests in the health insurance affiliate shall make capital contributions in cash or the cash equivalent in proportion to that person's ownership interests in the health insurance affiliate. The superintendent, in the superintendent's sole discretion, may permit other forms of capital contributions that do not have the effect of diluting the ownership or control of the health insurance affiliate by the nonprofit hospital and medical service organization.

7. Transactions with related persons. In addition to the requirements contained under Title 24-A and other applicable law, all transactions between a health insurance affiliate and any related person must be consistent with fair market value in an arm's length transaction. For purposes of this subsection, a "related person" means:

A. Any person who owns or controls an ownership interest in a health insurance affiliate;

B. Any person who is a beneficial owner, as defined in Title 24-A, section 222, subsection 2, paragraph A-1, of any ownership interest in the health insurance affiliate;

C. Any person who, directly or indirectly, has the power to control the management, policies or operations of the health insurance affiliate; or

D. Any affiliate of the health insurance affiliate or of any person described in paragraphs A to C.

8. Distribution of working capital and surplus. No less frequently than annually, a health insurance affiliate shall distribute to those persons who own or control any ownership interest providing for the right to receive dividends or distributions any excess working capital and surplus, subject to rules adopted and decisions issued by the superintendent. Nothing in this subsection limits the authority of the Superior Court under Title 5, section 194-A, subsection 7.

9. Investment restrictions. Any investment by a nonprofit hospital and medical service organization in a health insurance affiliate under this section is subject to all applicable investment restrictions, including, without limitation, Title 24-A, section 222 and Title 24-A, chapter 13-A. A health insurance affiliate in which an organization owns or controls 50% or more ownership interest is deemed to be a subsidiary of the organization for purposes of Title 24-A, section 1157, subsection 5, paragraph B.

10. Aggregate transactions. The superintendent may aggregate any transactions that are part of a plan or series of like transactions to determine whether those transactions comply with this section and other applicable laws.

11. Oversight. In addition to other applicable provisions of this Title and Title 24-A, any person whose domicile is outside the State that owns or controls an ownership interest in a health insurance affiliate and any affiliate of that organization:

A. Is subject to the jurisdiction of the superintendent and the courts of this State; and

B. Must appoint the superintendent as lawful agent for receipt of service of process.

12. Attorney General to intervene. In any proceeding before the superintendent involving the health insurance affiliate in which the Attorney General intervenes, the Attorney General has the right to review all documents or other information received by the superintendent or in connection with the proceeding. The Attorney General is subject to all confidentiality provisions for those documents or information that apply to the superintendent.

13. Rules. The superintendent may adopt rules to carry out the purposes of this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. 6. 24 MRSA §2321, as amended by PL 1991, c. 9, Pt. G, §5 and c. 48, §§1 and 2, is further amended to read:

§2321. Rate filings on individual subscriber and membership contracts

1. Filing of rate information. Every nonprofit hospital and medical service organization shall file with the superintendent, except as to group subscriber and membership contracts other than group Medicare supplement contracts as defined in Title 24-A, chapter 67 and group nursing home or long-term care contracts as defined in Title 24-A, chapter 68, every rate, rating formula and every modification of any of the foregoing that it proposes to use. Every filing under this subsection must state the effective date of the filing. Every filing under this subsection must be made not less than ~~90~~ 60 days in advance of the stated effective date unless the ~~90-day~~ 60-day requirement is waived by the superintendent ~~and the effective date may be suspended by the superintendent~~ for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection 4, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests. In the case of nursing home and long-term contracts, rates filed ~~prior to August 1, 1986, are effective until no later than August 1, 1989. Rates filed on or after August 1, 1986, for these types of contracts~~ are effective for no more than 3 years, except that rates for contracts with guaranteed level premiums are effective for the duration of the contract.

2. Filing information. When a filing is not accompanied by the information upon which the organization supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that the rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the organization to furnish the information upon which it supports the filing. A filing and supporting information ~~is a~~ are public ~~record~~ records within the meaning of Title 1, section 402, subsection 3 and ~~becomes~~ become part of the official record of any hearing held pursuant to section 2322. For the purpose of determining whether the filing produces rates that are not excessive, inadequate or unfairly discriminatory, the superintendent and the Attorney General each may employ consultants, including actuaries, and the reasonable costs of the consultants, including actuaries, which must include costs of testifying at any hearing held pursuant to section 2322, must be borne by the organization making such filing. The organization is not responsible for any costs from the Attorney General exceeding $40,000 for any filing.

~~**3. Three year review.** Every organization must submit the rate filings for contracts set forth in subsection 1 at least every 3 years.~~

4. Criteria for special rate hearings. Any filing of rates, rate formulas and modifications for Medicare supplement contracts as defined in Title 24-A, chapter 67 and for individual health plans as defined in Title 24-A, section 2736-C, subsection 1, paragraph C that satisfies the criteria set forth in this subsection is subject to the provisions of subsection 5.

A. The rate increase for any subscriber may not exceed the index of inflation multiplied by 1.5 excluding any approved rate differential based on age. For the purposes of this subsection, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the superintendent that includes Maine for the most recent 12-month period immediately preceding the date of the filing for which data is available.

B. The nonprofit hospital and medical service organization must demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratios of benefits incurred to premiums earned for said products average no less than 80% for the previous 12-month period.

C. The subscriber reserves of the nonprofit hospital and medical service organization may not exceed the level established by the superintendent.

D. Unless continued or modified by law, this subsection is repealed October 1, 2001.

5. Special rate hearing. A rate hearing conducted with respect to filings that meet the criteria in subsection 4 is subject to this subsection.

A. Any person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing notwithstanding the satisfaction of the criteria in subsection 4.

B. If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing notwithstanding the satisfaction of the criteria in subsection 4.

C. In any hearing conducted under this subsection, the Bureau of Insurance and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are

adequate and not unfairly discriminatory remains with the organization.

D. Unless continued or modified by law, this subsection is repealed October 1, 2001.

Sec. 7. 24 MRSA §§2321-A and 2321-B are enacted to read:

§2321-A. Standards for when filings are inadequate

In reviewing rates and rate modifications filed by a nonprofit hospital and medical service organization in accordance with this Title, the superintendent may not require the organization to charge rates that, taking into account investment income and the appropriate level of subscriber reserves, are inadequate to enable it to recover reasonably anticipated claims and administrative expenses and make reasonable contributions to subscriber reserves.

§2321-B. Appropriate level of subscriber reserves

The superintendent may adopt rules establishing the appropriate level of subscriber reserves. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

Sec. 8. 24-A MRSA §2736, as amended by PL 1985, c. 648, §10, is further amended to read:

§2736. Rate filings on individual health insurance policies

1. Filing of rate information. Every insurer shall file with the superintendent, except as to group policy rates other than those for group Medicare supplement policies as defined in chapter 67, and group nursing home care and long-term care insurance as defined in chapter 68, every rate, rating formula, classification of risks and every modification of any formula or classification ~~which~~ that it proposes to use. Every such filing must state the effective date of the filing. Every such filing ~~shall~~ must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection 3, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests. In the case of nursing home care and long-term care insurance policies, rates filed ~~prior to August 1, 1986, shall be effective until no later than August 1, 1989. Rates filed on or after August 1, 1986, for these types of policies shall be~~ are effective for no more than 3 years, except that rates for contracts with guaranteed level premiums ~~shall be~~ are effective for the duration of the contract.

2. Filing; information. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates ~~shall~~ not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. A filing and supporting information ~~shall be a~~ are public ~~record~~ records within the meaning of Title 1, section 402, subsection 3 and ~~shall~~ become part of the official record of any hearing held pursuant to section 2736-A.

3. Criteria for special rate hearings. Any filing of rates, rating formulas and modifications for Medicare supplement contracts as defined in chapter 67 and for individual health plans as defined in section 2736-C, subsection 1, paragraph C that satisfies the criteria set forth in this subsection is subject to the provisions of subsection 4.

A. The rate increase for any policyholder may not exceed the index of inflation multiplied by 1.5 excluding any approved rate differential based on age. For the purposes of this subsection, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the superintendent that includes Maine for the most recent 12-month period immediately preceding the date of the filing for which data are available.

B. The insurer must demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratios of benefits incurred to premiums earned for those products average no less than 80% for the previous 12-month period.

C. Unless continued or modified by law, this subsection is repealed October 1, 2001.

4. Special rate hearing. A rate hearing conducted with respect to filings that meet the criteria in subsection 3 is subject to this subsection.

A. Any person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing notwithstanding the satisfaction of the criteria in subsection 3.

B. If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing notwithstanding the satisfaction of the criteria in subsection 3.

C. In any hearing conducted under this subsection, the Bureau of Insurance and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate and not unfairly discriminatory remains with the insurer.

D. Unless continued or modified by law, this subsection is repealed October 1, 2001.

Sec. 9. P&SL 1939, c. 24, §3, as repealed and replaced by PL 1993, c. 702, Pt. A, §19, is repealed and the following enacted in its place:

Sec. 3. Purposes. The corporation is organized as a benevolent and charitable institution and a public charity for all purposes and activities permitted to hospital and medical service organizations under the Maine Revised Statutes, Title 24, chapter 19 and for all purposes and activities permitted to health maintenance organizations under Title 24-A, chapter 56. Subject to Title 24 and Title 24-A, the corporation has all of the general powers of corporations under Title 13-B, section 202. The purposes of the corporation include, but are not limited to, the following: providing access to medical care through affordable health insurance and affordable managed care products for persons of all incomes; identifying and addressing the State's unmet health care needs, particularly with regard to medically uninsured and underserved populations; making services and care available through participating providers; and improving the quality of care for medically uninsured and underserved populations.

Sec. 10. Statement of legislative intent. It is the intent of the Legislature that the Maine Revised Statutes, Title 5, section 194-A, subsection 2 confirm the prior declaration of the Legislature, as evidenced in the charter of Associated Hospital Services, Private and Special Law 1939, chapter 24, that the organization is a charitable and benevolent institution.

Sec. 11. Application provisions.

1. Tax exemption. Any nonprofit hospital and medical service organization, as defined in the Maine Revised Statutes, Title 5, section 194-A, and its funds and property are exempt from taxation until such time as the organization converts to a stock insurer or the organization materially changes its form and the Superior Court approves a modified charitable trust plan pursuant to the Maine Revised Statutes, Title 5, section 194-A, subsection 6, establishing a charitable trust that will receive the entire charitable interest in the organization.

2. Superintendent of Insurance; application of standards. When the legal standards applicable to reviewing rate filings of nonprofit hospital and medical service organizations as defined in the Maine Revised Statutes, Title 24, section 2308-A are the same as the legal standards applicable to health insurers under Title 24-A, the Superintendent of Insurance shall apply those legal standards in the same manner in reviewing all components of all rate filings, including, without limitation, loss ratios and reserves. The superintendent may decide in the superintendent's discretion the extent of review to be accorded rate filings based upon a variety of factors including the market share and market power of the organization or insurer in the affected line of insurance.

3. Superior Court; application of standards. The Superior Court in the proceeding set forth in the Maine Revised Statutes, Title 5, section 194-A, subsection 3 shall apply all applicable legal standards, including the legal standards applicable to standing.

4. Existing or future agreements, contracts, rights and relationships. With respect to the determination of the Superior Court pursuant to the Maine Revised Statutes, Title 5, section 194-A, subsection 3, this Act, including the statement of ownership interests and charitable purposes approved by the Superior Court, applies to and controls existing agreements, contracts, rights and relationships now existing or hereafter arising between a nonprofit hospital and medical service organization and its members, subscribers and contract holders.

5. Supremacy of law. With respect to the determination of the Superior Court pursuant to the Maine Revised Statutes, Title 5, section 194-A, subsection 3, this Act supersedes and controls with respect to any other laws of the State or any rules of any administrative agency of the State.

6. Authority of Attorney General and superintendent. This Act does not limit in any way the Attorney General's charitable authority or the Superintendent of Insurance's authority under the Maine Revised Statutes, Title 24 and Title 24-A except as expressly provided in this Act.

7. Transition. Notwithstanding the provisions of the Maine Revised Statutes, Title 1, section 302, any decision and order of the Superintendent of Insurance or decision of the court in an appeal from a decision and order of the superintendent continues in full force and effect after the effective date of this Act, to the extent not inconsistent with the provisions of this Act. This Act applies to any proceeding under the Attorney General's charitable authority pending on the effective date of this Act.

Sec. 12. Bureau of Insurance study. The Bureau of Insurance shall conduct, or cause to be conducted, a study of the market impact of reduced regulation of rates for Medicare supplement contracts and individual health plans. The study must include

examination of the competitiveness of the Medicare supplement and nongroup lines of insurance; the impact, if any, of managed care on nonprofit hospital and medical service organization and health insurance rates for these lines; the impact, if any, of 1997 statutory changes affecting the rates of these lines; and the continued need for review of rate filings for these lines. By January 1, 2001, the Bureau of Insurance shall submit a report of the study, including recommendations and any necessary legislation regarding whether these statutes should be amended, to the joint standing committee of the Legislature having jurisdiction over insurance matters.

Sec. 13. Allocation. The following funds are allocated from Other Special Revenue to carry out the purposes of this Act.

1997-98

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Bureau of Insurance

All Other	$85,200

Allocates funds for the costs of retaining certain consultants needed to conduct a required study.

See title page for effective date.

CHAPTER 345

H.P. 870 - L.D. 1187

An Act to Improve the Transition of People with Disabilities from Children's to Adult Services

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

Sec. 1. 20-A MRSA §7258 is enacted to read:

§7258. Transition to adult services

1. Attendance at pupil evaluation team meetings. Annually, representatives from appropriate state service agencies, as determined by the pupil evaluation team of the school administrative unit, and in accordance with special education rules, shall designate a transition contact person to participate in transition planning for students with disabilities. The transition contact person shall attend pupil evaluation team meetings or provide relevant information to the pupil evaluation team for transition planning purposes. This requirement applies to students with disabilities who have attained 16 years of age, or 14 years of age when determined by the pupil evaluation team to be appropriate.

2. Documentation. Annually, the transition planning team shall complete documentation that estimates the amount and type of anticipated services the pupil will require upon aging out or graduation and submit this annual documentation to the Department of Education. The department shall transmit the data to the appropriate state service agency.

3. Budget. State service agencies shall show evidence of having used the documentation completed pursuant to subsection 2 to develop their biennial budget beginning with the biennium ending June 30, 1999.

See title page for effective date.

CHAPTER 346

H.P. 9 - L.D. 6

An Act to Allow Certain County and Municipal Officials to Serve on the Maine Land Use Regulation Commission and the Board of Environmental Protection

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

Sec. 1. 12 MRSA §683, first ¶, as amended by PL 1995, c. 3, §2, is further amended to read:

The Maine Land Use Regulation Commission, as established by Title 5, section 12004-D, subsection 1 to carry out the purposes stated in section 681, is created within the Department of Conservation, and in this chapter called the "commission." The commission is charged with implementing this chapter in all of the unorganized and deorganized areas of the State. The commission consists of 7 public members, none of whom may be state employees, who must be appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over conservation matters and to confirmation by the Legislature, for staggered 4-year terms. Among the public members, there must be 4 who must be knowledgeable in at least one of each of the following areas: commerce and industry; fisheries and wildlife; forestry; and conservation. Of the potential appointees to the commission, the Governor shall actively seek and give consideration to persons residing in or near the unorganized areas of the State and to persons residing on unorganized coastal islands. At least 2 members must be residents within