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STATE OF MAINE

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insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985. All services provided by a health care practitioner in an office setting must be submitted on the standardized federal form used by noninstitutional providers and suppliers. Services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner. For purposes of this section, "office setting" means a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility.

Sec. 3. 24-A MRSA §2823-B, as amended by PL 2003, c. 469, Pt. D, §7 and affected by §9, is further amended to read:

§2823-B. Standardized claim forms

All insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985. All services provided by a health care practitioner in an office setting must be submitted on the standardized federal form used by noninstitutional providers and suppliers. Services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner. For purposes of this section, "office setting" means a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility.

Sec. 4. 24-A MRSA §4235, as amended by PL 2003, c. 469, Pt. D, §8 and affected by §9, is further amended to read:

§4235. Standardized claim forms

All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. A health maintenance organization may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985. All services provided by a health care practitioner in an office setting must be submitted on the standardized federal form used by noninstitutional providers and suppliers. Services in a nonoffice setting may be billed as negotiated between the health maintenance organization and health care practitioner. For purposes of this section, "office setting" means a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility.

See title page for effective date.

CHAPTER 98

S.P. 108 - L.D. 346

An Act To Amend Group Insurance Funding Requirements

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

Sec. 1. 39-A MRSA §403, sub-§3, as amended by PL 1999, c. 113, §30 and by PL 2001, c. 44, §11 and affected by §14, is further amended by amending the first blocked paragraph to read:

A self-insurer may, with the approval of the Superintendent of Insurance, use the following types of security to satisfy the self-insurer's responsibility to post security required by the superintendent: a surety

bond; an irrevocable standby letter of credit; cash deposits and acceptable securities; and an actuarially determined fully funded trust. For purposes of this section, "tangible net worth" means equity less assets that have no physical existence and depend on expected future benefits for their ascribed value. ~~A~~ Unless disapproved by the superintendent pursuant to paragraph C, subparagraphs (5) and (6), a group self-insurer that maintains a trust actuarially funded to the confidence level required by the superintendent may use an irrevocable standby letter of credit as follows: only in an amount not greater than the difference between the funding to the required confidence level and funding to the confidence level reduced by 10 percentage points; only as long as the trust assets are not used as collateral for the letter of credit; and only as long as the value of trust assets, excluding the value of the letter of credit, are at least equal to the present value of ultimate ~~expected~~ incurred claims, claims settlement costs and, if determined necessary by the superintendent, administrative costs.

Sec. 2. 39-A MRSA §403, sub-§3, ¶C, as amended by PL 1995, c. 619, §7, is further amended to read:

C. A self-insurer may establish an actuarially determined fully funded trust, funded at a level sufficient to discharge those obligations incurred by the employer pursuant to this Act as they become due and payable from time to time, as long as the Superintendent of Insurance requires that the value of trust assets be at least equal to the present value of ultimate expected incurred claims and claims settlement costs, plus required safety margins and, if determined necessary by the superintendent, administrative costs for the operation of the plan of self-insurance. For the purpose of determining whether an actuarially determined fully funded trust has a surplus of funds in excess of that required by this subsection, the superintendent shall consider, based upon the group's audit for all completed plan years, only the following assets held outside the trust account: cash up to $10,000; accounts receivable, limited to amounts collected and deposited in the trust account by the date of the surplus distribution; accrued interest on trust account assets that will be collected and deposited in the trust account within 6 months from the date of the surplus determination; tangible assets that will be converted to cash and deposited in the trust account prior to the distribution date of any surplus; and a letter of credit to be used to partially fund the trust to the extent allowed under this section and rules adopted by the superintendent, as supported in the actuarial review. The superintendent shall consider cash held outside the trust account in excess of $10,000 if the self-insurer provides, to the superintendent's satisfaction, documentation regarding why the money is being held outside the trust account. An actuarially determined fully funded trust must be funded as follows, as determined by the superintendent.

(1) For individual and group self-insurers, the amount of security must be determined based upon an actuarial review. The actuarial review must take into consideration the use by a group self-insurer of any irrevocable standby letter of credit. Except as provided in subparagraph (3), initial funding for each plan year must be maintained at the 90% or higher confidence level. Funding after the completion of the initial plan year may be established no lower than the 75% confidence level if the following has occurred:

(a) A year considered for reduction is completed;

(b) The supporting actuarial review includes an evaluation of the completed year experience with claims evaluated not less than 6 months from the end of the plan year, or in the case of a group self-insurer in existence for at least 36 months, not less than 4 months from the end of the plan year; and

(c) For individual self-insurers, prior approval from the superintendent is obtained.

For the purposes of determining the confidence level, all completed years at the same confidence level may be aggregated. For individual self-insurers, funds may not be released from the trust or transferred between years except as approved by the superintendent. The governing body of a group self-insurer may at any time declare a surplus of funds above the required confidence level, but may only release funds after the completion of any plan year. The superintendent may request information regarding any such declaration. Any distribution of surplus must be based upon an actuarial review of all outstanding obligations for all completed plan years, an audited financial statement of the group for all completed plan years and a surplus distribution worksheet for all completed plan years on a form approved by the superintendent. The group self-insurer must provide the required information within 10 days after the distribution. Any surplus de-

cleared or distributed pursuant to this paragraph is subject to adjustment after review by the superintendent within 60 days of the receipt of the required information. Any deficit below the required confidence level, as determined by the superintendent, that results from a distribution under this paragraph must be funded within 45 days from the date of the notice by the superintendent.

(2) A group self-insurer may elect to fund at a higher confidence level through the use of cash, marketable securities or reinsurance. If a member of a group self-insurer terminates membership in the group for any reason, that member shall fund the member's proportionate share of the liabilities and obligations of the trust to the 95% confidence level. If for any reason the departing member fails to fund the member's proportionate share of the trust's exposure to the 95% level of confidence, the remaining members of the group shall make the additional contribution no later than the anniversary date of the program as required to fund the departing member's exposure in accordance with this provision.

(3) ~~Depending upon the financial condition of the self-insurer, and if approved by the superintendent~~ Subject to prior approval by the superintendent in accordance with subparagraph (5), a self-insurer that has successfully maintained an actuarially determined fully funded trust for a period of 5 or more consecutive years may fund all years, including the prospective fund year, ~~in the aggregate~~ at the 75% or higher confidence level in the aggregate and a group self-insurer that has successfully maintained an actuarially determined fully funded trust for a period of 10 or more consecutive years may fund all years, including the prospective fund year, at the 65% or higher confidence level in the aggregate.

(4) Trust assets must consist of cash or marketable securities of a type and risk character as specified in subsection 9. The trustee shall submit a report to the superintendent not less frequently than quarterly that lists the assets comprising the corpus of the trust, including a statement of their market value and the investment activity during the period covered by the report. The trust must be established and maintained subject to the condition that trust assets may not be transferred or revert in any manner to the employer except to the extent that the superintendent finds that the value of the trust assets exceeds the present value of incurred claims and claims settlement costs with an actuarially indicated margin for future loss development. In all other respects, the trust instrument, including terms for certification, funding, designation of trustee and payout, must be as approved by the superintendent, except that the value of the trust account must be actuarially calculated at least annually by a casualty actuary who is a member of the American Academy of Actuaries and adjusted to the required level of funding.

(5) In determining whether a self-insurer that maintains an actuarially determined fully funded trust qualifies for a reduction in the required confidence level pursuant to subparagraph (1) or (3) or is subject to an enhanced confidence level pursuant to subparagraph (6), the superintendent shall consider the financial condition of the self-insurer in relation to the potential workers' compensation liabilities. The factors the superintendent may consider include the self-insurer's liquidity, leverage, tangible net worth, size and net income. For group self-insurers, the superintendent's review must be based on the aggregate financial condition of the group members. At the request of the superintendent, a group self-insurer shall report relevant financial information, on a form prescribed by the superintendent, at such intervals as the superintendent directs. The superintendent may establish additional review criteria or procedures by rule. Rules adopted pursuant to this subparagraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

(6) If the superintendent determines, based on an evaluation of a self-insurer's financial condition pursuant to subparagraph (5), that the confidence level at which the self-insurer has been authorized to fund its trust is not sufficient to provide adequate security for the self-insurer's reasonably anticipated potential workers' compensation liabilities, the superintendent shall make a determination of the appropriate confidence level and order the self-insurer to take prompt action to increase funding to that level within 60 days.

See title page for effective date.